DISSERTATION

Clinical Pastoral Education (CPE) and the Phenomenology Suffering in the Lived-Experience and Life-World of Clinical Pastoral Care Educators and Practitioners in Hospital Clinical Organizations (HCOs)

By

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Dedication

This dissertation is *dedicated* to the *Founders and Pioneers* of the *Clinical Pastoral Education Movement*, who used both *head and heart* to *care for* and *cure souls*, and to the *Confessors of the Faith* (COFs) in all ages. My work is also *dedicated* to my wife Wanda, who supported me with her understanding and loving spirit, and using her degree in Professional Communications read through three revisions of this work. She added an extra set of eyes, editorial insights and helpful suggestions in the effort to clear the forest of grammatical and syntactical impediments, so that my conceptual ideas could be better seen in the light of my horizon of understanding the Clinical Pastoral Education Movement.

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CLINICAL PASTORAL EDUCATION & THE PHENOMENOLOGY OF SUFFERING

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Abstract

Purpose: This dissertation's goal is to begin constructing a *phenomenology of suffering* and a related body of literature needed to develop *clinical pastoral education* (CPE) curriculums. ***Problem:*** There is no body of literature focused on the *phenomenology of suffering* for developing CPE curriculums. **Significance:** With this development CPE could improve reflective/reflexive learning among its student practitioners that is needed to achieve the CPE project of *caring for* and *curing souls* within HCOs. ***Methods:*** This dissertation uses *hermeneutic* and *transcendental phenomenological* methods (e.g. *horizonalization*) to developed clusters of thematic meaning to understand how clinical pastoral educators and practitioners experience suffering. This data can help CPE develop curriculums for educating its students. ***Findings:*** There are *five educational deficiencies* in CPE that can be cured by a new focus on *phenomenology of suffering*: *Deficiency I - CPE Learning Model* - clinical practitioner's feelings of *empathetic inversion* hampers efforts to do spiritual needs assessment of patient's. *Deficiency II - Clinical Verbatims* are used as pedagogical tool but not as research tools. *Deficiency III - Reflective/Reflexive Learning* – CPE student practitioners are not able to uncover horizons of meaning from experiences of suffering. *Deficiency IV - Spiritual Needs Assessment* - CPE student practitioners are unable to identify clusters of thematic horizons of *spiritual needs* contributing to spiritual suffering). *Deficiency V – Ethics of Care* - CPE student practitioners lacks focus on social justice as close attentiveness to others. This is essential to their pedagogical and clinical pastoral professional praxis. ***Keywords:*** *empathetic inversion; ethics of care; phenomenology; horizonalization; thematic horizons; reflective/reflexive learning; phenomenology of suffering; clinical pastoral care.*

CHAPTER 1: INTRODUCTION

This dissertation explores the "reflective" *lived experiences* of clinical pastoral care practitioners in the context of their *life world* dealing with the phenomenon of human suffering. The primary goal of this dissertation is to determine the thematic categories that emerge from these experiences so that a *phenomenology of suffering* can be constructed for pastoral care education. This primary goal also includes gathering a body of literature related to the phenomenology of suffering so that Clinical Pastoral Educators can design and development more effective CPE curriculums for its student practitioners, who are trying to become chaplaincy professionals in this human science discipline of care.

This dissertation uses both transcendental phenomenology (Moustakas, 1994), and hermeneutic phenomenological methods using a swing hermeneutic (i.e. back and forth hermeneutic-dialectic). This two phenomenological research methods are in order to understand the meaning of clusters of thematic *horizons* emerging from interview and textual data on the *phenomenon of suffering* that is gathered from CPE clinical pastoral care practitioners (i.e. professional Chaplains, CPE educators and students). (Van Manen, 1990, pp. 77-78; Gerlandson, Harris, Skipper, & Allen, 1993, pp. xiv-xv). These two basic phenomenological researcher methods will be used to acquire this data. Research on this topic is necessary so that:

(A) A new and/or gathered body of literature on the topic can help researchers develop a educational philosophy and research methodology for clinical pastoral care, which can be used to design and develop CPE higher education curriculums; (B) Pastoral care practitioner's can learn new educational theoretical perspectives and acquire new

didactic research tools to help them understand human suffering from a bio-ethical and social justice perspective in respect to human autonomy and wellbeing; and (C) Clinical pastoral education (CPE) can be provided a *phenomenology of suffering* research focus and literature that allow the to improve reflective/reflexive praxis and advance the CPE project of caring for and curing souls, that is, assessing spiritual needs and providing interventions to overcome spiritual suffering of patients domiciled in hospital clinical organizations such as The Christ Hospital (TCH) of Cincinnati, Ohio.

The human science discipline clinical pastoral education seeks to teach its clinical pastoral practitioners is how to deal with human suffering so that they can contribute to the rapid healing and wellbeing of patients in hospital clinical organizations (HCOs). However, the literature review in this dissertation demonstrates that there is little to no research being done in the area of pastoral care on the *lived experience* of pastoral care practitioners dealing with this phenomenon in HCOs. Consequently, pastoral care educators do not recognize how this research added to CPE curriculums would help practitioners contribute to the goals of their discipline. The first step toward the constructive goal of this dissertation is to access the higher education needs within CPE by interviewing CPE faculty and pastoral clinical practitioners using qualitative methods of phenomenology to understand their *lived-experience* and *life-world* of chaplaincy. Some of these pastoral clinical practitioners have long since completed their formal training and are now teaching others. Some have completed formal CPE Level I and II training in the last two or three years and are contemplating specialty chaplaincy professional areas (e.g. surgical chaplaincy, palliative care, critical care, grief chaplaincy, etc.). All are dedicated to the CPE project of caring for and curing souls.

This dissertation wants to know how pastoral clinical practitioners deal with human suffering and what they believe they need in the way of clinical training and didactic studies in order to effectively practice this human science discipline. Clinical Pastoral Education has long been called a human science of *head and heart* because it attempts formulate a *clinical theology* combined with *theological reflective/reflexive praxis* on human experience of illness. It has the goal of *caring for* and *curing souls*, which means that this *human science discipline of spiritual care* wants to access the *spiritual needs* of patients that are suffering from various physical, emotional, mental maladies, and how these maladies contribute to *spiritual suffering*.

This dissertation claims what is missing from CPE clinical/didactic education is a pedagogical focus on a *phenomenology of suffering* embodied in CPE literature or allied literature that can be used as theoretical basis for a deeper analysis of human suffering. This dissertation claims that CPE cannot effectively provide spiritual needs assessment and interventions to address spiritual suffering of patients without a new pedagogical focus on the *phenomenology of suffering*.

This dissertation supports its claims, conclusions, and findings using phenomenological analysis with ten interviews of CPE educators and clinical pastoral care practitioners, including analyzing the statements and claims of CPE witnesses from various human textual sources that also practice within this human science discipline. CPE has long focused on "studying living human documents" (Hall, 1992, p. 12). Van Manen (1990) has stated: "Hermeneutic phenomenology is a human science which studies persons," that is, the *life-world* and *lived-experience* of unique persons, who are "incomparable, unclassifiable, uncountable, irreplaceable," (Van Manen, 1990, p. 6).

This dissertation reveals a cluster of themes that emerges from a special group of these persons, who happen to deal daily with illness, suffering and sometimes death. This phenomenological exploration supports the idea that a *phenomenology of suffering* is needed in order to help these professional persons in the human science of Clinical Pastoral Education using their *head and heart* to achieve its historic goal of *caring for* and *curing souls*.

Hermeneutic phenomenology claims that one can only truly know that which you love, and that *love* and *care* are the foundation of true human science research that studies the *lived experience* of persons in their *life world*. (Van Manen, 1990, pp. 6-7). However, the research challenge lies in the fact that phenomenology, whether *hermeneutic* or *transcendental* in approach only *describes* or *reveals* clusters of meaning and themes around a person's experience of any particular phenomenon that is being examined for meaning. Therefore, phenomenology does not by itself allow a researcher to get at the kernel of the meaning of the human experience, but merely opens the door to allow entry into the experience as the researcher approaches the other who is suffering with their own life-world and lived-experience as a participant/contributor to a new horizon of understanding about what it means to suffer, or to be ill, or to experience an end-of-life situations, which is that dreadful and awful experience that contemplates *non-existence* embodied in our human mortality as consciousness as "being by which nothingness comes to things" (Sartre, 1943, p. 57). This dissertation is in part about the special people that practice the human science of spiritual care that *comes alongside, being there with,* and *walking with* the other on their journey of suffering, and who are specially educated to do so.

Nevertheless, this dissertation is concerned that these specialized group of people do not have all of the pedagogical, theoretical and methodological tools its needs to effectively accomplish the CPE project of *caring for* and *curing souls*. This dissertation claims that once phenomenology uncovers, discovers, or reveals meaning around the human experience of any particular phenomenon, in this case human suffering as experienced by clinical pastoral care practitioners, then reflective/reflexive practice and learning must be engaged in so that a new horizon of understanding of meaning is achieved. The "reflective act" according to Van Manen (1990) ensures that "Lived experience is the starting point and end point of phenomenological research. The aim of phenomenology is to transform lived experience into a textual expression of essence---in such a way that the effect of the text is at once a reflective re-living and a reflective appropriation of something meaningful: a notion by which a reader is powerfully animated in his/her own lived experience." (Van Manen, 1990, pp. 36, 38).

Reflective/reflexive phenomenological praxis is not only necessary for research, but is a process with which clinical pastoral care practitioners must engage in order to enter into the life-world and lived experience of patient/clients in HCOs, who are suffering spiritually, physically, emotionally, and/or mentally. They must engage in this phenomenological reflective/reflexive process in order to proceed with their mission of *caring for* and *curing souls*. Fortunately, the Clinical Pastoral Education Movement, which began in 1925, already has the essential elements necessary that would allow the incorporation of *phenomenology of suffering*, along with its reflective/reflexive and methodological components enter into its clinical and educational praxis. The contributions of CPE's founders and pioneers made this possible, as follows:

(1) Richard C. Cabot, M.D., one the chief founders affirmed that CPE could address spiritual suffering by using the findings from case study methodology in HCO clinical settings. Dr. Cabot did not see any inherent contradiction between *medical science* and *religion*, and he felt that a seminarian should "practice his theology where it is most needed . . . in personal contact with individuals in trouble" (Hall, 1992, p. 6); (2) Anton T. Boisen, the second main founder of the CPE Movement, maintained the view that qualitative methods (primarily case study) could produce empirical findings that would allow CPE practitioners using both *head and heart* discover "the interrelationship of religion and mental illness" (Hall, 1992, p. 9); and (3) Helen F. Dunbar, Ph.D., formally trained in psychiatry, "viewed science and religion as two facets of a single understanding . . . not antagonistic, but complementary . . . . While religion shared with medicine the aim of alleviating men's pain, religion held the specific task of 'guiding men in their adjustment to their total environment, outer and inner,' including 'that adjustment to the Infinite. . . ." (Hall, 1992, p.17).

More importantly Dunbar introduced into CPE praxis something she called "insight symbolism," which is a reflective/reflexive method that allowed entry into the meaning of suffering of the whole person. Hall (1992) states: "Dunbar was convinced that clergy with formal theological training and with clinical training could contribute to healing and health. Implicit in her view was the belief that both medicine and religion must focus on the whole person, albeit using different approaches." (Hall, 1992, p. 17).

No matter the starting point or perspective of these founders and pioneers of Clinical Pastoral Education they all believed they were engaged in the research task of constructing a *clinical theology* (Hall, 1992, p. 11) that would lend itself to the CPE

project of *caring for* and *curing souls*. This CPE aphorism refers to the clinical pastoral professional vocation of *assessing spiritual needs* in order to provide a *cure of spiritual suffering*, which is often related to the onset of human physical, emotional and mental illnesses. Clinical theology would then include theological reflective/reflexive praxis not on theological doctrine, but rather on human experience of phenomenon that brings about maladies of the body, mind and human spirit.

Phenomenology allows the researcher and/or the clinical pastoral educator and practitioner to *see* or *gaze* into meaning of human experience of phenomenon. However, reflective/reflexive praxis allows the researcher and/or clinical pastoral practitioner *to enter into the experience of human phenomenon*, in order to gain insight into the meaning of symbols. Ricoeur (1967) wrote a book on the phenomenology of evil, which he entitled *The Symbolism of Evil*. He called this gaining insight or seeing into something or *meaning symbols* the "advanced point of this awareness aroused by the absolute Seeing . . . . to penetrate into the enclosure of salvation through the strait gate of truth . . . This faith in the truth and justice of the Seeing" (Ricoeur, 1967, p. 85). People use symbols to describe phenomenon, such as suffering. For Ricoeur (1967) this a reflective/reflexive *interrogative act* that brings one to awareness of the phenomenon that is being experienced and seeks to prevent oneself while engaged in this *interrogative act* from becoming a mere object of what one experiences in ones *life-world*. Seeing oneself is the key to achieving this level of reflective/reflexive consciousness. Ricoeur (1967) states:

> The examination of conscience is thus justified: my own observation of myself is the attempt of self-awareness to approximate the absolute view; I desire to know myself is interrogation, the putting in question of the meaning of acts and

> motives. The absolute view separates the appearance from the reality by the sharp edge of suspicion. Suspicion of myself is thus the taking up by myself of the absolute viewpoint; it co-operates thus with the growth of interrogative thought, which perhaps owes more to the problem of evil than to the enigmas of meteorology. . . . This faith in the truth and justice of the Seeing (Regard) will have to grow weaker before the believer feels himself become an object. Consciousness congealed into an object arises from the decomposition of the primordial relation of the absolute Seeing to the Self." (Ricoeur, 1967, p. 85).

"Seeing to the Self" (Ricoeur, 1967, p. 85) is described necessarily by *meaning symbols* that describe the reflective/reflexive experience of the phenomenon in ones life-world. Phenomenologist, such as, Moustakas (1994) and Van Manen (1990) are going to refer to these *meaning symbols* as *clusters of thematic horizons*. Dunbar suggests, according to Hall (1992), that these meaning symbols or horizons of meaning that describe phenomenon can be accessed through reflective/reflexive praxis by her *insight symbolism*, "and indicated that symbols seek to express an underlying unity in life. (Hall, 1992, p. 17). Husserl (1999) thought that *seeing or gazing into the pre-given life-world* requires a *certain way of seeing*, as he states in his classic essay "Elements of Science of the Life World":

> Now if this pregiven world is to become a subject of investigation in its own right, so that we can arrive, or course, at scientifically defensible assertions, this requires special care in preparatory reflections. (Husserl, 1999, p. 363). In order to prepare the way for this new subject of investigation, which also essentially concerns the life-world but is not ontological, we shall undertake a general

> reflection---we, that is, as waking, living human beings in the life-world . . . . This general reflection will at the same time have the function of making evident an essential distinction among the possible ways in which the pregiven world, the ontic universe . . . can become thematic for us. Calling to mind what has repeatedly been said: the life-world, for us who wakingly live in it, is always already there, existing in advance for us, the "ground" of all praxis whether theoretical or extratheoretical. The world is pregiven to us, the waking, always somehow practically interested subjects, not occasionally but always and necessarily as the universal field of all actual and possible praxis, as horizon. To live is always to live-in-certainty-of-the-world. Waking life is being awake to the world, being constantly and directly "conscious" of the world and of oneself as living in the world, actually experiencing . . . and actually affecting the ontic certainty of the world. (Husserl, 1999, p. 375).

For Husserl (1999) seeing or reflecting on the pregiven life-world (i.e. the world in is primordial state of existence and the phenomenon that go with it) is the "ground of all praxis whether theoretical or extratheoretical" (Husserl, 1999, 375). For Husserl (1999) the world in its primordial state is our ontic universe (i.e. our life-world) that "can become thematic for us" (p. 375), and of course we describe this ontic thought world with thematic symbols.

In order for a clinical pastoral practitioner to gain access to the *ontic thought world* of his or her patient that uses meaning symbols to describe how they are experiencing the phenomenon of suffering, he or she must have a working understanding of phenomenology and phenomenological methodology, which is the theoretical and

methodological component of human science that specializes in seeing or gaining new horizons of insight into the meaning of phenomenon for humans. If the clinical pastoral practitioner, because of some *educational or clinical deficiencies*, do not have this phenomenological capability or the pedagogical tools to gain insight or entry into these human experiences that have to do with suffering, then they will not be able to access the spiritual needs of patients, who are undergoing various forms of spiritual suffering. It is therefore critical for CPE to have a *phenomenology of suffering* if its practitioners are going to be capable of pursuing the CPE project of *caring for* and *curing souls*.

The power inherent in this new horizon of understanding CPE will allow this dissertation to go beyond the philosophical and theoretical notions of Heidegger's *being together with* the other. Heidegger posits aphoristic notion to describe how one overcomes the dilemma of "Two beings which are objectively present with the world and are, moreover, *worldless* in themselves, can never "touch each other, neither can *"be" "together with"* the other" (Heidegger, 1953, p. 52).

It will become apparent in the data analysis portion of this dissertation that clinical pastoral practitioners believe they can overcome this Heideggerian dilemma by physically and spiritually *being there* or *present with* persons who are suffering, especially in grief or end-of-life situations. To go beyond Husserl's notion of just *being there* for the other in their pre-given "objectively true . . . life world" (Husserl, 1999, p. 369), phenomenology holds that one must love the other enough to *risk entering into their life world*, knowing that it will impact and perhaps change the life world of the pastoral care giver. We will see that pastoral clinical practitioners engage in *empathic inversion* to protect themselves from the impact of the other's life-world. *Empathetic*

inversion would be the natural human sensitivity to suffering and wanting to help the other coupled with the aversion to suffering, "because the dying" or suffering "patient" confronts a caregiver "with their own mortality." (Rando, 1984, p. vii).

In this dissertation *empathetic inversion* will be identified as one of clinical pastoral education's *pedagogical and clinical deficiencies* that while naturally human (i.e. the need *self-preservation*) actually prevents these pastoral care givers from assessing the patients *embodied spiritual needs* that indicates various forms of *spiritual suffering* associated with physical and emotional illnesses of both body and mind.

In practice Husserl's (1999) notion of *being there* or *being with* the *other* in their suffering is being accomplished by CPE palliative care strategies and methods, where the caregiver attempts within the context of a medical team to *come along side* the person who is suffering. The argument that phenomenology alone is insufficient to accomplish the CPE project in *caring for* and *curing souls* belonging to the other does not mean that phenomenology (especially the transcendental understanding) has no deeper relevance for the CPE project for caring for and curing the soul. Clinical pastoral praxis are indeed potent but this dissertation claims are not sufficient for the CPE project. In fact transcendental phenomenology not only is relevant; but also is critical to the CPE project, when this phenomenological approach is properly understood and applied to human suffering situations in HCOs like The Christ Hospital (TCH). Moustakas (1994) explains in his understanding of Husserl's philosophy. Moustakas (1994) states:

> The Other is not directly within me. Otherwise, Husserl (1977) asserts, the Other and I would be the same (p. 109). Thus my relationship to the Other is that of a copresence. I am aware that there is another body coexisting with my body and of

> similar appearance. This makes possible the analogizing apprehension "of that body as another animate organism" (Husserl, 1977, p. 111). Through analogy, I apprehend the other in a livingly present sense. "*Ego and alter ego* are always and necessarily given in an original 'pairing' " (Husserl, 1977, p. 112). "Pairing" is the way in which I experience someone else. In "pairing," the Other is within me and I within the Other. My existence and the Other's existence is copresent in intentional communion. This community sense exists as possibility in every human being. In principle, there is within me a realm of virtually infinite access to other human beings." (Moustakas, 1994, p. 37).

While I believe Moustakas is right about this, nevertheless I believe that the key to accessing this pre-given natural condition of pairing with the Other inherent to each human person is reflective/reflexive learning and practice. In the case of CPE this is theological reflective practice grounded in clinical theology. The other important aspect that Moustakas (1994) mentions is that the Other is not just understood in isolation of that persons life-world, and for that matter is not and perhaps cannot be understood outside the sometimes competing life-worlds of other people, including that life-world of the pastoral clinical practitioner and caregiver. These competing life-worlds are community's in which *lived-experience* of each the other are carried out, so that Moustakas (1994) can rightly say that this "community sense exists as possibility in every human being. In principle, there is within me a realm of virtually infinite access to other human beings" (p. 37). There is not better contextual situation where this notion of community is carried on daily than in HCOs, such as The Christ Hospital (TCH). Therefore it is incumbent on this dissertation to later discuss what community is, and its contextual role and

importance for constituting the reflective/reflexive life-world of pastoral clinical caregivers, who must learn to understand the special HCO community of patients, families, medical and professional staff in respect to *institutional social justice*. For the pastoral care practitioner to understand institutional social justice, bio-ethics, and how HCO administrative policies impact patient human autonomy. They need to know and understand that HCOs are powerful institutions that have within it competing communities of interest (i.e. patients and families, medical staff, and other clinical professionals) and that this organizational context where social injustice can occur quite easily. They therefore need to know what their moral/ethical role is within this organizational community dedicated to healing and how it might negatively impact the CPE project of *caring for* and *healing the soul* of those who are suffering.

Nevertheless, this dissertation issues a caution in respect to a total reliance on a *phenomenology of suffering* focus to cure all of CPE's pedagogical deficiencies. Phenomenology, while extremely important for the CPE project of *caring for* and *curing souls* is still insufficient for clinically determining through seeing and insight the meaning symbols the *spiritual needs* of people that are *spiritual suffering*. Reflective/reflexive praxis has to evolve also as a CPE human science component along with phenomenological method in order to acquire the cluster of thematic meaning (i.e. horizons of meaning) that emerge from phenomenological research. These two components are the key that opens the mind to new horizons of understanding and insight into the phenomenon suffering.

Moustakas (1994) uses Husserl's notion of *intersubjectivity* as the concept closest to what is meant in this dissertation by *reflection/reflexivity* as the key and gateway to

understanding emergent clusters of meaning surrounding someone else's experience of phenomenon and states: "I must first explicate my own intentional consciousness through transcendental processes before I can understand someone or something that is not my own, someone or something that is apprehended analogically. My own perception is primary; it includes the perception of the other by analogy." (Moustakas, 1994, p. 37).

This dissertation holds that there are a number of problems with this conception of *intersubjectivity* as a *reflective/reflexive method* of entering into another's experience of phenomenon. According to Caraway (2012): "Actually, my own perception is primary and NEED NOT DEPEND ON or include the other's perception, which may or may not be like or different from mine" (Caraway, 2012, Comments). Also this conception of intersubjectivity cannot go any further than analogous intentional consciousness, where one can come no closer to the other person's experience of phenomenon than mere empathy (i.e. putting yourself in the others shoes). This is not likely to be sufficient in helping the clinical pastoral care practitioner be successful in the CPE project of *caring for* and *curing souls*. Apparently, every human has the capacity for intersubjectivity, but are these specially trained pastoral care clinicians skilled in reflective/reflexive praxis and learning that brings *seeing* and *insight* into the human situation in order to accomplish the CPE project?

Intersubjectivity of consciousness, which is described only as analogous to the other persons experience of any particular phenomenon, is inadequate for the CPE project of *caring for* and *curing of soul*, is because experience of the phenomenon, especially suffering is *embodied experience*. This means that a person experiences suffering as an embodied experience of all dimensions of the ailment. If a person has cancer they do not

just experience the physical cancer systems. They also experience the associated anxiety of the possible end of life and therefore non-existence of whom they are, which includes physical existence. The spiritual dimensions of this embodiment cannot therefore be overlooked simply because someone believes or some anti-clerical view holds that religion and/or spirituality has nothing to do with the process of suffering or dying. The person just physically ceases to exist and that is all to it. There is neither need for religion and medicine nor room for the priest or minister in healing of the human person.

Fortunately, for those suffering at this acute level of human anxiety not all people believe this. According to Hall (1992) Anton Boisen, called "the father of clinical pastoral education," believed that religion could not be separated from embodiment problem or paradox of illness, and said: "If our findings are correct, the problem of mental illness centers in the disorganizations of the philosophy of life. It has to do with the sufferer's attitude toward his world and his conception of this own place therein. To understand his difficulty without taking account of his religion is therefore an utter impossibility." (Hall, 1992, p. 11).

Besides this notion Hall (1992) points out that Helen Flanders Dunbar, another of the early pioneers of the CPE Movement believed that embodied experience of illness could not be understood apart from its interrelatedness to faith of the individual and how the phenomenon that is apart of life is expressed by means of symbols, including those involved with religion and medicine. She was not anti-clerical but chided pastoral care providers and ministers that failed to recognize that they was a deficiency of their craft in respect of understanding the importance of symbolism used to describe phenomenological meaning. Hall (1992) states:

> Dunbar was convinced that clergy with formal theological training and with clinical training contributed to healing and health. Implicit in her holistic view as the belief that both medicine and religion must focus on the whole person, albeit using differing approaches. "Dunbar repeatedly chastised her clerical colleagues fro 'inadequate handling of the symbols through which religious concepts are expressed to the people' . . . . She warned that the people were 'in a period of unbelief today because we have forgotten the meaning of symbolism' and how to use it. . . . If a symbol be taken to have meaning in the realm of the intellect only and has failed to develop in the realm of the emotions or vice versa, infantile reactions persist I the personality which causes the individual to lose faith in himself and in the universe." . . . . Dunbar's emphasis on the interrelatedness of the intellect and emotions, as well as her holistic approach to understanding the meaning of life, helped shape the Clinical Pastoral Education Movement." (Hall, 1992, p. 17).

Another CPE pioneer voice in this chorus to explain and define the role of religion in the life-world and lived-experience of people who suffer and how to train pastoral clinical practitioners to understand the connections, including the close relationship between religion and embodied experience of real phenomenon in the life-world of human person who suffer came from Carroll Wise. Hall (1992) states:

> For Wise, religion was the integrating factor in life and this integration, he believed, came through the meaning of religious symbols. Religious symbols of action, object, color and sound varieties are woven into religious ritual. . . . Word symbols are woven into creeds and beliefs. . . . Being the structuralization of inner

> experience, creeds and beliefs raise meanings to a conscious level, even though all the components of experiences may not be conscious. In this structuralizaion, inner conflicts and tensions play an important role, as they create the problems for which meaning is the solution." (Hall, 1992, pp. 19-20).

Uncovering meaning of phenomenon acquired by clusters of thematic meaning statements is the stuff of phenomenology. If pastoral care clinical practitioners do not understanding meaning symbolism, especially in respect to spirituality and its relationship to human health, how will they be able to advance their human science discipline of care? This is one of the reasons why this dissertation claims that CPE needs a *phenomenology of suffering*.

However, there seems to be some belief afoot that spirituality and thus spiritual suffering is all subjective or grounded in intersubjective consciousness, and therefore what the person is experiencing has no reality for them, or the caregiver, which can be touched or felt as *really real*. Husserl (1999) believed that was an ontic certainty of the world through consciousness that is real. Husserl (1999) states that being aware of this real state of being has to do with actually being in the world and is "being constantly and directly "conscious" of the world and of oneself as living in the world, actually experiencing . . . and actually effecting the ontic certainty of the world. (Husserl, 1999, p. 375).

Husserl (1999), in a continued effort to explain what he means by *going back to the things themselves*, that is, *back to the pre-given, pre-scientific ontic world of certainty* is the basis for understanding how phenomenon, or external objects, or things that have

natural embodiment are experienced as *really real* (i.e. concrete reality) by the human person in their *life-world.* Husserl (1999) states:

> Things, objects (always understood purely in the sense of the life-world), are "given" as being valid for us in each case (in some mode or other of ontic certainty) but in principle only in such a way that we are conscious of them as things or objects *within the world-horizon*. Each one is something, "something of" the world of which we are constantly conscious as a horizon. On the other hand, we are conscious of this horizon only as a horizon for existing objects: without particular objects of consciousness it cannot be actual . . . . Every object has its possible varying modes of being valid, the modalizations of ontic certainty. (Husserl, 1999, p. 376).

This *modalization* of "ontic certainty" of the life-world has some kind of concrete embodiment in the world and can come only from the lived-experienced of the human person actually living in that world with those objects, situations, and circumstances that are a part of the experience of the concrete phenomenon. A person may not perceive the concrete phenomenon and may even use the wrong meaning symbols to give expression to what they are feelings or experiencing. Yet that does not negate the fact that the experiences of the phenomenon or concrete and real. They are not in the persons head even if they are mistaken about what they are experiencing or incapable of giving an accurate description of what the phenomenon is or what how they are experiencing it.

Spiritual suffering therefore presupposes some concrete reality in the life-world of the person that experiences the phenomenon as negative embodiment suggesting a spiritual need in relationship to this reality that has up to now not been met.

The connection and the relationship to the person and the embodied experience are very real. Something real or embodied in their life-world brought about the condition or has caused the person's spiritual malady. It is not all just in their mind! However, the cause could be the relationship of the mind (in its mode of perception) to the embodied experience of the phenomenon (i.e. what is *really real*).

The phenomenologist Maurice Merleau-Ponty (1945/2012) has the most telling analysis of what embodiment of phenomenological experiences means for the human person. Merleau-Ponty (1945/2012) explains the close relationship between the perception of the human person and real concrete (embodied) phenomenon. Merleau-Ponty (1945/2012) in his *Phenomenology of Perception* states:

> Our perception ends in objects, and the object, once constituted, appears as the reason for all the experiences of it that we have or that we could have. . . . To see an object is either to have it in the margins of the visual field and to be able to focus on it, or actually to respond to this solicitation by focusing on it. When I focus on it, I anchor myself in it, but this "pausing" of the gaze is but a modality of its movements: I continue within one object the same exploration that, just a moment ago, surveyed all of them. With a single movement, I close off the landscape and open up the object. . . . More precisely, the inner horizon of an object cannot become an object without the surrounding objects becoming a horizon, and so vision is a two-sided act. . . . The horizon, then, is what assures the identity of the object throughout the exploration, it is the correlate of the imminent power my gaze has over the objects that it has just glanced over and the power it already has over the new details that it is about to discover. No express

> memory and no explicit conjecture could play this role --- they could only provide a probable synthesis, whereas perception is given as actual. (Merleau-Ponte, 1945/1999, p. 69-70).

Merleau-Ponte is suggesting that all of our experiences of phenomenon are based on perception of objects. Perception then has embodiment in the consciousness of the human person and is experienced as actual. This modality of experience of external phenomenon is taken into the consciousness as concrete reality even if it is mistaken. Merleau-Ponte (1945/1999) goes on to state:

> Obsessed with being, and forgetting the perspectivism of my experience, I henceforth treat my experience as an object and I deduce it from a relation among objects. I consider my body, which is my point of view upon the world, as one of the objects of that world. . . . . I take flight from my experience and I pass over to the *idea*. Like the object, the idea claims to be the same for everyone, valid for all times and for all places, and the individuation of the object at an objective point of time and space appears, in the end, as the experience of a universal positing power. I no longer pay attention to my body, to time, or to the world as such as I live them in pre-predicative knowledge, that is, in the inner communication that I have with them. I only speak of my body as an idea, of the universe as an idea, and of the idea of time. (Merleau-Ponte, 1945/2012, pp. 73-74).

What this seems to mean in respect to human illness is that the objective experience of this phenomenon becomes not just an idea in the mind but takes on a larger-than-life ontic or ontological reality that may go beyond the objective reality of the illness itself, and so become not just a psychic pathology needing psychological therapy

but may reach the level of the inner core of the person's being, in which the person and the idea of the phenomenon become one. Therefore, to person experiencing the ravaging and toll that cancer takes upon the body knows that is concrete and real. It is no illusion of the mind, but what is not generally understood that *anxiety* associated with the illness becomes just as real and embodied in the mind of the human person. The thoughts of death or the end of life becomes real and an embodied experiences for the person, even though death that ends life has not yet occurred.

This is a significant understanding for CPE educators and practitioners pursuing the CPE project of *caring for* and *curing souls*. Merleau-Ponte (1945/2012) seems to be saying that the objective world of phenomenon that is experienced in the life-world passes by means of perception into consciousness as an *idea* that has reality and concreteness, because it is grounded in experience of external objects that include also the body of the human person.

Once conceived at this ontic level of realty the associated object and experience of the object become virtually one. This includes the body. If that body is sick or ill the experience of this phenomenon becomes an *idea* that has concrete reality and takes on spiritual significance in terms of needs as the person actually embodies the illness as belonging to them at the ontic level of consciousness. Someone has to help them bridge that ontic modality of embodied experience of spiritual suffering grounded in the reality of the illness (as an *idea*) in order for their spiritual needs to be met and the curing of the soul to take place. This dissertation holds that CPE needs this kind of phenomenological analysis in order to better pursue the CPE project of *caring for* and *curing souls*.

In some respects CPE educators and practitioners innately understand these modalities of human experience of suffering, as my interviews with them will show. However, for the most part they have left behind these innate ideas that were first presented to CPE by its founders and pioneers. This is this holds that a new qualitative approach to meaning that either hermeneutic or transcendental phenomenology can provide, allied with reflective/reflexive practice, will allow CPE to return to its foundational theoretical moorings with a phenomenological methodology in pursuit of the goal and aim of its clinical pastoral practitioners to *care for* and *cure souls*.

This dissertation is in pursuit of this objective, which seeks to bring together hermeneutic phenomenology and CPE theological reflective praxis in order to open the door to a new horizon or understanding of clinical pastoral care. I want to begin constructing a *phenomenology of suffering* that aims at the *care for* and *cure of souls*, a project that is already implicit within Clinical Pastoral Education (CPE) clinical theological tradition and educational praxis.

This dissertation explores the *life world* and *lived experience* of clinical pastoral care educators and clinical practitioners within the human science discipline of *Clinical Pastoral Education* (CPE). The primary goal of this dissertation is to discover the thematic categories and clusters of meaning associated with these experiences so that a *phenomenology of suffering* can be constructed as a basis for designing relevant CPE higher education curriculums, didactic seminars and other educational programs in training students desiring to become professional practitioners in this human science discipline of spiritual healthcare. A phenomenology of human suffering applied to CPE praxis will help give clinical pastoral educators and practitioners a new horizon of

understanding about the meaning of human *spiritual suffering*. This new horizon of understanding will contribute to improving clinical practice, didactic learning, theological reflection, and qualitative research efforts on how to *care for* and *cure of souls* that have *spiritual needs* and are suffering from various spiritual maladies effecting the physical, emotional, mental health, and well-being patient/clients domiciled in acute care hospital clinical organizations (HCOs).

Purpose Statement

This dissertation's goal is to help eliminate the void in the CPE research literature in a substantial way by making a contribution where the gap is most apparent. This gap exists in the area of the *phenomenon of suffering*, as it relates to *pastoral care*, *spiritual needs*, and *pastoral care education*. This dissertation is therefore constructive in nature and wants to construct a *phenomenology of suffering* for clinical pastoral care education, which the general name used in the existing literature to discuss all aspects of the discipline.

If the literature surrounding this research focus is missing then the dialogic conversation resulting in a literature to sustain, broaden, and uncover the research questions CPE develops will also be missing. Ironically, what appears to be happening is that CPE, in its clinical and didactic forms, is dealing daily with the phenomenon of suffering, but clinical pastoral education and scholarly research for this human science discipline has not benefited directly from its praxis. The clinical practice of pastoral care should be followed by robust and rigorous research studies from the practitioners themselves dealing with various aspects of this phenomenon. Rather clinical pastoral education seems satisfied with dispensing the findings of other allied human science

research that may have some bearing on clinical pastoral practice. However, CPE does not have its own research literature in the important area of the phenomenology and phenomenology of suffering within its own human science discipline that has been gathered, tested, and/or good enough to inform from an interdisciplinary perspective the practices of other allied human science practices. The interviews conducted at The Christ Hospital (TCH) for **Chapter 4 – Data Analysis** demonstrates that this situation has not changed. There was little to no evidence that the chaplaincy interviewees shared a common research literature on the phenomenon of suffering that informs their daily healthcare and clinical practices.

This dissertation shows that a new or *newly gathered* body of literature on the *phenomenology of suffering* (i.e. understanding how the human person experiences suffering) can meaningfully benefit CPE educators, who are engaged in designing and developing higher education curriculums for pastoral care students and clinical practitioners. A *phenomenology of suffering* is also needed for the following reasons:

(1) So that pastoral care practitioners, such as chaplains can acquire a better understanding of the human science of suffering from a phenomenological point of view and thereby help them meaningfully contribute to the rapid healing and flourishing of patient/clients in a collaborative effort alongside medical professionals that have the same goal and aim; (2) So that a new body of research literature dealing with the *phenomenon of suffering* will be added to the existing body of knowledge in the higher education discipline of clinical pastoral education; (3) So that theoretical foundations for clinical practitioners, who daily deal with the phenomenon of human suffering, will be available, and finally; (4) So that clinical pastoral educators and practitioners can begin to see more

clearly the bio-ethical and social justice issues effecting human autonomy and how violation of bio-ethical norms contribute to human suffering.

Problem Statement

This dissertation shows that CPE has in part left its first love outlined for the CPE movement by Anton Theophilus Boisen (1876-1965), "the father of clinical pastoral education." This dissertation shows that CPE's first love was *caring for* and *curing souls* by studying "understanding living human documents" (Hall, 1992, p. 10). *Caring for* and *curing souls* refers simply to the practice of *assessing spiritual needs* and *providing interventions that alleviate spiritual suffering* that impede the rapid healing and well-being of human persons that are ill. According to Hall (1992) Boisen hoped to "develop . . . a new method of theological study" grounded in human experience of phenomenon rather than from the horizon of established faith traditions, where "Experience will no longer be fitted to the system but system to experience . . . . Studying the human personality in health and disease, in prosperity and in disaster, seeking patiently and systematically and reverently to discover the motive forces and the machinery which are involved and to formulate the laws which govern them" (Hall, 1992, pp. 10).

Boisen tried to achieve these lofty goals of curing the maladies of the human mind, body and spirit by using the *qualitative case study methods* borrowed from the work of his teacher and mentor, Dr. Richard Clarke Cabot (1868-1939) "a professor of medicine at Harvard, and a founder of medical social work," who was instrumental in helping to found CPE within hospital organizational (HCO) settings through his personal efforts, and his "well-known article "A Plea for a Clinical Year in the Course of Theological Study," which would not be a "medical year or a sociological year but a year

of practice in applying religious beliefs," where theological students under supervision in clinical work would provide "care of persons in the various institutions." (Hall, 1992, p. 6). Apparently, Dr. Cabot hoped that he and others could use the seminary experiences of professional minister's who already work with the sick and dying, marriage, family problems, sexual problems, alcoholism, drugs, delinquency, and add to it clinical training in HCO settings.

The history of CPE demonstrates that it has taken great pains not to violate the patient's right to be free of sectarian evangelical pressures from chaplains. In doing so CPE has tried uphold the *social justice principles of human autonomy and self-determination* in respect to a persons heath decisions, and whether they wish the spiritual services offered by a chaplain or minister. The danger of this happening is always present when the life-world of the chaplain comes in contact with or joins in with the life-world and lived experience of the patient. In every case when these two worlds come together it is the chaplain's responsibility to know that they are not there to *save the soul*, but are there to *care for* and *cure the soul.*

According to Hall's (1992) understanding of the CPE movement that began in 1925 the founders and pioneers of this form of higher education wanted to construct a *clinical theology* that sought to understand traditional theological concepts as they relate to human experience. (Hall, 1992, p. xv). So from their horizon of understanding (some being seminarians and others medical professionals) this could best be accomplished in either mental hospitals or general hospitals. According to Hall (1992) Cabot stated: "In recommending a clinical year . . . . When we urge a theological student to get 'clinical experience' outside his lecture rooms and his chapel, to visit the sick, the insane, the

prisons and the almshouses, it is not because we want him to get away from his theology but because we want him to practice his theology where it is most needed, i.e., in personal contact with individuals in trouble." (Hall, 1992, p. 6).

Clinical pastoral educators like Boisen, whose primary CPE work was done in mental hospitals (where patients were domiciled longer) thought that *case study* used by medical professionals was the best methodological approach for CPE work, clinical training and learning. Others like Dicks, who worked primarily in the general acute care hospital (where patients length of stay was typically much shorter) thought that the *long interview* or the *verbatim interview* was the best methodological approach to understanding the phenomenon of suffering patients. Dick's methodological approach to CPE learning eventually won out the methodological battle, and so the *verbatim* is today the standard pedagogical tool used in CPE Level I and II, including supervisory clinical training in most CPE/HCO certified approved centers by the Association of Clinical Education (ACPE).

However, this dissertation shows that the use of this tool has been trivialized and fails to meet the original goal and vision for it in clinical education that Dicks originally had in mind. This dissertation shows how the verbatim interview, using Phenomenological Reduction and its components of *epoche* and horizonalization, can move this CPE tool for clinical praxis back to his original purpose, and also beyond that to become not only a rich tool of CPE clinical praxis, but a dynamic research tool that will allow CPE to advance its goal of *caring for* and *curing souls*. This phenomenological methodology tool can be the corner stone for a *constructive phenomenology of suffering*.

This dissertation shows from an analysis of ten interviews with clinical pastoral care practitioners (i.e. chaplains) and other sources used in phenomenological research that while CPE educators and practitioners have in great part kept to the aims and goals of both Boisen and Dr. Cabot they have been drawn away from using the qualitative case study methods. CPE has continued to use verbatims in its clinical praxis. However, the use of the verbatim has been limited to clinical exercises and some theological reflection in formal CPE Level I and II training. It has not evolved as a research tool as it was meant to do by its CPE pioneer educators. Thus one of the deficiencies that this dissertation discovered that the verbatim as valuable as it is for pastoral clinical training has not been allied to a qualitative research methodology like phenomenology in order to discover the rich thematic meanings and horizons that could emerge to help CPE practitioners assess their patients spiritual needs and provide interventions for spiritual suffering.

Both Boisen and Cabot believed that qualitative case study methods were scientific and were the best way to gain access to human experience of spiritual maladies that caused suffering. This dissertation acknowledges that this is true, but holds that phenomenological methods of research is the best qualitative methodology to access the meaning of spiritual suffering, and that such a research focus will allow clinical pastoral care educators and practitioners to improve its practice and so return CPE to its first love in *caring for* and *curing souls*. CPE's return to its original purpose of accessing spiritual needs of human persons in their *life-world* and through their *lived-experience* of spiritual suffering will allow it to advance its human science discipline and praxis.

This dissertation claims the best way to refocus clinical pastoral education on its original goals and aims is putting emphasis on its praxis of *theological reflection* and *reflexive learning* acquired from clinical experiences with and didactic studies of human persons who are suffering. This return has to be allied to a phenomenology of suffering to ensure that the reflection is focused on the CPE project and not some other allied disciplinary concern that is interesting, but tangentially related. The current interest of chaplains in the allied field of psychology and reliance on its methods is a case in point. The psychology of the human person is interesting and may have some insights into pastoral care, but it is not and should not be the core study or primary literature source for clinical pastoral education (CPE).

This dissertation offers a new perspective on the meaning of theological reflection with the CPE original goal and aim in mind to *care for* and *cure souls*. It has been suggested by some clinical pastoral practitioners like Xolani Kacela (2006) that the best theological reflective/reflexive praxis to accomplish these goals is the mystical approach taken by Howard Thurman. Thurman (1954) calls his approach the *centering moment* or the *sacramental moment,* and offers it as a spiritual discipline, where the human person's "needs, which are so intimately our own, mingle and become one with the needs of all who together in this moment. (Thurman, 1954, pp. 20-21). In this dissertation we will have occasion to revisit Kacela's (2006) understanding of this approach and Thurman's (1954) contributions to CPE reflective/reflexive praxis.

This dissertation holds that once phenomenology of suffering is incorporated into Clinical Pastoral Education praxis then CPE curriculums can be developed within HCO/CPE centers that will help clinical pastoral educators and clinical care givers

improve practice in *caring for* and *curing souls*, as originally understood by the *Clinical Pastoral Education Movement*, which is now under the governance of the *Association of Clinical Pastoral Education* (ACPE).

According to the Cleveland Clinic (2012), which is the premier acute care general hospital in the Midwest, Clinical Pastoral Education is higher education and has the same recognizable learning structures normally associated with learning institutions at all level of higher education in the United States, although its pedagogy is unique to its own educational philosophy, mission, and humans science disciplinary horizon of understanding. Accordingly:

> CPE is graduate-level theological training for clergy of all faiths conducted in a clinical setting under the on-site supervision of a person certified by the **Association of Clinical Pastoral Education, Inc.** (www.acpe.edu). This organization, recognized by the **U. S. Department of Education**, is the premier training source for professional clergy of all faiths, whether they serve congregations or in multi-faith secular institutions (hospitals, hospice, penal system, military, nursing facility, etc.). Much like the medical training model (and borrowing heavily from it), CPE takes persons who are at or near the end of their graduate academic training (either the 3-year Master of Divinity or in some cases a 2-year Master of Pastoral Care) and places them in a clinical context to practice interfaith ministry under supervision . . . . Students learn (by observation, practice and clinical case presentations) to serve as the spiritual care practitioner (chaplain) on the health care team. Student chaplains serve in all capacities with the hospital. According to the **Joint Commission on the Accreditation of Health**

> **Organizations (JCAHO)**, all patients have the right to have their spiritual needs addressed as part of their overall treatment plan. Medicare and Medicaid reimburse for these required services. . . . The CPE curriculum is based mainly in . . . direct ministry with people and on the related activities of reflection, discussion, and evaluation with other students and supervisors. . . . There will be opportunities to learn from the behavioral sciences and to reflect theologically so that you can draw from both in understanding the human condition. You will be challenged to think about groups and social structures as well as individuals in defining your ministry. (Cleveland Clinic Pastoral Education, 2012, p. 5).

Thus CPE by its own history and its recognized status as a higher education discipline is well established but far from complete in terms of its pedagogical focus, which of late has been misdirected by allied disciplines and overawed by its association with medical science. Both of these connections threaten to make CPE forget its project of *caring for* and *curing souls* by developing a clinical theology allied to human experience and qualitative methods like phenomenology that can reveal the meaning of those experiences.

This dissertation uses the methodological approaches of both hermeneutic (Van Manen, 1990) and transcendental (Moustakas, 1994) phenomenology that are grounded in the human science philosophies of Husserl (1905, 1907, 1910) in his *On the Phenomenology of Intersubjectivity* (1905), *The Idea of Phenomenology: Five Lectures* (1907), *Basic Problems of Phenomenology* (1910-191), and Heidegger (1955) in *Being and Time*. This dissertation refers to this combined theoretical horizon of understanding as *swing hermeneutic process phenomenology* grounded in CPE reflective/reflexive

learning and its associated spiritual discipline related to spiritual healthcare. This dissertation holds that clinical pastoral education has lost its original focus on spiritual *care for* and the *cure of souls*. Further this lost focus is because it does not have an explicit phenomenology of suffering to guide its educators and clinical practitioners toward this ultimate concern. Below will follow two diagrams (Figures 1 and 2) that graphically describes this problem:

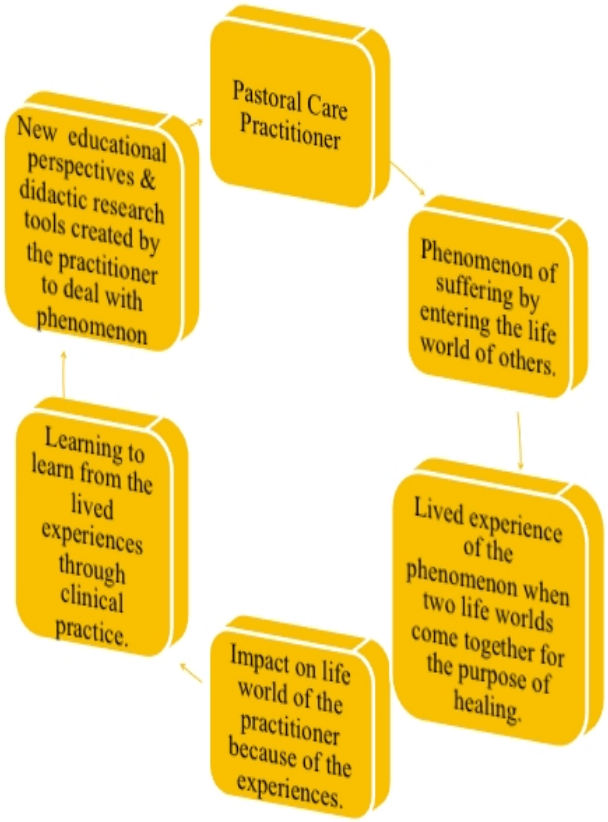


Figure 1. *Swing Hermeneutic Process Phenomenology* applied to CPE reflective praxis

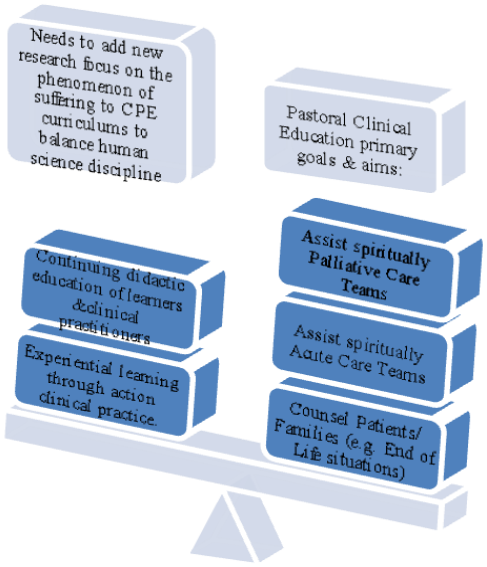


Figure 2. Pedagogical imbalance in CPE Reflective/Reflexive Praxis

Research Questions

This dissertation uses the methodological approach of phenomenology seeks to remedy the imbalance in CPE educational pedagogy describe above or at least point the way. To begin doing so this dissertation needs to construct set of general research questions that will focus the research on the problem. This dissertation therefore deals with *one phenomenon*, and with two basic questions involving the *life world* and *lived experience* of one group of healthcare practitioners in the context of their praxis at The Christ Hospital. Their human science discipline focuses on *one primary phenomenon* that informs the discipline and its practice, which is suffering. This dissertation's questions focuses on the phenomenon of suffering, as it is understood within the discipline of pastoral care, and seeks to know how that phenomenon is experienced in the clinical and educational *life world* of chaplains and other pastoral care. My research questions are the following:

Question One

How do you as a chaplain within the context of *life world* and *lived experience* as pastoral care practitioner experience the phenomenon of suffering of patient/clients domiciled in this Hospital Clinical Organization (HCO)?

Question Two

How does your *lived experience* of suffering inform your clinical practice, education, reflective praxis, and research within the context of your human science discipline?

This dissertation study was conducted at The Christ Hospital (TCH) using the results from personal interviews with chaplains to flush out the thematic categories and clusters of meaning for the lived experience of human suffering within the context of pastoral care. This dissertation is interested in the work of chaplains and others clinical pastoral care providers, who in daily practice of CPE standards and clinical praxis, are confronted with phenomenon of suffering of patient/clients in critical care hospital clinical organizations (HCOs), such as The Christ Hospital, and how they experience human suffering within these kinds of clinical settings.

The central focus of this human science discipline in the healing arts is assessing spiritual needs and spiritual suffering, which historically has been called *caring for* and *curing of souls*. CPE practitioners believe that *spiritual suffering* has a negative impact on the physical, emotional and psychological health of the human person. Clinical Pastoral Education, originally called Clinical Pastoral Training, according to John J. Gleason (2004) began as a joint hospital and seminary movement in 1925. Gleason (2004) states:

> Anton T. Boisen (1876-1965), a Presbyterian minister who was convinced that his own psychotic episodes had religious significance, dedicated his life to the study of "living human documents" (those suffering from mental illness) in the cause of understanding the meanings and messages (Head) of those experiences (Heart). In so doing, Boisen became a founder of the Clinical Pastoral Education (CPE) movement when as a chaplain he brought the first four seminarians to Worchester State Hospital for training in the summer of 1925. A major contribution of Boisen to Pastoral Research was the adaptation to theological education of the medical case method that had just been developed by another founder of clinical pastoral education, Richard C. Cabot, MD. For Boisen, the desired effect was to get seminarians to pay careful attention to life experience (Heart) toward integration in their theological formation (Head). Boisen joined Cabot in his call for a clinical year for all seminarians so that they could address, case by case, the relationship between functional mental disorders and religious experience. Boisen also called for "some plan for encouraging high-grade research work on the part of pastors in the field, comparable to what medical [scientists] are doing. (Gleason, 2004, p. 297).

Since this time spiritual needs assessment of spiritual suffering in Clinical Pastoral Educational Movement has been referred to as the *care* and *cure of souls*, which can be accomplished through various clinical pastoral methodologies. Clinical pastoral education needs a *phenomenology of suffering* as its primary methodology to achieve its CPE project of caring for and curing souls. This human science disciplinary area needs this research focus and scholarly literature to support it, because human suffering is the

primary focus of pastoral clinical practice. Clinical pastoral education (CPE) is aimed at understanding human suffering in the context of Hospital Clinical Organizations (HCOs) CPE teachers its clinical pastoral practitioners to deal with suffering so that they can help contribute along side medical and other healthcare professional to the rapid healing and flourishing of humans domiciled as patient/clients in HCOs.

This dissertation claims that little to no research is being done that focuses on this area of pastoral care, and almost none exists that deals with the *life world* and *lived experience* of pastoral care practitioners dealing with the phenomenon of human illness and suffering everyday. Of course Therese A. Rando's (1984) work entitled *Grief, Dying, and Death: Clinical Interventions for Caregivers*, which is focus on clinical caregivers deal with grief, dying and death is the exception to the rule, and in fact demonstrates that is not exceptional at all in that Dr. Rando (1984) is a researcher from the allied field of clinical psychology, and her study uses quantitative methods rather than qualitative methods for her findings. This only shows that CPE researches do not have equivalent interests in doing such research and doing so using qualitative approaches more suited to the nature of their human science discipline. It would be more likely that CPE educators and clinical pastoral practitioners would rather rely on important researches that Rando's (1984) rather than produce their own.

There seems to be no recognition how such research added to the curriculums of clinical pastoral education would help eventual professional practitioners contribute to the goal and aims of the CPE human science discipline. CPE is in a very good position to do so, because it operates within medical science facilities, and its goals and aims correlate very well with the goals and aims of the HCOs.

One thing that I noticed was missing in the responses from the ten chaplaincy interviews (or at least was not very evident) was the paucity of theoretical literature their clinical praxis should be based on. Very little was said about the foundational or theoretical foundations relied on that informed their clinical practices, even when they were prompted by follow-up questions with this focus. Everything said was based on their individual clinical experiences that they had in dealing with suffering. The second research question on how the phenomenon of suffering informed their didactic students and research brought limited positive responses. None of them, even when asked, could described any papers or research they had done to flesh out and report their experience with suffering, which could be a foundation for further studies and research in the respective chaplaincy specialties, such as, critical care chaplaincy, surgical chaplaincy, palliative care chaplaincy, Eucharistic chaplaincy, and grief chaplaincy.

The absence of these pedagogical references became more glaring as more interviews were done, and more data was gathered. The emerging picture reminded one of what VanderCreek (1996) said about the failure of clinical pastoral practitioners and educators to publish their findings using either quantitative or qualitative research in clinical practice. Rather the pastoral care clinical practitioners have relied on the research findings of allied or interdisciplinary human sciences like psychology to inform their practice and provide the theoretical foundations for CPE clinical praxis. One reason for this is the argument that CPE has not fully developed into its own human science discipline, which is the reason it so heavily relies on other allied research. This is an argument this dissertation denies, but the reasons for the argument are serious enough to examine.

Julie Thompson Klein 1990) suggests that “disciplinarity,” that is, breaking up knowledge into specialized areas was a product of the nineteenth century era of scientific positivism. It was by no means the normative way to learn or to acquire knowledge. What was normative was “interdisplinarity” associated with the Renaissance period and the ideal of the “Renaissance Man.” (Kline, 1990, p. 21). This so-called Renaissance man was searching for *renewal* and so put new wine (new techniques) into old wine skins to bring back the glory of the Greek and Roman past in art, architecture, sculpture, and literature. This cultural and technological movement allied to creative art, architecture, sculpture, and literature called for a vast array of knowledge and required crossing over into many different so-called “disciplines” to recreate their vision of the world.

Kline (1990) therefore cautiously states that interdisciplinarity “simply refers to the use of more than one discipline in pursuing a particular inquiry” (p. 27). What is contradictory about this definition, based on the notion that interdisciplinary approaches to knowledge preceded disciplinary approaches to knowledge, is that the body of knowledge referred to must be a discipline before being able to engage in interdisciplinary study and research. The problem with CPE (in this light) is that while it claims to be a particular human science discipline it has not had until recently any body of literature of its own, but has been content to borrow from allied disciplines and bodies of knowledge. How can CPE involve itself in interdisciplinary research and study before it becomes a discipline itself, according to foregoing argument? This dissertation the contrary states that CPE is a human science discipline that is at a certain stage of development and that it currently borrows from other allied disciplines is not argument that it does not have its own educational philosophy and pedagogy that is distinctive to

say the least. In fact CPE is actually doing what the allied disciplines had to do in their development, which was to at first borrow heavily from other allied disciplines in an interdisciplinary fashion before each one finally achieved its own distinct identity.

CPE has actually done this already to a great degree, but is deficient in a number of pedagogical and methodological areas identified in this dissertation that will advance it more toward its own human science distinctiveness as a discipline. CPE is not hybrid discipline. However it must listen to the voices that are calling it to toward becoming what its founders and pioneers envisioned it to be. One of these voices is Larry VanderCreek (1996). VanderCreek (1996), as quoted by J. S. Hemenway, 1996, states:

> We have been unable to put the capstone in place. That is, we have not built an empirical research tradition, which tests our observations and theories. . . As members of our respective organizations we have been too ready to make a living on existing, borrowed insights and practice patterns, and not ready enough to test our own insights. Consequently, we have legitimately been seen in the scientific world as a 'do nothing' profession which has failed to make a contribution to knowledge in a scientific age (Hemenway, 1996, pp. 17, 29-30).

VanderCreek's (1996) criticism will continue to be the case until somehow CPE builds its own human science theory grounded in its own body of knowledge and methodology. Can it borrow allied methodologies? Of course it can as long as these methods genuinely support its educational philosophy, pedagogy, and CPE project to *care for* and *cure souls.* This dissertation argues that CPE should begin this development by focusing its attention on building a *phenomenology of suffering*.

Significance of the Study

Answering these two major questions has profound implications for the continued advancement of the human science discipline of pastoral care education and raises a series of corollary and related questions. When these questions are either answered or sufficiently explored then CPE researchers should be able to determine (1) what is the relevant literature associated with the question; (2) how this literature informs the clinical practice of these pastoral care professionals, (3) and in a swing hermeneutic process how the related clinical practice contributes to the further development of the literature. Educators will then be able to discover the gaps in the literature and perhaps discover that there is a paucity of pastoral care literature that deals with the *phenomenon of suffering* and how that void affects the development, practice and advancement of clinical pastoral care. Finally, with these questions answered or sufficiently unpacked then CPE educators should be able to develop and design curriculums for pastoral care higher education that meet the needs of clinical pastoral care practitioners (e.g. chaplains, etc.) so they will be better informed about bio-ethical, bio-medical, and social justice issues and concerns that contribute to the suffering of patient/clients and that arise in the daily practice of their discipline. With a curriculum designed with this focus CPE educators should be able to develop higher educational curriculums that allow CPE practitioners to cope better with human suffering and therefore contribute to the rapid healing and flourishing of their patient/clients domiciled within HCOs.

However, this begs the question on how CPE is going to develop these curriculums without a *educational philosophy* that would be the guiding light toward advancing its disciplinary praxis and human science. This educational philosophy should

have the following characteristics according to David Elkind (1989), which is taken from his essay "Developmentally Appropriate Practice: Philosophical and Practical Implications: "Any philosophy of education must include some conception of the learner, of the learning process, of the information to be acquired, and of the goals or aims of education." (Elkind, 1989, 107). This dissertation argues that Clinical Pastoral Education (CPE) can acquire similar attributes for its own educational philosophy by focusing on developing a body of knowledge grounded in the phenomenology of suffering that can easily incorporate phenomenological philosophy and methods into its educational and clinical perspective. Once this is accomplished then it will be easy to develop and design CPE curriculums with this phenomenological focus to advance its human science discipline and to advance its CPE project of *caring for* and *curing souls*.

Philosophical and Theoretical Foundations

This dissertation focus on the *life world* and *lived experience* of pastoral care professional will help teach pastoral care practitioners and pastoral care educators what Heidegger (1953) means by *being there* (*Da-sein*) in his *Being in Time* and how his *hermeneutical phenomenology* ("in the things themselves") will allow the practitioner to enter and understand the *life world* of human sufferers through the researchers own *lived experience* that Heidegger (1953) contrary to his teacher Husserl, who uses *transcendental phenomenology* (outside the things themselves) using the method of *epoche*, i.e. bracketing of ones own experience, says is necessary in order to understand the human phenomenon under discussion and study. Although the phenomenological and hermeneutic views, ideas, and approaches of Husserl (1905, 1907, 1910), Sartre (1956), Ricoeur 1967, 1980), Gadamer (2002) and Hegel (1807) will be used in the study, the

views, ideas and approaches of Heidegger (1953) will be primary and paramount in my study. Heidegger (1953) holds that all human beings (Da-sein) are beings in time. Heidegger (1953) states: "Da-sein not only has the inclination to be entangled in the world in which it is and to interpret itself in terms of that world by its reflected light; at the same time Da-sein is also entangled in a tradition which it more or less explicitly grasps" (p. 18).

This allows the human participant/researcher to share the experience of the subject of the phenomenon and achieve an uncommon level of understanding and empathy with the phenomenological circumstances and situation. Heidegger (1953) states that it is impossible to do otherwise when Da-sein or human beings are confronted with a particular phenomenon (e.g. suffering, etc.):

> But just as opening oneself up or closing oneself off are grounded in the actual mode of being of being-with-one-another, in fact *is* nothing besides this mode itself, even the explicit disclosure of the other in concern grows only out of one's primarily being-with him. Such a disclosure of the other which is indeed *thematic*, but not in the mode of theoretical psychology, easily becomes the phenomenon that first comes to view for the theoretical problematic of understanding the "psychical life of other." What "initially" presents phenomenally a way of being-with-one-another that understands---is at the same time, however, taken to mean that which "originally" and primordially makes possible and constitutes being toward others. This phenomenon, which is none too happily designated as "*empathy*," is then supposed, as it were, to provide the first ontological bridge

> from one's own subject, initially given by itself, to the other subject, which is initially quite inaccessible. (Heidegger, 1953, p. 116-117).

According to Heidegger (1953) this *ontological bridge* between *Da-sein* and *Da-sein* (i.e. "human person" to "human person" who are experiencing a life world and lived experience together) is what makes human science research possible and will bring about a new horizon of scientific understanding of human persons (researcher/participant and subject/participant) as they experience fundamental phenomenon in their *life world*, and so makes a construction of a phenomenology of suffering possible, as a fundamental aspect of human science research that now stands void in clinical pastoral education. Heidegger (1953) states:

> Being is always the being of a being. The totality of beings can, with respect to its various domains, become the field where particular areas of knowledge are exposed and delimited. These arrears---for example, history, nature, space, life, human being, language, and so on---can in their turn become thematized as objects of scientific investigations. Scientific research demarcates and first establishes these areas of knowledge in a rough and ready fashion. The elaboration of the area in its fundamental structures is in a way already accomplished by prescientific experience and interpretation of the domain of being to which the area of knowledge is itself confined. The resulting "fundamental concepts" comprise the guidelines for the first concrete disclosure of the area. (Heidegger, 1953, p. 7).

This dissertation study is doing precisely what Heidegger (1953) suggests a phenomenological study would do. I have demarcated out an area of study involving Da-

sein (human beings) and their *lived experience* with the phenomenon of suffering, which will result in "fundamental concepts" that "comprise the guidelines for the first concrete disclosure of the area" (Heidegger, 1953, p. 7) for clinical pastoral education.

Methodology and Approach

I will be using the hermeneutic phenomenological methodology of Van Manen (1990) as the primary approach to This dissertation study, because, first, I believe that his hermeneutic phenomenology (based on Heidegger's notion of *Da-sein* fits with what actually is happening while phenomenological research is being conducted and that both the researcher and the subject are both experiencing the phenomenon under study together and cannot do otherwise so that it is unrealistic and therefore unscientific to otherwise knowing that the thematic categories acquired are suffused with not only the subject's experiences but those of the researcher as well no matter how hard the research tries to keep them out or at bay. It is better to acknowledge this characteristic of *Da-sein*, human to human experience of the phenomenon, identify them as best as one can and consider that the researcher and the subject are co-participants in the human science study or project under consideration.

Secondly, I believe that Moustakas's (1994) concept of bracketing the researcher's experiences from those of the subject (based on Husserl's method of *epoche*) in order to better understand the phenomenon being studied or under consideration is flawed. Even if this were achievable the researcher interpreting the qualitative data would have to contend with Gadamer's (2002) hermeneutic paradox (i.e., the hermeneutic circle) that the researcher will necessarily add their horizon of understanding to the thematic data acquired from the phenomenological experiences of the other subject and

necessarily create a new horizon of understanding altogether. The phenomenon studied then becomes not merely the *thing itself* but in the description of what it is. It becomes *something new* entirely. This paradox befuddles any attempt to clearly understand the phenomenon related to *Da-sein* (human person to human person) *as it really is* or as they experience it without the interjection of our own experiences to interpret the other. Therefore, *bracketing out* the researchers experiences does absolutely no good, since it will reenter the study again when interpretation of the thematic categories are being conducted.

Husserl's (1999) concept of *epoche* essentially means that the researcher *brackets out* the nonessential aspects of the phenomenon in order that the essential aspects will emerge. Van Manen (1990) takes exception to this and suggests that meaning statements or horizons are so rich in meaning that it is hard or next to impossible to discover what is essential or not essential given the fact that experiences of the same phenomenon can change over time. This is also complicated by the fact that each experience of the same phenomenon (e.g. love, suffering, etc.) is obscured in its original meaning as each experience of the phenomenon gives rise to a new horizon of understanding. When this happens the experience is forever changed from the original meaning, and for that matter the original meaning is forever changing with each new occurrence. How then can you bracket out the researchers experience when the researcher is likely to be the CPE educator and/or pastoral care practitioner searching for horizons of meaning they are having with patients as their two life-world and lived-experience comes together in a fundamental union for spiritual healing of the human soul? Gadamer (2002) makes this clear and states:

To be historically means that knowledge of oneself can never be complete. All self-knowledge arises from what is historically pregiven, what with Hegel we call "substance," because it underlies all subjective intentions and actions, and hence both prescribes and limits every possibility for understanding any tradition whatsoever in its historical alterity. This almost defines the aim of philosophic hermeneutics: its tasks are to retrace the path of Hegel's phenomenology of mind until we discover in all that is subjective the substantiality that determines it. Every finite present has it limitations We define the concept of "situation" by saying that it represents a standpoint that limits the possibility of vision. Hence essential to the concept of situation is the concept of "*horizon.*" The horizon is the range of vision that includes everything that can be seen from a particular vantage point. Applying this to the thinking mind, we speak of narrowness of horizon, of the possible expansion of horizon, of the opening up of new horizons, and so forth. . . . A person who has no horizon does not see far enough and hence overvalues what is nearest to him. On the other hand, "to have a horizon" means not being limited to what is nearby but being able to see beyond it. A person who has an horizon knows the relative significance of everything with this horizon, whether it is near or far, great or small. Similarly, working out the hermeneutic situation means acquiring the right horizon of inquiry for the questions evoked by the encounter with tradition. . . . The same is true of conversation that we have with someone simply in order to get to know him --- i.e., to discover where he is coming from and his horizon. This is not true conversation--- that is; we are not seeking agreement on some subject---because the specific contents of the

> conversation are only a means to get to know the horizon of the other person. Examples are oral communication and certain kinds of conversation between doctor and patient. . . In both cases, the person understanding has, as it were, stopped trying to reach an agreement. He himself cannot be reached. By factoring the other person's standpoint into what he is claiming to say, we are making our own standpoint safely unattainable. . . . We think we understand when we see the past from a historical standpoint---i.e., transpose ourselves into the historical situation and try to reconstruct the historical horizon. In fact, however, we have given up the claim to find in the past any truth that is valid and intelligible for ourselves. Acknowledging the otherness of the other in this way, making him the object of objective knowledge, involves the fundamental suspension of his claim to truth. (Gadamer, 2002, pp. 302-304).

I am afraid that this is exactly what happens when the researcher tries to enter and understand the *life world* and *lived experience* of the subject who is experiencing any phenomenon, including the human phenomenon of suffering. The acknowledgement of the subject is insufficient to understanding their horizon of understanding, meaning the way they understand the phenomenon. This is additionally complicated when attempting to interpret the data because the researcher's horizon of understanding is necessarily in play and cannot be *bracketed* when interpreting the thematic categories acquired from the study. Although I am not sure if Van Manen's (1990) hermeneutic phenomenological approach offers solution to Gadamer's (2002) paradox of the hermeneutic circle of horizon of understanding but at least Van Manen's (1990) approach acknowledges the

problem and attempts to use it in a positive way to understand the phenomenon being studied.

Thirdly, Van Manen's approach is important for my study because it relates hermeneutic phenomenology to education pedagogy and since my study deals with constructing a phenomenology of suffering for clinical pastoral education it would seem to me that Van Manen's (1990) views, ideas and approach would be the appropriate guide as I am trying to create a new horizon of understanding involving the phenomenology of suffering that is directly related to the pedagogy of clinical pastoral care education.

In fact Van Manen (1990) does not believe that phenomenology is engaged in to solve a problem and because of that is different from any other qualitative approach that has this as its aim and objective. In order to engage in hermeneutic phenomenology one has to first give up the idea that one is doing a research project in order to solve a problem. Qualitative researchers from quantitative research grounded in scientific positivism have inherited this viewpoint. Van Manen (1990) states:

> It is important as well to realize that phenomenology cannot be used to show or prove, for example, that one reading method is more *effective* than another reading method, or that certain instructional techniques produce higher achievement scores, and so forth. . . . *Phenomenology does not problem solve*. Problem questions seek solutions, "correct" knowledge, effective procedures, winning strategies, calculative techniques, "methods" which get results! A research study that pursues a certain problem is completed when the problem is solved (Marcel, 1950). *Phenomenological questions are meaning questions*. They

> ask for the meaning and significance of certain phenomena. Meaning questions cannot be "solved" and thus done away with (Marcel, 1949). Meaning questions can be better or more deeply understood, so that, on the basis of this understanding I may be able to act more thoughtfully and more tactfully in certain situations. But in some sense meaning questions can never be closed down, they will always remain the subject matter of the conversational relations of lived life, and they will need to be appropriated, in a personal way, by anyone who hopes to benefit from such insights. (Van Manen, 1990, pp. 22-23).

So does this mean that phenomenology, as a qualitative methodology, is any less rigorous than a quantitative study? A related or corollary question is how do you benefit from a method of research that does not solve problems? The answer to both is that phenomenology in its methods seeks to acquire themes of meaning or clusters of meaning or thematic categories that require just as much rigor to obtain and analysis as does a quantitative study that has to spend most of its energy defending itself from internal and external threats to the study and get the results it wants or expects. Caraway (2012) suggests that no apologetic (i.e. defense) of phenomenology over against quantitative studies are needed for the following reasons: "You don't have to defend phenomenology against quantitative studies, for phenomenology entails a different kind of epistemology (i.e. way of knowing, my insertion) congruent with the subject matter. Quantitative studies matter. Quantitative studies are observational. Phenomenological studies---insofar as they are human studies—depend, not on observation, but on the subject's revealing himself/herself in the epistemological interaction (Caraway, 2012, Comments, RSCH 901).

Van Manen (1990) certainly would agree that phenomenology is a different kind of epistemology or way of knowing, but would disagree that phenomenology is purely based on epistemological interaction between the researcher and the subject. Van Manen (1990) would not want to rule out observations made by the researcher, which could very well produce meaning statements as the researcher observes the subject in relationship to how they experience the phenomenon. Van Manen (1990) states: "A third way of collecting experiential material from others is the more direct method of *close observation* (p. 68). Close observation and other means, including direct interaction of the researcher with the subject should all be taken into consideration when gathering phenomenological data. Van Manen (1990) states that the rigor of phenomenological research is characterized by the fact that you are dealing with only one primary object, aim or concern, and only in this regard was an apologetic statement necessary when comparing phenomenological as a qualitative methodological approach over against quantitative approaches. Van Manen (1990) states:

> Every project of phenomenological inquiry is driven by a commitment of turning to an abiding concern. "To think is to confine yourself to a single thought that one day stands still like a star in the world's sky," said Heidegger (1971, p. 4). This commitment of never wavering from thinking a single thought more deeply is the practice of thoughtfulness, of a fullness of thinking. . . . A corollary is that phenomenological research does not start or proceed in a disembodied fashion. It is always a project of someone: a real person, who, in the context of particular individual, social, and historical life circumstances, sets out to make sense of a certain aspect of human existence. . . . A phenomenological description is always

> *one* interpretation, and no single interpretation of human experience will ever exhaust the possibility of yet another complementary, or even potentially *richer* or *deeper* description. . . *Investigating experience as we live it:* Phenomenological research aims at establishing a renewed contact with original experience. Merleau-Ponty (1962) showed that turning to the phenomena of lived experience means re-learning to look at the world by re-awakening the basic experience of the world (p. viii). This turning to some abiding concern of lived experience has been called turning "to the things themselves," *Zu den Sachen* (Husserl, 1911/80, p. 116). . . On the one hand it means that phenomenological research requires of the researcher that he or she stands in the fullness of life, in the midst of the world of living relations and shared situation. On the other hand it means that the research actively explores the category of lived experience in all its modalities and aspects. (Van Manen, 1990, pp. 31-32).

Some very knowledgeable scholars would make a sharp distinction between phenomenological method, where the participants in the study *reveal the meaning* of their understanding of phenomenon to the researcher, and scientific method that uses observation. However, as we have shown above Van Manen (1990) does not accept this sharp distinction in hermeneutic phenomenology and that the *method of close observation* is not the exclusive province of scientific method. Phenomenology from Van Manen's (1990) perspective may use *close observation* to derive meaning statements or horizons of understanding from observing the participant in the study.

Phenomenology seeks to acquire clusters of thematic horizons from meaning statements from *close observation*, and scientific method seeks to acquire quantifiable

categories from *close observation*, based on actions, non-actions, and/or events related to the participant, so that actions and events can be measured and correlated. From this perspective *close observation* would not be the sole province of scientific method, otherwise neither the qualitative methods of ethnography nor case study could be said to be human science using methods appropriated to its own discipline. Both of ethnography and case study are qualitative methods, and both use information from a wide variety of sources that *allow the participant to reveal themselves*, and what the phenomenon being experienced means to them in their life-world and lived-experience. Creswell (2007), for instance, describes the case study method, which has a long history in CPE. He states:

> Case study research is a qualitative approach in which the investigator explores a bounded system (a *case*) or multiple bounded systems (cases) over time, through detailed, in-depth data collection involving ***multiple sources of information*** (e.g., observations, interviews, audiovisual material, and documents and reports), and reports a case ***description*** and case-based themes. . . . The case study approach is familiar to social scientists because of its popularity in psychology (Freud), medicine (case analysis of a problem), law (case law), and political science (case reports). Case study has a long, distinguished history across many disciplines. (Creswell, 2007, p. 73).

What Creswell (2007) has to say about the use of observations as a source of data for the collection of thematic material related to meaning also is applicable to phenomenology. The phenomenologist may consider close observation of the subject in relationship to the phenomenon, which again is not the sole province of scientific methods. Creswell (2007) states:

> Data are collected from the individuals who have experienced the phenomenon. Often data collection in phenomenological studies consists of in-depth interviews and multiple interviews with participants. Polkinghorne (1989) recommends that researchers interview from 5 to 25 individuals who have all experienced the phenomenon. Other forms of data may also be collected, such as observations, journals, art, poetry, music, and other forms of art. Van Manen (1990) mentions taped conversations, formally written responses, accounts of vicarious experiences of drama, films, poetry, and novels. (Creswell, 2007, p. 61).

Therefore, it is not the methods used to gather the data that distinguishes phenomenological methods from scientific methods, but rather the purpose for the collection of the data, and the kind of methodological analysis that is applied to the data gathered. Scientific method may use the same data acquired by means of *close observation* that phenomenology also using this same approach. However, scientific method will subject this data to statistical and correlational analysis, while phenomenology, seeking acquire clusters of thematic meaning, will use phenomenological reduction methods of *horizonalization*, *textual, descriptions, structural descriptions*, and *imaginative variation* to develop *clusters of meaning* (Creswell, 2007, p. 61).

Generally qualitative studies with the exception of ethnographic research would not be interested in statistical and correlational analysis acquired by scientific methods. Even at that the ethnographer would not do the statistical and correlational analysis himself or herself, but rather use this scientific data to "develop shared patterns of behavior, beliefs, and ***language***. . . . As a process, ethnography involves extended

observations of the group, most often through ***participant observation***, in which the researcher is ***immersed*** in the day-to-day lives of the people and observes and interviews the group participants. Ethnographers study the meaning of the behavior, the language, and the interactions among members of the culture-sharing group." (Creswell, 2007, pp. 68-69). Whether case study, ethnography or phenomenology is being used the goal and aim of collecting the data is similar, which is to acquire clusters or meaning, either from the case, or the group, or the individual, where the participants directly (using interviews) or indirectly (using observation, and/or related documents) *reveal meaning and themselves* to the researcher.

Van Manen (1990) relies on the phenomenology of Heidegger (1953) for his *hermeneutic phenomenological* method and approach. But Moustakas (1994) relies on Husserl (1911) for his *transcendental phenomenological* method. In respect to Moustakas's (1*994*) understanding of Husserl (1911) a case can be made that he *misunderstands* Husserl's (1911) concept of *epoche* or bracketing. Husserl (1911) was not talking about *bracketing out the researchers own experience of the phenomenon*, as Moustakas (1994) suggests, but rather bracketing-out non-essential meaning or thematic horizons, that is, *bracketing-in* the *essential* horizons of meaning, and *bracketing-out* the *unessential*. In his essay "Phenomenology as Transcendental Philosophy" under the subheading "*The phenomenological* e>poxh<" Husserl (1999) actually used the word "parenthesizing" for what Moustakas (1994) calls bracketing. Husserl (1999) states:

> But our purpose is to discover a new scientific domain, one that is to be gained *by the method of parenthesizing* which, therefore must be a definitely restricted one. The restriction can be designated in a word. *We put out of action the general*

> *positing which belongs to the essence of the natural attitude;* we parenthesize everything which that positing encompasses with respect to being: *thus the whole natural world* which is continually "there for us," "on hand," and which will always remain there according to consciousness as an "actuality" even if we choose to parenthesize it . . . . . rather I am exercising the "phenomenological" e>poxh< which also *completely shuts me off from any judgment about spatiotemporal factual being. Thus I exclude all sciences relating to this natural world* no matter how firmly they stand there for me, no matter how much I admire them, ... as long as it is understood as it is presented in one of those sciences as truth *about actualities* of this world. (Husserl, 1999, p. 65).

Parenthetical method used by Husserl (1999) to "put out of action" for the time being even scientific truths that is claimed by positivism to be absolute truth is what he means by *epoche*. Moustakas (1994) refers to this method as "bracketing" in his phenomenological method, but with a meaning that is perhaps unrecognizable in respect to Husserl's (1999) original understanding described above. Moustakas (1994) states:

> For a while, I became an isolate, in the way that Husserl advised, withdrawing completely into myself, while seeking to acquire knowledge of science through concentrated studies of experience and the reflective powers of the self. I sought to place myself in Husserl's world of transcendental phenomenology, whole recognizing that my own knowledge and experience, in a free and imaginative sense, ultimately would determine the core ideas and values that would linger and endure. . . . Husserl was concerned with the discovery of meanings and essences in knowledge. . . . The challenge facing the human science researcher is to

> describe things in themselves, to permit what is before one to enter consciousness and be understood in its meaning and essences in the light of intuition and self-reflection. The process involves a blending of what is really present with what is imagined as present from the vantage point of possible meaning; thus the unity of the real and the ideal. . . . Husserl (1977) does not claim that transcendental phenomenology is the only approach to a knowledge of human experience, but rather he emphasizes that it is a science of pure possibilities carried out with systematic concreteness and that it precedes, and makes possible, the empirical sciences, the sciences of actualities. . . (Moustakas, 1994, pp. 25-28).

Husserl (1999) said nothing about the researcher withdrawing completely within themselves, that is, within their own consciousness in order to avoid contaminating acquired meanings that emerge from the research. Rather Husserl (1999) recommended going back to the *things themselves*, that is, the pregiven world of being, and did not recommend *parenthesizing* ones own experience of phenomenon unless they were deemed non-essential. The researchers own experience of the phenomenon might be one of the things coming from or being there in the pregiven world that would be essential and therefore you want to acquire meaning from.

What is *parenthesized* are the natural world and so-called scientific truth statements about that world that closes off further discussion or understanding. This *parenthetical method* is used only as temporary method until the meaning statement or cluster of thematic horizons emerge from the phenomenon.

Both Van Manen (1990) and Moustakas (1994) do agree in their claims that whatever the nuances of the hermeneutical and transcendental phenomenological

approaches both phenomenology's share the view that meaning of human experience in its pregiven state of being (back to the things themselves) is what is being acquired.

Van Manen, however, does not make the heuristic claim for hermeneutic phenomenology, as Moustakas (1994) does for transcendental phenomenology, when he states that transcendental phenomenology "proceeds, and makes possible, the empirical sciences, the sciences of actualities" (Moustakas, 1994, p. 28). This dissertation does not see the need to make such a claim, but doe hold that hermeneutic phenomenology standing alone can acquire meaning from human experience of phenomenon, and so through acquisition and appropriation of clusters of meaning and thematic categories, can produce a body of human science research on the phenomenon of human suffering. Pastoral care educators and practitioners to advance the CPE project of *caring for* and *curing souls* can use the data acquired.

What Has Already Been Done

This dissertation cannot claim that nothing has been done to research the *phenomenon of suffering*. That claim would not be true. However, this dissertation can claim that the literature and research on the topic is sparse and scattered and that there has been no systematic attempt to gather what is there in some intelligible form. A researcher at present cannot put the topic title into a research engine and come up with a well-defined body of studies, dissertations, journals and books on this one subject. In addition to this, little to nothing has been done on studying how pastoral care practitioners experience human suffering in their daily clinical practice. This situation has prevented because pastoral care educators from being able to design and develop curriculums around this vital topic that is central to the work of clinical pastoral practitioners.

This situation exists because a body of literature on the topic of phenomenology of suffering does not exist, or has not been identified and gathered. Here and there you will find a study similar to the one this dissertation is examining, such as, Kahane's (2001) dissertation on "A phenomenological study of therapists' experiences of love for their clients." Interestingly, Kahane (2001) explores this theme along with a whole cluster of other themes that are relevant, including the phenomenon of suffering. Kahane (2001) uses hermeneutic phenomenology as the approach for her dissertation, and states:

> This dissertation explores the experience of psychotherapists' love for their clients. A review of the literature examines definitions and forms of love as well as countertransference love according to psychoanalytic, object relations, self psychology, Jungian, existential, and feminist theories. . . . Nowhere has it been named and explored explicitly, thoroughly, and phenomenologically. This study addresses that gap by examining therapists' experiences of love for their clients through in-depth interviews with eight psychotherapists from a variety of theoretical orientations. Analysis of the data using a hermeneutic phenomenological method reveals 23 themes descriptive of the experience, including vision of the client's deeper essence and the concomitant experience of their unique beauty; understanding; authenticity, discernment, and truth; vulnerability; open, welcoming, and presence; union; meeting, mutuality, and reciprocity; sacrifice, suffering, and the related experience of hate in the therapeutic relationship; dangers and illusions of love; lack of support from the profession for loving one's clients; and love as a mystery involving a larger source beyond the self. (Kahane, 2001, *Abstract*).

Kahane (2001) explores each theme in the cluster surrounding her concern to understanding the *phenomenology of love.* One thematic category that she is particularly interested in is *human suffering*, and so she explores the phenomenology and *theology of suffering* as support for her own thesis, which was presented by Pope John Paul II (1984) in his Apostolic Letter *Salvifici* and lectures on the "Theology of the Body." Kahane (2001) states:

> Pope John Paul II's 1984 Apostolic Letter *Salvifici* doloris shares a common anthropology with his "Theology of the Body" audiences delivered between 1979 and 1984. In them, drawing on his work in phenomenology as a professional philosopher, he discusses the revelatory potential of the human body. His method of inquiry into man's self-understanding of his nature and the struggles he faces invites academic investigation of both issues of human sexuality and human suffering. Analogous to his description of man's coming to understand a language of the body between spouses, there is also the potential for a communion of persons to be released in the experience of the mystery of human suffering by both the suffering person and the one who cares for him. This dissertation investigates the themes addressed in Wojityula/John Paul's teaching, particularly in the "Theology of the Body" with the purpose of synthesizing an anthropology found there in order to present an expanded theology of suffering . . . . Wojityula/John Paul's view will be shown to counteract this mindset, treating the experiences of suffering, though an evil in itself, as uniquely affording the potential to release love and hope in the suffering person's relationship with God and others, as well as . . . for those who care for him. Part I addresses the need for

> a better grounding of the issue of suffering in our current culture by evaluating the lack of discussion of this mystery in the realms of medical ethics, for even with Christian reflection the topic of suffering is often dismissed or eliminated rather than addressed as a revelatory part of human experience. (Kahane, 2001, *Abstract*).

Certainly, Kahane (2001) is important for my own study based on the phenomenological method she has chosen and the emphasis she places on fleshing out the meaning of human suffering, in her case to understand better the phenomenon of human love and how it is embodied in human suffering. Nevertheless, these kinds of studies are rare. Kahane (2001) notes that this topic conversation is neither discussed by those involves in Christian reflective discourse or by those concerned with medical ethics.

Ricoeur ((1967) has written a valuable book *The Symbolism of Evil*, which deals with the *phenomenology of evil*, that is, *the human experience of evil*, and how it is symbolized and described by persons experiencing this phenomenon that threatens human existence, while paradoxically offering or enticing humans the perceived benefits and joys of *demonic experience* related, for example, to *power*, *money*, and/or *sex*.

According to Ricoeur (1967) experience of evil is a kind of suffering that brings on other thematic related clusters of meaning, such as *human guilt*, *defilement*, and *sin* as the primary *human symbols* related to the experience of evil. Evil is partially expiated by means of the *phenomenology of confession*. It is the way humans cope with the suffering that results from being touched by the *finger of evil*. Ricoeur (1967) states:

> The venture would be hopeless if, lower than gnosis and myth, there were no longer any language. But is this not the case; there is the language of *confession,* which in the languages of myth and speculation is raised to the second and third degrees. This language of confession is the counterpart of the triple character of the experience it brings to light: blindness, equivocalness, scandalousness. The experience of which the penitent makes confession is a blind experience, still embedded in the matrix of emotion, fear, anguish. It is this emotional note that gives rise to objectification in discourse; the confession expresses, pushes to the outside, the emotion which without it would shut up in itself, as an impression in the soul. Language is the light of the emotions. Through confession the consciousness of fault is brought into the light of speech; through confession man remains speech, even the experience of his own absurdity, suffering, and anguish. (Ricoeur, 1967, p. 7).

These are the kinds of studies that pastoral care practitioners and educators are need to study and include in their body of research in order to do their jobs. The problem is that practitioners in pastoral clinical practice and CPE education did none of these studies, so that they are derived from or related directly to CPE clinical and didactic praxis. This situation has to change so that dependency on this allied literature (although valuable) is minimized, and replaced with a research literature arising out of the clinical practice itself in a swing hermeneutic (back and forth) process that advances this disciplinary field of higher education and pedagogy. I believe a phenomenological study dealing with how these practitioner's experience human suffering will go a long way in remedying this emphasis and reliance. Strunk (2004) states:

> Mostly, I suspect, I have come to understand --- truly *understand* --- a shibboleth often noted in the pages of this journal: that is, that there is a gap between the technology of care and human touch. Intellectually I've always known this to be true. Now, existentially, I know about that gap --- or, more accurately, about that *chasm*. I also know, intellectually, that phenomenology, whether it be philosophical or psychological, is anything but a unified theory of knowing, an established epistemology. Still, despite phenomenology's various schools, hues, and emphases, it does value highly the essence, structure, and form of *human experience* as revealed through primarily descriptive techniques and disciplined reflection. All this to say that we need to continue producing a literature that includes --- alongside our scientific and objective efforts and studies thoroughly *subjective* descriptions of what it *means* to be ill . . . (Strunk, 2004, pp. 293-294).

Value and Contribution to Knowledge

Strunk (2004) does not exactly endorse phenomenology as a means to understanding human illness, because he is still enamored with "our scientific and objective efforts and studies" to understand human illness (p. 294). Nevertheless, he sees value in using phenomenological method, not standing alone as a method, but coming alongside scientific (i.e. quantitative) and *objective* studies. Apparently, while endorsing phenomenology (perhaps in some kind of mixed methods study) he does not see it as yet *objective methodology*, but *subjective methodology*, and so is not scientific, needing scientific method as a means to give phenomenology legitimacy.

Strunk (2004), who is a pastoral care psychologist and managing editor of The Journal of Pastoral Care & Counseling, represents the current thinking on qualitative

methods like phenomenology in relationship to so-called scientific quantitative methods. Strunk (2004) sees something out of place with quantitative methods that do not involve the "human touch" in its efforts to be more scientific. And he recognizes that qualitative methods, such as, phenomenology are needed to remedy this deficiency in quantitative methods and analysis that really cannot get close enough to the human person to understand their predicament in their concrete *life-world*. Yet Strunk (2004) and other CPE thinkers like him are not willing to trust that qualitative methods such as phenomenology are good enough (meaning "scientific" enough) to provide answers to research questions that are valid.

There is little recognition that quantitative analysis grounded in scientific method and qualitative methods such as phenomenology are asking different questions and therefore require different methodologies that each in its own sphere are valid for the questions asked. This dissertation claims that the research questions for CPE are different from those human science disciplines like psychology that until now have been strongly wedded to scientific methodology.

Once the research question for CPE are selected for the kinds of questions it needs to answer, then it will be discovered that qualitative analysis and methods, such as, phenomenology are the best fit for CPE's project of *caring for* and *curing souls*. When these questions are sufficiently unpacked clinical pastoral care educators should be prompted to call for further research studies on the *phenomenology of suffering*.

Despite his reticence, Orlo C. Strunk, Jr. (2004) has begun to call for the development of a *phenomenology of illness*, as a way of developing a "thoroughly *subjective* description of what it *means* to be ill; what it's like to be a person with a

"borderline personality disorder"; what it's like to "lose faith"; what it feels like to be treated as an "object"; what the experience *is* of having to admit to the hospital admissions clerk that you have no health insurance; what it feels like when, in extreme pain and discomfort, and expert in perfunctory style says, "I know how you feel. . ." (Strunk, 2004, p. 294) when in fact the expert does not really know how this person feels, and the person suffering know it.

An understanding of the phenomenology of suffering placed within the curriculums provided to pastoral care practitioners like chaplains, will better inform their clinical practice and allow them to use their clinical pastoral skills to in turn inform the development of literature devoted to this phenomenon. Strunk (2004) has already noted that there is a gap in the pastoral care literature related to illness and suffering, and so this dissertation's questions are timely in respect to the human science discipline of pastoral care, within the context of Hospital Clinical Organizations (HCOs).

New Horizons of Understanding

Clinical Pastoral Education (CPE) is one of the best exemplars of what is meant by learning institutions. In an increasingly American secular culture where intellectual protagonists to religion envision a society without religion governed by rational free thinkers, and based solely on scientific positivism, it is strange to see the *unholy* marriage between the disciplines of *medical care* and *spiritual care* working together in hospital clinical organizations (HCOs). One discipline (medicine) is grounded in science and the other (clinical pastoral care) is grounded in theology and religion.

Nevertheless, both disciplines within an HCO context see the value and need to work together in an interdisciplinary collaborative effort to provide healthcare deliver to

those who are suffering. Three institutions dedicated to higher learning and the spiritual and physical health of the human person have kept the clinical pastoral education (CPE) movement alive and well, providing it with a well trained and disciplined cadre of clinical pastoral practitioners: (1) the seminaries where the movement was born, (2) hospital clinical organizations, whose administration and medical staff see its value for healing of the whole person and has accepted it as a partner in healthcare delivery within its acute care centers, and (3) its primary professional certifying and oversight organization the *Association of Clinical Pastoral Education* (ACPE) that states "Clinical Pastoral Education (CPE) is interfaith professional education for ministry. It brings theological students, ministers, and laypersons into supervised encounters with person in crisis." (ACPE, 2004, p. 201).

Clinical Pastoral Education (CPE) focuses on clinical praxis and didactic learning by means of reflective practice (i.e. *action ---- reflection ----- new action*). Reflective practice or reflective learning is CPE's primary methodological approach to its enterprise of the *cure of souls*. CPE, as a human science discipline of learning, understands that the *lived experience* of persons who are ill and face the phenomenon of suffering is the human person's peculiar *sitzen leben* (lit. German "setting of life"), that is, the human person's *life world*. CPE presupposes that human persons are *human texts* bound up within their *life world* of *lived experiences*. Because people are *human texts* that are full of meaning they can be read and understood within their own *situation of life*. Once the human person's *life world* (i.e. situation of life), and their *lived experience* within the context of their *life world* is understand then the *cure of soul* can take place.

With this understanding of the human person, that is, *coming along side* (palliative care), or *being present with* (crisis care) the human person who is experiencing the *phenomenon of suffering*, has been the traditional way CPE has approached its goal and aim of the *cure of souls*. CPE clinical practitioners learn from these encounters with human persons who suffer by means of theological reflection/reflexive praxis that deal with clinical situations. When they engage in reflective/reflexive learning it improves clinical and didactic praxis, and advances this human science discipline of care. However, this reflective/reflexive approach to learning the art of *curing souls* is deficient in its praxis in that it cannot achieve its primary goal and/or aim. This is because it seeks only to be *present with* (e.g. Husserl's *being there*) or to *come along side* (e.g. *together with*, Heidegger's, 1953, p. 52) those souls (i.e. those human persons who are ill, suffering or dying) rather than *present in* the *lived experience* and l*ife world* (*sitzen leben*; "setting of life") of those souls who are ill, suffering or experiencing an end of life situation. Van Manen (1990) explores the "situated person" as the human text from the very point of view and states:

> Phenomenology appeals to our immediate common experiences in order to conduct a structural analysis of what is most common, most familiar, and most self-evident to us. The aim is to construct an animating, evocative description (text) of human actions, behaviors, intentions, and experiences as we meet them in the lifeworld. To this purpose the human scientist likes to make use of the works of poets, authors, artists, cinematographers----because it is in this material that the human being can be found as *situated person*, and it is in this work that

> the variety and possibility of human experience may be found in condensed and transcended form. (Van Manen, 1990, p. 19).

However, we do not want to past by the significant problems in achieving the aim of curing the soul (i.e. of the *situated person*) by *transcending* the human person's experience of the phenomenon of suffering in their *life situation*. Rather the meaning of their *situation of life* has to be understood in participation with them in their *life-world*.

Heidegger (1953) already highlighted the problem of merely *coming along side* (i.e. *together with*) the other that is experiencing the phenomenon of suffering when he states:

> A being can only touch an objectively present being within the world if it fundamentally has the kind of being of being-in---only if with its Da-sein something like world is already discovered in terms of which beings can reveal themselves through touch and thus become accessible in their objective presence. Two beings are objectively present with the world and are, moreover, *worldless* in themselves, can never "touch" each other, neither can "*be*" "*together with*" the other. (Heidegger (1953), p. 52).

We have already seen above that Strunk (2004) in calling for a phenomenology of illness was concerned about caregiver's ability to engage in authentic empathy with care recipients, but wonders how this can be operationalized or objectified when "there is a gap between technology of care and human touch" (p. 293). It is apparent that objective presence of the caregiver in the life-world of the care recipient cannot be objectified without the quality of human touch, or the caregiver willing to take the risk of human touch. Human touch means only that the caregiver is more than just *present with* the

patient, but *present in* the patient's life world, where they are able to experience of the phenomenon of suffering with them.

This dissertation holds that CPE cannot limit itself to preparing CPE students and clinical pastoral care practitioners to merely be *present with* or *come along side* human persons that are experiencing the *phenomenon of suffering*. Rather, CPE must prepare student clinical practitioners to be *present in* the life-world and the lived-experience of their patients to the greatest extent possible. CPE students and clinical practitioners need to be *present in* the *life world* and *lived experience* of the human persons suffering if their aim is to improve their praxis and advance the art of the *cure of souls*. They must also do this if they want to provide appropriate spiritual interventions that lead to curing of the soul of the person who is suffering.

CPE clinical practice and educational pedagogy must begin reflect this new emphasis and focus if it wants to advance its project of caring for and curing souls. The role of the CPE researcher is to produce the scholarly literature that this pedagogical focus will demand. However, they can only do so by being participants in the life-world and lived experience of those they wish to heal. They must achieve a new horizon of understanding from these phenomenological experiential encounters with human suffering.

This dissertation describes being *present in* as seeking to *become one with the spirit of the person* by *centering oneness* in the love of God. However, there are some feminist ethicists like Nel Noddings (1984) that universal love and God has nothing to do with the ethic of caring for the other. Noddings (1984) wants to strip away every device used to implore or demand that people care for each other "Laws, manifestos, and

proclamations," "moral guides," or even notions of "perfect justice," and so rely solely on the individual that alone has the moral choice to decide to adhere to the *ethical ideal* within themselves to care (pp. 27-29) Nodding's (1984) argues in so many ways argues: what does love (even human love) have to do with caring and suggests that caring is a two way obligation between the one following the ethical ideal of care and the one receiving the care.

Care, therefore, cannot be imposed even it vitally needed in order to preserve human autonomy, and so Noddings (1984) states that "There must be exist the possibility for our caring to be competed in the other" (p. 17), meaning that the obligation to care is only invoke when care recipient is willing and capable of receiving it, otherwise the ethical obligation to care does not exist. Nodding (1984) uses the example of a mothers care for her child and states: "If the mother does not care naturally, then she must summon ethical caring to support her as one-caring. She may not ethically ignore the child's cry to live" (p. 17). Nodding's (1984) argument that nothing but the ethical ideal of choosing to care based purely upon ethical considerations begs the question of how do you habituate someone to ethically care if they do not care naturally, or care because they adhere to some moral standard, or some religious motivation grounded in either human love or theologically the love of God.

This dissertation is not willing to strip caring down to this notion of the ethical ideal that has no other motive than moral duty detached from actually caring for the human person grounded at least in empathetic sharing of their life-world and lived-experience. It is difficult to believe that caring for the other can be grounded only in some form of deontological notion of moral ethical duty.

This dissertation claims that the human science researcher and the clinical practitioner must love what is the object of their ultimate concern in order to care for and/or understand it within the context of its *life-world* and *lived-experience*. Both Moustakas (1994) and Van Manen (1990) explore the relationship between love, research and/or the object of one's ultimate concern. The research maxim would be that you must love the object of your research in order to fully see the thematic categories and cluster of meaning that surround the object that is experiencing any particular phenomenon.

Moustakas (1994) speaks of this notion in respect to its meaning for philosophy (i.e. the love of wisdom), and states: "Husserl himself realized that his work would be of no value to closed minds, to those who have not known the despair of 'one who has the misfortune to be in love with his philosophy' (1931, p. 29). This being "in love with philosophy" captures me also and evokes a desire to employ phenomenology in discoveries of knowledge and in theories and applications of human science." (Moustakas, 1994, p. 25).

This dissertation acknowledges that knowing the human person is not merely an act of the *mind*, or *head*, but one of the *heart*. CPE educational research has to take this pedagogical tradition seriously if it wishes to be true to itself. as well, and therefore should not be a mere nod in educational research. CPE has employed *head and heart* in *caring for* and the *cure of souls* since it's founding in 1925. But other support for this idea exists outside this human science tradition.

Bentz and Shapiro ((1998) takes the concept of love seriously in relationship to the object of one's ultimate concern, and suggests the following about the importance of love in mindful inquiry in social research using a Buddhist perspective:

> Buddhism, too, preaches the ultimate unity of all beings and the illusion of duality---- of the distinction between self and other, even the existence of self at all. But this unity is attained through increased mindfulness rather than mindlessness; but it is one that is attained through mindfulness and through compassion for and love of all things. . . . With regard to inquiry, this can be taken to imply that love and compassion are the underlying attitude that we should take toward all beings: that our knowledge that this advocacy of love occurs in a passage devoted to the attainment of calm. The statement follows it almost immediately "whether one stands, walks, sits or lies down, as long as one is awake, one should maintain this mindfulness" (Rahula, 1974, p. 98). (Bentz & Shapiro, 1998, p. 167).

Van Manen (1990) also suggests that love is important in understanding the *lived-experience* and *life-world* of a human person that is the object of our ultimate concern.

Van Manen (1990) states:

> We can only understand something or someone for whom we care. In this sense of how we come to know a human being, the words of Goethe are especially valid: "One learns to know only what one loves, and the deeper and fuller the knowledge is to be, the more powerful and vivid must be the love, indeed the passion" (1963, p. 83). I do not suggest that love or care itself is a way or method for knowing, but Frederik Buytenmdijk said in his 1947 inaugural lecture, love is foundational for all knowing of human existence. That knowing is not a purely cognitive act is a principle to which we nod occasionally in educational research. Contemporary phenomenologist like the Frenchman Emmanuel Levinas (1981)

> have attempted to demonstrate the deep philosophical truth of this insight. Especially where I meet the other person in his or her weakness, vulnerability or innocence, I experience the undeniable presence of loving responsibility. . . . When I love a person (a child or adult) I want to know what contributes toward the good of that person. So the principle that guides my actions is a sense of the pedagogic Good (van Manen, 1982d); at the same time I remain sensitive to the uniqueness of the person in this particular situation. (Van Manen, 1990, p. 6).

According to Van Manen (1990) then a person involved in either the cure of souls or understanding how this cure is obtained or its meaning must be a participant in the lived experience of the one suffering in a way that demonstrates that this is the caregivers ultimate concern motivated by love of the one who is suffering. The human person, who is suffering, is not merely an object of study, but love would direct that the human person who is suffering be their ultimate concern in the moment in which the caregiver and one receiving care share together the experience of suffering. This ultimate concern through shared experience of suffering would then call for the person concerned with curing the soul and understanding what it means to do so to take an intervening action though at time a risk for the caregiver.

But here we must issue a cautionary note learned from ethicist Nel Nodding (1984). The caregiver and the one receiving care each respective to their participatory roles in healing must transcend their phenomenological situation of life to arrive and new meaning and more importantly each must be willing and capable of both giving and receiving the love of the other. This must be the case or otherwise spiritual healing may not take place, because Nodding (1984) states: “There must exist the possibility for our

caring to be completed in the other" (p. 17). Love can be given, but it can also be rejected and healing power that comes with it. Love cannot still be given, but it cannot be forced on the other. This means that any interventions that are offered out of love can be rejected as well. Love is therefore a relationship and so precious is it for human healing that it is offer at no cost, but will not violate the human will to accept its offer of care. The caregiver only has the deontological moral duty to love and offer love, and nothing more.

Dr. Howard Thurman, Dean of Chaplains, Pastoral Theologian and Christian mystic called this culminating goal of caring the *centering moment*. For Howard Thurman (1954) this transcendent moment occurs when our *sitzen leben* or *life-world* and our *lived-experience* of suffering are co-mingled with the other, both who brought together, where the relationship of love and care are articulated by the spirit and love of God. Thurman (1954) states:

> We share in the quietness and wide variety of common concerns. Though our personal needs are tailored to the measurement of our private lives, these needs, which are so intimately our own, mingle and become one with the needs of all who gather together in this moment. The overarching demands of the agonies of our times do not leave us untouched---the miseries of the children of men as they struggle in various parts of the world for fulfillment and for self-realization, all of those who are cut off from the normal intercourse of their lives by withering illness, and by despair and anguish which somehow cannot be shared---we are not unmindful of the agonies of our time as the movement of the spirit of God makes itself articulate in us. (Thurman, 1954, p. 21).

Xolani Kacela (2006) suggests that Dr. Thurman's pastoral and mystical theology can be described as *action motivated by the love of God* that leads to two results: (1) ushering the person who is suffering into the presence of God "to help persons experience personal encounters with God's loving presence," and (2) social action and transformation of the human person that "inform pastoral caregivers that mystical experiences may have a purpose other than knowing God only for oneself. Persons can utilize their mystical experience to help bring about transformation in their families, churches, communities, and beyond . . . . Life is filled with tension. . . . tension is often represented by our desire for deep, emotional religious experience and the more common reality of wondering how God is moving in our daily experiences" (Kacela, 2006, p. 92).

Kacela's (2006) view suggests that for the pastoral caregiver the ordinary *lived-experience* is filled with moments of tension in the *life situation* or *life world* of one who is suffering. Somehow this person must *center this experience* within the spirit of God, who is the true source of the cure of the soul. The pastoral caregiver must share (co-mingle their experience of the phenomenon) to help achieve this *transcendent centering moment* with the person who is suffering in order for the cure of the soul to take place.

CPE: Definitions

However, some conceptual problems related to the goals of this human science discipline aimed at curing souls exists that need to be explained, clarified, and some terms defined. CPE's higher learning goal of curing souls presents its own conceptual barriers in the minds of some people, because it is mistakenly viewed and identified with efforts of Christian evangelism to *save souls*. This is partly because CPE evolved as a

special theological discipline coming out of the seminaries that would eventually be called *clinical pastoral education*, seeking to create a *clinical theology of care*.

Miller, Lawrence and Powell (2003) suggest that this misunderstanding of the goals and aims of CPE in respect to curing of souls has more to do with the turf struggle between the so called professional social science disciplines and the CPE human science discipline. Miller, Lawrence and Powell (2003) state:

> Religious traditions have been engaged in the cure of souls since the beginning of history, and for most of history they alone have carried on this task. The "cure of souls" is a construct of Latin and Germanic etymological roots with the same meaning as "psychotherapy" using Greek etymological roots. Through this etymological legerdemain secular professions co-opted the work of the cure of souls. The 20th century introduced the new secular professions of psychologists (theorist of the soul), psychotherapist (healer of the soul), and psychiatrist (physician of the soul). In the face of these new secular professions, religious professionals largely retreated from the task of the cure of souls, leaving it to the secularist (Miller, Lawrence & Powell, 2003, p. 112). Into this disciplinary vacuum stepped the CPE movement founded by Anton Theophilus Boisen 75 years ago and suggested that "we may be able to bring to bear, according to the needs of the particular case, the forces of healing and power" which lie with religion. One must assess the situation in order to apply the most appropriate assistance" (Miller, Lawrence & Powell, 2003, p. 112).

God-talk (i.e. theology, especially theological reflection and reflexive thinking) therefore should not be displaced in this dissertation, because, (1) it has no evangelical

goal to *save the soul*, and (2) it language is central to the work and core mission of CPE practitioners and the work they do in respect of their patient/clients.

If the work that these human science educators and practitioners is to be understood from a phenomenological perspective in respect to how they understand human suffering and what meaning it has for them, then God-talk within that life-world is essential. Career Counselor, Richard Nelson Bolles (2007), in his book *What Color is Your Parachute: A Practical Manual for Job-Hunters and Career-Changers*, suggests that the contemporary tendency to substitute talk about God with more politically correct (PC) terms like "spirituality," "soul," and/or "mission" is a mistake since God-talk is essential to understanding one's career, work and/or mission in life. Bolles (2007) states:

> When used with respect to our life and work *Mission* has always been a religious concept, from beginning to end. It is defined by *Webster's* as "a continuing task or responsibility that one is destined or fitted to do or specially called upon to undertake," and historically has had two major synonyms: *Calling* and *Vocation*. These, of course, are the same word in two different languages, English and Latin. Both imply God. To be given a Vocation or Calling implies *Someone who* calls. To have a Destiny implies *Someone who determines the destination for us*. Thus, the concept of Mission lands us inevitably in the lap of God, before we have hardly begun. I emphasize this, because there is an increasing trend in our culture to try to speak about religious subjects without reference to God. This is true of "spirituality," "soul," and "Mission," in particular. More and more books talk about Mission as though it were simply "a purpose you choose for your own life, by

> indentifying your enthusiasms." This attempt to obliterate all reference to God from the originally religious concept of Mission, is particularly ironic because the proposed substitute word—enthusiasms—is derived from two Greek words, "en theos," and means "God in us." . . . . What is not so clear is whether we think about God in connection with our work. Often these two subjects---spiritual beliefs and Work---live in separate mental ghettos within the same person's head. (Bolles, 2007, pp. 321-322).

However the case either for or against Bolles (2007) assertions, a study on Clinical Pastoral Education (CPE), in respect to its human science discipline and praxis, cannot proceed without taking God-talk seriously. God-talk (i.e. talk about God in relationship to healing the maladies of human persons) is the central focus of CPE's project of caring for and curing souls.

Nevertheless, it needs to be made clear that the theological goal and aim of the church to *save souls* is not the same as the CPE goal (despite its seminary origins) to *curing souls* or *care for souls*. The cure of souls by caring for the human person that is suffering is related to the question: What is *spiritual suffering* and the nature of *human spirituality*? Clinical pastoral care praxis in CPE/HCO contexts can be understood only when this question is answered and its connection is made to the idea of *curing the soul*.

Curing the soul involves helping the human person deal with *spiritual suffering* that could have some mild to serious impact on the person's physical, emotional and psychic health (i.e. those maladies that immediately affect the health of the human body and its wellbeing). Once human spirituality and spiritual suffering is defined then it will be clear what curing the soul means, and what clinical pastoral care practitioners do and

how they feel when dealing with human suffering. The big question then is what is human spirituality and spiritual suffering?

Fortunately, Bartel (2004) gives a clear answer by focusing on five spiritual needs of the human person (i.e. love, faith, hope, virtue, and beauty) nineteen different religious and philosophical perspectives. Once these are laid out Bartel (2004) shows what are the possible negative indicators of spiritual suffering in each category that clinical pastoral practitioners need to address in their practice and didactic studies dealing with the cure of souls. (Bartel, 2004, pp. 188-195). Bartel (2004) states:

> With these categories in mind, it can be seen that spiritual suffering arises when these needs are unfulfilled. When one can no longer trust those nearby, spiritual suffering is experienced. When beauty is absent from one's life, one suffers spiritually. When one's hope is gone, spiritual suffering can be acute. Much as physical pain signals an injury to the physical body, spiritual suffering can be seen as an indication that one or more spiritual needs is threatened or going unmet. While physical suffering can include a threat to one's mobility, spiritual suffering includes threats to one's beliefs and purpose in life. It is often experienced as "spiritual dissonance," where the dissonance lies between one's faith and critical events happening in one's life. Spiritual suffering is found clearly in those difficult times "when individuals are unable to find sources of meaning, hope, love, peace, comfort, strength and connection in life. In our calling to provide spiritual care, we strive to recognize such suffering and we seek to aid in its healing. We strive to assess and intervene in ways that focus on the types of suffering that can be overlooked by other disciplines. (Bartel, 2004, p. 194).

The grammatical origins of the phrase *cure of souls* will clearly show that CPE has a legitimate claim to this term to characterize the goal and aim of its human science discipline and that this usage has nothing to do with theological notion of salvation or *saving souls*. Also it must be made clear that spiritual suffering and physical suffering has a unified embodiment in the perception of the one suffering. Sometimes it is difficult to conceptually distinguish between the two in order to provide a cure for the one, which assists in the healing of the other, so intricate is the composite nature of the human person, made up of body and soul. Spiritual suffering and physical suffering are not the same. However, they cannot be separated in the human person, who as a composite being holds both together in one body. The human person experiences these two kinds of suffering as one unified embodied experience.

Finally, the human science disciplines of psychology and medicine borrowed the root term for soul, and as such began depriving it of its original meaning. Before this cooption the *soul* in its *physical*, *emotional* and *spiritual* nature was never thought of as separate aspects of the human person that could be understood, cared for, or healed without reference or consideration of all aspects together until of late.

Louw and Nida (1988/1989) show that the Greek term for *soul* refers to the whole person. Under the domain of *psychological faculties* the Greek term yuxh< and yuxh? (i.e. *psuche* and *psuches*) are the root words from which we get *psychic*. The Greek terms refer to the human *soul, life, and being, essence of life* in terms of *thinking, willing, and feeling*. These terms also refers to the *inner self, mind, thoughts, heart and desire*. (Louw & Nida, 1988/1989, p. 321, Sec. 26.4). Under the domain of psychological faculties the root word *soul* is broken down into two aspects of human nature (i.e. spiritual and

material), which unfortunately in the human science disciplines of psychology and psychiatry are generally thought of as separate, if not unrelated. The two aspects of the *soul* are as follows:

(1) *Sum-psuchos* (su<myuxoj) is the *spiritual nature* or aspect of human nature that connotes harmonious, united being in one spirit. (Louw & Nida, 1988/1989, p. 322).

(2) *Sarchos* (sarxo<j) is the *flesh nature*, *natural*, *human being*, or aspect of the *human person*, which according to Louw and Nida (1988/1989) is "the psychological aspect of human nature which contrasts with the spiritual nature; in other words, that aspect of human nature which is characterized by or reflects typical human reasoning and desires in contrast with those aspects of human thought and behavior which related to God and spiritual life. . ." (p. 322).

The human science disciplines with the exception of Clinical Pastoral Education (CPE) have lost the necessary connection between these two aspects of human nature. Traditional theology as a discipline has done just as badly in understanding these grammatical distinctions. Theology as a discipline has generally lost the connection within its God-talk on human nature and so is focused on *saving the soul*, by shepherding the soul back into a relationship with God. In order for theology to truly understand its mission, aim, and goal it would have to reestablish its original understanding of the two aspects of the soul in human nature in order to do its saving work related to the whole person. In a sense theology saw its own disciplinary deficiency and it order to cure this deficiency and also at one an the same time save its theological identity cooperated in creating the CPE Movement, allowing its seminarians who wanted a clinical theological perspective to branch off into the realm of caring for and curing of the soul rather than

saving the soul. Thus the theological discipline cleverly spun off itself a new disciplinary horizon of understanding, which in some respects it no longer recognizes as one of its children that it gave birth too as a new discipline.

This dissertation is suggesting that CPE has gone so far in the direction of the allied human and social sciences that it is threatened with forgetting its own theological mother that gave it birth. In some respects to appease secularism and appear to be more scientific, CPE is seeking to in some respect to change its theological language and God-talk in exchange for the foreign tongue of the allied human and social sciences, which ironically borrowed the language first from CPE's theological mother. Theology was at one time called the *Queen of the Sciences*. It was during the High Middle Ages that theology took this academic seat of authority. For a time it became the premier discipline to which the others, especially philosophy were allied. Theology as an academic discipline was once part of the European university system, and according to Howard (2006) presided over both the *Trivium* (i.e. grammar, logic, and rhetoric) and the *Quadrivium* (i.e. arithmetic, geometry, astronomy, and music). (Howard, 2006, p. 56).

How strange a turn of events that in these modern times all of these university disciplines, including the seminary discipline of theology have forgotten the interdisciplinary nature of theology and it's God-talk that is so interested in human nature in all of its aspects, body, mind and soul, and its flexible character such that it can spin off a CPE discipline to take care of a special area of human care that it by itself without collaboration between it and medical science, cannot address.

Psychology and psychotherapy have lost the necessary connection with emphasis on being *theorists of the soul* or *healers of the soul* (the object being only the human

emotions and the mind). Practitioners of this human science discipline would need to regain the etymological origins and grammatical understanding of the root word for its discipline if it wishes to be a *healer of the whole human person*. Even the words *theory* and *therapy* hold clues to reclaiming this old horizon of understanding and should lead to proper diagnosis of human maladies so that the proper therapeutic approach can be taken, whether spiritual or psychological.

(1) *Theoria* (qewri<a), is the Greek word for *contemplation*, *speculating,* or *looking at things* by means of *comprehension* of *consciousness* or *nous* (i.e. the *eye of the soul*). Within the root word is *theo* that according to *Webster's New World Dictionary of the American Language* (1968, p. 1510) means "God" reflected in the Greek combined form qeoz (i.e. theos). Certainly the old form of *theoria* (theo-ri) and its connection to the root *theo* (God) has been lost to all of the human sciences that use the word, but may be recovered by recovering the syllable *ri* from Egyptian hieroglyphic word *re* (i.e. , word symbol for things done with the mouth by means of the intellect or rational mind), which means *speech, words, opinions* (Budge, 1968, p. 416, Vol. 1).

If this etymology is correct then *theory* would have originally meant "God's speech," or "God's utterance," or "God's talk," which would be the divine source by which the *nous* or *human consciousness* understands itself. *Theory* then would be the *divine/human* means by which understanding the maladies of the whole human nature could be understood, so that *caring of the soul* could take place, and *curing of the soul*, as understood in CPE praxis, would be made possible. The process of *curing of the soul*, which includes accessing the nous or eye of the soul with divine assistance, would lead to clinical pastoral therapeutic practice, where:

(2) *Therapeuo* (qerapeu<w) or therapy means "to cause someone to recover heath, often with the implication of having taken care of such a person – to heal, to cure, to take care of, healing" (Louw & Nida, 1988/1989, p. 269, 23:139). This dissertation make the claim that Clinical Pastoral Education has somehow retained the kernel, if not the whole fruit pod, of the old etymological and grammatical forms, expressed in its praxis, which sees the soul as composite but unified human nature. CPE still recognizes that these human maladies must be addressed from a spiritual horizon of understanding, even though it is overly captivated by the views and methodologies of allied human and social sciences it thinks can provide it the tools to advance its human science project of *caring for* and *curing the soul*.

CPE's horizon of understanding is not explicit as it should be, but the understanding it does have is embedded deep within its traditional clinical theological reflective pedagogy born out of its connection with both the seminary and the hospital since 1925. CPE coming out of that dual movement began with a clear understanding of its theological nature and spiritual mission. Of late this clear vision has been somewhat dimmed, which is the motive force behind this dissertation study. CPE needs to be reawakened to his theological nature and its spiritual mission that is buried deep in its educational pedagogy and clinical praxis.

It is also important for this dissertation to briefly explain how God and references to God are used in this dissertation. The use is contextual and based on the understanding that CPE clinical pastoral care educators and clinical pastoral practitioners understand God and the role God plays in their clinical praxis within Hospital Clinical Organizations (HCOs). Neither the CPE educators nor pastoral practitioners (all of whom express

personal belief in God and belong to various religious faith traditions) that I interviewed see the need to provide an apology (i.e. apologetic defense) or a theodicy (i.e. defense of God's righteousness) in their praxis of curing of the soul that needs to make reference to God.

It is generally thought in CPE praxis, and its literature that God needs no defense, and that God has called them as educators and practitioners within the context of the CPE/HCO contexts to transcend, suspend or work through their own religious or spiritual reflexivity, belief and faith. This, of course, must be down without violating their own faith traditions in order to address human spiritual suffering, and without violating the personhood or faith of those patients that are suffering, whether they believe in God or not, or belong to, or do not belong to any particular religious communion or community.

This dissertation holds that the cure of souls is concerned with spiritual suffering within an embodied context of concrete ontic reality of experience of phenomenon. The faith of its pastoral care provider should never interfere with this primary goal and aim.

Bartel (2004) makes this faith stance clear as he talks about the need to understand and define spirituality and spiritual suffering in the context of CPE praxis. He states:

> A broad and foundational definition is needed for the terms "spiritual" and "spiritual suffering" that can be embraced by both the religious and non-religious traditions of the world. If we believe that all humans are spiritual beings, then "we need such an inclusive discussion because the spiritual needs of the unreligious must also be met." As pastoral care and counseling continue to broaden in scope to include the many cultures and traditions of the globe, our conceptual

> framework needs to broaden to encompass the spiritual experience of all those we serve. . . . With an understanding of the human spiritual needs for love, faith, hope, virtue, and beauty and how we suffer spiritually when those needs are not met, our caregiving goals can be reached. We can identify more of the needs, let fewer needs languish unseen and focus our limited time where it is most needed. Most of all, we will be part of the healing of others' spiritual suffering. This is our calling. (Bartel, 2004, p. 200).

CPE: Social Justice Considerations

This pastoral horizon of understanding and disciplinary stance taken by CPE that Bartel (2004) summarizes, and my research findings also confirm, is a social justice stance on behalf of those who are suffering. This social justice horizon of understanding yet guides the clinical practice of its pastoral care providers, even though there are some pedagogical deficiencies in terms of including bio-ethics and medical ethics within CPE curriculums. Nevertheless, this social justice horizon of understanding also defines the nature and character of its CPE praxis that seeks to include all human persons within the scope of its disciplinary aim of the care and cure of souls.

However, as my research will show CPE has not clearly defined its social justice stance; nor has it provided for itself a methodology grown out of its own reflexivity, clinical and didactic praxis that would allow it to deal with institutional injustice within the context of the HCO on behalf of the patients it care for. Clinical Pastoral Education engages in interpretive qualitative research but has not focused sufficiently on either social justice or self-reflective (reflexive) nature of its disciplinary calling that allows them to see the social justice needs and concerns of its patient/clients in respect to the

negative impact hospital clinical organizations have on the autonomy of human persons domiciled within it or associated with the families of those who are suffering.

For example, it is not generally know that in some states two physicians can agree that life-support from a loved one of the family objections of the family and thus secure a court order affirming this medical decision. In some few cases this is done because of institutional needs that supersede that of the needs of family and the patient. Sadly, sometimes such decisions are purely arbitrary and guided by relations between physicians and families that have deteriorated of end-of-life issues. Sometimes the decision involves the projected longevity of care over costs and use of other hospital resources, all of which can rapidly become moral/ethical and social justice issues. In these situations what should the moral/ethical and/or theological stance be for the clinical pastoral care provider, who is standing within the lived-experience of the one who is suffering?

Both reflexive and reflective thinking are needed to improve CPE praxis and bring it to understand more clearly its role in providing a social justice element and the correct perspective within powerful healthcare clinical organizations. The pursuit of this twin goals is extremely important given the recognized need to respect the human autonomy of those who are ill and suffering, even though the cure of souls is still the primary aim for CPE. On the other hand, while alleviating spiritual suffering is the primary aim of CPE, it can never forget that institutional injustice violates the human person who suffers, and so can impede CPE's project of *care for* and *cure of the soul*.

Creswell (2007) describes the tension between the goals interpretive research practices and social justice that in my research apply to the reflexive and reflective practice of Clinical Pastoral Education. Creswell (2007) stated:

> Some have argued that the purpose of qualitative research should be to advance a social justice agenda (Denzin & Lincoln, 2005). While one needs to acknowledge that our society has become more diverse, cognizant of underrepresented groups, and educated about racial and ethnic tensions, not all qualitative projects *must* have this agenda as a central feature. All studies should acknowledge and recognize these issues as part of all inquiry and actively write about them. (Creswell, 2007, p. 3).

This tension will be displayed in this dissertation as well. How can CPE overcome its deficiencies in its own horizon of understanding in respect to a broader social justice role as its practitioners deal with the phenomenon of spiritual suffering? How can it improve its clinical praxis and methods appropriate to its own human science discipline that is spiritual in both character and nature? This dissertation proposes as a partial remedy the little known conceptual methodology and reflective praxis referred as the *centering moment* as understood by the Rev. Dr. Howard Thurman (1969), Dean of March Chapel at Boston University. Dr. Thurman's conceptualization bridges the gap between dealing with spiritual suffering and societal injustice and sees spiritual solution to this societal dilemma where each human person seeks to center itself empathetically within the life-world and lived experience of the *other*. This dissertation has already started to talk about this above in its discussion on the role of the love of God in caring for the one who is suffering.

We have already said this view of Dr. Thurman (1969) is called the *centering moment of transcendence* that allows mutual healing of the human spirit that suffers because it is no longer divided against itself and the *other*. Dr. Thurman (1969), whose

spiritual theology has been influential in the clinical pastoral care movement and is found prominently in its literature, will also call this move a *sacramental moment*. From Dr. Thurman's (1971) perspective on social justice and its spiritual/human nature, he states:

> The man who seeks community within his own spirit, who searches for it in his experience with the literal facts of the external world, who makes this his formal intent as he seeks to bring order out of the chaos of his collective life, is not going against life but will be sustained and supported by life. And for the world of modern man this is crucial. In the conflicts between man and man, between group and group, between nation and nation, the loneliness of the seeker for community is sometimes unendurable. The radical tension between good and evil, as man sees it and feels it, does not have the last word about the meaning of life and the nature of existence. There is a spirit in man and in the world working always against the thing that destroys and lays waste. Always he must know that the contradictions of life are not final or ultimate; he must distinguish between failure and a many-sided awareness so that he will not mistake conformity for harmony, uniformity for synthesis. He will know that for all men to be alike is the death of life in man, and yet perceive the harmony that transcends all diversities and in which diversity finds its richness and significance. (Thurman, 1971, p. 6).

CHAPTER 2 – LITERATURE REVIEW

This chapter is a continuation of literature review process that began with EDU 891 Literature Review Seminar. This chapter is a new contribution, more comprehensive, and a necessity if the reader is to understand the depth and breath of what literature is needed to answer my research questions about the phenomenology of suffering in respect to pastoral care higher education. This literature review chapter describes three levels of literature related to the dissertation research questions.

The primary or core data for the pastoral literature is *The Journal of Pastoral Care & Counseling* (JPCC) covering the period between 2003 and 2008. Of course some of these journals refer as far back as 1975 with "John Florell's replication studies with 150 orthopedic surgery patients and Mills' work with 100 open-heart surgery patients also showed a high correlation between acceptance and healing" (Gleason, 2004, p. 299). Of course these early studies were quantitative. Qualitative research would have come well after this period into the decade I am primarily reviewing (2003 to 2010) because of the influence of positivism and empirical theoretical and methodological assumptions we will examine in Chapter Three on methods. The key words for pastoral care and the defining of terms are included below in the appropriate sections. The three levels of literature are as follows: (1) philosophical, (2) theoretical or methodological, and (3) clinical pastoral care, which will be further subdivided into (a) clinical pastoral care, (b) pastoral care education, and (c) spiritual needs.

Overview: Care Pastoral Literature

Before going into the essential philosophical, theoretical, and methodological literature that serves as a foundation for understanding my research questions within the

overall discipline of clinical pastoral care education and practice this dissertation provides a general overview of the pastoral care literature and narrow the three main areas of literature from the vast array of literature that are part of this discipline. This will help those readers who may not be familiar with the literature of this discipline. This will avoid confusion and misunderstanding if this is done first, that is, before presenting the philosophical, theoretical and methodological literature that are fundamental in dealing with the research questions, and also understanding what pastoral care means as a human science discipline in respect to its focus on the phenomenon of human suffering.

The initial exploration in the literature that has evolved from clinical pastoral education and clinical practice is guided by the dissertation proposal to study how clinical pastoral students and practitioners experience the phenomenon of pastoral clinical education in both its didactic and clinical forms. In order to begin this gathering and systematic study it is important in this literature review to delineate the discrete varieties of care in the higher education discipline of clinical pastoral education. It is important to know when reviewing the literature that it is difficult to separate the topics of pastoral care and clinical professional education and practice in the context of healthcare delivery.

When discussing the discipline of pastoral care you are (it seems) discussing clinical pastoral care education and practice at one and the same time. However, there is a structure that emerges, which can guide the reviewer/researcher into specific and well defined areas or domains of knowledge: (1) Healthcare Delivery, (2) Measurement Studies and Empirical Research on Pastoral Care, (3) Pastoral Counseling, (4) Clinical Pastoral Education, (5) Importance and Role of Chaplaincy, (6) Measurement Studies and Conceptualizations on Religion and Spirituality, (7) Meta-Ethical and Bioethical Studies

of Healthcare Ethics, (8) Pastoral Psychology, and (9) Pastoral Care Theology. (Mari-Jata, 2010, p. 3).

However, the broad areas in which the literature on pastoral care are traditionally organized are (1) pastoral care, (2) pastoral counseling, (3) pastoral care education, (4) spiritual needs, and (5) pastoral care psychotherapy. For the sake of this literature review we will confine ourselves to pastoral care, pastoral care education, and spiritual needs areas of clinical pastoral care. The first three areas of the discipline are germane to CPE formal programs and achieving the associated competencies leading to board certification of chaplains. The last two areas can be considered as specialties adopted by personal preferences and interest of the pastoral researcher. It is obvious that I will not be able to neglect the vital areas of pastoral counseling and pastoral care psychotherapy in my larger and more formal literature review for this dissertation.

Over the years pastoral care and counseling literature has coalesced and developed around achieving the core competencies surrounding these primary areas for pastoral care. All five areas of clinical pastoral education focus on the phenomenon of human suffering and each area addresses it from its own unique perspective. The researches in these areas, however, do not hesitate to approach this phenomenon using interdisciplinary methods borrowed from the five areas and also from other allied disciplines. (Mari-Jata, 2010, p. 4). The general focus on understanding and alleviating human suffering is the rational fulcrum or horizon of understanding one can use to study and research the literature that would at first seem bewildering and also incomprehensible. In this regard Miller, Lawrence and Powell (2003) state:

> Considerable confusion exists regarding the competency of clinically-trained pastors in the area of what traditionally has been called the "cure of souls." The language we use in describing varieties of pastoral assistance befuddles us . . . Due to the complexities of existence, nothing is more human than suffering. We respond to another's pain with humility and courage---even audacity---accepting the anxiety that accompanies risk. Our response is always an act of faith. Our response is "pastoral"---from the Latin *pascere*, "to feel"---when we shift our focus from self-absorption to the compassionate nurturance of others. Clergy, whether lay or ordained, participate in this nuturant act of faith when they attempt to assist those who are in physical, mental, or spiritual distress. We should not minimize the strength of the pastoral role. Some clergy have sought and obtained specialized clinical training to enhance their competence in providing such help. This Guest Editorial is one attempt to clarify the broad-based and rich expertise required by clinically-trained clergy. As the modern pastoral professional has evolved, three types of nurturant intervention have emerged: "Pastoral Care," "Pastoral Counseling," and "Pastoral Psychotherapy." This typology accurately conveys the full range of expertise in the pastoral armamentarium. Each is characterized by a distinct complexity of involvement, depending on the needs of the suffering individual, and each requires differing skills and training. (Miller, Lawrence & Powell, 2003, p. 111).

In this literature review I will focus primarily on two primary areas of clinical pastoral care mentioned above by Miller, Lawrence and Powell (2003) and spiritual needs assessment and spiritual suffering based on the research of Mark Bartel (2004). As

we have already pointed out assessing spiritual needs and alleviating spiritual suffering related to physical, emotional, and/or psychic distress is the goal and aim of *caring for* and *curing souls*, as understood by clinical pastoral educators and practitioners.

I believe this is core educational focus and process of higher learning that CPE describes as *head and heart*. *Head and heart* is a theological concept that has a long and varied history but has naturally found in its home in CPE clinical praxis and scholarship. Charles E. Hall (1992) in his book *Head and Heart: The Story of the Clinical Pastoral Education Movement* and others have described its historical development. Howard Thurman (1979) in his book *With Head and Heart: The Autobiography of Howard Thurman* and many theological works such as *Deep is the Hunger* (1951), *The Inward Journey* (1961), *Disciplines of the Spirit* (1963), *The Luminous Darkness* (1965), *The Centering Moment* (1969), *The Search for Common Ground* (1971), and *Jesus and the Disinherited* (1976) have flushed out the meaning of *head and heart* for human *spiritual needs* and *spiritual suffering* in the concrete situations of the human person's *life-world* and *lived-experience* with associated social justice implications that contribute to both human maladies of the body and soul.

There is whole body of spiritual needs literature related to this clinical pastoral focused on suffering and discipline of care related to physical and mental health research inspired by the Clinical Pastoral Care (CPE) movement with its goal to *care for* and *cure the soul* that sadly has been co-opted by researchers from allied heath fields like psychology. Research literature from these human science fields seems to be concerned with how to *measure* religion and spirituality and its meaning and/or implications for mental health research using mostly quantitative research methods. The goal of

discovering the *meaning* of religion and spirituality in order to assess *spiritual needs* and alleviate *spiritual suffering* has been lost in an unwarranted effort to detach the *life-world* and *lived-experience* of the researcher from persons that are suffering in the name of scientific positivism.

This dissertation claims that a *phenomenology of suffering* is needed in order reclaim and redirect CPE educators and clinical pastoral practitioners back to their original purpose and aim to care for and cure souls, that is, as Heidegger (1953/1996) says in his phenomenological maxim one must go back "To the things themselves" (p. 24). Going back to what? Husserl (1999) says that phenomenology wants to go back to the human *life-world*, that is, back to the:

> Pregiven world in which science and every other life-praxis is engaged. In this life-praxis, knowledge, as prescientific knowledge, plays a constant role, together with its goals, which are in general satisfactorily achieved in the sense which is intended and in each case usually in order to make practical life possible. . . . into the pregiven world. It is pregiven to us all quite naturally, as persons within the horizon of our fellow men, i.e., in every actual connection with others, as "the" world common to us all. . . . now if this pregiven world is to become a subject of investigation in its own right, so that we can arrive, of course, at scientifically defensible assertions, this requires special care in preparatory reflections. It is not easy to achieve clarity about what kind of peculiar scientific and hence universal tasks are to be posed under the title "life-world" . . . . The life-world was always there for mankind before science, then, just as it continues its manner of being in the epoch of science. Thus one can put forward by itself the problem of the

> manner of being of the life-world; one can place oneself completely upon the ground of this straightforwardly intuited world, putting out of play all objective-scientific opinions and cognitions, in order to consider generally what kind of "scientific" tasks, i.e., tasks to be resolved with universal validity arise in respect to this world's own manner of being. (Husserl, 1999, pp. 363-364).

Husserl's (1999) statement "putting out of play all objective-scientific opinions and cognitions" in order to understand the human persons pre-scientific life-world (i.e. the world and its phenomenon that is the object of human lived-experience) is precisely what he means by the concept of *epoche*. This concept has been misunderstood by contemporary transcendental phenomenologist like Moustakas (1994) who has relegated this philosophical principle to a mere phenomenological method that actually by-passes the ordinary world of the human person experiencing a particular phenomenon based on the Greek definition of epoche, which Moustakas (1994) means "to refrain from judgment, to abstain from or stay away from the everyday, ordinary way of perceiving things" (p. 33).

Husserl (1999) meant quite the opposite and suggested that it is in fact the ordinary practical life-world, the pre-scientific world of the human person we are trying to understand in relations to the lived-experience of phenomenon and the kind of judgment and opinion to be suspended in order to understand this life-world is that based on scientific methodology, that is, "objective-scientific opinions and cognitions" (Husserl, 1999, p. 364), until a proper scientific method and task can be discovered to assess the meaning of "this world's own manner of being" (p. 364).

Therefore, this phenomenological goal cannot be achieved by standing outside the *life-world* and lived-*experience* of a person who is experiencing the phenomenon of suffering, whether physical, emotional, psychic or spiritual. Somehow the clinical practitioner/educator/researcher must get behind the phenomenon being experienced to discover its meaning for the one who is suffering, that is, get behind the pre-given life-world to discover the spiritual needs and discover a cure for spiritual suffering of the human person.

This clinical pastoral care view of the human problem of spiritual needs and spiritual sufferings is currently far removed from allied fields of research, which sadly CPE curriculums have been relying on for many years in formulating their educational program for its students and clinical pastoral practitioners. So-to-speak CPE has left its first love in curing souls and as I am claiming no longer has the *five smooth stone and sling-shot* to fell the Goliath of human spiritual suffering, because it is wearing the methodological armor of its allied human science that do not fit its original purpose, goals or aims.

Psychologist such as Hill and Pargament (2003) are apparently excited by the new developments in this area of study and state:

> There is now a substantial literature that connects religion and spirituality to physical health. . . and mental heath. What is it about religion and spirituality that accounts for their link to health? Researchers have suggested various possible psychological, social, and physiological mediators that may account for the religion and spirituality---health connection. However, it is possible that the explanation for these effects may also lie in the nature of religion and spirituality

> themselves. More finely delineated measures of these constructs might relate more directly to physical and mental health. (Hill & Pargament, 2003, p. 64)

This literature coming primarily from the psychology researchers interested in religion is undeniably important to clinical pastoral care practitioners but is not designed *per se* to assist pastoral professionals to deal with the phenomenon of suffering. The best that can be done with this kind of literature is view it as an interdisciplinary ally of clinical pastoral education and use it as one among many other tools that fit the CPE research goals, theory and clinical practice. (Mari-Jata, 2010, pp. 4-6).

Overview: Philosophical Literature

Another area of study that is relatively new and guided by the recognition that all five primary areas of clinical pastoral education focus on human suffering, and so there has been a call to examine the phenomenological ground that justifies this focus. Phenomenology as a pastoral clinical approach has not been much talked about, since it is seen as purely philosophical and theoretical in nature and not as an operational methodology that can be used in actual clinical settings. This dissertation claims that this is not true. The evidence for this claim can be seen in the early development of the Clinical Pastoral Education (CPE) Movement, which we will explore briefly following this nature and characterization of the philosophical and theoretical literature necessary to This dissertation focus. (Mari-Jata, 2010, p. 6). The reason philosophical literature dealing with phenomenology is important for this dissertation is that:

(1) This dissertation questions deal with the phenomenon of suffering, (2) I have chosen to use the qualitative methods of Van Manen (1990), who is a proponent of *hermeneutic phenomenology* and Moustakas (1994), who is a proponent of

transcendental phenomenology. Both of these scholars have grounded their phenomenological methodologies in the phenomenology of Heidegger (1953) and Husserl (1931). Heidegger's (1953) philosophy serves as the basis for hermeneutic phenomenology and Husserl's (1931) philosophy serves as the basis for transcendental phenomenology.

It therefore is important that the philosophical ground for the method be understood. And while they are the most important in respect of this understanding other perspectives on philosophical phenomenology are important as well. This dissertation describes some of this literature first and then summarize the perspectives of Heidegger (1953) and Husserl (1931) last since detailed description of their views in given in the methods section, and also in that section gives some sense of how this literature as a whole can illuminate or advance our understanding about the phenomenon of suffering, even without application of the intervening methodologies.

If one wants to understand the *lived experience* of pastoral care practitioners as they experience the phenomenon of suffering one must try and understand their *inner consciousness* of this *thing outside themselves* from a spiritual perspective. This is a spiritual and not a psychological process, which deals more with helping the person *bring out* the inner consciousness things that are not necessarily related directly to experience of their *life world*. The spiritual needs area of pastoral care is particularly interested in understanding the inner consciousness of a person dealing with suffering apart from psychological considerations, that is, spiritual needs is interested in how these persons deal with suffering as a *thing outside themselves.* If this is the case then it is essential that

these practitioners understand Hegel's (1807, 1977) *Phenomenology of the Spirit*. Hegel (1807, 1977) states:

> The *being* of this object for consciousness is mediated by the movement of *appearance*, in which the *being of perception* and the sensuously objective in general has merely a negative significance. Consciousness, therefore, reflects itself out of this movement back into itself as the True; but, *qua* consciousness, converts this truth again into an objective *inner*, and distinguishes this reflection of things from its own reflection into itself. . . . This inner is, therefore, for consciousness an extreme over against it; but it is for consciousness the True, ... With this *inner truth*, as the *absolute universal* . . . . the individual and has become the object of the *Understanding*, there now opens up above the *sensuous* world, which is the world of *appearance*, a *supersensible* world which henceforth is the *true* world, above the vanishing *present* world there opens up a permanent *beyond; an* in-itself which is the first, and therefore imperfect, appearance of Reason, or only the pure element in which the truth has its *essence.* (Hegel, 1807, 1977, pp. 87-88).

First, Hegel (1807, 1997) states that consciousness is mediated by the "movement of appearance," that is from phenomenon external to the individual. This seems to be mere common sense. But what a phenomenologist wants to know is what does this movement outside the person mean to the person. Hegel (1807, 1977) provides that answer. To the person who receives the phenomenon outside themselves into their inner-being (not just their mind, but into their being, i.e. spirit) the mediate consciousness receives it finally as pure truth for them in their life-world, which experience vanishes the

moment the phenomenon occurs as immediate, but becomes permanent as truth within the person if the phenomenon in fact has meaning or in Hegel's (1807, 1977) words true essence, where the phenomenon becomes real.

Since phenomenology as a method is seeking to abstract clusters of meaning and themes that explains how a person experiences a phenomenon outside themselves, such as suffering, or illness then Hegel's (1807, 1997) observations about how the human consciousness (spirit) works is essential to obtaining this knowledge and why certain phenomenon are true for some persons and not true for some other persons, who experience the same phenomenon, all other things being equal with their life worlds.

Since human experience of the phenomenon of suffering and or illness often produces anxiety and those who come alongside to assist persons in their life-world sometime experience the same anxiety, it is important to understand what anxiety is, and is it in fact a mere by-product of human suffering or something deeper. That answer will come by including in my literature review the work of Jean-Paul Sartre (1943, 1956), an existentialist who considers himself a phenomenologist. According to Barnes (1956) the translator of Sartre's (1943, 1956) work *Being and Nothingness*: "In general in speaking of the theory of phenomenology Sartre refers to the work of Husserl. It should be noted, however, that in spite of many points of disagreement with Husserl, Sartre considers his own work a phenomenological study." (Sartre, 1943, 1956, p. 805). Sartre (1943/1956) has some instructive criticism of phenomenology as understood by Husserl (1931) and states:

> Modern thought has realized considerable progress by reducing the existent to the series of appearances which manifest it. Its aim was to overcome a certain number

> of dualisms which have embarrassed philosophy and to replace them by the monism of the phenomenon. (Sartre, 1943, 1956, p. 3).

If this reductionism is a problem for philosophical phenomenology then it must be taken into consideration for any method that grounded with it. It is understood that the human person is not a simple organism but a complex being. Phenomenology is a beautiful human science made even more appealing because it attempts to explain meaning or clusters of meaning or themes from human experience of phenomenon by reducing the experience to one phenomenon, which in fact human persons experience multiple phenomena almost instantaneously and not sequentially as phenomenological method may give the impression.

Sartre (1943, 1956) therefore warns against reducing human experiences of phenomenon to a series of outward appearances. Something else is going on within the human person that conditions it toward any phenomenon it experiences. One of these conditions is human anxiety grounded in their fear of non-being or nothingness, a kind of primordial condition of the human person that is always present. For Sartre (1943, 1956) *being* and *non-being* is not a dualism but one essence and experienced as one phenomenon of the mind, and so states:

> Thus Being cut from Essence which is its ground becomes “mere empty immediacy.” This is how the *Phenomenology of the Mind* defines it by presenting pure Being “from the point of view of truth” as the immediate. . . . But Being thus undetermined immediately “passes into” its opposite. “This pure Being,” writes Hegel in *Logic*. . . , is “pure abstraction and consequently absolute negation,

> which taken in its immediate moment is also non-being." (Sartre, 1943, 1956, p. 45).

For Sartre (1956), therefore, human anxiety (fear of non-being or negation) is not a mere passive state brought on by suffering but a permanent fixture of the human mental make-up. Anxiety is always there because humans whether they are sick or not, suffering or not, fear the one thing all of us must face, which is, *non-being* or maybe something worst, *negation of being*, a kind of living death where the person is not only not durable but not useful any more. Suffering, sickness, and end of life situations are only reminders of our mortality and our relative durability as human persons.

When a pastoral care practitioner walks into a hospital room he/she should understand that anxiety is a permanent part of the human condition as limited and fragile beings, and so what is said or not said becomes the phenomenon that can be experienced as anxiety, and finally that they themselves are not immune from this experience within the confines of another person's life-world. Pastoral care practitioner who comes along side to help is in fact one a phenomenon that is experienced within the inner being of the person. This dissertation has dealt with Heidegger (1953, 1996) and his *Being and Time* in the methods section where it is noted that his work is the basis for Van Manen's (1990) hermeneutic phenomenological method, which explains a person's experience of phenomenon in terms of their *lived experience* and *life-world*. This dissertation seeks to say more about Husserl (1931) and his *A General Introduction to Pure Phenomenology*, since this work among others is the foundation for Moustakas' (1994) transcendental phenomenology. According to Rank (2011) Husserl distinguishes between two viewpoints on phenomenology, as follows:

> In *Ideas: A General Introduction to Pure Phenomenology* (1931), Husserl distinguishes between the natural standpoint and the phenomenological standpoint. The former is our ordinary everyday viewpoint and the ordinary stance of the natural sciences, describing things and states-of-affairs. The latter is the special viewpoint achieved by the phenomenologist as he or she focuses not on things but on our consciousness of things. (This is sometimes confused by the fact that Husserl insists that the phenomenologist pay attention to "the things themselves," by which he means the phenomena, or our conscious ideas of things, not natural objects.) One arrives at the phenomenological standpoint by way of a series of phenomenological "reductions," which eliminate certain aspects of our experience from consideration. Husserl formulates several of these, and their nature shifts throughout his career, but two of them deserve special mention. The first and best-known is the *epoché* or "suspension" that he describes in *Ideas*, in which the phenomenologist "brackets" all questions of truth or reality and simply describes the contents of consciousness. (Rank, 2011, http://science.jrank.org/pages/10639/Phenomenology-Edmund-Husserl.html).

Husserl's (1931) is mentioned in this regard because his principle of *epoche* or bracketing the reductionist method of either eliminating or suspending experiences from consideration when confronted with a phenomenon is for the researcher a problem. It is quite possible for people to experience a series of closely related phenomenon as *one thing*. If this *one thing* appears to them as *truth* as we have indicated above, then how is it possible to bracket the experience of these phenomenon from consideration when the researcher or pastoral care practitioner experience the same phenomenon?

However, the researcher has to be concerned with bracketing the aspects of the phenomenon that are nonessential. However, this begs the question as to what point in the research one is able to say what is essential and nonessential until all of the meaning statements and cluster of thematic horizons emerge. The then researcher can analyze the meaning statements over against the research question and did which are essential or not essential to the research question proposed for the study.

Overview: Theoretical Literature

This dissertation has begun to explore the theoretical literature that seeks to understand qualitative research and methodology in terms of the naturalistic post-positive paradigm of Lincoln and Guba (1985) and more work on this emerging literature needs to be done. Naturalistic inquiry seeks to provide a theoretical understanding of qualitative research without necessarily relying on philosophical grounding. Naturalistic inquiry proposes that the positive paradigm that uses scientific methodology is no longer the preeminent paradigm for getting at the truth.

If phenomenological research can incorporate the naturalistic methodology into its perspective then it will finally have a theoretical foundation that will allow it to move independently of its philosophical moorings. Lincoln and Guba (1985) are saying that a new postpositivist paradigm is challenging the positivist hubristic claims (once you understand the positivist stance) that *scientific method* is the only way of knowing or the only epistemological method. What is needed is a new paradigm inquiry based on different methods and procedures that heretofore those challenging the positivist claims have failed to develop. Dr. James Caraway (2012), who presented a paper called “Two Ways of Knowing” at a conference in Las Vegas (March 2012) suggests the following

perspective that could be one of the corner stone or key stone for building such a model. Caraway (2012) "affirmed the scientific method as usually considered was inadequate or unable to establish knowledge of persons, for it excluded 'subjective intentionality' which is at the heart of being a person. My suggesting was that a different epistemology was necessary. I referred to it as *revelational epistemology* rather than observational" (Caraway, 2012, Comments). Caraway's (2012) allows one to avoid the claim that phenomenology is using scientific methods rather than qualitative methods aimed at acquiring meaning as *revealed* by human participants in the study.

However, I have show in the introduction that one can dodge this bullet by denying that scientific method has exclusive ownership of *close observational* methodology, and in addition I have shown that *close observation* is used by qualitative studies, such as, *ethnography*, *case study*, as well as *phenomenology*. Nevertheless, Dr. Caraway (2012) notion that revelational epistemology ought to take the place of so-called close observation in qualitative studies, because it allow such studies to acquire its on epistemological language that describes what it is actual doing, and at the same time avoid any confusion from the uninitiated in qualitative study that scientific methods are being relied on, which is a key part of the positivist paradigm.

Positivism refers to a philosophical science or set of epistemological perspectives that hold that scientific method is the optimum approach to discovery and revealing processes by which both human and physical events in the universe occur. Lincoln and Guba (1985) give the theoretical structure for their claims and state that there are four truths: (1) *metaphysical truth*, or $\mathbf{T_1}$; *ethical truth*, or $\mathbf{T_2}$; *logical truth*, or $\mathbf{T_3}$, and *empirical truth*, or $\mathbf{T_4}$. Truths $\mathbf{T_2}$, $\mathbf{T_3}$, and $\mathbf{T_4}$ are predicated on, and grounded in $\mathbf{T_1}$.

Truth$_1$, or *metaphysical* truth has the preeminent characteristic of being foundational for all the others, and therefore not subject to being proved true or false and simply must be accepted. (Lincoln & Guba, 1985, pp. 14-15).

The notion that metaphysical truth, or T4 cannot be only known but not proved and too that it is the foundation of all other truths, including the preeminent T4, or *empirical* truth resonated with qualitative researchers seeking a theoretical ground upon which to take a stand for the qualitative approach to knowing and a new paradigm method of acquiring the data from which human phenomenon could be known and understood. The idea that everything that is to be known cannot be known by T2, ethical, T3, logical, and/or some combination of T4 with the others was nothing short of a new paradigm model of research in education, psychology and other human sciences that had heretofore been dominated by quantitative research and methodology. The theoretical foundations and grounding for hermeneutic phenomenology and transcendental phenomenology, as well as other qualitative approaches had now been given some independent basis for establishing its own norms and methods of research independent of the hubristic claims, especially of T4, empirical research and its vaunted and unassailable *scientific method*. (Mari-Jata, 2011, pp. 13-14).

CPE Movement: Development of Pastoral Care Literature

Phenomenology has been used in clinical settings as an operational methodology (although until recently it has not been recognized as such) via the clinical use of the verbatim since about 1925. The movement was according to Gleason (2004) was founded by “Anton T. Boisen (1876-1965), a Presbyterian minister who was convinced that his own psychotic episodes had religious significance, dedicating his life to the study of

"living human documents" (those suffering from mental illness) in the cause of understanding the meanings and messages (head) of those experiences (heart)" (Gleason, 2004, p. 297).

Boisen began his clinical practice and research using the case study clinical methods (adopted from the medical clinical practices of the time) and thus "brought four seminarians to Worcester State Hospital for training in the summer of 1925" (Gleason, 2004, p. 297). He joined forces with a physician by the name of Richard C. Cabot, who called "for a clinical year for all seminarians so that they could address, case by case, the relationship between functional mental disorders and religious experience.

Boisen also called for some plan for encouraging high-grade research work on the part of pastors in the field, comparable to what medical (scientists) were doing" (Gleason, 2004, p. 297). Boisen was attempting to develop a theology of crisis for theological education but some others in the CPE movement began to take it in more scientific directions relying on the developing allied sciences rather than the movement's purely theological foundations, and supposed outdated verbatim methods of inquiry about how patients were experiencing illness. According to Gleason (2004):

> As the CPE movement matured toward its present form, the strong emphasis on the application of clinical findings to the day-to-day work of ministry using the verbatim record of pastoral care, instituted by Russell Dicks (1906-1965), a Methodist chaplain/educator at Massachusetts General Hospital, at the expense of depth studies and theological perspectives, was a considerable disappointment to Boisen. . . Charles E. Hall (1919-2000), the first executive director of the Association for Clinical Pastoral Education, Inc. (ACPE), aptly titled his book on

> the history of CPE *Head and Heart*, and wrote in his introduction: "I discovered an overarching theme of the CPE movement: an attempt to integrate the messages of the head and the heart." CPE developed out of a dissatisfaction with the intellectual assumptions of systematic theology separated from religious experience and dissatisfaction with ministry based on that separation. In that separation the movement relied heavily on psychology, was strongly influenced by psychoanalysis, and, as already noted, became focused nearly exclusively upon the day-to-day chaplain-to-patient action *via* the verbatim (heart) to the near total exclusion of the depth studies, empirical research, and the theological reflection (head) deemed so important by Boisen. (Gleason, 2004, p. 298).

CPE Movement: A Brief History of Early CPE Scholarship

The early history of the CPE movement given above is designed to bring us closer to the history of scholarship and literature in the discipline from which it was derived and developed. The first recognized study in this the CPE discipline began with Robert B. Reeves, Jr, who was a chaplain at Presbyterian Hospital from 1954 to 1974. The formal study began with a grant given to Reeves and his colleagues after Reeves was asked by an eye surgeon to see a patient who had a detached retina, but was not healing. In talking with the patient "Reeves discovered that earlier every close relationship the patient had ever known had become poisoned. On his second visit, the patient 'poured forth an almost incredible tale of bitterness, hatred, fear, and guilt.' The morning following, the surgeon called Reeves to tell him that overnight the patient had caught up in her healing: her eye was as it should be at that time" (Gleason, 2004, pp. 298-299).

Following the lead from this experience Reeves' formal research studied "the impact on healing of pastoral interventions with other ophthalmology patients. Reeves and his investigative team found that interventions by the chaplain positively correlated with high acceptance and rapid healing on the part of detached retina surgery patients" (Gleason, 2004, p. 299).

Reeves' studies ended in 1975 but nothing else was done at the level of formal research along these same lines. According to Gleason (2004) only a few studies between 1976 and 1984 "produced only a few religious research studies directly addressing pastoral care and healthcare *per se*" (Gleason, 2004, p. 299). Even as late as 1997 it was discovered by Kenneth I. Pargament, who "classified some 250 students in five categories of religious coping in his comprehensive book, *The Psychology of Religion and Coping*," with respect to the religious researchers to pastoral researchers ratio, only one pastoral researcher in those 250 religious research reports could be identified: Larry VandeCreek" (Gleason, 2004, p. 301).

According to Gleason (2004) the general conclusion from research "that religious involvement is a valued method of coping with illness" was data "provided primarily by religious researchers, not pastoral researchers. The continuing reticence of clinical chaplains overall to engage the head in their heart work has left a void in the very essence of chaplaincy into which other disciplines have moved, thanks to their research-based contributions to the understanding of religion's impact upon healing.

This void is being filled not only by religious researchers but by practitioners as well" (Gleason, 2004, p. 301). According to Chaplain Margot Hover (1994) in the Foreword to *Research in Pastoral Care and Counseling* a "small but determined corps of

chaplains and pastoral counselors is gaining momentum. Increasing numbers of chaplains and pastoral counselors are turning to quantitative and qualitative research methodologies to pinpoint such cost-effective relationships as the correlation between pastoral visits and length of hospital stay or the frequency of use of pain medication. More chaplains are submitting proposals to institutional review boards. Chaplain residents are increasingly required to undertake research projects. . . Yet much remains to be done" (Gleason, 2004, p. 302).

CPE Movement: Pastoral Care Literature Since 1990

One of the earliest and most important pastoral care researchers mentioned above is Larry VanderCreek. VanderCreek (1995/1996) is a key figure if you want to understand the current state of CPE literature, because he is among the very first to try to gather up, characterize and systematize the literature, especially the quantitative literature related to pastoral care. VanderCreek (1994) did the same thing for qualitative literature in his book *Research in Pastoral Care and Counseling: Quantitative and Qualitative Approaches*. However, he is chief among a growing number of CPE researchers who thinks the quantitative approaches are more scientific, and with that much remains to be done by pastoral care researchers themselves instead of leaving the field void and in the hands of non-pastoral researchers who do not understand the theological impetus behind the CPE movement.

The hazards of leaving this void were made clear by Hover (1994), and others. According to Gleason (2004), noting Hover's concerns states: "Those hazards include pop spirituality, the co-option of the care of souls by other disciplines, the temptation to allow other disciplines' definitions of research to drive their work, and other disciplines'

agenda to dominate" (Gleason, 2004, p. 302). VanderCreek (1996) wants pastoral care researchers' to take the initiative and is an advocate of quantitative research to achieve this goal. VanderCreek (1996) states:

> We have been unable to put the capstone in place. That is, we have not built an empirical research tradition, which tests our observations and theories. As is, we have not built an empirical research tradition, which tests our observations and theories. As members of our respective organizations we have been too ready to make a living on existing, borrowed insights and practice patterns, and not ready enough to test our own insights. Consequently, we can legitimately be seen in the scientific world as a 'do nothing' profession which has failed to make a contributions to knowledge in a scientific age. (VanderCreek, 1996, 17, 29-30).

VanderCreek (1995), therefore, is a radical advocate of quantitative over qualitative research and the reasons given above suggests why that might be the case. VanderCreek, in the Preface to his edited work *Spiritual Needs: Readings in Research & Pastoral Services*, states:

> Pastoral caregivers are increasing their interest in and attention to quantitative research. My goal in editing this book is to nurture that interest and attention. Hopefully this is accomplished by placing between these covers 23 previously published but widely scattered research reports, which can inform the work of general hospital chaplains, and parish pastors. Many chaplains and pastors assume that few, if any, research results exist that can enlighten their pastoral practice. In truth, the literature contains many such studies; so many, in fact, that I set strident standards for inclusion in this volume. . . What were the inclusion/exclusion

> criteria? I considered only published quantitative research reports concerning pastoral care carried out within a general hospital, outpatient setting, or a congregation. What does this exclude? It excludes qualitative as well as theory building articles. . . It excludes material about pastoral care in settings such as psychiatric hospitals and prisons. It excludes research concerning training for pastoral care as found in clinical pastoral education as well as studies that focus on the personal or educational factors that influence ministry. (VanderCreek, 1995, p. VII).

In this work VanderCreek goes back to 1969 to pick up the threads of quantitative research that heretofore have only been scattered throughout various journals, some of which were not related directly to pastoral care (e.g. *Journal of Religion and Health, Bulletin of the American Protestant Hospital Association, Research in Nursing and Health, Southern Medical Journal,* etc.) and other assorted non-pastoral clinical journals in which some pastoral care practitioners doing quantitative research have found a hearing. One important aspect of VanderCreek's (1995) research is that he has established that qualitative literature having to do with pastoral clinical literature exists. VanderCreek (1995) apparently believes that quantitative studies are the primary way that pastoral care researchers can establish the legitimacy they need in the eyes of researchers in allied disciplines. I believe this is faulty reasoning and militates against the development of qualitative studies in the CPE discipline, including those based on phenomenology. (Mari-Jata, 2010, p. 11).

Of course, I believe the drive in this direction opposes the value that the CPE movement puts on the relationship between the *head and the heart* and the time tested

clinical practice of using verbatims to gather the data associated with the phenomenon of illness and suffering. Verbatims outline in detail the discussions between the pastoral care giver and the patient, but I do not believe this ought to be the only tool used to reveal how the patient and the care giver are experiencing the phenomenon of suffering. On the other hand verbatim should not be replaced by formal pastoral care studies, but rather should be included in them as a tool to gather primary human science data.

Even better I propose that verbatim take the historical stage it once held and become a clinical research tool as originally intended by Dicks the inventor of this approach for CPE. Dicks did not have a way of realizing this then but Moustakas's (1994) Phenomenological Reduction using *epoche* and *horizonalization* hold the promise that Dicks' vision can be realized. My data analysis of my ten interviews will make it clear how this is possible. It appears the reason why VanderCreek wants to exclude "research concerning training for pastoral care as found in clinical pastoral education" (p. VII) is because he knows that this training has a strong affinity to phenomenological methodology and therefore is an instrument and tool for that kind of qualitative research. However, VanderCreek (1995/1996) is not the only pastoral care researcher who is enamored with quantitative studies and reports. In one respect this is not so bad for my own dissertation proposal in that it leaves open a wider field for qualitative research in a discipline that is uniquely suited to phenomenology. (Mari-Jata, 2010, p. 11).

Flannelly, Oppenheimer, Liu, Weaver and Larson (2003) did *An Evaluation of the Quantity and Quality of Empirical Research in Three Pastoral Care and Counseling Journals, 1990-1999* and asked the question "has anything changed?" (p. 167). This was a quantitative study of the nature and kind of literature found in three major pastoral care

journals, namely *Pastoral Psychology*, *The Journal of Religion and Health*, and *The Journal of Pastoral Care*. Flannelly, Oppenheimer, Liu, Weaver, and Larson (2003) reviewed over 737 scholarly articles in *Pastoral Psychology*, *The Journal of Religion and Health*, and *The Journal of Pastoral Care* between 1900 and 1999. There were 165 articles (22.4%) that were research studies. They state, "original research in the field of pastoral care is necessary to inform professional practitioners and guide clinical practice." (Flannelly, etal., 2003, p. 168).

In their interviews of members of the American Association of Pastoral Counselors (AAPC) they "found that approximately two-thirds of those who responded considered research in pastoral care to be either "important" or "very important." (Flannelly, etal., 2003, p. 168). These researchers were trying to determine the "proportion of research studies, especially quantitative studies, increased significantly between the first and second half of the study period" (Flannelly, Oppenheimer, Liu, Weaver & Larson, 2003, p. 167).

Flannelly, Oppenheimer, Liu, Weaver & Larson (2003) concluded in their results section as follows: "More than eight out of 10 articles published in these three journals during the last decade were quantitative studies" and that ten of the studies identified were qualitative studies, which met their qualifications as quantitative studies "because they presented statistical results" (p. 167). Further they break down the percentage of qualitative and quantitative research articles between 1990 and 1999 as follows: Between 1990 and 1994 3.4% of the research articles were qualitative, while 16.2% of the research articles were quantitative in nature.

Between 1995 and 1999 this imbalance was a little different with 4.2% of qualitative articles and 20.2% of the quantitative articles. (Flannelly, Oppenheimer, Liu, Weaver & Larson, 2003, p. 171). It would seem that the major researchers in the discipline of pastoral care favor quantitative over qualitative research under the misguided assumption that quantitative research is more "scientific" than qualitative research. If the word "scientific" is replaced with the applied concept of "rigor" to either research methodology then the claim that quantitative is superior to qualitative research will be exposed as a false assumption.

In fact Flannelly, Oppenheimer, Liu, Weaver and Larson (2003) were honest enough to cite their critics, for example William S. Schmidt (1990) who challenged this assumption in an earlier study stated: "The article has appropriately challenged our methodological rigor whether we pursue the quantitative or qualitative factors which govern our theory and practice . . . Rector added that a stronger commitment needed to be made to providing pastoral counselors with the training required to conduct sound research" (Flannelly, Oppenheimer, Liu, Weaver & Weaver, 2003, p. 168).

The evaluation of whether a specific study or methodology used in the study is good, valid or sound is not whether it is quantitative or qualitative, but how rigorously the criteria, methods and critical analysis are applied in the study or research. The methodological assumptions made by pastoral care researchers, such as, VanderCreek (1995/1996) and Flannelly, et al. (2003) may not only be unfair but according to the views of Chris Hart (2008) wrong headed. Hart (2008) in his *Doing a Literature Review* suggests that there are other ways of knowing that are just as valid as research that claims to be scientific or seeks legitimacy by claiming to be scientific.

Hart (2008) in the section of his work on "Phenomenological reading technique" under "Argumentation analysis" is concerned about methodological fallacies in argumentation, the kind of fallacy I think VanderCreek and others have made regarding the relative scientific value of quantitative studies over qualitative studies. Hart (2008) examines the ideas of Edmund Husserl (1859-1938) the father of phenomenology in respect to methodological fallacies and states:

> Husserl is interested in a pure description of the phenomenon (noumena) that humans experience. He is not interested, therefore, in the causation of such experiences or the history of the phenomenon. Husserl is recommending that if we want to know what a thing is like, what its essential features must be in order that it can be recognized as an example of that thing, then we must place brackets around the assumptions and understanding that we taken for granted. Issues about the ethics, morals, politics, consequences and especially reality (ontology) of a thing should not, Husserl recommended, be of primary concern. When used by sociologist like Francis, Husserl's phenomenology places a priority upon describing the different ways in which the intention people have influences the ways they understood everyday life. . .Applying this attitude to science, the mathematical approach of, say, physics, and the analytical approach of, say, semiotics, are only two from many ways in which the world can be understood. . . .The scientific approach, whether in natural or social sciences, takes for granted that there is a world having prior existence to the world of causality and relationships between things that scientists aim to describe. The mundane world in which we all exist . . . is the one from which the scientific approach is derived.

> Hence, following Husserl's ideas, Francis takes the position that the kinds of analysis produced by scientists are abstractions and idealizations about the world in which we live and have little to do with the properties of the things that we experience in everyday life. . . Hence, those things that are classified as belonging to this or that class of things (phenomena) are not a matter for study as things in themselves. Added to this is the point many phenomenological social scientists make: the 'correctness' of any scientific analysis of a phenomenon is not validated by comparing it with how it is usually experienced in everyday life. Rather, the issue of validity is looked at from within science by ensuring that the procedures used were correct and rational. Ironically, when the world of everyday life is used, it is used with the intent to provide a correction to what is assumed to be our partial view of reality. Hence, one of Husserl's followers, Alfred Schutz (1967), argued that the procedures and intent of science are incomparable with the procedures and intent used by people in everyday life. (Hart, 2008, pp. 103-104).

The bottom line is that quantitative research contains this fallacy of methodology if it presumes that it is superior over qualitative research because it is more scientific. The most that can be claimed is that quantitative and qualitative studies (among them phenomenology) are among two ways of knowing or in the case of phenomenology knowing reality through *lived experience*, and that both methodological approaches require the rigorous applications of the methods and criteria appropriate to each one.

However one views this in regard to the literature that champions one approach over the other with its various methods and criteria, it is now being recognized that the theoretical foundation on which the act of care is based is phenomenologically grounded

and must be seen not only as a theoretical study but as an operational method that needs to be understood and used in clinical pastoral settings, When these studies are fully developed the care giver should be able to understand the phenomenology of suffering not only in relationship to the patient, that is, how they experience suffering and the healing process, but also how the caregiver experiences suffering as the one offering care and healing.

With this in mind, Orlo C. Strunk, Jr. (2004) has said what the research literature in this discipline needs is a "Phenomenology of Illness" (Strunk, 2004, p. 293). Strunk (2004) believes that the current body of literature (at least before 2004) lacks an understanding about the very methodology that it has used in the care of the suffering, but which has not been well defined or written about in the journal literature as much as it should be. Strunk (2004) states:

> I am compelled to believe that one of the qualities desperately missing in the "treatment arena" is authentic empathy – a characteristic seemingly difficult for both caregivers and care recipients to "operationalize." Readers, particularly healthcare chaplains, may find such musings of an *oh-hum* quality; but frankly, I am a bit startled by this realization, especially in light of the reality that I have spent most of my adult life either as a caregiver or as one who reads and edits – on almost a daily basis – the accounts of professional caregivers describing what they do and the research that engages them. Mostly, I suspect, I have come to understand – truly *understand* – a shibboleth often noted in the pages of this journal; that is, that there is a gap between the technology of care and human touch. Intellectually, I've always known this to be true. Now, existentially, I know

> about that gap – or, more accurately, about that *chasm*. I also know, intellectually, that phenomenology, whether it be philosophical or psychological, is anything but a unified theory of knowing, an established epistemology. Still, despite phenomenology's various schools, hues, and emphases, it does value highly the essence, structure, and form of *human experience* as revealed through primary descriptive techniques and disciplined reflection. (Strunk, 2004, p. 293).

The development of phenomenological literature related to suffering in clinical settings appears to be a developmental area of pastoral care education, and as such represents a vital area that I need to develop more fully in the literature review of This dissertation. The objective of my full literature review will be to isolate these various phenomenological studies and research literature and make an original contribution at this one level by seeing for the first time how the phenomenological researches are approaching and valuing their study within clinical pastoral education.

I suspect that this will be a hard mountain to climb because a review of the literature shows that direct studies on the clinical professional education has taken a back seat to the studies on general pastoral care, the role of chaplaincy with HCOs, pastoral counseling and even measurements studies on religion and spirituality. Clinical professional education is structured in a two-tier system of education with didactical training taking second place to clinical praxis. There is not a uniform curriculum for HCO centers. This is because the accrediting organization like the accrediting organizations such as the *Association for Clinical Pastoral Education* (ACPE) set the general educational standards and competencies and leaves it to the HCO/CPE centers to develop and design the curriculum that will satisfy the standards and meet the

competencies for professional certification. You will have as many curriculums' as there are HCO centers.

It is apparent from my research that very little work has been done to study the various curriculum programs at HCOs to see how these CPE curriculums are emerging and how pastoral care interns are experiencing the didactic and clinical practice that these curriculums employ. On the other hand the absence of these studies will allow me to make a contribution in this area of research, especially in the field of phenomenology of suffering and its impact on the pastoral clinical care giver and practitioner. (Mari-Jata, 2010, p. 16).

Methodological Assumptions: Three Primary Fields of CPE

The primary assumption behind clinical pastoral education is that pastoral care is an integral part of the general healthcare system, which aims as a discipline to supply the spiritual component needed to assist patient/clients at HCOs (Heath Care Clinical Organizations) receive the emotional and spiritual care they need in healing of the mind and body. The goal is the rapid recovery and care of patients and another assumption is that people need and appreciate spiritual care as part of the healing process. The discipline of pastoral care therefore supplies something that other healthcare disciplines are not equipped to furnish. It sees itself as a partner in human healing.

These assumptions within the discipline guide the research goals, questions and inform the literature that describes what the research has found. The primary method of deliver is clinical in nature. The lessons and experience learned from clinical praxis becomes the primary source for the data needed to fuel CPE research efforts. This is important because the clinical experience feeds back into the theory and is the impetus

for further research to answer questions raised in the practice of the discipline. The methodology is phenomenological in nature. The different studies, whether dealing with the importance of the role of chaplains, the views that HCO medical staffs, patient/clients have of the importance of chaplaincy roles, clinical pastoral education and praxis or issues dealing with spirituality, religion in relationship to healthcare are all centered on understanding the discipline of pastoral care from one or two perspectives: didactics and praxis. The roles and impact of curricula on clinical praxis, and/or the learning outcomes from clinical praxis that re-informs didactical training (CPE) and changes some of its earlier assumptions find their way into new studies and other research. This two-way process of learning enriches this discipline. Clinical praxis is dominant over didactical training even though there is a symbiotic and dynamic relationship between the two. Clinical pastoral education is directed toward the human enterprise of healing and so it is not a mere theoretical educational enterprise. Formal CPE education is important but HCO centers put more emphasis on praxis sense the whole reason for clinical pastoral education is to train spiritual care givers how to care for patients on a one on one basis. As has been said the learning comes from both processes and inform each other. (Mari-Jata, 2010, p. 17).

Three Primary Fields and Related Literature

We have already cited some of the major ideas and key in the field of pastoral care education, including Larry VandeCreek and Andrew J. Weaver and in the field of clinical pastoral practice the key researcher and theorists of which is Kevin J. Flannelly. In the field of pastoral counseling the key theorist is Andrew J. Weaver. Flannelly and Weaver have done a number of studies together, but VanderCreek has surpassed them in

doing independent work and publishing as well as joint research projects. Kevin J. Flannelly, Ph.D. is Associate Director of Research for journal *HealthCare Chaplaincy*, Andrew J. Weaver, M.Th., Ph.D. is Director of Research for the same journal. Larry VanderCreek, D.Min. is a researcher in the Department of Pastoral Research for The HealthCare Chaplaincy, Inc. (Mari-Jata, 2010, p. 18).

Spiritual Needs

However these are not the only key thinkers in the field of pastoral care. I already stated that he area of *spiritual needs* of pastoral care seems to be dominated by researchers in the field of psychology interested in doing studies on the relationship among religion, spirituality, mental and even physical suffering. These researchers often use quantitative approaches in the studies and CPE researchers who borrow from them have to find a way to translate the data into a usable form that meets their *head and heart* methods of knowing, which seem intrinsic to the didactic and clinical practice. As I said earlier finding ways of measuring religious and spiritual responses to suffering seems to be the preoccupation of these psychoanalytic research projects.

However, as recent as 2003 it appears that CPE researchers are attempting to take charge and do their own *spiritual needs* research using the tools that seem to be intrinsic to the discipline and at least in this area of pastoral care are qualitative in approach. For instance, Robert W. Shuford (2003), a staff chaplain at Our Lady of the Resurrection Medical Center, Chicago, Illinois, did a *biographical study* on an organ transplant patient, which is identified by Creswell (2007) as a second form of *narrative study*. Creswell (2007) states:

> As Pinnegar and Daynes (2006) suggest, narrative can be both a method and *the phenomenon* or study. As a method, it begins with the experiences as expressed in lived and told stories of individuals. Writers have provided ways of analyzing and understanding the stories lived and told. I will define it here as a specific type of qualitative design in which "narrative is understood as a spoken or written text giving an account of an event/action or series of events/actions, chronologically connected" . . . The procedures for implementing this research consist of focusing on studying one or two individuals, gathering data through the collection of their stories, reporting individual experiences, and chronologically ordering (or using *life course stages*) the meaning of those stages. . . A second approach is to emphasize the variety of forms found in narrative research practices. . . A *biographical study* is a form of narrative study in which the researcher writes and records the experiences of another person's life. **Autobiography** is written and recorded by the individual who are the subject of the study. . . A *life history* portrays an individual's entire life, while a personal experience story is a narrative study of an individual's personal experience found in a single or multiple episodes, private situations, or communal folklore. . . An *oral history* consists of gathering personal reflections of events and their causes and effects from one individual or several individuals . . ." (Creswell, 2007, pp. 54-55).

It appears that Shuford (2003) was using the verbatim clinical form of data gathering that allowed his patients over a series of meetings to tell their story in oral form as a way of understanding how they were dealing with the experience and phenomenon of being an organ transplant patient within the context of HCO. The story was told by

both Karl (the liver transplant patient) and his daughter Susan. Shuford (2003) allowed them to tell their story with some intervening background followed by analysis, and states:

> On my next visit Karl began by telling me that he was a Catholic and that he wanted to see a priest for confession. I said I would arrange it right away, but before I could leave to make the call he began to share about the breakup of his marriage three years before. I wondered if he had decided to confess to me. "The point is that I used to be very bitter toward her, but I don't feel that way any more." The break-up had come in the middle of his liver failure when everything else seemed to be falling apart. The fire department had had to let him go, not because of poor job performance but because his condition put him at risk. . . Some time later we talked about his divorce again, this time with his daughter, Susan, present. I asked them both if his illness had had anything to do with the break-up. . ."Oh yes, definitely," Susan responded immediately. "I mean, it put a strain on things. . . While Susan spoke, Karl was silent, just looking at her with pain in his eyes, and then he said simply, "We'd been married thirty-five years." It gave me a glimpse of just how painful it had been. Later I would learn more about the ten years that led up to the transplant. . .He was evaluated and in six months was on the list. The same month he had moved in with his daughter, Susan, and her family. It was a difficult time for all of them. "I lost my work, I lost my marriage, I lost my health, and I was losing my dignity. I had worked hard all my life and now I was losing everything. I felt, like, God, what's going on? What did I do to deserve this?" He was angry and irritable much of time, and

> increasingly dependent. As his condition worsened, Karl and Susan experienced a role reversal. She and her husband became his "babysitters," needing to watch him carefully, placing increasing limits on him. . . As hard as it was, their experience was not unusual for liver transplant candidates. Because the supply of livers is limited and selection is based on need, you have to be very sick to get a liver. From the standpoint of policy this may make sense, but from the perspective of those on "the list" and their families, it is a rather cruel irony. The sicker you get, the closer you are to being made well again. The closer you come to dying, the closer you are to a new life. This is the gantlet one must pass through that is unique to the world of liver transplantation. (Shuford, 2003, pp. 192-193).

This example of a qualitative study based on narrative method was given to demonstrate how naturally the CPE verbatim methodology and tool of analysis can adopt qualitative approaches, in this case *biography*, centered on the *lived experience* Karl had with the life changing phenomenon of liver transplantation process. Shuford (2003) employed this methodology with a focus on *spiritual needs*. Shuford (2008) concludes from his narrative study the following:

> Making the journey of liver transplantation with Karl and his daughters has made me more aware as a chaplain of the spiritual depth that this experience touches. In its broadest sense, the theme of gift is one that resonates through all religious traditions---the divine gift of creation, of life, of mercy. It is what, in our best moments, motivates our worship and instills in us the desire to live generously. How extraordinary that this high-tech medical marvel of organ transplantation should bring us back to the central and enduring reality of our faith. To have been

> with Karl on a journey of such depth is, in itself, a gift to me. It is holy ground. (Shuford, 2003, p. 196).

However, this hopeful beginning for qualitative research in the *spiritual needs* area of pastoral care it seems that the quantitative approach still dominates. In the *Journal of Pastoral Care & Counseling* (Fall 2005) I found two quantitative studies that focused on religion, spiritual and health issues but no qualitative studies with the same emphasis on measurement. Overvold, Weaver, Flannelly and Koenig (2005) did "A Study of Religion, Ministry, and Meaning in Caregiving Among Health Professionals in an Institutional Setting in New York City," which questionnaires were distributed to a sample of 430 staff at Florence Nightingale Health Center and the Rehab Institute of New York, where 60% of the patients suffer from "Alzheimer's disease or some other form of dementia and resided on both long-term and sub-acute units" (Overvold, Weaver, Flannelly & Koenig, 2005, pp. 226-227). The purpose of the study was focused on how frequently caregivers in these healthcare institutions "report reliance on religion" in the dealing with critical situations with these patients (p. 226).

Besides the questionable ethical practice of attaching the questionnaires to the employees paycheck, which may have given the impression that you had to fill out the form if you wanted to continue to get paid and that the employer was demanding participations (Overvold, Weaver, Flannelly & Koenig, 2005, p. 227), the researchers sought to secure age and education data using a nominal scale and defined religiosity operationally "by six questions adapted from previously published research" from a number of psychological and social sciences journals (e.g. *Journal of Aging and Health, Journal of Gerontology: Social Sciences*, etc.). (Overvold, Weaver, Flannelly & Koenig).

I point these facts out to demonstrate what Hover (1994) feared; the over dependence of CPE researchers doing quantitative studies on the conclusions and measurement tools of researchers in allied health fields and failing to develop the natural relationship or intrinsic relationship or natural affinity that CPE clinical practice has with qualitative approaches to research. (Mari-Jata, 2010, p. 22).

B. Pastoral Care

This is of course a broad designation and so the studies can focus on the pastoral care of patients, families physicians, nurses, healthcare support staff, and the pastoral care giver themselves and how they experience their education and their clinical work dealing with suffering. The literature is replete with both qualitative and quantitative studies that deal with the care of patients, as it should. There is a body of literature that is growing, and that deals with the pastoral care of medical professionals as well.

However, my preliminary literature review does not reveal the same amount of interest in studying how the pastoral care giver deals with the phenomenon of suffering or what impact this clinical work has on them as *lived experience*, even though I can see such studies beginning to emerge from about 2005 to 2008 in *The Journal of Pastoral Care & Counseling*. Of course this impression has to be verified in my larger literature review by examining no less than three or four major journals on pastoral care to be sure that my intuition is correct about the scarcity of literature related to the experiences of the care giver in dealing with suffering in their clinical work. The first major study I found that dealt with the care giver in traumatic situations was a quantitative study by Dodd-McCue and Trataglia (2005). These two researchers state their interest as follows: “The

impact of stress on health care chaplains" and complain that quantitative studies on the subject are:

> Scarce and has not systematically examined the topic. Additionally, studies on stress for religious professionals in regard to professional role are limited. . . that research on stress and the clergy tends to rely upon personal reflections and qualitative measures of stress. Among the research on stress and the clergy is their study of diocesan priests, which identified work overload, role ambiguity, conflicting job tasks and work demands, and the grief of those served as their primary work related stressors. . . A recent study of chaplains and clergy who responded following the events of 9/11 found pastoral care responders at significant risk for compassion fatigue, and suggests that caring professionals, such as clergy, may experience the emotional and/or spiritual distress of those with whom they work. (Dodd-McCue & Tartaglia, 2005, pp. 346-347).

I don't want to be charged with the fallacy of methodological argumentation as I did with VanderCreek for implying that quantitative study was the only way of knowing in the discipline of pastoral care and so make the claim here that qualitative studies are the only valid way of knowing about the lived experiences of pastoral care workers, but I do want to suggest that some balance ought to be sought after, given the affinity of pastoral care research with qualitative research methodology. It might be possible to suggest mixed research methods from both areas that are compatible, such as action research. In fact I do believe that some qualitative research in this discipline can be rather shallow and in such cases quantitative research is to be preferred. (Mari-Jata, 2010, p. 23). However as Dr. Caraway (2012) has noted: "Shallow research by one methodology

does not entail that one change the methodology as a corrective; rather, it requires. . . that the research be thorough, disciplined, exhaustive, and congruent with strict epistemological requirements. (Caraway, 2012, Comments).

One such qualitative research study or report that may qualify for this charge was done by Denise Giacomozzi May (2008) who wrote a kind of reflection paper called "When a Chaplain Needs a Chaplain." May (2008) describes her experience during "the last two weeks" of her father's life, where "the days and nights and nights and days seemed to meld into one another" (May, 2008, p. 391). I guess you could call this a narrative study but one in which the chaplains own personal experience is described facing the suffering and death of a loved one. Depending on whether you adopted the view of Moustakas (1994) or Van Manen (1990) this could hardly be called a phenomenology since in the view of Moustakas (1994) it would not qualify. This is because while there is a single phenomenon under consideration the researcher's views are not bracketed. Here Moustakas (1994) has a mistaken idea of Husserl's notion of *epoche.* Husserl (1999) notion of *epoche* does not focus on bracketing the researchers feelings or experiences of the phenomenon. Husserl (1999) rather is interested in parenthesizing the "nonessential descriptor of the phenomenon continuously until one gets to the essence" (Caraway, 2012, Comments). Husserl (1999) is willing to parenthesize the researchers experiences but not entirely and not forever. The researchers experiences must also be subjected to phenomenological reduction and Moustakas (1994) appears to know this despite the slant and weight he gives to it in his bid to make phenomenology *scientific*. Moustakas (1994) states: "I must first explicate my own intentional consciousness through transcendental processes before I can understand

someone or something that is not my own, someone or something that is apprehended analogically. My own perception is primary; it includes the perception of the other by analogy." (Moustakas, 1994, p. 37).

Moustakas (1994) also seems to be concerned with bracketing the researchers experiences of the phenomenon by using *phenomenological reduction*, because he thinks this makes transcendental phenomenology more scientific. In other words Moustakas (1994) has a high interest in achieving the kind of respect scientific positivism has achieved using scientific methods. However (1994) this become curious in that he knows very well that Husserl parenthesizes scientific positivism, its vaunted scientific method, and it unwarranted claim to know truth behind phenomenology which seeks to *go back to the things themselves*, that is, the pregiven life-world of phenomenon that are the raw material scientific positivism needs to establish truth. Moustakas (1994) himself states:

> Husserl (1977) does not claim that that transcendental phenomenology is the only approach to a knowledge of human experience, but rather he emphasizes that it is a science of pure possibilities carried out with systematic concreteness and that I precedes, and makes possible, the empirical sciences, the sciences of actualities (p. 77). (Moustakas, 1994, p. 28).

Denise Giacomozzi May's (2008) reflection paper called "When a Chaplain Needs a Chaplain" would not count as a phenomenology using Van Manen's (1990) hermeneutical phenomenology, as well, because, while her experience of the phenomenon of suffering of her father is legitimate, her father's experiences are for the must part moot, in that she says very little about how the father experiences his own end of life experience. It is all about the chaplain and not the one dying. We will discover

later that this is because of *empathetic inversion*, which is one of the deficiencies of CPE pedagogical learning. It allows the chaplain to put themselves first when they come along side the another person who is experiencing suffering and allows them to justify not taking the risk as they meet the other person in their life-world and lived-experience of suffering. Moustakas (1994) partially supports this natural feeling of the empathic person but suggest that they must be ready to engage the Other in a much closer relationship in order to understand their experience of any particular phenomenon, such as, suffering. Moustakas (1994) states:

> The Other is not directly within me. Otherwise, Husserl (1977) asserts, the Other and I would be the same (p. 109). Thus my relationship to the Other is that of a copresence. I am aware that there is another body coexisting with my body and of similar appearance. This makes possible the analogizing apprehension "of that body as another animate organism" (Husserl, 197, p. 111). Through analogy, I apprehend the other in a livingly present sense. "*Ego* and *alter ego* are always and necessarily given in an original 'paring' " (Husserl, 1977, p. 112). "Paring" is the way in which I experience someone else. In "paring," the Other is within me and I within the Other. My existence and the Other's existence are copresent in intentional communion. In principle, there is within me a realm of virtually infinite access to other human beings. (Moustakas, 1994, p. 37).

From Van Manen's (1990) view there must be at least two human documents and in this case the father is merely a foil for the experiences of the daughter. The problem is that without this other human document the description the daughter gives of her own experiences becomes inexplicable and unconvincing. This kind of qualitative presentation

may be why some CPE researchers prefer to do quantitative studies. One could, however, question whether quantitative analysis of suffering or other phenomenon like "love" "joy" "happiness" and/or "hate" which are human qualities of feeling could be measured. It would seem that qualitative research in this human science area would make more sense.

Pastoral Care Education

Articles or studies dealing directly with pastoral care education did not fare much better than the body of literature on pastoral care of pastoral care practitioners. They were scarce and widely scattered in *The Journal of Pastoral Care & Counseling* (JPCC). In 2006 a supplement to this journal was published as if it had forgotten something. That something consisted of articles on pastoral education. The publishers quickly put together three articles that were little more than reflections of CPE practitioners about their didactic and clinical experiences while studying for the chaplaincy. It is good to anything at all along these lines but there is still a dearth of this material in the *JPCC.* (Mari-Jata, 2010, p. 24). If the *JPCC* contributions in this area are any indication then you would expect to find that the other major journals mirror the same dearth of literature on this topic. More contribution are needed such as that coming from Bacote (2006). In Bacote's (2006) he describes his CPE experience as follows:

> Prior to an intense year of CPE in 2004-2005, I grappled with a self-depreciating and unflattering self-image. I skillfully concealed this lonely struggle from friends, former colleagues, seminary classmates, and others who thought they knew the "real me." That fact that I was outwardly functioning as a "wounded healer" while inwardly navigating through life emotionally shackled with a

> damaged self-concept, perpetuating daily self-hatred and constant internal self-depreciation. Many of the people that I have met throughout my life and consider friends or associates would describe me as a creative, energetic, passionate, humorous, tenderhearted, professional, organized, respected, conscientious, nurturing, lively, animated person. . . qualities of an eagle, soaring high, boldly facing the sun, with a sense of confidence in the face of adventure. Unbeknownst to the extraordinary people that I have been blessed to encounter over the years, there was another side of me that they were not privileged or trusted to behold, the underside of the eagle. . . I now accept that God chose to invite someone like me to join the servant team on earth as a minister. Indeed, I could become a chaplain and wounded healer capable of enabling others to experience the liberation that I claimed in CPE. . . CPE afforded me the opportunity to experience several *kairos* moments that have provided the pastoral care tools so essential as I strive *to be present* with those who look to me today as "Chaplain Della," including the hospital staff, families, patients, and significant others I encounter in the wee hours of the night, in my solitary flights of care and concern. (Bacote, 2006, pp. 441-443).

Quite possibly a quantitative researcher would dismiss these musings as rubbish and not worthy to be classed as data for serious study purposes, but this would be a mistake. As scarce as this kind of literature in pastoral care education is it is the kind of stuff that phenomenology as a methodology thrives on. First, while Moustakas (1994) favors the "long interview" as "the method through which data is collected on the topic and question" for phenomenological investigation (p. 114), he also states that

"nontechnical literature 'can be used as primary data, especially historical and biographical studies. In most studies [i.e., letters, biographies, diaries, reports, videotapes, and newspapers] are important sources of data, supplementing the most usual interviews and observations' . . ." (Moustakas, 1994, p. 113). Understanding "Chaplain Della" from her own narrative experience with the phenomenon of clinical professional educations as a "wounded healer" who "strives *to be present*" with her patients also resonates well with the hermeneutical phenomenology of Van Manen (1990) who believes that in the study of the human sciences the researcher is permitted to and actually should become a part in some way of the *lived experience* of the phenomenon under investigation. Van Manen (1990) states:

> Phenomenological research aims at establishing a renewed contact with original experience. . .This turning to some abiding concern of lived experience has been called a turning "to the things themselves," *Zu den Sachen* (Husserl, 1911/80, p. 116). It is becoming full of the world, full of lived experience. "Being experienced" is a wisdom of the practice of living which results from having lived life deeply. In doing phenomenological research this practical wisdom is sought in the understanding of the nature of lived experience itself. On the one hand it means that phenomenological research requires of the researcher that he or she stands in the fullness of life, in the midst of the world of living relations and shared situations. On the other hand it means that the researcher actively explores the category of lived experience in all its modalities and aspects. (Van Manen, 1990, pp. 31-32).

If I can find the kind of CPE education literature that "Chaplain Della's" documented experience represents then it will be of great value as supplement to my long interviews dealing with the same kind of CPE education phenomenon. Chaplain Della actually describes what Heidegger (1996), a follow of Husserl meant by *being there* as a way of knowing and understanding phenomena. Heidegger claims that to understand the phenomenon I am faced with in the world I must allow myself as being taken into, absorbed by the everydayness in the world, and in respect to the phenomenon "taken in by its world" if I expect to know and understand it. (Heidegger, 1996, p. 107). While this literature has been limited to three major areas of clinical pastoral care (e.g. pastoral care, clinical pastoral education, and spiritual needs) and did not venture into pastoral counseling or pastoral psychology, I still have been able to delineate areas of this overall human science discipline that suggest that a phenomenology of suffering is needed for CPE. This dissertation marks out an area that is still underdeveloped so that it makes a significant contribution to this field of higher education. (Mari-Jata, 2010, p. 26).

CPE Literature: Reflection/Reflexive Learning[1]

I knew from the inception of this dissertation that the research, including my work in EDU 705 Current Issues in Higher Education, would be a significant and relevant contribution to since the literature on reflection relates to my argument that reflective practice is integral to how clinical pastoral practitioners gain access to human experience of suffering and are able thereby to provide *care for* and seek the *cure of souls* through

[1] I have incorporated of my work from EDU 705 Current Issues in Higher Education. The plan in preparation of this seminar paper from the beginning with the permission of the instructor was to create a section of work that might be able to be incorporated in This dissertation in this literature review and was seen as a continuation of the literature review process. The original seminar paper was entitled "Annotated Bibliography on Reflective Practice in Clinical Pastoral Education" (Mari-Jata, 2011).

this method of learning. I have also argued that reflective and reflexive practice and learning is a key component of formulating a phenomenology of suffering and is the ground for the spiritual disciplinary method of the centering moment that permits the clinical pastoral care provider to go from reflective theological analysis to positively engaging the *life-world* and *life-experiences* of persons who are spiritually suffering in order to effect a cure.

The annotated critical bibliographies in this paper focus on *CPE reflective practice* as the methodology that will help me bridge the gap between hermeneutic and transcendental phenomenology approaches on the role of the researcher. A methodological bridge is a linear conception that serves to link certain aspects of research methodologies. Reflective practice, should function like Morgan's (2006) "action-learning" or "double-loop learning" (Morgan, 2006, pp. 84, 85). What Morgan (2006) is referring to when he distinguishes the differences in the way human institutions learn is called single-loop vs. double-loop learning, when dealing with specific organizational phenomenon. These human encounters with varieties of phenomenon make up a human organizations *lived-experience* and its *life-world*, which is then used to interpret and understand the meaning of other human life-worlds and lived experience within organizational settings.

Action learning/Double-loop learning has the capacity to help researchers engage in *learning to learn*, that is, to know what they are learning and reflect on its derived meaning to improve practice within their situational or organizational research framework. Morgan (2006) states: "Double-loop learning depends on being able to take a 'double look' at the situation by questioning the relevance of operating norms" (p. 85).

This process of learning aims to improve the overall performance of the practice of human persons within an organizational framework. Reflective practice and learning can be applied to what CPE educators and practitioners do in hospital clinical organizations (HCOs), as they *learn to learn* using *reflective practice* to observe and understanding the meaning of human suffering in their life-world and lived-experience.

Key Words: reflective practice, reflective learning, action learning, hermeneutic phenomenology, transcendental phenomenology, clinical pastoral education.

I have been looking for a methodological key that would allow me to bridge the conceptual gap between hermeneutic and transcendental phenomenology on how the life world and lived experienced of the researcher should be treated within the research project. I think I have found the answer in a well-known methodology used in both higher education and the medical profession disciplines (e.g. among physicians and nurses, etc.), which is called reflective practice or reflective learning. This methodological link between educational and medical disciplines is an opportune interdisciplinary marriage, since This dissertation deals with clinical pastoral education (CPE) within hospital clinical organizations (HCOs). According to Karen Lorraine Milheim (2008), in her dissertation for the doctor of education degree at Pennsylvania State University Graduate School of Education, reflective practice, began its development for practitioners and professionals in two disciplines, which were higher education and medical practice. Later other professions took up the method and applied it to their fields of practice, such as human resources, etc. (Milheim, 2008, p. 22-23).

Milheim (2008) states: “The idea of reflection as a method to develop professionals within practice, referred to as ‘reflective practice,’ is prevalent in the

literature, with a particular focus on the development of educators . . . and medical professionals. . .” (p. 23). Although Milheim (2008) does not believe that there is one single definition of reflective practice, she states that “in essence reflective practice involves consideration of both ‘seeing’ and ‘action’ to enhance possibilities of learning through experience (Loughran, 2002). Also, ‘reflective practice allows one to make judgments in complex and murky situations – judgments based on experience and prior knowledge . . .” (Milheim, 2008, p. 22). Milheim’s (2008) observations as to what reflective practice is about includes “seeing,” “action,” and using “judgments” about complex human phenomenon, whose meaning has to be accessed based on both experience and prior knowledge of the human situation, predicament, or in short the phenomenon experienced. This method gains the researcher access into the human phenomenon by being both engaged within the experience and standing back to examine what was experienced and its meaning based on the knowledge gained or prior knowledge of similar situations. I can find a way to use reflective practice with both Moustakas’s (1994) and Van Manen’s (1990) conceptual notions of reflection in phenomenology. I can see how the researcher could use his or her prior knowledge of one’s own bracketed experiences with a phenomenon and then later apply them through a process of intentional analogy to situation of the human subject being studied in relationship to the phenomenon (e.g. suffering, etc.) as Moustakas (1994) suggests should be done. I also can see how the researcher could come along side (or be present in the moment of) the human subject in an act of seeing firsthand what and how they experience by means of empathic intentionality, as Van Manen (1990) suggests should be done.

Fortunately, reflection plays an essential part in both Moustakas's (1994) and Van Manen's (1990) understanding of transcendental and hermeneutic phenomenology. Moustakas (1994) states: "The empirical phenomenological approach involves a return to experience in order to obtain comprehensive descriptions that provide the basis for a reflective structural analysis that portrays the essences of the experience. . . . the researcher describes the structures of the experience based on reflective analysis and interpretation of the research participant's account or story. . ." (Moustakas, 1994, p. 13).

For Moustakas (1994) this means access to the "structures of the experience" of the human subject; and are what he calls reflective analysis of human experience. This treatment is given separately to both the human subject and to the researcher, which are later brought together in reflective analysis by means of analogy of the two human experiences, so as not to affect the outcomes of one or the other in respect to the phenomenon under study. This is why Moustakas (2008) refers to his transcendental phenomenology as the "empirical phenomenological approach" (p. 13). However, for Van Manen (1990) reflection on the experience of human phenomenon is not something you do from the outside in order to protect the empirical nature of the research study. From beginning to end the researcher is involved in an active, close encounter with the human phenomenon that they and the human subject experience together. Reflection upon the experience is immediate, even though there is a moment when the researcher has to take a step back to see what has happened, what is happening, and the meaning of what has and is happening.

Van Manen (1990) states: "Lived experience is the starting point and end point of phenomenological research. The aim of phenomenology is to transform lived experience

into a textual expression of its essence---in such a way that the effect of the text is at once a reflexive re-living and a reflective appropriation of something meaningful: a notion by which a reader is powerfully animated in his or her own lived experience." (Van Manen, 1990, p. 36). On the other hand there is a sense in which the human researcher in the "reflective act" also stands apart from the human experience of the actual phenomenon in what Van Manen (1990) calls "non-reflective" consciousness. Van Manen (1990) states:

> But preceding or even apart from the reflective act, there reigns an implicit, non-thematic, non-reflective type of consciousness in our daily life, which consists in a simple presence to what I am doing. . . . In other words, to live life means being fatherly, motherly, teacherly, lovingly, actively, emotionally in the world --- it is a non-thematic being conscious in the world. In contrast, reflective consciousness is continually fed by this non-reflective dimensions of life, which it thematizes. (Van Manen, 1990, p. 38).

What Van Manen (1990) is teaching here is that the researcher does his or her work within a paradox of reflective learning. The researcher is both present (being there) within the experience of another human person experiencing a phenomenon and at one and the same time standing outside of this experience. This allows the researcher to both learn firsthand what is experienced by another and also stand outside it using reflective learning to understand what is going on and discover the thematic categories that describe what is experienced.

While CPE has been doing reflective practice for years to improve clinical practice, rarely have CPE practitioners explicitly recognized that they were engaged in using this as a methodology. The majority of the annotations that I have in this project are

CPE educators and/or clinical practitioners actively engaged in reflective practice and learning, without explicit acknowledgement of this method that is evident in clinical practice, but is based on what these CPE educators and clinical practitioners claim they are doing and feeling when they bring their lived experience and life world alongside that of patient/clients in HCOs.

Critical Annotation 1

Logan C. Jones (2006, February). Baptism by fire in clinical pastoral education: The theory and practice of learning in the art of pastoral care through the verbatim. *Reflective Practice, 7:1,* 125-142. This article is about the use of verbatims as a tool by clinical pastoral practitioners "as a reflective teaching method for learning the art of pastoral care in a clinical pastoral education (CPE) setting" (Jones, 2006, p. 125). Jones (2006) believes that the "act of caring for another person is a fundamental part of what it means to be a human person" and that in Christian communities of faith "these acts of caring are traditionally known as pastoral care" (Jones, 2006, p. 125). Jones (2006) interprets this from the Christian perspective as the "care of souls" (p. 125). But how is this care of souls accomplished as a human act that defines the clinical pastoral educator and/or clinical practitioner as a human person? According to Jones (2006):

> Clinical pastoral education was developed with this social, academic, context as an experiential, process-oriented method so theological students could 'develop their pastoral identity, interpersonal competence, and spirituality; the skills of pastoral assessment; interprofessional collaboration, group leadership, pastoral care and counseling; and pastoral theological reflection (Thornton, 1990, pp. 177-178). Thus, education for ministry in clinical pastoral education begins with the

> assumption that learning comes from the actual practice of ministry to persons in crisis and from the subsequent reflection upon that ministry. . . As a method of theological education, CPE stands over and against the backdrop of classical theological education. As such, the use of actually practice of ministry as a tool for education and reflection places students in a paradoxical learning predicament. (Jones, 2006, pp. 126-127).

Therefore, according to Jones (2006) learning in CPE is achieved by (1) actual clinical practice in helping the human person who is suffering, and then (2) reflecting upon the meaning of that human encounter and effort in order to improve understanding of this human phenomenon, where improved understanding through reflection will lead to further improved clinical practice. But what is this paradox of learning that Jones (2006) refers to? Jones (2006) relies on Donald Schon (1987) in his book Educating the reflective practitioner to described the predicament as follows: “The paradox of learning a really new competence is this: that a student cannot at first understand what he needs to learn, can learn it only by educating himself, and can educate himself only by beginning to what he does not yet understand. (Schon, 1987, p. 93).” (Jones, 2006, p. 127). Jones (2006) states:

> There is neither an easy nor simple way to learn how to care pastorally for another person. A student can read books about it, attend lectures and take notes about the theology, theory and practice. But that is not enough. Until the actual practice of pastoral care is done at the bedside, in the ‘trenches” of the Emergency Department and the Intensive Care Unit, and in the messiness of human

> relationships, it is not deeply learned, nor can there be transformation of the person (Mezirow, 1991; Mezirow & Associates, 2000). (Jones, 2006, p 127).

Jones (2006) concludes that in order to achieve this transformation of the CPE practitioner in their human science discipline they must actually write down their thoughts using the verbatim we will discuss below in respect to the phenomenon of each encounter with patient/clients who are experiencing suffering and so "reflect on these distinct aspects of the encounter in a brief paragraph. . . . these required analytical paragraphs serve to challenge the student to move deeper into reflective process. For instance, the reflective analysis of The Person invites the student to explore his or her understanding of the patient and the issues involved. This reflection may involve some insights or interpretation of the meaning of the illness." (Jones, 2006, p. 134).

Jones (2006) states that his paper "will explore how the art of pastoral care is learned through the method of the verbatim" and he defines a verbatim as "a written record of a pastoral conversation. This written record then becomes the tool through which a student learns about and reflects on his or her care to another person and, equally true, learns about and reflects on his or her own self as a person and a pastor" (p. 127). Jones (2006) goes further to state: "The idea is to reproduce, as closely as possible, the actual conversation between the chaplain and the patient. The purpose is to allow the chaplain to reflect upon the 'effectiveness, appropriateness, and congruence of the pastor's response to a person in crisis' (Asquith, 1990, p. 124). The conversation is recorded in dialogue form." (p. 129). Jones (2006) states that verbatim "are used extensively in the discipline of clinical pastoral education" (p. 127) and it is apparent that he champions this reflective method, even though he recognizes that there are other

methods that have been used in CPE to achieve the same goals. For example, Jones (2006) and cites the work of Creswell (1998) and states "case studies comprise one of the ways of doing qualitative research" but goes on to say that the case study method picked up early by CPE practitioners from medical field practitioners (i.e. physicians, etc.) in HCOs was deemed by the early founders of CPE to be "not entirely suitable" (p. 128). Jones (2006) states the reason why this is true even today, as follows:

> In the mid-1930s, Russell Dicks, chaplain at Massachusetts General Hospital, discovered that a record of an actual conversations with a patient was more helpful to him than a detailed life history (Powell, 1975). Lengthy case studies simply did not work with patients in the general hospital settings, where the length of stay was shorter than those in a mental hospital. For example, the average length of stay in Rex Healthcare today is under four days. (Jones, 2006, p. 128).

It is not that case study is not an adequate methodological tool to meet the goals and aims of the CPE practitioner, according to Jones (2006). It is that the method used must fit the contextual conditions for short stays in a general hospital. According to Caraway (2012) for any research . . . the method used must fit the contextual conditions . . . This is why the methodology of the knowledge of things – i.e. the scientific method – cannot produce knowledge of persons." (Caraway, 2012, Comments). The case study method for CPE was first used and championed in mental hospital and the reason they worked was because the patients were there for much more longer periods of time so that a full case study could be carried out over a significant period of time to analyze and reflect on the changes that would likely occur in the patient over time.

Creswell (2007) shows that the case study properly done requires an extensive battery of sources and tools used to get at the data and states: “The data collection in case study research is typically extensive, drawing on multiple sources of information, such as observations, interviews, documents, and audiovisual materials. For example, Yin (2003) recommends six types of information to collect: documents, archival records, interviews, direct observations, participant-observations, and physical artifacts.” (Creswell, 2007, p. 75). Since this is true it is evident that Jones (2006) has good grounds for saying that case studies used in HCOs would not work, not because case studies would not yield the qualitative data needed by CPE practitioners, but because the time needed to do so is inadequate for acquiring the data needed. The general hospital offers no such opportunity for such long observations, and collection efforts, and so for Jones (2006) the verbatim in this clinical setting is methodological tool of choice.

Jones (2006) is a chaplain in the Department of Pastoral Care at Rex Healthcare in Raleigh, North Carolina. He is not an outsider but an insider, falling well within the CPE tradition that champions the verbatim for the reasons given above. Jones (2006) also is influenced by his local organization and social location where the verbatim is the methodological tool of choice, and so needs Jones (2006) to present a systemic rationale for its value and use in that HCO setting. The fact that this methodological tool used for reflective practice falls well within the CPE tradition gives support for its continuation, even though some of its inadequacies for the aims and goals for CPE practitioners could be enhanced and advanced by other methods.

One of Jones’s (2006) assumptions is that to be a human person one must somehow be in the business of caring for another person. This is particularly poignant

observation for pastoral care practitioners, who claim that caring for spiritual well being and flourishing of suffering patient/clients is the focus of their human science discipline. You would think that such an astute observation would lead Jones (2006) to see the social justice implication implicit in the assumption, but throughout his article he does not make the connection. Caraway (2012) makes a very good observation in respect to Jones (2006) failure to see the social justice implications in his assumptions. Caraway (2012) states:

> This is a definition rather than a description, a concept which Nietzsche would characterize as "a lie" for it treats unlikes as if they were "likes" Do we really affirm that to be a human person (somewhat redundant) one must be caring Or is it the case that one could be a person who is not caring, and thereby be classified as a nonhuman person? This is important for the pastoral care practitioner for he/she wants the person to be caring, which is a dynamic associated with healing But, such transcendent expectations curb the practitioner's attempts to except the person as she is and have predisposed ideas of the outcome prior to allowing the patient to reveal herself to the practitioner. (Caraway, 2012, Comments).

I think this is true because he seems entirely focused on how the verbatim assists the CPE practitioners through reflective practice to understand their own life world and lived experience, which seems to overshadow the life world and lived experience of the patient. This I think is one of the *deficiencies of the verbatim method* in that it could lead to an unwarranted focus on the life world and lived experience of the CPE practitioner alone, rather than seeing it as a tool that would allow the CPE to approach reflective learning synoptically, that is, seeing together both life worlds and lived experiences.

Verbatims then could turn out to be about only what the experience of suffering means for the CPE practitioner and not what it means for the patient.

Jones (2006) does a good job in explaining and describing the use and rationale for verbatim by CPE practitioners, which is the traditional and dominant reflective tool for this human science discipline. I believe he overstates the case for its value for CPE practitioners as the only viable tool available in general hospitals involved in acute healthcare. For instance, the case study method is still being used by the medical professionals and this method is not just confined to mental hospitals. The case study method is working well in general hospitals, even though the time a patient is in these facilities is about four days on average. Nevertheless, the thick descriptions by medical and pastoral staff of the cases are what is important and not the time frame for the patient residency. However, modern computer software such as EPIC that pastoral clinical pastoral care practitioners use along with medical staff (i.e. physicians and nurses, etc.) to record facts, data and reflections on the patient/client case, before and after visiting patients can provide the data necessary to develop thick descriptions. These descriptions provide physician and nurses with facts, data and reflective notes on the condition of the patients, including how they are responding to the treatment emotionally and physically.

When this information is gathered for clinical follow-up on behalf of patients, it can also be used for reflection and IRB approved research. This data also form the basis for thick descriptions and can be used to provide the clinical pastoral practitioner with the information needed to engage in reflective practice and/or action learning. These thick descriptions can also be used in phenomenological studies or case studies. I, therefore, do not agree with Jones (2006) that verbatim should be the best method that could be used in

CPE reflective practice. I do not think verbatim should be omitted from reflective practice, but should be one among other legitimate sources that should be considered part of CPE reflective practice and learning.

Critical Annotation 2

Carl A. Jensen (2003, Summer). Toward pastoral counseling integration: One Bowen orientated approach. *The Journal of Pastoral Care & Counseling*. *57:2,* 117-129.

With this article this dissertation presents a contrast of CPE methodology to that of Jones (2006), which instead of the verbatim approach uses thick description grounded in an individual case study of the patient/clients needs, and so puts emphasis on *action learning* within reflective practice. We have already stated above in the introduction that Milheim (2008) does not believe that there is one single definition of reflective practice and that "in essence reflective practice involves consideration of both 'seeing' and 'action' to enhance possibilities of learning through experience (Loughran, 2002).

Also, 'reflective practice allows one to make judgments in complex and murky situations – judgments based on experience and prior knowledge . . ."(Milheim, 2008, p. 22). The *One Bowen interventionist approach* is *action learning* that uses the individual case study method to *see* what the patient needs to achieve rapid healing and continued emotional and spiritual wellbeing. This approach has to its credit that it focuses more on the patient/client's suffering and less on how the CPE practitioner feels about it. This approach does not exclude reflecting on this important aspect of learning, but rather seeks to understand the meaning of suffering from the patient/clients perspective and then discover a critical insight into the situation that would allow the practitioner to intervene with a positive solution that moves the patient toward rapid healing and well-being. The

Bowen One approach has the following theoretical framework, according to Jensen (2003):

> A chief aim of treatment is "differentiation of self" or "emotional maturity," at least at the functional level and hopefully at the basic level. This broad concept involves (a) a balance between thinking and feeling and (b) actions that affirm one's own sense of individuality while being in emotional contact with significant others. Differentiation and chronic anxiety are opposite concepts, so that the higher level of differentiation, the lower the level of chronic anxiety. Lowering anxiety is seen as leading to reduction of symptoms. (Jensen, 2003, p. 121).

How does Jensen (2003) put this broad understanding of the One Bowen approach into concrete form so that it could be used by the clinical pastoral practitioner? In other words what is his purpose in adopting this broad theoretical framework? Jensen (2003) states:

> This article applies the concept of an emotional triangle. Simply stated, when the tension in a dyad reaches a certain level, one or both seek to bring in one or more other parties in many possible ways, such as the following: as an ally for self against the other, as a common cause to unite for, as a common enemy to unite against, as the savior of the relationship, as the blame for problems in the relationship, *etc.* The examples are legion. Triangles are natural, automatic ways to manage anxiety, which they may do more or less effectively. They provide stability with requiring substantive change, which is both advantage and disadvantage. Normally, all points of a triangle involve persons. Yet in broad

terms, a point of a triangle can be an idea, belief action, or thing. However the divine is understood, God can be involved in a triangle." (Jensen, 2003, p. 121).

What Jensen (2003) suggests with this triad methodology derived from the One Bowen theoretical framework for action is that the CPE practitioner seek to differentiate themselves significantly enough from the patient's feelings about the phenomenon of suffering but not to such an extent that the practitioners stands outside the relationship or the phenomenon of suffering. To fully bracket one's own relationship to the other that you are trying to heal spiritually is to defeat the advantage that the *One Bowen* approach provides. The CPE practitioner must, however, avoid a linear relationship with the patient that could result in the practitioners using the patient's experience of the phenomenon of suffering for the practitioner's own spiritual growth and/or therapeutic emotional issues of the same phenomenon, however it is being experienced.

Rather, what must be done is create a natural triangular relationship with the patient with the CPE practitioner as one point of the triangle, the patient on other point, and by insight of the CPE practitioner, placing on the third point of the triangle whatever is needed to help reduce the patients' anxiety that they are experiencing with the phenomenon of suffering. The idea is to expiate the anxiety away from the patient and not into the emotional *life-world* of the CPE practitioners, but onto a third point that is able to absorb the anxiety the patient is feeling and which is contributing negatively to their physical, emotional and spiritual health.

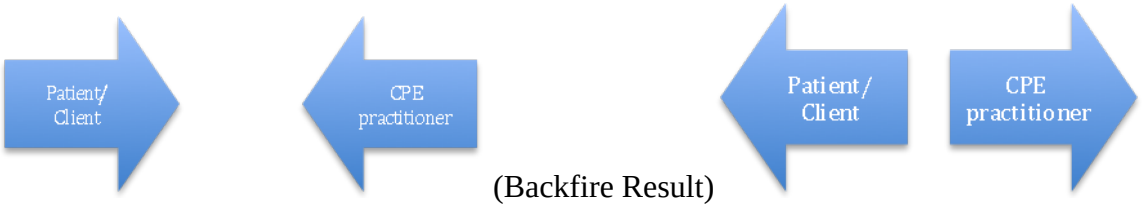
Jensen (2006) suggests among the many things that could serve as the point of expiation for human anxiety when dealing with the phenomenon of suffering is God. God by definition is All-Caring and All-Powerful, who should (in the mind of the patient and

practitioner) be both willing and able to handle natural human anxiety that builds up when threatened with existential non-being that the phenomenon of suffering often poses to humans in suffering and end of life situations.

Jensen's (2006) application of the *One Bowen* approach and the triangular relationships between persons would look something like the following, where God is the ground for expiation of anxiety build-up in both the patient/client and clinical pastoral practitioner as a result of confronting the phenomenon of suffering within their lived-experience and life world:

Triangular Expiation of Anxiety: A Symptom of Human Suffering

On the other hand, a linear approach normally practiced in CPE between the life worlds/lived experiences of the patient and clinical pastoral care practitioner is likely to lead to a back-fired situation, in which each one moving away from each other and the goal and aim of spiritual healing defeated, because the patient and the clinical pastoral practitioner has no third point where expiation of anxiety can be grounded. So this situation would look something like the following:



(Backfire Result)

Jensen (2003) explains his perspective that leads him to adopt the *One Bowen* theoretical framework for clinical pastoral practice in the counseling area, which is action orientated and aimed at both seeing that allows insight into an appropriate intervention, and so states: "The writer's basic framework for treatment has been influenced by a number of sources. One is the work of psychiatrist and researcher David Larson on the use of spiritual-religious material in assessment and treatment. Larson's research indicates that one's lived out spiritual-religious involvement is often a positive factor in health and healing. . . . As a matter of his own theology, this writer perceives God to be in relationship with all of humanity. This gives rise to a spiritual dimension that is present in every person, whether it is foreground or background in a given therapy." (Jensen, 2003, p. 120). I believe that Jensen's (2003) application of the One Bowen approach is valid as long as its intervention remains on the spiritual level or addresses the spiritual dimension of a human person's anxiety when dealing with the phenomenon of suffering.

The danger is that the CPE practitioner could lose sight of his or her object, which is to help the patient expiate their anxiety onto the shoulders of God, who is able to deal with in God's inner subjectivity. The CPE practitioner could easily move over into the emotional area or dimension where the human person condition is more pathological in respect to mental disease and needs not a pastor but psychologist or psychiatrist. Fortunately, Jensen (2003) recognizes this problem and suggests that neutrality on the part of the CPE practitioner should be practiced.

What does he mean by this? The key to effectively using the One Bowen approach as he describes the triangular relationship between persons is to understand the function or role each person in the triangle plays. Jensen (2003) has already said that the

role of God as one of the persons, in this case the divine person is to be a place for the patient/client and, if we have said it before, for the CPE practitioners to expiate their feelings of anxiety in respect to the phenomenon of human suffering. However, the function and role of the CPE practitioner in this triad is necessary as well. That role is neutrality. Jensen (2003) explains what this means and states:

> Neutrality is particularly important for two reasons. One is as a matter of basic ethics and fundamental respect for the right and responsibility of clients to make their own decisions in this highly personal area of life. The other is a matter of how triangles work. As noted previously, the more one person anxiously tries to change the relationship between the two other people, then the more likely these efforts are to "backfire" and to have unintended effects. Thus, a therapist whose own personal faith would predispose him or her towards wanting the client to have a close relationship with God needs to be careful. Anxiously pushing for this result would make it less likely to happen. . . . In principle, this need for neutrality in the triangle with God is the same with any other triangle. . . . The same dynamics of "backfire" apply to all of these triangles. The issue is how a therapist can offer to the client his or her best thinking, stay in emotional contact, and "let go" of what the client chooses to do. (Jensen, 2003, p. 123).

Awareness of the ethical, professional and spiritual dimensions of operating within Jensen's (2003) notion of triune relationship of persons for the purpose of spiritual healing is paramount for the clinical pastoral practitioner, who in this case has adopted the role of counselor and/or therapist at the spiritual level only. Without this awareness in this dynamic spiritual relationship Jensen (2003) warns of "backfire" that could have

ethical, professional, and spiritual consequences. Jensen (2003) has done a good job of describing the One Bowen approach and his own application of framework for intervention (coming alongside the patient in a triangular relationship) after *seeing* (reflection on) the nature of the patient's anxiety issues and concerns with their suffering.

This palliative care approach will have the best chance of working if the clinical pastoral care practitioner does not forget their neutral function in this human/divine triangle of persons. The reflective learning appears to be (1) understanding the meaning behind the patient's anxiety with the phenomenon of suffering based on a thick analysis of the situation, (2) *creative insight* as to how to help the patient expiate this anxiety about suffering onto something more powerful (e.g. God), (3) *awareness* of the need for both *differentiation* of the practitioners *lived-experience* and life-world from that of the patient/client, and (4) *awareness* of the need for personal neutrality that allows the patient/client to decide to accept God (in this case) as the appropriate source of expiation. Jenson's (2003) One Bowen triangular framework may offer an intermediate solution between hermeneutic phenomenology that encourages the clinical pastoral practitioner to fuse their own *lived-experience* of the phenomenon of suffering (which at any rate cannot be avoided) with that of the patient and transcendental phenomenology that claims such a close connection will corrupt the process and distort meaning.

Critical Annotation 3

Orlo G. Strunk, Jr. (2004, Winter). Needed: Phenomenology of illness. *The Journal of Pastoral Care & Counseling*. *58:4*, 293-294. Strunk (2004) states: "one of the qualities desperately missing in the 'treatment arena' is authentic empathy – characteristic seemingly difficult for both caregivers and care recipients to

"operationalize." (Strunk, 2004, p. 293). What he means is that medical and pastoral staff, including patients have found no way to put authentic empathy in to practice in HCOs on a daily basis. Strunk (2004) has concluded that this is true based of his years in participating in and observing the interrelationships between caregivers and patients, and finally based on the experience of the patient himself dealing with the phenomenon of illness.

What bothers Strunk (2004) more than anything else about what he has observed is that health care chaplains lack the same quality of empathy of care. If there is any human science discipline that could lay claims to this quality it should be clinical pastoral care practitioners, such as chaplains. Yet Strunk (2004) claims this is not the case and states that these spiritual caregivers are likely to take an "*oh-hum*" (p. 293) attitude toward his observations. Nevertheless, Strunk (2004) goes on to state: "but, frankly, I am a bit startled by this realization, especially in light of the reality that I have spent most of my adult life either as a caregiver or as one who reads and edits – on almost a daily basis – the accounts of professional caregivers describing what they do and the research that engages them. . . . I suspect, I have come to understand – truly *understand* . . . that there is a gap between the technology of care and human touch. Intellectually, I've always know this to be true. Now, existentially, I know about that gap – or more accurately, about that *chasm*." (Strunk, 2004, p. 293).

What does Strunk (2004) believe would allow authentic empathy to become a reality and operational in clinical pastoral care practice? Strunk (2004) thinks that clinical pastoral care needs a *phenomenology of illness*. Strunk (2004) believes that phenomenology, while it "is anything but a unified theory of knowing. . . . does value

highly the essence, structure, and form of *human experience* as revealed through primarily descriptive techniques and disciplined reflection" (p. 293). These two attributes of phenomenology applied to human illness would in his view open the door to *authentic empathy* in the spiritual care of patient/clients.

Strunk (2004) wants to find a way to develop authentic empathy in the care of patients in HCOs. He believes this is of particular importance for clinical pastoral care-givers and practitioners, whose human science discipline is the care of souls (i.e. spiritual care of human persons), which is to say shepherd them in the direction of spiritual wellbeing and human flourishing. However, Strunk (2004) believes that the practice of clinical pastoral care in respect to human suffering has to be informed by a theoretical and methodological approach that has two qualities that (1) can describe and understand the meaning of human suffering, and (2) calls for disciplined reflection on the meaning of human suffering to further inform practice in the human science discipline of spiritual care. In order to do this Struck (2004) claims "that we need to continue producing a literature that includes – alongside our scientific and objective efforts and studies --- thoroughly *subjective* descriptions of what it *means* to be ill; what it's like to *be* a person with a 'borderline personality disorder"; what it's like to 'lose faith'' what it feels like to be treated as an 'object'; what the experience *is* of having to admit to the hospital admissions clerk that you have no health insurance; what it feels like when, in extreme pain and discomfort, an expert in a perfunctory style says, 'I know how you feel. . .' (Strunk, 2004, pp. 293-294).

Caraway (2012) thinks that Strunk's (2004) call for "*subjective* descriptions of what it *means* to be ill" laudable but begs the question of how to describe human

experience "in general" that is collectively without diminishing an person's individual experience. Caraway (2012) states:

> This is a laudable expectation. Yet, the very idea of phenomenology, at least as far as Brentano and Husserl are concerned, is that each individual person's experience is idiosyncratic and by generalization we lose the individual experience and treat unlikes as if they were alike, and thereby "tell the lie" Nietzsche. So, the problem still is: How do we describe an experience "in general" without missing or denying significant dynamics of individual experiences? One criticism of Husserl has been that he ridded himself of Platonic essences merely to establish an individual essence for each entity/experience. We are faced with the dilemma that the greater we move toward generalization the more we repudiate the strength of the phenomenological description. (Caraway, 2012, Comments).

This observation by Caraway (2012) forces Strunk's (2004) call for more empathetic CPE literature to become a social justice concern, which is one of the areas that this dissertation suggests is a deficiency in CPE clinical praxis and pedagogy. How do you turn mere empathic literature about caring for the patient into deeper social justice analysis for CPE educators and practitioners? A greater focus on a phenomenology of suffering is key to a new social justice focus, because the methodology itself will drive the CPE toward this higher human concern.

Strunk (2004) phenomenology has the theoretical and methodological attributes and qualities to answer these meaning questions related to social justice concerns for the patient's autonomy, which CPE calls care or empathy. We have seen above that Struck

(2004) believes that this call for care and empathy can become hollow platitudes that do not address the spiritual needs or social justice concerns of a patient domiciled in hospital clinical organizations (HCOs). Strunk's (2004) perspective is informed by his own experience with illness and suffering, both as a clinical pastoral care giver, researcher, and as a patient, who had hither to experience only good health. Strunk (2004) states:

> This past year I have experienced what it is like to be a patient. I've had surgeries, and I've spent considerable time waiting in hospital and physician outer offices. Mostly, for me this had been a new way-of-being, if you will --- quite different from my over half-century of being "healthy." I have listened to the conversations of other patients waiting to be cared for, and I have listened to the dialogue in my own head while I was waiting. I have observed, and, when possible, eavesdropped on the chatter of a variety of caregivers---physicians, nurses, orderlies, management fold as they busied themselves with technological paraphernalia, with one another, and with patient as well as impatient patients. I have paid particular attention to the ways in which caregivers attempt to communicate care and how I --- admittedly, a field type --- perceive and evaluate such attempts. (Strunk, 2004, p. 293).

Strunk's (2004) reflections on his experiences in his life-world gave him the insight that a phenomenology of illness is needed to infuse CPE practice with *authentic empathy*. The question is what authentic empathy is. Strunk (2004) does not define what it is explicitly, but rather uses an inductive strategy that describes the experiences of how patients feel when they do not experience authentic empathy from their caregivers. The reader is left to read into the examples used their own idea of what Strunk means.

On the one hand people like either lexical or stipulative definitions because they claim to make things clear. However, a second look suggests that Strunk (2004) is actually approaching the meaning of what authentic empathy is from a phenomenological perspective by using a number of examples of what patients experience in HCO enamored with the medical technology and procedures that ends up treating the patient as an "object." (p. 294). Phenomenology would engage in thick description and not impose a definition of meaning that would exclude all of the relevant cluster of themes that could be derived from the experience, even negative experiences. Had Strunk (2004) gone further and actually expanded his musings as he calls them (p. 293) into a full examination of how *phenomenological reflection* would advance or create authentic empathy in HCOs, this methodological approach would be consistent with a phenomenological theoretical framework.

Critical Annotation 4

Henri J. M. Nouwen (1989). *In the name of Jesus: Reflections on Christian leadership*. New York: The Crossroad Publishing Company. Nouwen's (1989) work is a classic text used by CPE educators in CPE programs for two reasons: (1) It seeks to teach CPE students the discipline of theological reflection, and (2) to remind the CPE student that this discipline is spiritual in nature and not merely a humanistic enterprise. On the second count it does so by reinforcing the notion that clinical pastoral care givers who are chaplains are responsible to Jesus Christ and therefore however human directed or whatever human tools are used, such as reflective practice, the pastoral clinical enterprise from beginning to end is the *care for* and *cure of souls* that are experiencing the phenomenon of illness and suffering.

Theological reflection then becomes a special category of reflective practice and learning fit only for the human science discipline of clinical pastoral education (CPE). In Nouwen's (1989) chapter on "The Discipline: Theological Reflection" describes the purpose and reasons why theological reflection is important considering the alluring dangers of the spiritual enterprise and its purpose and aims being co-opted by humanistic (man-centered) solution to spiritual care of the human person. Nouwen (1989) states:

> Just as prayer keeps us connected with the first love and just as confession and forgiveness keep our ministry communal and mutual, so strenuous theological reflection will allow us to discern critically where we are being led. Few ministers and priests think theologically. Most of us have been educated in a climate in which the behavioral sciences, such as psychology and sociology, so dominate the educational milieu that little true theology was being learned. . . . Real theological thinking, which is thinking with the mind of Christ, is hard to find in the practice of the ministry. Without solid theological reflection, future leaders will be little more than pseudo-psychologists, pseudo-sociologists, pseudo-social workers. . . . But that has little to do with Christian leadership because the Christian leader thinks, speaks, and acts in the name of Jesus, who came to free humanity from the power of death and open the way to eternal life. (Nouwen, 1989, pp. 85-86).

Nouwen (1989) establishes the proper focus for pastoral care of souls and when this focus is applied to clinical pastoral care it become more significant. It is very easy for chaplains, as clinical pastoral care practitioners, educated as they are in many aspects of the behavioral sciences with its positive scientific expectation grounded in Socratic methods of investigation, to forget that clinical pastoral education (CPE) was formulated

in Christian seminaries and left that place to enter hospital clinical organizations (HCOs) for the express purpose to provide spiritual care for souls and spiritual healing of humans that suffer maladies that effect their spiritual constitutions.

Even methods like the *One Bowen* approach, which considers God to be part of the triangular intervention can be overstepped and become a mere humanistic tool that gives the impression that human persons are being directed toward divine sources of healing. There are a number of assumptions that underlay Nouwen's (1989) views. One of the assumptions is that this clinical pastoral aim in the name of Jesus is both needed and acceptable to all souls in HCO settings. Certainly clinical pastoral practitioners, who are Christian chaplains, would betray faith in their own human science discipline of spiritual care if they did not believe that their aim for the spiritual care of souls was not needed by all who suffer maladies. They have to believe that this Christian clinical pastoral ministry and practice has value and legitimacy and this is despite the fact that not all human persons who are suffering find this clinical ministry acceptable and necessary for them.

The imposition of the clinical pastoral care practitioner's own lived-experience of spirituality or doctrinal faith on to another person (i.e. patient who is suffering) derived from the practitioner's life-world would be an ethical violation of the autonomy of the human person and become then a social justice issue. However, this is where Nouwen's (1989) notion of theological reflection helps the clinical pastoral practitioner stay faithful to their discipline and practice. At the same time they can honor the decision of other persons, even when faced with physical and mental maladies, and/or end of life phenomenon, not to have to deal with the spiritual life-world and lived-experience of

their pastoral caregiver if that is what the patient desires and prefers. Nothing in the policy statement of the *Joint Commission of the Accreditation of Health Care Organizations* (JCAHO), which stipulates that "all patients have the right to have their spiritual needs addressed as part of their overall treatment plan" (Cleveland Clinic, 2012, p.5) would allow or sanction the imposition for the faith tradition or beliefs of the pastoral care giver incorporated into their *life-world* and *lived-experience* into the *life-world* and *lived-experience* of the patient without their consent. This is why advocates of the **One Bowen Orientated Approach** to spiritual needs assessment and spiritual care that allows God in the triangular dyad of care as "Next of Kin" "neutrality" of the pastoral care giver as necessary component of this approach. (Jensen, 2003, p. 123). However, this said, Jensen (2003) warns about the misuse of the *Bowen One Approach*, and states:

> On the other hand, some therapists, as a matter of principle, we see religious conversion or repentance as the essential next step toward health. They see themselves as bound by duty and by love to present this perspective to clients. In these situations, neutrality is limited as an operative value of therapy. Then it would be seem appropriate that these therapists state their values and principles at the very outset of treatment as an "I position," so that clients may make informed decisions about whether to consent to this type of treatment. (Jensen, 2003, p. 126).

Fortunately, this possibility of this happening in spiritual care is only in private clinical practice. Neither the Hospital Clinical Organization (HCO) or Clinical Pastoral Education (CPE) and its departments within HCO centers would allow the presentation of

I-positions, even under conditions of neutrality. Human freedom of choice is a necessary component for human autonomy freedom, and institutional social justice. Although it's little understood among the faithful this idea of human freedom and choice is also normative in the Abrahamic religions with Islam making the clearest and shortest statement "There is no compulsion in religion." Christianity also is governed by this norm of religious freedom, despite how some of its adherents have violated it in their religious zeal. Nouwen (1989), however, is at pains to demonstrate that pastoral caregivers, as proclaimed shepherds of the human soul grounded in faith, should not for all of that give up their own human freedom to speak out of that faith in attempt to provide spiritual care to all who need it and accept it.

A demonic gag order to be silent then would invalidate this human science discipline of spiritual care and if done then clinical pastoral care providers might as well give up this clinical practice if this normative stance of faith is denied. In other words if pastoral care givers cannot do or are not permitted to do anything else they still have a faith call to *speak truth to dark spiritual forces* that they believe hold human persons in both spiritual and physical bondage. In this regard Nouwen (1989) states:

> The task of future Christian leaders is not to make a little contribution to the solution of the pains and tribulations of their time, but to identify and announce the ways in which Jesus is leading God's people out of slavery, through the desert to a new land of freedom. . . . They have to say no to every form of fatalism, defeatism, accidentalism, or incidentalism that makes people believe that statistics are telling us the truth. . . to say no to every form of despair in which human life is seen as a pure matter of good luck or bad luck. . . . to say no to sentimental

> attempts to make people develop a spirit of resignation or stoic indifference in the face of the unavoidability of pain, suffering, and death. (Nouwen, 1989, pp. 87-89).

While this view may be objectionable to secularists in this post-post modern environment, where all authority, including religious authority is challenged to prove itself or be silent, I find that Nouwen's (1989) views theological reflection that supports these conclusions are at the least consistent with the primary aims and goals of clinical pastoral practice, which is in an environment that demands positivistic affirmation for the legitimacy of its existence as a human science spiritual discipline. Nouwen (1989) does, therefore, a good job of refocusing pastoral care practitioners back to the ground of their existence, which is the faith that they have been called to spiritual healing of the human person in the name of Jesus.

Critical Annotation 5

Della P. Bacote (2006, Supplement). The miracle of metamorphosis: From chicken to eagle. *The Journal of Pastoral Care & Counseling*. *60:5,* 441-443. I have dealt with some of the methodological ramifications of CPE reflective practice in the previous critical annotation, which was necessary to see how this method used in both education and the medical field is used in various ways in clinical pastoral education. Here and in the following annotations this dissertation seeks to know how CPE practitioners actually engage in reflective practice in respect to how human suffering impacts their life-world and lived experience from a phenomenological perspective. This dissertation seeks to know how phenomenology incorporates reflective learning in actual CPE practice and

how it helps CPE pastoral practitioners draw meaning for their practice from their contact with human suffering within HCOs.

In this article Bacote (2006) describes her chaplaincy journey from confronting her life-world as chicken to dealing with it as an eagle. She describes herself as a "wounded healer" (p. 441), based on her *lived experience* as an orphan and lifelong ill treatment by her adopted mother. Bacote (2006) states: "Allow me to relate a bit of the journey from chicken to eagle. Prior to an intense year of CPE in 2004-2005, I grappled with a self-depreciating and unflattering self-image. I skillfully concealed this lonely struggle from friends, former colleagues, seminary classmates, and others who thought they knew the 'real me'." (p. 441). Yet, Bacote (2006) believes this hurtful lived experience has accrued to the benefit of her patients, who are experiencing suffering, and to the overall improvement of her clinical pastoral practice. Bacote (2006) states:

> Just a few months removed from Clinical Pastoral Education (CPE), I find myself reflecting on the woes and joys of life as a hospital night chaplain. I refer to this as the "solitary flight of the night eagle." In the wee hours of the night and often far from the source, my ears tune in to intercept moans of agony. My eyes focus on the tracks of steady tears rolling down faces. I perceive unspoken frustrations and sighs of relief. And often I move in closely, slowly to gently touch the trembling hands of weary and sick souls. Every busy is the eagle, tending broken hearts and bodies, mending and meeting needs. (Bacote, 2006, p. 441).

Bacote (2006) believes that she obtained her emotional status of eagle because of the support she received from CPE faculty and students. She began to see her negative lived-experience prior to CPE leading her from dealing with life as chicken to dealing

with it as an eagle soaring high above it. Bacote (2006) states: “I now see that my pain, self-doubt, and hatred have become pools of insight into the human condition, especially its mysterious capacity for renewal and tenacity. I now accept that God chose to invite someone like me to join the servant team on earth as a minister. Indeed, I could become a chaplain and wounded healer capable of enabling others to experience the liberation that I claimed in CPE.” (Bacote, 2006, pp. 442-443).

It is apparent that Bacote (2006) used her contextual situation as a night chaplain in an HCO to reflect on her entire life-world of experiences and see through reflective practice how those experiences informs her new understanding and view of herself as a “wounded healer” is nevertheless and even because of it able to help others through their own human suffering and deprecating maladies. Here Bacote (2006) has from a phenomenological perspective engaged in thick description of her own lived-experience and used it to inform positively her own clinical pastoral practice.

Critical Annotation 6

Denise Giacomozzi (2008, Winter). When a chaplain needs a chaplain. *The Journal of Pastoral Care & Counseling*. 62:4, 391-393. The proverbial challenge to Jesus, “Physician heal thyself” (Luke 4:23) has been followed by an equally poignant advise to physicians that should follow their own advice and see a doctor rather than diagnosis and treat their own maladies. This advice is perhaps good for chaplains too when reflective practice needs the assistance of another chaplain, who is able to see things more objectively. This means that reflective practice may fail to transform the situation when a chaplain is faced with phenomenon of suffering that is not sufficiently differentiated from their own lived-experience (as advised in the *One Bowen* approach)

and is likely most ineffective when the chaplain faces an end-of-life situation that is personal.

This is when the proverb "Physician heal thyself" becomes more than a challenge, but something almost impossible to overcome and process within reflective consciousness as a mere learning experience. This happened to Chaplain Denise Giacomozzi (2008) upon the impending death of her father, where a chaplain all by herself she felt helpless. This feeling was aggravated by the fact that she had a strained relationship with her father, who was now leaving her to pick-up the tattered scraps of his life and get him buried, even though he had left the Catholic church years ago and did not want to see a priest. Somehow she found herself in the pastoral office of the hospital where her father was resident. She met with Chaplain Louise Kingston, who herself had just experienced a horrible disfigurement of her face in an accident, the loss of her job as director of pastoral services and herself experiencing loss as a result of these all too human events leading to tragedy. Giacomozzi (2008) states:

> Chaplain Louise Kingston was an appalling sight to behold. Her face was severely disfigured. . . . Louise's first day back after her accident, that it would be best if she remained in the office so as to not frighten the patients. Before I had dashed by she had been sitting at her desk wondering what use she was ever going to be that day. All of that explained her eagerness to help. And help she did. She was truly the most wonderful chaplain. She did everything chaplains are trained to do. Not only was she compassionate, but she also helped me in very practical ways. One of these ways included something I had been agonizing over: how to handle my father's funeral. My father long since stopped practicing Catholicism, and my

> mother, outraged over the cover-up of pedophilia in the Church, had stopped attending Mass. Thus neither of my parents was known to any parish. . . . Chaplain Louise's pastoral care did not end there. She listened to not only what I said through my tears about the life-long conflicted relationship I had had with my father, but she also gently raised the notion that perhaps I might consider shedding these tears in my father's presence. (Giacomozzi, 2008, pp. 391-392).

This last bit of advice to shed tears in her father's presence likely could not have come as a result of reflective practice when a chaplain is one who is grieving. This insight provided to her by Chaplain Louise allow her to reflect on its meaning. Giacomozzi (2008) reflects on this insight and states what she learned:

> It is part of our training as chaplains to learn about the loses and grief that not only family members go through surrounding their loved one's dying, but also those grief's that the person who is dying is going through as well. While family members are losing one beloved person, the person who is dying is losing everyone and everything. And, despite my expertise, in my own grief I had lost sight of that truth until Chaplain Louise brought it to the forefront. (Giacomozzi, 2008, p. 392).

What Giacomozzi (2008) has demonstrated well that reflective practice has its limits and is not strictly a solo subjective exercise, but at times and especially when the pastoral care practitioners own lived-experience of the phenomenon of suffering is close, reflective practice to work well must become a communal reflective practice. Someone else has to speak and help the wounded-healer find an insightful solution to grief.

Critical Annotation 7

Katherine Murray (2004, Winter). Something to say. *The Journal of Pastoral Care & Counseling*. *58:4*, 369-370. In this article Murray (2004) reflects on internal work of pastoral care practice in respect to dealing with the phenomenon of suffering. Murray (2004) states: "My experience at the hospital is teaching me about suffering and about not having the answers for others when they are in almost unbearable pain. I haven't discovered the celebration in that yet. . . But in Clinical Pastoral Education I find that ministry takes me to places beyond my learned skills, where all I can do is simply be with those who feel powerless in moments of unfathomable loss. And the kicker is that before I can share others' burdens in those moments, I have to first be willing to travel to those places myself." (Murray, 2004, p. 369). Through reflective learning Murray (2004) has discovered two central truths about clinical pastoral care practice: (1) that being present with those suffering is sometimes more important than words of comfort, meaning you have to somehow be present in the moment of suffering with the one who is suffering (e.g. authentic empathy), but in addition, (2) the pastoral care practitioners must somehow have a shared experience of the other's life-world before being present can be achieved. Being present in the moment with the other, even if that is mere silence, is more challenging than merely coming alongside the one who is suffering (i.e. palliative care).

Being present is sharing in the suffering to such an extent that it is felt by the caregiver at a deeper level than the intellect but at the level of the heart. Murray (2004) makes this plain and states: "Those moments and those feelings connect me with my patients, and I know I am being deeply changed in the hope of healing. The tears that

come feel ancient; and I'm sometimes not sure who I'm grieving for---myself, my loved one, or any of us who have felt anguish wondering where God is in our deep pain." (Murray, 2004, pp. 369-370). Here Murray (2004) describes what *authentic empathy* means, something that Strunk (2004, p. 293) did not define in his article "Needed: A Phenomenology of Illness." Somehow Murray has discovered what it is through her own reflective practice of what it means to suffer, and so obtains a remarkable insight that being present in the moment within the life world and life experience of another person can shed light on one's own experience of the phenomenon, and then that learning in a kind of swing hermeneutic learning process can allow the pastoral care practitioner to do more than come along side (i.e. palliative approach to healing) but authentically enter the experience of suffering with the one who is suffering.

Critical Bibliography 8

Kevin Boyd (2008, Winter). A hospital chaplain's reflection on Ash Wednesday. *The Journal of Pastoral Care & Counseling*. 62:4, 379-380. In this article Boyd (2008) tells of his experience with an end of life situation in the hospital on Ash Wednesday. It was not the death of a woman, who was a long time family friend, and it was not merely the fact that she died on Ash Wednesday itself that made him reflect on the meaning of this holy day for Catholics. It was not even the conjunction of her death with this religious holy day that caused him to reflect on its meaning for human mortality and the gift of life; but the fact that it meant so much for this woman and her husband to receive their ashes, which they had not missed together for over fifty years. Boyd (2008) discovered that is not the holy day that gives it sacred meaning, but human life that for

some reason holds that day sacred and meaningful for them. Boyd (2008) as their chaplain arrived too late to administer the ashes while she was present and states:

> I thought, 'Too late.' And I wondered what we might do instead because I felt that the symbolic power of the ashes was impotent in the face of the stark reality of death. My sense of poetic justice was offended because this business felt unfinished. As I stood there, in my own mourning, her husband stopped beside me. It took me a minute to realize that he was waiting for me to give her the ashes, and I realized that it would take more power than . . . death to disrupt this 50 year tradition, and what it meant to him, and to her. And this time it meant something different to me. I hardly needed to remind anyone there of our mortality, of the shortness of our time in this place. And if there is something awkward about saying, "to dust you shall return" to a living person then there is something sacred and profound, something almost too real in speaking those words to a dead woman --- she who knows by experience of what I speak. (Boyd, 2008, pp. 379-380).

Boyd (2008) then reflects on human mortality and states: "Ashes are not just about repentance, or death, nor are they just about life: they are about us, made up of the same stuff as us, creatures who will live and die, and yet still live. They are about remembering our finitude and also acknowledging the fact that death is not the end of our own story" (p. 380). Through the profound experience of a friend's death on this holy day Boyd (2008) was able to move his reflection in regions of thought and feeling that took him beyond the temporary condition of human mortality to affirm human immortality.

Boyd's (2008) presentation of this reflective experience is convincing even though as he suggests only the person who dies knows the truth of his claims. It then is clear that Boyd (2008) already believed in the immortality of the soul. Had he not so believed then his reflection on his friend's death on this Catholic holy day might have been different. Nevertheless, he expresses authentic empathy, which is necessary to experience or make sense of another's suffering and/or death.

CHAPTER 3 – METHODS

Methods: Quantitative vs. Qualitative

I would like to avoid the tired debate and comparisons between the quantitative and qualitative approaches and methods in research, where quantitative research methods deal by-and-large with *measurement* of things and the relationship between things, and qualitative research methodology deals with human meaning and reaction to phenomenon. Yet this discussion cannot be totally avoided because vestiges of the debate are still evident and clarity is still needed in respect to appropriate methodologies, where the danger still exists that inappropriate methods might creep into This dissertation. I am reminded of this danger by Judith M. Meloy (2002) in her *Writing the Qualitative Dissertation* that: "By outward appearances, some dissertations using qualitative research methodologies look like traditional, quantitative theses. We are still in the process of identifying ways of communicating exemplary qualitative research" (Meloy, 2002, p. 18).

This problem for qualitative research is not only because researchers using this approach are doing mixed methods research. Some qualitative researchers are still trying to be "scientific" by adopting devices like *epoche*, so that the claim can be made for qualitative research that it "requires the elimination of suppositions and the raising of knowledge above every possible doubt" (Moustakas, 1994, p. 26). On the other hand Van Manen (1990) is going to suggests that "raising doubt" in human science research is just what phenomenological study is supposed to do, that is, keeping the question of human *lived experience* always open to new and richer possibilities that are revealed by a *discovery* of the *cluster of themes*, when human persons are confronted with various

phenomenon. Raising doubt, not eliminating it should be the central focus of the human sciences, especially when doing phenomenological research.

Van Manen (1990) states: "A phenomenological description is always *one* interpretation, and no single interpretation of human experience will ever exhaust the possibility of yet another complementary, or even potentially *richer* or *deeper* description" (Van Manen, 1990, p. 31). This is true not only because *doubt leads to knowledge and discovery* but also because phenomenological swing hermeneutics of human *lived experiences* (in its various *life worlds*) necessarily demand and makes it so.

I claim that Van Manen's (1990) view is more advanced and more "scientific" than Moustakas (1994), because Van Manen (1990) understands that the "elimination of suppositions and raising of knowledge above every possible doubt" (Moustakas, 1994, p. 26) cuts off research from the richness of human experiences, when confronted with variety of phenomenon, and therefore unnecessarily delimits *new discovery*. Methods (e.g. *epoche*) should never nullify human science *discovery* but *reveal* them. If it does this then the methods themselves need to be revisited by examining the meta-theoretical assumptions and/or philosophical foundations that led to the methods use and design. Moustakas (1994) understanding of Husserl's method of *epoche* that he calls *bracketing* is one such qualitative methodology that needs to be *revisited*.

In This dissertation I am not trying to justify why this is a qualitative study rather than a quantitative study. I do not intend to be "scientific" by adopting pseudo-scientific methodologies (even if they can be distinguished from quantitative methods). However, I will be no less rigorous in the methods and procedures adopted and used. This dissertation adopts the methods suited to the research question being posed for the study

and the qualitative approach that can help answer the research question(s). Fundamentally that choice is dialectical arrangement dictated by the overall research question and then once the choice is made, grounded in the question; then appropriate methodologies can be chosen to help answer the research question proposed.

However, this dissertation needs to be clear about the differences between both qualitative and quantitative research approaches in a general sense, because this dissertation seeks to be sure it is using the appropriate methods that belong to a qualitative dissertation research. Judith M. Meloy (2002) in her book, *Writing the Qualitative Dissertation* believes this is absolutely crucial. Meloy (2002) believes that uncertainty about the choice between the two approaches in human science research is because researchers do not understand the differences between the methodologies. This dissertation does not disagree, but claims it is not only this, but also because:

(1) the research question is not clear and so the researcher does not know what they want to discover, that is, what the topic is, the approach chosen in relationship to methods adopted; (2) a general failure to understand that the research question will guide them to which approach to use and then once the approach is chosen to the appropriate methodologies and procedures; and (3) there is a general failure to discover the philosophical and/or theoretical foundations for the approach chosen to answer the research question(s). Without this horizon of understanding the study will be unclear. Nevertheless, Meloy (2002) has a point and states:

> If some doctoral students feel defensive about their decision to undertake qualitative research, then might it be less from the fact of their methodological choices per se as it is from the fact that they are inexperienced researchers and

> methodologists, less able to explain and argue their choices and less sure about knowing what they are doing and why? Tim offers several suggestions, which make sense to me. "Have a concrete idea about what qualitative research means to you. Until you are confident in your understanding of what you are going to do and how you are going to do it, you will never be certain if you are conducting the research properly."

Meloy (2002) continues:

> Stress the importance of knowing both sides of the paradigm dialogue. Although Dr. Wolcott said qualitative researchers no longer needed to defend their paradigm in addition to their research in theses and dissertations, he is speaking from an educational research perspective, where qualitative research is more accepted. Students should know the assumptions of both the qualitative and quantitative perspectives to better define and defend their own work. As long as their work is under the evaluative control of researchers unsympathetic to qualitative research, qualitative researchers will have to defend their perspective as a whole, if only to place their own work in context for their reviewers. (Meloy, 2002, pp. 46-47).

According to Meloy (2002) this debate between qualitative and quantitative research began in earnest in the late 1980's. The debate began with Lincoln and Guba's (1985) classic work, *Naturalistic Inquiry*. Fortunately though, according to Meloy (2002) "the qualitative-quantitative arguments have long filtered down from the lofty level of articulate debate in the late 80s to the concrete level of implications for practice" (Meloy, 2002, p. 48). Today the debate is more a contest between qualitative approaches (e.g.

narrative research, phenomenology (hermeneutics vs. transcendental), grounded theory, ethnography, case study, naturalistic, or heuristic) grounded in theoretical and foundational paradigms (each with its own assumptions) presented by various interpretive communities researchers following, according to Creswell (2007), a number of worldviews (pre-positivism, positivism, post-positivism, social constructivism, advocacy/participation, pragmatism) and/or hermeneutic perspectives, such as, postmodern, feminists, critical theory and critical race theory (CRT), queer theory, and disability theory (Creswell, 2007, pp. 19-30).

Meloy (2002) states: "One of the reviewers of this book suggested that the current arena for dissonance appears to be less the quantitative-qualitative paradigm struggle than the methodological differences among the variety of approaches to qualitative research." (p. 38). If this is indeed the case then this is where qualitative study should struggle to justify and legitimize its own disciplinary perspectives including the appropriate method that goes with each type of qualitative study. Yet the old debate continues like a bad headache long past the memory of which will not go away. The residue of this old debate is evident among some novice researchers still yet.

One such researcher, according to Meloy (2002) states: "Why do you all feel so guilty about qualitative research?" I'm not really sure why, but I think we are continually squaring ourselves with science and not just our committee" (p. 44). Another researcher states (with a little more gusto and even passion): "Is qualitative research getting a 'bad rap' because it is viewed as easy? I think it is somehow viewed as not as rigorous, because it does not involve statistics and all of the mumbo jumbo that goes with extensive statistical analysis." (Meloy, 2002, p. 46).

These are all surface arguments about the debate. The real problem is that the debaters are not educational philosophers or philosophers of education and do not understand that the roots of the debate are found in the deeper philosophical arguments and meta-theoretical assumptions between the so-called *natural science research*, which relies on and revels in *scientific method* and the *human science research* still having a headache trying to prove it is "scientific" by using some kind of pseudo-scientific method rather than relying on the rigor of its on methodologies and procedures. Here, I take the view of Dr. Walcott presented above, even though I am not using quantitative approaches and its associated methods.

I further adopt the attitude of the doctoral student who, according to Meloy (2002) stated: "Although I believe qualitative research stands on its own merits, I felt it was necessary for *me* to ground my methodological choice in a solid understanding of the options available. *I still believe that understanding one's methodological framework and its implications from "problem" conception to final presentation---is a necessary and important aspect of learning how to do qualitative research well*. (Meloy, 2002, p. 39).

I do not think, therefore, that there is a need to justify one approach over the other in terms of methodological rigor or the kinds of data and knowledge each is trying to uncover in research. They are just different approaches searching for data and using different methods to acquire that data that are appropriate to its own realm. The only value I can see in comparing the two approaches is for the sake of clarity so that each kind of researcher can clearly see the appropriate methods that should be used in each and if mixed methods are what the research questions demands, to see how the data of the

two approaches may be *triangulated* so that the conclusions from the mixed methods data are useful.

With this said, I don't believe that one needs to resolve the debate by proposing that qualitative research, especially in educational studies, needs to use mixed methods if the research question does not dictate or strongly move the researcher in this direction. It must be remembered that the research question itself is what needs to be answered and so the approach and methods adopted should conform to this aim and purpose. Nevertheless, some researchers and scholars are of a different opinion.

Fraenkel and Wallen (2003), for instance, are of the opinion that "educational research increasingly is, and should be, a mixture of quantitative and qualitative approaches. . ." (Fraenkel & Wallen, 2003, p. 430). They present the debate between the two approaches depicting three researches arguing over which approach to use. The qualitative researcher states: "You quantitative researchers are so preoccupied with control that you never see the big picture." The quantitative researcher states: "You qualitative researchers are so subjective, you never can be sure what you've found or where it applies." The mixed methods researcher states: "Why don't you two try to work together? You would then have the best of both worlds." (Fraenkel & Wallen, 2003, p. 428). The last narrative comment may be true but the impasse between the two approaches is more fundamental and is more problematic when it comes to human science research.

Quantitative research and methodology reigns supreme when it comes to researching "things" in the universe, because it is dealing with *quantities*, *measurements* and using the abstract language of *numbers*. However, when these same kinds of methods

and analytical tools are applied to “persons” or “humans” (as one prefers) then it comes up against some limitations in dealing with and explaining human qualities and clusters of meaning derived from human interaction or *lived experience* with phenomenon in the *life world* of the human person. Numbers (which is an abstract language in and of itself) as a tool of abstracting themes of human meaning cannot explain precisely what the human science researcher is seeing in the data. In quantitative research a number of things respecting human persons can be done and may even be valuable to the qualitative researcher doing a mixed methods study, such as “comparisons between alternate methods of teaching (as in experimental research); examining research among variables (as in correlational relationships); comparing groups of individuals in terms of existing differences on certain variables (as in causal comparative research; or interviewing different groups of educational professionals, such as teachers, administrators, and counselors (as survey research).” (Fraenkel & Wallen, 2003, p. 430).

However, this type of research differs from qualitative research “that investigate the quality of relationships, activities, situations. . . “ where “ there is a greater emphasis on holistic description --- that is, on describing in detail all of what goes on in a particular activity or situation rather than on comparing the effects of a particular treatment (as in experimental research), say, or on describing the attitudes or behaviors or people (as in survey research).” (Fraenkel & Wallen, 2003, p. 431).

Methods: Human Sciences vs. Naturalistic

A more useful comparison for This dissertation study in terms of justifying the methods used is the differences in methodological approaches between the *natural sciences* and the *human sciences*. It is useful to know that the foundations of quantitative

research methodology are grounded in the natural science approach to knowledge and that the foundation for qualitative research methodology is grounded in human science approach to knowledge. Where quantitative research may have overstepped itself in respect to human science research is the wholesale application of natural science methodology to human behavioral phenomenon with the implied suggestion that this is the only way of knowing, the only epistemological method for acquiring the data on the human person and understanding human phenomenon.

This hubristic claim by implication may have encouraged the publication of Lincoln and Guba (1985) classic *Naturalistic Inquiry*, which has influenced and informed many such qualitative studies and works, such as, Gleason's (1999) *Becoming Qualitative Researchers* and allowed qualitative researchers to take the same or similar hubristic stance. Lincoln and Guba (1985) stated:

> Today we live in the age of science. The eternal questions are best answered, it is asserted, by putting queries directly to Nature and letting Nature itself answer. This empirical approach is undoubtedly the most powerful dynamic stimulating the emergence of what we are now pleased to call the Age of Enlightenment. That this answer is right can hardly be doubted. The spectacular successes of modern physics, modern medicine, and modern space technology, but also of modern nuclear weaponry, all trace their beginnings to this shift from pre-scientific to scientific thinking. But the ancient questions are not so easily stilled. Having thought them settled, we find that they reappear in new guises, not only in the very domain in which they have been so well answered, the so-called hard sciences, but also and most particularly in the "softer" sciences, that is, the human

> and social sciences. Cracks have begun to appear in science's magnificent edifice as new "fact" are uncovered with which the old paradigm cannot deal or explain. Normal science in the Kuhnian sense is becoming more and more difficult to sustain. Serious challenges are being mounted from the perspective of alternative paradigms that suggest new and different answers. This book is about such a challenge. It describes an alternate paradigm that, largely through historical accident, is now traveling under the name "naturalistic." It has other aliases as well, for example: the postpositivistic, ethnographic, phenomenological, subjective, case study, qualitative, hermeneutic, humanistic." (Lincoln & Guba, 1985, pp. 7-8).

Following these observations, Lincoln and Guba (1985) made their own hubristic claim for the post-positivistic paradigm, one of the aliases for "naturalistic." Lincoln and Guba claim that:

> It is the authors' posture that inquiry, whether in the physical or social sciences, has passed through a number of "paradigm eras" periods in which certain sets of basic beliefs guided inquiry in quite different ways. We shall briefly describe these periods as prepositivist, positivist, and postpositivist, and show that each period had it own unique set of "basic beliefs" or metaphysical principles in which its adherents believed and upon which they acted. We shall take the position that the positivists posture, while discredited by vanguard thinkers in every known discipline continues to this day to guide the efforts of practitioners of inquiry, particularly in the social or human sciences. Further, we shall argue that, since these methods are based on metaphysical principles that are dissonant

> with the principles guiding the vanguard development of substantive (discipline) thought, it is imperative that inquiry itself be shifted from a positivist to a postpositivist stance. *For, if a new paradigm of thought and belief is emerging, it is necessary to construct a parallel new paradigm of inquiry*. (Lincoln & Guba, 1985, pp. 15-16).

Lincoln and Guba (1985) are therefore saying that while a new postpositivist paradigm is challenging the positivist hubristic claims (once you understand the positivist stance) that *scientific method* is the only way of knowing or the only epistemological method, what is needed is a new paradigm inquiry based on different methods and procedures, which heretofore those challenging the positivist claims have failed to develop. *Positivism* refers to a philosophical science or set of epistemological perspectives that hold that scientific method is the optimum approach to discovery and revealing processes by which both human and physical events in the universe occur.

Positivism was first developed by Auguste Comte (1848/1851), a sociologist and philosopher of science in his six volume book, *Cours de Philosophie Positive*, published between 1830 and 1842). In the English translation of this work, *A General View of Positivism*, Comte (1848, 1851) makes the following hubristic claim for positivistic theoretical approach and methods in respect to its taking "possession" of the social and human sciences, where once this only held true in mathematics, astronomy (where it began), physics and biology. Comte (1848, 1851) states:

> But all Positive speculations owe their first origin to the occupations of practical life; and, consequently they have always given some indication of their capacity for regulating our active powers, which had been omitted from every former

> synthesis. . . . The importance that we attach to theories which teach the laws of phenomena, and give us the power of prevision, is chiefly due to the fact that *they alone* (my emphasis) can regulate our otherwise blind action upon the external world. Hence it is that while the Positive spirit has been growing more and more theoretical, and has gradually extended to every department of speculation, it has never lost the practical tendencies which it derived from its sources and this even in the case of researchers useless in themselves, and only to be justified as logical exercises. From its first origin in mathematics and astronomy, it has always shown its tendency to systematize the whole of our conceptions in every new subject which has been brought within the scope of its fundamental principle. . . . Positivism has gradually taken possession of the preliminary sciences of Physics and Biology, and in these the old system no longer prevails. All that remained was to complete the range of its influence by including the study of social phenomena. . . . I believe my work on Positive Philosophy has so far supplied what wanted. I think the Positive spirit can embrace the entire range of thought. . . . And it is a further guarantee for the stability of the new intellectual synthesis that Social science which is the final result of our researches, gives them that systematic character in which they had hitherto been wanting by supplying the only connecting link of which they all admit. (Comte, 1848/1851, pp. 8-9).

Comte (1848/1851) therefore intended to use the theoretical methodology that had been used for the hard sciences and apply them to the social and human sciences, like sociology, etc. His positivist philosophy set the stage and rationale for applying scientific methods to social and human research, which later supported and legitimized the use of

quantitative methods in human science research, along with its formerly hubristic claims that this was only legitimate epistemology or way of knowing or understanding human phenomenon.

Quantitative research is tied to positivism by claiming that it carries no theoretical or philosophical pre-commitments. However, this is a false claim since it uses the scientific method of *positivism*, and positivism itself as a philosophy sought to replace the old paradigm supported by theological presupposition about how the world works. Comte (1848, 1851) makes it clear that positivism was the new paradigm for the human sciences and that it arose in the social sciences to supplant theology and states:

> But such a system would still be far from realizing that universal character without which Positivism would be incompetent to supersede Theology in the spiritual government of Humanity. . . . The failure would be even greater than the failure of Theology in dealing with practical questions. . . . And although theology is now palpably on the decline, yet it will still retain, in principle at least, some legitimate claims to the direction of society so long as the new philosophy fails to occupy this important vantage-ground. (Comte, 1848, 1851, p. 9).

This means that there is no quantitative research or even qualitative study that is value free, because quantitative study itself is grounded in positivist philosophy and theoretical methodology. Comte (1848, 1851) made no such claim that positive was value free. It was hubristic and had the clear aim to supplant theology as the dominant epistemological paradigm for the human sciences as the level of the spirit and human behavior. Certainly, Comte (1848, 1951) needed to supplant this paradigm in favor of his new human science discipline of sociology that wants to understand how people behave

in collective society and within institutions. This is why I feel it is unnecessary for transcendental phenomenology, for example, to continue to labor under the presumption of the necessity of bracketing the researchers experiences of the phenomenon being studied in order to meet the expectation of positivist assumptions about value free research. Hermeneutical phenomenology works under no such positivist presumptions and even goes further to say that the researcher's *live-experience* should somehow be incorporated within the study.

Naturalistic inquiry gives the theoretical justifications for the view that value free qualitative methods are impossible since there is no way in human science research for a researcher to bracket their experiences of the phenomenon being studied. This is a quantitative methodological presumption of human science research that is mistakenly assumed from Comte (1848, 1851) research and promotion of the positivist epistemological paradigm that sought to replace the theological epistemological paradigm. He said no such thing. No research is value free. Quantitative research is therefore grounded in *positivism*, as I claim qualitative research is being born or rather brought to maturity by the *post-positivism* theoretical approach. *Post-positivism* or post-empiricism is the meta-theoretical stance that holds that human knowledge is not based on foundations that cannot be challenged but is based upon assumptions and conjectures that are subject to change at any time new evidence emerges.

The chief theorists of this theoretical stance that has opened the door to "naturalism" and therefore qualitative research that carries with it a new methodological paradigm are Thomas Kuhn (1922-1996) and Karl Popper. Karl Popper (1959) is the lesser light of the two philosophers of science but for our purposes is the most significant

and the only one we need examine in any length. Popper (1959) did not want to rid the world of research of positivism but in his book *The Logic of Scientific Discovery* wants to amend positivisms most hubristic epistemological assumptions as being the only way of knowing. Popper (1959) states in Chapter 1, section 5 on "Method as Experience":

> The task of formulating an acceptable definition of the idea of an 'empirical science' is not without its difficulties. Some of these arise from *the fact there must be many theoretical systems* with a logical structure very similar to the one which at any particular time is the accepted system of empirical science. This situation is sometimes described by saying that there is a great number --- presumably an infinite number --- of 'logically possible worlds'. Yet the system called 'empirical science" is intended to represent only *one* world: the 'real world' or the 'world of our experiences'. . . . But how is the system that represents our world of experience to be distinguished? The answer is: by the fact that it has been submitted to tests, and has stood up to tests. This means that it is to be distinguished by applying to it that deductive method which it is my aim to analyse (sic.), and to describe. 'Experience', on this view, appears as a distinctive *method* whereby one theoretical system may be distinguished from others; so that empirical science is to be characterized not only by its logical form but, in addition, by its distinctive *method*. (Popper, 1959, pp. 16-17).

Popper (1959) states that empirical science is the only way of knowing *per se* but only if it recognizes that there are many possible worlds of experience that positivism should incorporate. It cannot exclude any world of experience along with its distinctive methodologies. This is nothing less than the continuation of Comte's (1948, 1951)

program to have positivism to incorporate any world of knowing into its own empirical system or epistemological horizon of understanding. Whatever world of experience there is must be incorporated with this system but must be able to be subjected to the deductive and analytical methods of empirical science. However, Popper (1959) holds that empirical science has a problem in incorporating subjective experience within its horizon of understanding unless such statements are part of the human science discipline of psychology. Popper (1959) states:

> We may now return to a point made in the previous section to my thesis that a subjective experience, or a feeling of conviction, can never justify a scientific statement, and that within science it can play no part. . . . no matter how intense a feeling of conviction it may be it can never justify a statement. . . . Considerations like these do not of course provide an answer to the problem of the empirical basis. But at least they help us to see its main difficulty. In demanding objectivity for basic statements as well as for other scientific statements, we deprive ourselves of any logical means by which we might have hoped to reduce the truth of scientific statements to our experience. Moreover we debar ourselves from granting any favoured status to statements which describe experience such as those statements which describe our perceptions. . . . They can occur in science only as psychological statements of a kind whose standards of inter-subjectivity testing . . . are certainly not very high. (Popper, 1959, pp. 24-25).

Popper of course has exposed the dilemma of positivism and its theoretical basis and claims. Positivism cannot pursue its aim to incorporate all ways of knowing when those ways of knowing are said to be based on the *live-experienced* of human

phenomenon often expressed in feeling and/or perceptions. Since these cannot be rigorously tested according to positivism even within the human science of the mind, positivism is left without a method for asserting the truth of this way of knowing, which Popper (1959) declares experience and perception to be. Popper (1959) points out the attitude of the positivists when dealing with human experience and the idea that it is a way of knowing but cannot be fully tested by empirical methodology and how this attitude prevents a solution to the problem of the empirical basis. Popper (1959) states:

> The hint I gave in the previous section as to the deep-seated difference between my position and that of the positivists is in need of some amplification. The positivist dislikes the idea that there should be meaningful problems outside the field of 'positive' empirical science --- problems to be dealt with by genuine philosophical theory. He dislikes the idea that there should be a genuine theory of knowledge, and epistemology or a methodology . . . . And time and again do the despised defenders of traditional philosophy try to explain to the leaders of the latest positivist assault that the main problem of philosophy is the critical analysis of the appeal to the authority of experience. . . (Popper, 1959, 29-30)

Although Popper (1959) points out positivists are wary of any forms of knowledge and the methods that uphold them outside of the positivist methodological paradigm yet he is not willing to abandon the empirical method for any form of knowledge that does not admit the use of such a method to test its theoretical and philosophical foundations and assumptions. Naturalistic methodology for Popper (1959) comes under this category of thought. Naturalist theory and method are in fact legitimate forms of knowing. However, for Popper (1959) the dilemma is how to subject this way of

knowing to the empirical method or basis as he calls it. Popper (1959) wants to know if there is an objective way to test the naturalist assumptions regarding human experience as a way of knowing. Popper (1959) continues his positivist critique but leads into the problem with naturalism and states:

> For only two kinds of statement exists for them: logical tautologies and empirical statements. If methodology is not logic, then, they will conclude, it must be a branch of some empirical science --- the science say, of the verbatim of scientists at work. This view, according to which methodology is an empirical science in its turn --- a study of the actual verbatim of scientists, or the actual procedure of 'science' --- may be described as '*naturalistic*'. A naturalistic methodology . . . has its value no doubt . . . Thus I reject the naturalist view. It is uncritical. Its upholders fail to notice that whenever they believe themselves to have discovered a fact, they have only proposed a convention. Hence the convention is liable to turn into a dogma. This criticism of the naturalistic view applies not only to is criterion of meaning, but to its idea of science, and consequently to its idea of empirical method. (Popper, 1959, pp. 30-31).

For Popper (1959) any way of knowing (even subjectivist or naturalistic) must have an objective empirical basis for testing its assumptions and truth. Truth can be grounded in subjective experience but the empirical method must somehow be able to test it. Hence the problem of the empirical basis he is trying to resolve, but on the other hand avoid the conclusion of the positivists that such ways of knowing are not scientific because they cannot be tested by objective methods. Popper (1959) wants to continue the program of Comte (1848, 1851) of including all knowledge or ways of knowing under

the positivist banner but in order to do that he must find a way of admitting the phenomenon of experience or the naturalistic paradigm to empirical method. Popper (1959) is not willing to accept any paradigm that is relativistic and so disclaims any objective means or method of testing its truth.

However, the naturalistic stance should never be equated with relativism (truth is relative) or with post-modern thought that believes that *there is only one absolute truth; that there is no absolute truth* and so truth cannot be tested. The post-positivism that Lincoln and Guba (1995) seem to hold is that there is objective truth that can be tested, otherwise post-positivism would have no ground for its conjectures and the methods they use to arrive at them, especially in the human sciences. Lincoln and Guba (1985) give the theoretical structure for their claims and state that there are four truths: (1) *metaphysical truth,* or $\mathbf{T_1}$; *ethical truth,* or $\mathbf{T_2}$; *logical truth,* or $\mathbf{T_3}$, and *empirical truth,* or $\mathbf{T_4}$. Truths $\mathbf{T_2}$, $\mathbf{T_3}$, and $\mathbf{T_4}$ are predicated on, and grounded in $\mathbf{T_1}$. Truth_1 , or *metaphysical* truth has the preeminent characteristic of being foundational for all the others, and therefore not subject to being proved true or false and simply must be accepted. Lincoln and Guba (1985) state:

> The history of humankind is replete with instances of attempts to understand the world . . . What is the world? How can we come to know it? How can we control it for our purposes? What is, after all, the *truth* about these matters? The concept of truth is an elusive one. Julienne Ford . . . asserts that the term *truth* may have four different meanings, which symbolizes as Truth_1, Truth_2, Truth_3, and Truth_4. Truth_4 is the familiar *empirical* truth of the scientist; a claim in the form of hypothesis or predicate (an affirmation or denial of something) is T_4 if it is

> consistent with "nature" . . . . $Truth_3$ is *logical* truth; a claim (hypothesis or predicate) if T_3, if it is logically or mathematically true . . . . $Truth_2$ is *ethical* truth; a claim is T_2 if the person who asserts it is acting in conformity with the moral or professional standards of conduct. $Truth_1$, with which we are most concerned here, may be called *metaphysical* truth. Unlike the case of a claim being T_2, T_3 or T_4, a claim that is said to be T_1 cannot be tested for truthfulness against some exterior norm such as correspondence with nature, logical deductibility, or professional standards of conduct. Metaphysical beliefs must be accepted as face value. . . basic beliefs can never be proven T_4---in conformity with nature---or false. They present the ultimate benchmarks against which *everything else* is tested, for if there were something more fundamental against which a test might be made, then that more fundamental entity would become *the* basic belief whose truth (T_1) must be taken for granted. (Lincoln & Guba, 1985, pp. 14-15).

This notion that metaphysical truth, or T4 cannot be known but not proved and that it is the foundation of all other truths, including the preeminent T4, or *empirical* truth resonated with qualitative researchers seeking a theoretical ground upon which to take a stand for the qualitative approach to knowing and a new paradigm method of acquiring the data from which human phenomenon could be known and understood.

The idea that everything that is to be known cannot be known by T2, ethical, T3, logical, and/or some combination of T4 with the others was nothing short of a new paradigm model of research in education, psychology and other human sciences that had here-to-fore been dominated by quantitative research and methodology. The theoretical

foundations and grounding for hermeneutic phenomenology and transcendental phenomenology, as well as other qualitative approaches had now been given some independent basis for establishing its own norms and methods of research independent of the hubristic claims, especially of T4, empirical research and its vaunted and unassailable *scientific method*.

Methods: Hermeneutic vs. Transcendental Phenomenological Approach

Echo's of Lincoln and Guba's (1985) ground breaking paradigm (model) theory of knowing or truth can be seen in Van Manen's (1990) book, *Researching Lived Experience: Human Science For An Action Sensitive Pedagogy*. Van Manen (1990) is the premier adherent of hermeneutical phenomenology, which has its philosophical grounding in the work of Martin Heidegger (1953 & 1996) *Being and Time*. Van Manen (1990) in regard to Heidegger's (1953) influence on phenomenology states:

> Every project of phenomenological inquiry is driven by a commitment of turning to an abiding concern. 'To think is to confine yourself to a single thought that one day stands still like a star in the world's sky,' said Heidegger . . . . This commitment of never wavering from thinking a single thought more deeply is the practice of thoughtfulness, of a fullness of thinking. To be full of thought means not that we have a whole lot on our mind, but rather that we recognize our lot of minding the Whole---that which renders fullness or wholeness to life. So phenomenological research is being-given-over to some quest, a true task, a deep questioning of something that restores an original sense of what it means to be a thinker, a researcher, a theorist. A corollary is that phenomenological research does not start or proceed in a disembodied fashion. It is always a project of

> someone: a real person, who in the context of particular individual, social, and historical life circumstances, sets out to make sense of a certain aspect of human existence." (Van Manen, 1990, p. 31).

Fraenkel and Wallen (2003) affirm "holistic description" is a hall mark of qualitative research and methodology and that phenomenology as one type of qualitative approach "investigates various reactions to, or perceptions of, a particular phenomenon . . . . The researcher hopes to gain some insight into the world of his or her participants and to describe their perceptions through in-depth interviewing" (Fraenkel & Wallen, 2003, pp. 431, 437). While Heidegger (1951) provided the philosophical ground for *hermeneutical phenomenology* (major proponent Merleau-Ponty, 1962 & Van Manen, 1990) and Husserl's (1970) book *The Crisis of European Sciences and Transcendental Phenomenology* (major proponent Moustakas, 1994) provided the philosophical ground for transcendental phenomenology, neither philosophy of the human sciences provided the theoretical ground that led to the *how to* methodology.

These two philosophical perspectives operated as the meta-theory or theory above theory that seeks to justify any approach by constantly requiring it to ask itself questions about its own theories, approaches and methods. The theory or theoretical procedure that fully opened the door for phenomenology of both perspectives to seek its own method was provided by Lincoln and Guba (1985) as demonstrated above. *Theo + re*, literally means "God utters" or "God knows," or "God's knowledge," and so *theology* has had the correct understanding that what it is doing is *faith seeking understanding*, which is St. Anselm of Canterbury's *fides quaerens intellectum*, that is, the knowledge of God, and

God's knowledge of the metaphysical and even the material universe, and the source of *all knowledge*, which it is certain the *positivist theoretical* stance will not admit.

Since the root of the word *theory* lies in the above definition, anything conjectured by human reason stands to be corrected or proved false at anytime, leaving the possibility of gaining knowledge of *truth open and inexhaustible*. It then may be said that phenomenology as an approach grounded in post-positivist theory (i.e. naturalistic inquiry) is qualitative research seeking a method that allows it to arrive at human meaning that is inexhaustible, as long as it does not adopt a heuristic claim of a superior epistemology and methodology.

It must therefore view humans faced with various phenomenon as a rich inexhaustible source of meaning and understanding and that the nuances of meaning, themes, and clusters of meaning goes through a necessary metamorphosis within the context of each human *life world* confronted by various phenomenon. These discoveries and/or revelations (if you like) cannot be put into a testing laboratory or even reduced to the abstract methodological language of numbers or quantities if you are seeking the full meaning of what is going on in the *lived experience* of each human *life world*.

This theoretical perspective dominates hermeneutical phenomenology (Van Manen, 1990) and haunts transcendental phenomenology (Moustakas, 1994) that yet tries to hold on to some vestiges of the empirical T4 truth by means of Husserl's notion of *Epoche* process. This process of bracketing of the researchers own experience of the phenomenon "requires the elimination of suppositions and the raising of knowledge above every possible doubt" (Moustakas, 1994, p. 26). Moustakas (1994) calls Husserl's (1970) concept bracketing, meaning that the researcher in order to arrive at truth

necessarily has to bracket out their experiences of the phenomenon in order to arrive at its truth and meaning. While this philosophical notion is ever present in Moustakas (1994), so is the theoretical perspective (at least the hubristic portion of the theory) of Lincoln and Guba (1985), which juxtaposed in some unholy alliance that forsakes the most salient aspect that **Truth$_1$** or metaphysical truth cannot be proved true or false; but must be merely accepted if other truths are to have any ground whatever.

What this means is that phenomenology cannot really claim to "raising of knowledge above every possible doubt" (Moustakas, 1994, p. 26), as **T$_4$** or *empirical* truth claims to do and yet maintain that *transcendental phenomenology* is superior because its **T$_1$** theoretical ground is superior to that of **T$_4$**, merely because it has *epoche* or *bracketing* as part of its methodological procedures. Yet this is precisely what transcendental phenomenology claims. Moustakas (1994) states: "Husserl (1977) does not claim that transcendental phenomenology is the only approach to a knowledge of human experience, but rather he emphasizes that it is a science of pure possibilities carried out with systematic concreteness and that it precedes, and makes possible, the empirical sciences, the sciences of actualities . . . " (p. 28).

Van Manen (1990), on the other hand, does not attempt to make a hubristic claim for hermeneutic phenomenological research as a **T$_1$** theoretical approach to knowledge of the human sciences. Rather, Van Manen (1990) thinks that by nature phenomenology (whether it is superior to **T$_2$, T$_3$, T$_4$** approaches and ways of knowing) must reject the notion of *epoche* (bracketing of the researchers experiences of the phenomenon from consideration) and disclaim that what hermeneutic phenomenology can know closes the door to further discovery and human possibilities inherent in the rich *lived experience* of

phenomenon in the *life world* of the human person. The theoretical perspective of **T_1** metaphysical truth informs this phenomenological approach in the sense that nothing in the human sciences should be subject to deductive proof as in being absolutely true or false.

It would follow then that all truth at the level of human meaning, because of its apparent inexhaustible variety of experience of the same phenomenon (by different persons and by the same person at different times), ought to be left open for other possibilities, themes, and cluster of meanings. There is then no claim that hermeneutical phenomenology grounded in **T_1** *metaphysical* theory is superior to **T_4** *empirical* theory but only that **T_1** is not inferior to **T_4**, because of its openness to an array of rich human possibilities, even contradictory ones.

There is then a continual need to explore and *exhaust the inexhaustible* meaning of lived experience of phenomenon in each life world of the human person. This is what human science does and natural science should do (shorn of its hubristic claims), which is supported by scientific method and quantitative approaches and procedures. The reformation of post-positivist theory worked out in a practical educational pedagogy by hermeneutic phenomenology does not suggest that qualitative researchers should throw out the "baby (qualitative approaches and methods) with its dirty bath water (hubristic claims of a superior epistemological methodology).

Methods: Research Questions and Dialectic Relationship to Method

I have stated in this chapter that there is dialectical relationship between the methodology used and the research question proposed, and that *the research approach seeks its own method*. Formulating the research question, that is, what the research is

concerned about or is the researchers *ultimate concern* is the vital first step in selecting the research approach taken and the method(s) adopted. The method(s) in this dissertation follows this process of thinking about how to answer the question that is my ultimate concern.

Van Manen (1990) states: "Every project of phenomenological inquiry is driven by a commitment of turning to an abiding concern. 'To think is to confine yourself to a single thought that one day stands still like a star in the world's sky," said Heidegger (1971, p. 4). This commitment of never wavering from thinking a single thought more deeply is the practice of thoughtfulness . . . . So phenomenological research is . . . being-given over to some quest, a true task, a deep questioning of something that restores an original sense of what it means to be a thinker, a researcher, a theorist" (Van Manen, 1990, p. 31). Moustakas (1994) more concretely states in his section on "Methods of Preparation" that:

> The first challenge of the researcher, in preparing to conduct a phenomenological investigation, is to arrive at a topic and question that have both social meaning and personal significance. The question must be stated in clear and concrete terms. The key words of the question should be defined, discussed, and clarified so that the intent and purpose of the investigation are evident. The position of each key word, or focus, of the question determines what is primary in pursuing the topic and what data will be collected. In phenomenological research, the question grows out of an intense interest in a particular problem or topic." (Moustakas, 1994, p. 104).

My ultimate concern, challenge, and intense interest in this dissertation is how do pastoral care practitioners experience the phenomenon of human suffering in its didactic

and clinical forms within hospital acute care organizations? This dissertation seeks to discover or help create a research literature that supports such a phenomenology of suffering, and see how such a study and literature would support the development of a core clinical pastoral curriculum design with this phenomenological focus.

The connection between developing a phenomenology of suffering and the practice of clinical pastoral care has not been made in the research literature and therefore CPE curricula developed at the HCO pastoral sites have not developed in this direction. This gives me the opening I need to make this connection between the areas of head and heart vital to the discipline of clinical pastoral education. I can now reframe my research questions and focus from my original phenomenological research plan. The phenomenon that this dissertation seeks to examine is how CPE pastoral health care interns in HCO (Hospital Clinical Organizations) settings experience the phenomenon of CPE education in both its didactic and clinical (praxis) forms?

Methods: Data Collection and the Sample

Both Moustakas (1994) and Creswell (2007) recommend that the researcher interview between 5 and 25 persons, participants, patient/clients, or co-researchers as one prefers. Participants in this dissertation will be current and former clinical pastoral interns, chaplains, CPE supervisors, CPE faculty members at HCO certified CPE centers, specifically The Christ Hospital (TCH). I hope to conduct interviews from between 5 and 15 participants and to do follow-up interviews on at least half if not all the participants to both enrich and exhaust the cluster of themes that will emerge from the study.

The interviews were done in person and by telephone. The participating HCOs are Christ Hospital and any others with which the participants were affiliated. The HCO

organizations must have the capability to host a pastoral care unit or full pastoral department. Christ Hospital is located in an urban setting but there is no real reason to rule out HCOs that are located in rural settings. The experiences of pastoral care practitioners will be sought, meaning those who have been trained using the ACPE curriculum designs. My data will be collected and transcribed from the interviews, observations, questionnaires and gathered documents (e.g. journals, books, dissertations, etc.).

Methods: Data Collection and Procedures

Moustakas's (1994) transcendental (i.e. also known as empirical or psychological) phenomenology, puts more emphasis on description of the lived experience and less on the interpretive process. Moustakas (1994) believes that the best way to elucidate the lived experience is to "bracket" the researchers interpretation based on Husserl's notion of *epoche*, in which the researcher or "investigator set aside their experiences (of the phenomenon), as much as possible, to take a fresh perspective toward the phenomenon under examination. Hence, "transcendental" means "in which everything is perceived freshly, as if for the first time." (Creswell, 2007, pp. 59-60). There are strident objections of Moustakas' (1994) phenomenology in respect to how it is applied to the researcher. Caraway (2012) states:

> I have a lot of trouble with Moustakas' use of phenomenology here. We are not at all interested in the researcher's experience here. We are only interested on the lived experiences as revealed by those interviewed. THEN, what the researcher does, is BRACKET the insignificant, irrelevant, accidental, peripheral dimensions of the description to get at the essential dimensions after the nonessential has been

> bracketed. The bracketing has to do with the experience as examined, NOT the researcher's experience. IN fact, the researcher may have never had the experience. If one knows he is doing gleaning knowledge of "X's" experience of "Y" then there is not even a question of bracketing his, the researcher's, experience of "Y" for it is not even being considered. (Caraway, 2012, Comments).

In some respects Caraway's (2012) antipathy toward Moustakas' (1994) view of bracketing it understandable in that if the researcher's experience is not to be considered then talking about bracketing it does not make sense. Moustakas (1994) is not the primary advocate of the view that the researcher's experience of the phenomenon must be bracketed. Van Manen (1990) argues that the researcher's experience of the phenomenon must necessarily be considered, because like it or not the researcher experiences the same phenomenon as the participant through some means that may be called empathic oneness or shared experience.

While this is antithetical to Caraway's (2012) view that *only* the experience of the participant should be considered this view does not square with the hermeneutical phenomenology. Van Manen (1990) states: "To establish a strong relation with a certain question, phenomenon, or notion, the researcher cannot afford to adopt an attitude of so-called scientific-disinterestedness. To be oriented to an object means that we are animated by the object in a full and human sense" (Van Manen, 1990, p. 33).

Van Manen (1990) does not therefore objecting to the inclusion of the researchers experience of the phenomenon being considered in the research. Rather Van Manen

(1990) is concerned how bracketing those experiences of the phenomenon the researcher is to be accomplished. Van Manen (1990) states:

> How do we best suspend or bracket these beliefs? Husserl, who was at first a mathematician, used the term "bracketing" to describe how one must take hold of the phenomenon and then place outside of it one's knowledge about the phenomenon (1970b, pp. 33-42). But how does none put out of play everything one knows about an experience that one has selected for study? If we simply try to forget or ignore what we already "know," we may found that the presuppositions persistently creep back into our reflections. It is better to make explicit our understandings, beliefs, biases, assumptions, presuppositions, and theories. (Van Manen, 1990, p. 47).

Again I repeat Heidegger (1953) to reemphasize the truth that one cannot know anything about the Other's experience of phenomenon *standing outside of the experience*. The researcher has to somehow *stand inside the experience* of the same phenomenon that the Other is experiencing. Heidegger (1953) states:

> Two beings which are objectively present within the world and are, moreover, *wordless* in themselves, can never "touch" each other, neither can "be" "together with" the other. The supplement "which are moreover worldless" must not be left out, because shoes beings which are not worldless, for example Da-sein itself, are objectively present "in" the world too. (Heidegger, 1953, p. 52).

The bottom line is the researcher is not wordless, that is, without their own life-world and lived-experience, which they cannot leave at home when they come to research how the participant experiences phenomenon such as suffering that they themselves have

either experienced or can empathize with the one who is experiencing it in their immediacy. If the researcher is in fact in the world as is the participant then the researcher is able to "touch" the feelings of the participant and the participant is able to "touch" the feelings of the researcher in regard to the phenomenon being studied.

Van Manen (1990) who grounds his hermeneutic phenomenology in Heidegger's (1953) philosophy does not believe that the researcher can stand outside the *lived-experience* and *life-world* of the participant that is interviewed in order to objectively look at the data in the sense that positivist scientific methodology would demand. If Van Manen (1990) did this wouldn't this posture emulate the positivistic stance of scientific methodology? Isn't the positivistic posture of scientific methodology the very thing that both naturalistic inquiry and qualitative research is trying to break away from? How can the phenomenological researcher even begin to understand the *lived-experience* and *life-world* of the participant without some kind of *empathic joining of the two life-worlds?* In fact to stand outside this world with a collection of interviews is to guarantee that one will not be able to understanding the cluster of thematic horizons one is attempting to develop descriptions of meaning for.

Moustakas (1994) has eight rather than six research activities or processes, where **(1)** the researcher determines if the phenomenon is best examined using phenomenology, **(2)** one and only one phenomenon of interest is chosen, which from Moustakas' view is virtually unlimited, **(3**) the researcher recognizes and specifies the broad philosophical assumptions of phenomenology, **(4)** collect the data from the participants via in-depth interviews and multiple interviews with participants (5 to 25 persons), along with the collection field observations recorded in a journal, taped conversations, formally written

responses (questionnaires), accounts of vicarious experiences of the phenomenon that could have been derived from drama, films, poetry and even novels, **(5)** participants are asked two broad and general questions: "What have you experienced in terms of the phenomenon? What contexts or situations have typically influenced or affected your experiences of the phenomenon? Other open-ended questions may also be asked, but these two, especially, focus attention on gathering data that will lead to a textural description and a structural description of the experiences, and ultimately provide an understanding of the common experiences (composite experiences) of the participants," (Creswell, 2007, p. 61), as if they are one person, **(6)** do a phenomenological data analysis, building on the data from the first and second major research question collected from the transcriptions gathered, where "significant statements, sentences or quotes are made by the participants in order to understand how they experienced the phenomenon" (Creswell, 2007, p. 61).

According to Creswell "Moustakas (1994) calls this step *horizonalization*," through which "the researcher develops *clusters of meaning* from these significant statements into theme," (Creswell, 2007, pp. 61), which should produce a new horizon of understanding of the phenomenon, **(7)** write a *textual description* of what the participants experienced after so to speak the participants as a human text of the experience(s) have been read, and finally **(8)** making sure that the researcher's own experiences of the phenomenon has been bracketed through some process or method Husserl calls *epoche*, the researcher writes a composite description from the structural and textural data gathered and presents the "essence" or nature of the phenomenon, "called *essential, invariant structure (or essence*)" (Creswell, 2007, p. 62).

Creswell (2007) states: “phenomenological study describes the meaning for several individuals (recommends between 5 and 25 persons, p. 61) of their lived experiences of a concept or a phenomenon, where each *participant is perceived as a human text to be read*, in light of their *lived experienced*. Phenomenologist’s, therefore, focus on describing what all participants have in common as they experience a phenomenon,” (Creswell, 2007, pp. 57-58), such as grief, insomnia, anger, undergoing bypass surgery, a program, running, driving, mothering a profession, a developing career, etc. According to Creswell (2007) “The basic purpose of phenomenology is to reduce individual experiences with a phenomenon to description of the universal essence” of the lived experience to a “composite description of the essence of the experience for all of the individuals,” (Creswell, 2007, p. 58) that is, what they experienced and how they experienced it.

On the philosophical level it seeks to describe the phenomenological object of the human experience in order to understand and “grasp the very nature of the thing”; in fact the universal nature of the thing (p. 58), a metaphysical study therefore of the nature of its being as understood by Edmund Husserl (1859-1938), Heidegger (in his *Being and Time*), Sartre and Merleau-Ponty (Spiegelberg, 1982). More specifically This dissertation is a mixture of hermeneutical and transcendental phenomenological approaches. Hermeneutical phenomenology was, according to Creswell (2007) developed by Van Manen (1990), who is widely quoted in the health literature (p. 59).

Hermeneutical phenomenology, as developed by Van Manen (1990) “is not only a description (of the lived experience or phenomenon of the participants of the study), but it is also seen as an interpretive process in which the researcher makes and interpretation

(mediates back and forth in a kind of swing hermeneutical process) of the meaning of the lived experiences." (Creswell, 2007, p. 59). Therefore Van Manen (1990) includes the interpretation of the researcher among the six research activities he proposes: (1) Discover a concept or phenomenon that has for the researcher an abiding or ultimate concern, (2) reflect on the essential themes of the lived experience in order to see "what constitutes the nature of this lived experience," (3) write a description of the phenomenon, (4) discover the different meanings derived from the phenomenon being studied, (5) maintain a strong relationship (interplay) between the topic of the study, that is, its parts to the whole, and finally, (6) make an interpretation or "mediate" between the different meanings of the lived experiences, which I call a *swing hermeneutical process* of understanding, resulting in a new horizon of understanding of the phenomenon. (Creswell, 2007, p. 59). Van Manen (1990) claims to propose a method for hermeneutical phenomenology that is no method. Van Manen (1990) states what he means:

> Perhaps the best answer to the questions of what is involved in a hermeneutic phenomenology human science research method is "scholarship!" A human science researcher is a scholar: a sensitive observer of the subtleties of everyday life, and an avid reader of relevant texts in the human science tradition of the humanities, history, philosophy, anthropology, and the social sciences as they pertain to his or her domain of interest. . . . So in a serious sense there is not really a "method" understood as a set of investigative procedures that one can master relatively quickly. Indeed it has been said that *the method of phenomenology and hermeneutics is that there is no method!* (Gadamer, 1975; Rorty, 1979). And yet, phenomenology wants to claim that it can have it both ways. While it is true that

> the method of phenomenology is that there is no method, yet there is tradition, a body of knowledge and insights, a history of lives of thinkers and authors, which, taken as an example, constitute both a source and a methodological ground for present human science research practices. Thus the broad field of phenomenological scholarship can be considered as a set of guides and recommendations for a principled form of inquiry that neither simply rejects or ignores tradition, nor slavishly follows or kneels in front of it. (Van Manen, 1990, pp. 29-30).

Nevertheless, while Van Manen (1990) states that hermeneutical phenomenology has no method he has to ask the question like any researcher would: “How can human science research be pursued? Reduced to its elemental methodical structure, hermeneutic phenomenology research may be seen as a dynamic interplay among six research activities:

(1) turning to a phenomenon which seriously interests us and commits us to the world;

(2) investigating experience as we live it rather than as we conceptualize it;

(3) reflecting on the essential themes which characterize the phenomenon;

(4) describing the phenomenon through the art of writing and rewriting;

(5) maintaining a strong and orientated pedagogical relation to the phenomenon; and

(6) balancing the research context by considering parts and whole. (Van Manen, 1990, pp. 30-31).

Methods: Significance of the Study

With this new research focus I believe I am on the threshold of what is the essence of my original phenomenological research plan. Both the interviews and literature review allowed this deeper focus and understanding and has opened up perhaps a whole new field of inquiry into the phenomenology of suffering as it relates to pastoral care education. This dissertation has significant implications for the development of clinical pastoral education (CPE) and should enhance clinical practice of pastoral care in hospital clinical organizations (HCOs). This study should lead to a better understanding of human sufferings by pastoral care givers participating in this discipline of higher education and as a result contribute to rapid healing and flourishing of patients, which is the primary goal (or should be) of hospital clinical organizations (HCOs). It also may lead to a new field of exploration and studies in pastoral care literature devoted to developing a phenomenology of suffering.

Orlo C. Strunk, Jr. (2004) is the researcher who called for the development of a *phenomenology of Illness* as way of developing a "thoroughly *subjective* description of what it *means* to be ill; what it's like to *be* a person with a "borderline personality disorder"; what it's like to "lose faith"; what it feels like to be treated as an "object"; what the experience *is* of having to admit to the hospital admissions clerk that you have no health insurance; what it feels like when, in extreme pain and discomfort, and expert in a perfunctory style says, "I know how you feel. . ." (Strunk, 2004, p. 294). Strunk (2004) believes that phenomenology as a subjective approach ought to be placed "alongside our scientific and objective efforts and studies" (p. 294). In order to

understand human illness better and thereby contribute to the kind of knowledge that could help alleviate it. Strunk (2004) states:

> Mostly, I suspect, I have come to understand --- truly *understand* --- a shibboleth often noted in the pages of this journal: that is, that there is a gap between the technology of care and human touch. Intellectually I've always known this to be true. Now, existentially, I know about that gap --- or, more accurately, about that *chasm*. I also know, intellectually, that phenomenology, whether it be philosophical or psychological, is anything but a unified theory of knowing, an established epistemology. Still, despite phenomenology's various schools, hues, and emphases, it does value highly the essence, structure, and form of *human experience* as revealed through primarily descriptive techniques and disciplined reflection. All this to say that we need to continue producing a literature that includes --- alongside our scientific and objective efforts and studies ---thoroughly *subjective* descriptions of what it *means* to be ill. . . (Strunk, 2004, pp. 293-294).

Of course I disagree that phenomenology as a methodological approach is not an established epistemology (a rigorous way of knowing a phenomenon) and that as a qualitative approach is any less scientific than quantitative studies exploring the same area of human science. Yet Strunk (2004) sees the need for the development of such a phenomenological literature on human illness so that medical and pastoral healthcare givers can contribute positively to the rapid healing, physical, mental, emotional and spiritual flourishing of patients who are suffering. However, I question whether pastoral care givers can understand the phenomenology of illness, even with the development of a supporting research literature unless they themselves know how they experience this

phenomenon they work with and are confronted with on a daily basis. This is the basic reason this dissertation seeks to explore the phenomenology of suffering and illness more deeply in relationship to the experiences of the pastoral care giver.

Such a phenomenological research focus has vast implications for not only the development of a CPE curriculum that encompasses a focus on phenomenological study; but will allow fuller exploration of related social justice and bio-ethical implications and concerns that impact human autonomy, and the associate rights a person has in deciding life and death issues for themselves, when confronted with illness. I believe a shift in research emphasis and a corresponding shift in the focus of pastoral care literature would allow this exploration, and so I call for *phenomenology of human suffering* rather than just a *phenomenology of human illness*. This will likely open the door for a wider exploration of what contributes to human illness; the sources of which may be hidden within the social fabric of our institutions, even institutions, such as hospital clinical acute care organizations, ostensibly devoted to the rapid healing and flourishing of its patient/clients. For example, something as simple as Strunk's (2004) statement on "what it feels like to be treated as an object" or a well meaning statement to an ill patient "I know how you feel" (Strunk, 2004, p. 294), carries with it ethical implication that are often overlooked; implications that a phenomenology of illness or suffering would uncover for the pastoral care practitioner.

Currently, this kind of research emphasis on the implications involved in using trite responses to illness are scattered and are not framed as phenomenological issues or questions. The ethical concerns are out there but no researcher appears to be looking at the concerns from a phenomenological point of view or perspective. For instance,

Meilaender (1993) talks about death and medical ethics in his research on the thought of William F. May and states:

> Thus, for example, when May characterizes death as a "sacral power," he considers what sort of "fitting, decorous, appropriate" manner we ought to adopt in speaking with the dying. Very often physicians, family members, and even ministers have practiced evasion cloaked in paternalistic beneficence. Against this approach others will argue that blunt talk, straightforward truth-telling is needed if we are to avoid paternalism, respect the dignity of the dying person, and retain authentic communication to the end. (Meilaender, 1993, p. 108).

The ethical question here is how can one preserve and even defend the human person's right to know and make decisions about their own health condition? If this information is withheld is not this a violation of their human autonomy over their own being (i.e. body, mind, soul)? Is not this treating them as an object and aren't statements like the one above "I know how feel" trite and really an evasion of our moral/ethical duty to the dying? These are tough ethical questions that I maintain can be illuminated though a phenomenological study of suffering, understood through the experiences of pastoral care practitioners.

I believed that such a study should be within the context of hospital acute care organizations and be examined through the experiences of pastoral care practitioners like chaplains, who experience the phenomenon of suffering and/or illness; not only by means of the head (intellectual intuitive understanding and knowledge gained by studying the literature), but also by means of the heart (spiritual intuitive understanding and

knowledge gained through clinical practice), with human persons who are suffering physical, mental, and/or spiritual maladies.

What would a CPE curriculum design look like that encompass' such a phenomenology, the result of which would lead to best practices (e.g. taking into consideration ethical, moral, and bio-ethical issues that contribute to illness and other forms of suffering, etc) in HCO clinical settings? However, that is precisely the problem. No such CPE curriculum can currently be developed, because the literature it would be based on is either non-existent and needs to be developed; or is so scattered throughout existing pastoral care literature as to be unrecognizable as phenomenology, and therefore needs to be gathered and *reframed* as *phenomenological studies on illness and/or suffering*. The aim of This dissertation is to find out which situation exists and how it may be alleviated by examining the literature and comparing its themes with the *lived experience* of pastoral care practitioners confronted with the *phenomenon of illness and suffering*. A thorough literature review will be necessary in order to determine which of the above situations is actually the case.

I have already done a preliminary literature review that underscores the justification and need for a pastoral care literature devoted to a phenomenology of suffering. First, it shows that my study is justified because clinical pastoral education (CPE) is a discipline of both the head and heart. What this means is that CPE from its very beginnings was and is (one and at the same time) a research and clinical discipline that deals predominately with human suffering, and seeks by means of clinical epistemology and didactic pedagogy to understand suffering and how to help alleviate it. According to Gleason (2004):

> As the CPE movement matured toward its present form, the strong emphasis on the application of clinical findings to the day-to-day work of ministry using the verbatim record of pastoral care, instituted by Russell Dicks (1906-1965), a Methodist chaplain/educator at Massachusetts General Hospital, at the expense of depth studies and theological perspectives, was a considerable disappointment to Boisen . . . Charles E. Hall (1919-2000), the first executive director of the Association for Clinical Pastoral Education, Inc. (ACPE), aptly titled his book on the history of CPE *Head and Heart*, and wrote in his introduction: "I discovered an overarching theme of the CPE movement: an attempt to integrate the messages of the head and the heart." CPE developed out of a dissatisfaction with the intellectual assumptions of systematic theology separated from religious experience and dissatisfaction with ministry based on that separation." (Gleason, 2004, p. 298).

However, this dissatisfaction has not lead to an independent formulation of what the *head and heart* means and therefore a phenomenological study of the core of this discipline, which deals with *lived experience of suffering* is warranted. VanderCreek (1996) makes the case that this dissatisfaction has not lead to independent studies or insufficient independent work by chaplains and other pastoral clinical practitioners in the field; although he believes that the studies should be quantitative for the most part; a view that I believe will move the research further away from its purpose to develop a discipline based on the head and heart. VanderCreek (1996) states:

> We have been unable to put the capstone in place. That is, we have not built an empirical research tradition, which tests our observations and theories. . . As

> members of our respective organizations we have been too ready to make a living on existing, borrowed insights and practice patterns, and not ready enough to test our own insights. Consequently, we can legitimately be seen in the scientific world as a 'do nothing' profession, which has failed to make a contribution to knowledge in a scientific age. (Hemenway, 1996, pp. 17, 29-30).

Phenomenology has been used in clinical settings as an operational methodology (although until recently it has not been recognized as such) via the clinical use of verbatims since about 1925. My purpose for this dissertation therefore is to make the connection between phenomenology and clinical practice clear by delineating the pastoral care literature that will support a study of chaplaincy practitioners, who experience the phenomenon of human suffering daily. These clinical practitioners use phenomenological methodology on a daily basis without recognizing it as methodological human science that can help them advance the CPE project of *caring for* and *curing souls*, that is, assessing spiritual needs in order to deal with various kinds of spiritual suffering and maladies of the human mind and heart.

I believe this study will support my thesis that the phenomenon that clinical pastoral practitioners are dealing with and that clinical pastoral education (e.g. via its curriculum and clinical practice) ought to address is human suffering; in all of its dimensions (i.e. the physical, mental, spiritual, ethical, moral). My study also reveals the social justice implications, as well, because human care is delivered by HCOs and these organizations (ostensibly devoted to healing) often have interests counterpoised to that of the individual who is suffering and human autonomy that raises both moral/ethical and bio-ethical concern is often in jeopardy. Therefore, the best way to uncover what

phenomenology means for the discipline of clinical pastoral education, and at the same time explore the phenomenological literature that such a study is based on is to study how pastoral care givers (like chaplains) experience the phenomenon of suffering and then see what literature is available or needed that mirrors these phenomenological experiences.

Methods: Summary and Conclusions

The development of phenomenological literature related to suffering in clinical settings appears to be a developmental area of pastoral care education, and as such represents a vital area that needs to be developed more fully in pastoral care professional journals. The objective of my proposed dissertation will be to isolate these various phenomenological studies and research literature and apply this data to the *lived experiences* of chaplains and perhaps other pastoral care practitioners to uncover the cluster of themes and meaning of these experiences, so that a new horizon of understanding of clinical pastoral practice can be derived, based on a *phenomenology of suffering*. This focus should allow me to make an original contribution at this one level by seeing for the first time what the value of phenomenological research means or implies for the discipline of clinical pastoral education (CPE). Such a study and developmental literature can contribute to CPE curriculum designs and enhance clinical pastoral practice. The end result should be a cadre of pastoral practitioners better able to understand their own *lived experiences* when confronted with the *phenomenon of suffering*, and so be able to make a positive contribution to the rapid healing of the patient/clients they serve in hospital clinical organizations (HCOs).

CHAPTER 4 - DATA ANALYSIS

This dissertation reveals a cluster of themes that emerged from phenomenological exploration of a rich array of sources that support my thesis that a *phenomenology of suffering* is needed in Clinical Pastoral Education (CPE) where it's practitioners using *head and heart* seek to achieve its historic goal of *caring for* and *curing souls*. After IRB approvals both the *Union Institute & University* and *The Christ Hospital* (TCH) ten interviews were conducted at TCH from January 2012 to February 2012. The interviews included a CPE director of pastoral care, CPE educators and faculty, critical care chaplains, surgical chaplains, palliative care chaplains, and grief chaplains.

The participants given the interviews represented a number of differing faith traditions, primarily Catholic and Protestant. Four of the participants were male and six female that had various lengths of clinical pastoral practice ranging from thirty-two years to one-year. All but one participant had formal CPE training, most completing CPE Level I and Level II meeting the Association of Clinical Pastoral Education Standards. One participant was a Director of Pastoral Care and had CPE Supervisory Level education, two levels beyond CPE Level I and II. The average length of clinical pastoral care experience for the participants was around ten and one half years.

The participants were allowed to see the interview transcripts and provide additional comments and clarification on their responses to the questions. This approach helped thicken the research data and emerging results. In addition to these interviews are included the data analysis various CPE textual witnesses that had the same or similar clinical pastoral background as my participant interviewees to deepen my research on the

questions involving these practitioners *lived-experience* of the phenomenon of suffering. This data was obtained primarily from *The Journal of Pastoral Care and Counseling.*

This dissertation does not include this researchers lived-experience of the phenomenon of suffering in this data analysis chapter, although this research has the same or similar theological and seminary background that the participant interviewees do. In addition this researcher did his internship at The Christ Hospital Pastoral Services Department for one full year followed by another full year as volunteer chaplain to deepen my understanding of the work that is done by pastoral care chaplains within their various specialties (e.g. critical care, surgical care, palliative care, grieve chaplaincy). The decision not to include this researcher as a participant/researcher does not invalidate Van Manen's (1990) argument that the researcher's life-world and lived-experience cannot but somehow be comingled with that of the participant interviewees.

Therefore this researcher needs to push back on this thought, because it is fundamental to the dissertation argument that CPE educators and practitioners must overcome *empathetic inversion* by loving the subject of their care to the extent that they are willing to not merely come alongside the patient but to *be with* patient by entering into their life-world and lived experience in the deepest sense. This must be done even if they have to somehow put at risk their own life-world and live-experience in order to care for and cure the soul that is suffering. In doing this the chaplain is not merely the caregiver but a participant/researcher in the experience of the phenomenon of suffering with the patient. If the standout side the suffering situation by bracketing out their own lived-experience of the suffering then they will not be able to effectively discover the spiritual needs for the kind of spiritual suffering the patient is experiencing.

The view that they need to bracket their experiences and prejudices in fact supports the CPE deficiency of *empathetic inversion*. Van Manen (1990) believes (as we have pointed out) that it is unrealistic to hold that the life-world and lived-experience of participants and the researcher do not affect one another, especially if they share the same life-world such as chaplaincy, or some other profession that is under study. What is ironic about a position that says that the interviewer should not be included in such a study is that fact that such exclusion is in effect bracketing those experiences or prejudices, while at the same time saying that bracketing is unnecessary, because the experiences and prejudices of the researcher are not included.

Phenomenological *epoche* in fact does bracket out non-essential themes meaning statements related to experiences of phenomenon, and it includes and should only include those cluster of themes and/or horizons that are essential as Husserl (1953) says is its function. But what Van Manen (1990) would argue is that if you arbitrarily bracket out the researchers own experience (which he says you can't do anyway) then you may be bracketing out essential meaning statements relevant to the research.

Although, this researcher was trained at TCH in grief chaplaincy and participated in clinical work with families suffering lost of loved ones, the decision was still made not to explicitly include this researchers own experiences of the phenomenon of suffering. One reason is that phenomenology has not yet found a way to affectively bracket-out the non-essential aspects of the researchers own experience of the phenomenon so that his or her "presuppositions" do not "persistently creep back into" his or her "reflections" on the phenomenon under study. (Van Manen, 1990, p. 47). Until that is done it would be irresponsible for any researcher to proceed with the explicit inclusion of their own

experiences of the phenomenon that may contaminate the acquired cluster of themes and meaning statements.

This researcher began to work at The Christ Hospital (TCH) as an graduate intern in chaplaincy in order to deepen his understanding how pastoral care practitioners experience human suffering at its most existential level of understanding (i.e. fear, anxiety about death and the notion of existence/non-existence). This researcher cannot possibly bracket those experiences out. That attempt would nullify any experiential learning and block any understanding of how chaplains experience the phenomenon of suffering. *Hermeneutic phenomenology* would encourage any researcher to mingle his or her own lived-experience in with the participant interviewees as long as the researcher shares a similar *life-world* and *lived experience*.

However, this researcher has not explicitly included his own experience of the phenomenon of suffering in order to focus on the gathered interview data and data from similarly situated human textual sources from which clusters of thematic meaning and horizons will emerge. This is not to say that this researcher's own *life-world* and *lived-experience* of suffering is not significant. That would invalidate this researchers experience as a *grief chaplain*, which allows this researcher to understand the interviewees and other similar situated sources. This researcher does not want to include his experiences here to avoid fusing the composite themes coming from the participants with those themes coming from the researcher.

To assist this researcher with the data analysis he employed the use of ATLAS.ti 6 (2011), which is software for qualitative data analysis, management, and model building, and styled by its German developer of scientific software GmbH, Berlin as the

knowledge workbench. This software allowed me to insert digital audio of interviews, interview transcript data, and other textual data sources into *hermeneutic units* for analysis, using *primary documents* (PD or PDoc), *quotes*, *codes*, *memos*, and *families* from which emerged clusters of meaning surrounding the questions and answers derived from the interviews and textual witnesses on the question of the phenomenon of suffering and what such phenomenon means in the lived-experience and life-world of clinical pastoral educators and practitioners.

This dissertation, therefore, presents the voice of the interview participants and other similar textual witnesses from whose views and perspective emerge a cluster of themes that support my primary thesis that an explicit phenomenology of suffering is needed in order to help CPE educators and clinical practitioners carry out the historic and traditional mission of the CPE movement in this human science discipline to *care for* and *cure souls*, that is, to assess *spiritual needs* and the nature of *spiritual suffering* of the human person who are experiencing the phenomenon of suffering because of various bodily, mental, emotional maladies that impact the human spirit that has lost its way to love, faith, hope, virtue, and beauty. (Bartel, 2004, pp. 188-189).

The primary cluster of themes that emerges derived from the interviewees and supported by similar situated textual witnesses in relationship to the phenomenon of suffering and the CPE human science goal of *caring for* and *curing souls* are: (1) meaning of empathetic presence and feeling, (2) meaning of theological reflection/reflexive learning aimed creating a clinical theology, (3) meaning of head and heart in theoretical and experiential praxis, (4) meaning of spiritual needs and spiritual suffering, (5) swing hermeneutic relationship between clinical practice and didactic

learning, (6) meaning of lived-experience and the life-world for CPE practitioners, (7) meaning of perceptions and embodied experience, and (8) meaning of symbolism and suffering.

This dissertation supports its claims, conclusions, and findings using phenomenological analysis of ten verbatim interviews of CPE educators and clinical pastoral care practitioners at The Christ Hospital in addition to analyzing the statements and claims of similarly situated textual witnesses or human documents that practice CPE within this human science discipline, along with other relevant data sources that support my thesis. I have allowed myself this wider array of sources for data collection because phenomenological research seeks to describe lived-experience of a person's life-world, which include not only *things out there in world* but *things* (e.g. conceptualization, perceptions, embodied experiences, horizons of understanding, perspectives, feelings, etc.) that exist *within* the conscious and/or subconscious world of the human person.

For phenomenological purposes these *unseen things* also encompass the human person's *life-world* and *lived-experience* so that the *things within this world* are just as real as the *things out there in the world* and are for that reason subject to phenomenological investigation. Since the *things out there in the world* and those *things within the conscious or subconscious world* of the human subject of the investigation are located in a vast array of sources then *all* relevant data sources that provide a description of *what these things mean* to the human person in order for the researcher to gain insight into how the human person experiences any specific phenomenon under investigation are justified. The long interviews are from clinical pastoral care educators and practitioners of course are the primary sources for this chapter. However, the data gathered from this

source have necessarily moved me to research other sources including other similarly situated *human documents* and textual sources to help explain what was learned in the interviews.

Moustakas (1994) states that human science research, with an emphasis on its empirical character, takes "into account the experiencing person and the connection between human consciousness and the objects that exist in the material world" (p. 43) and that "Typically in the phenomenological investigation the long interview is the method through which data is collected on the topic and question" in order to describe these experiences of *things* or *phenomenon* in the material world. (Moustakas, 1994, p. 114). Moustakas (1994) *long interview* is the same in form as CPE's verbatim used in CPE training to teach students reflective/reflexive learning: however, he uses the long or verbatim interview as a research data analysis tool to arrive at clusters of meaning through a process of horizonalization, which he views as dimension of phenomenological reduction. Moustakas (1994) adopted the notion of *reduction* from Husserl's methodology of *epoche* or "bracketing" experiences *for the time being* that does not allow one to "focus on some specific situation, person, or issue," (p. 89), that some phenomenon under consideration.

Moustakas (1994) views "Epoche" as "the first step in coming to know things, in being inclined toward seeing things as they appear, in returning to things themselves, free of prejudgments and preconceptions. In Phenomenological Reduction, the task is that of describing in textual language just what one sees, not only in terms of the external object but also the internal act of consciousness, the experience as such, the rhythm and relationship between the phenomenon and self" (p. 90).

This is classical phenomenological thinking based on Husserl's (1999) phenomenology that allows one access to understanding the *pre-given* life-world of the human person, where positivism and science itself must begin: "When science poses and answers questions, these are from the start, and hence from then on, questions resting upon the ground of, and addressed to, the elements of this pregiven world in which science and every other life praxis is engaged. In this life-praxis, knowledge, as prescientific knowledge, plays a constant role. . . . and in each case usually in order to make practical life possible" (p. 363). Epoche (e>poxh<) as the primary dimension of phenomenological reductionism in Husserl's (1999) understanding actually refuses to allow scientific positivism to make any claims or assumptions since science itself stands on the foundation of and within this pre-given world and prescientific knowledge. Husserl (1999) in his essay "The Basic Approach of Phenomenology" states:

> The e>poxh< in question here is not to be mistaken for the one which positivism requires, but which indeed, as we had to persuade ourselves, is itself violated by such positivism. It is not now a matter of excluding all prejudices that cloud the pure objectivity of research, not a matter of constituting a science "free of theories," "free of metaphysics," by groundings all of which go back to the immediate findings, nor a matter of means for attaining such ends, about value of which there is, indeed, no question. What *we* demand lies in another direction. The whole prediscovered world posited in the natural attitude, actually found in experience and taken with perfect "freedom from theories" as it is actually experienced, as it clearly shows itself in the concatenations of experience, is now

> without validity for us; without being tested and also without being contested, is shall be parenthesized. (Husserl, 1999, p. 65).

Moustakas (1994) calls this notion in Husserl's (1999) understanding of phenomenological reduction "prereflective description of things just as they appear and a reduction to what is horizontal and thematic" (p. 91). Yet Moustakas (1994) admits that not all preflective experience of things are "bracketable" and states:

> Although the Epoche is rarely perfectly achieved, the energy, attention, and work involved in reflection and self-dialogue, the intention that underlies the process, and the attitude and frame of reference, significantly reduce the influence of preconceived thoughts, judgments and biases. Further, regular practice of the Epoche process increases one's competency in achieving a presuppositionaless state and in being open to receive whatever appears in consciousness, as such. Despite practice, some entities are simply not "bracketable." There are life experiences that are so severe, intense, and telling, some things that are so ingrained, and some people so attached to or against each other and themselves that clear openness or pure consciousness is virtually an impossibility. (Moustakas, 1994, p. 90).

There are two questions at this stage regarding using verbatim interviews for phenomenological data analysis in respect to Moustakas's (1994) understanding: (1) What is Moustakas's (1994) understanding of horizonalization of meaning in phenomenological reduction in respect to verbatim interview?; (2) Does he have any practical examples that can show how horizonalization is applied to verbatim interviews so that CPE use of this tool can advance its own learning and project?, and (3) How

would advancing verbatims from their current limited use for reflection/reflexive learning to phenomenological analysis of data using horizonalization advance CPE learning and its project of caring for and curing souls?

I will attempt to demonstrate this by using this method in analyzing my verbatim interviews in order to derive meaning for how the clinical pastoral practitioners interviewed experienced the phenomenon of suffering and what clusters of meaning emerged from this particular set of data. But what I do there cannot be understood without answering the above three questions. First, what is horizonalization? Moustakas (1994) states:

> Another dimension of Phenomenological Reduction is the process of horizonalization. Horizons are unlimited. We can never exhaust completely our experience of things no matter how many times we reconsider them or view them. A new horizon arises each time that one recedes. It is a never-ending process and, though we may reach a stopping point and discontinue our perception of something, the possibility for discovery is unlimited. The horizontal makes of conscious experience a continuing mystery, one that opens regions of laughter and hope or pain and anguish as these enter our conscious life. We may think that some perception of experience will forever remain, but the contents of conscious life appear and disappear. No horizon lasts indefinitely regardless of wish, hope, or fear. . . . we experience things that exist in the world from the vantage point of self-awareness, self-reflection, and self-knowledge. Things enter conscious awareness and recede only to return again. . . . Each horizon as it comes into our conscious experience is the grounding or condition of the phenomenon that gives

> it a distinctive character. We consider each of the horizons and the textural qualities that enable us to understand an experience. When we horizonalize, each phenomenon has equal value as we seek to disclose its nature and essence. (Moustakas, 1994, p. 95).

Hans-Georg Gadamer (2002), a student of Heidegger and author of the classic work *Truth and Method* of course would not agree that each phenomenon that gives rise to a new horizon of understanding is of equal value. Rather there is a relationship between each new phenomenon that necessarily gives rise to a new horizon of understanding. Suffering, joy, health, love and all other such phenomenon would become part of a person's hermeneutic circle of understanding the phenomenon and how it fits within their conscious understanding. Gadamer (2002) states:

> Every finite present has its limitations. We define the concept of "situation" by saying that it represents a standpoint that limits the possibility of vision. Hence essential to the concept of situation is the concept of "*horizon*." The horizon is the range of vision that includes everything that can be seen from a particular vantage point. Applying this to the thinking mind, we speak of narrowness of horizon, the possible expansion of horizon of the opening up of new horizons, and so forth. . . . A person who has no horizon does not see far enough and hence over-values what is nearest to him. On the other hand, "to have a horizon" means not being limited to what is nearby but being able to see beyond it. A person who has an horizon, whether it is near or far, great or small. (Gadamer, 2002, p. 302).

According to Gadamer (2002) each situation or phenomenon that comes into view is not equal in value to the one experiencing the phenomenon or situation as he calls it,

but rather each phenomenon has significant value because it necessarily is part of a person's new horizon of understanding of its meaning for them. This expanded horizon of understanding allows a person for example to see beyond the situation or phenomenon of suffering and thereby overvalue its significance because it is the nearest to him or her. The human person would be able to see beyond the phenomenon of ill health, suffering and/or grief and from the horizon of hope see the possibility of heath and a renewal of vigor.

According to Gadamer (2002) "To acquire a horizon means that one learns to look beyond what is close at hand---not in order to look away from it but to see it better, within a larger whole and in truer proportion. . . . We are always affected, in hope and fear, by what is nearest to us, and hence we approach the testimony of the past under its influence. Thus it is constantly necessary to guard against overhastily assimilating the past to our own expectations of meaning." (Gadamer, 2002, p. 305). All phenomenon do not have equal value as Moustakas (1994) maintains, but all phenomenon has significance for developing new horizons of understanding, which included various situations of human suffering that lead to new vistas of hope beyond the immediacy of the situation. How then does Moustakas (1994) analyze verbatim interviews using horizonalization as an analytical tool to uncover clusters of meaning that emerge from conversations with human texts dealing with various phenomenon within their *life-world* and *lived-experience*? Looking at Moustakas's (1994) analysis of verbatim interview records using his conception of horizonalization will allow the reader of This dissertation see how I used this phenomenological method to derive clusters of meaning from the interviews I conducted. However, it should be noted that I did not rely slavishly on

horizonalization for I have already inferred that there are at least two limitations to this methodological approach, where (1) Moustakas (1994) admits himself that some life experiences "are so severe, intense, and telling" that they cannot be merely "bracketed" or analyzed using Husserl's phenomenological reduction methods, which include horizonalization (p. 90), and (2) that Moustakas (1994) is wrong to believe that all phenomenon are of equal value, even though according to Gadamer (2002) they are all significant in the process of hermeneutical circle of human understanding that deal with each unique situation or phenomenon.

This means for a complete analysis of the interview data and other similarly situated human textual witnesses I will need to use other phenomenological methods that fortunately are provided for by Van Manen (1990) in his hermeneutical phenomenology. After we see Moustakas's (1994) contribution to my data analysis then I will show why Van Manen (1990) methods of analysis are significant, as well and should not be overlooked, and how some of them are applied to my interviews and to other similar situated human textual documents.

Moustakas (1994) summarizes the steps in Phenomenological Reduction that he uses in data analysis of a number of long interviews that look remarkably like the traditional CPE verbatim. In fact in his examples of long interviews he refers to them as "verbatim transcripts of the experience" and recognizes these as derived from living human documents that become "individual textural-structured descriptions" of human experience of specific phenomenon (p. 122). Below I present abstracts of two of Moustakas's (1994) examples that relate to two themes that emerge from my own long verbatim interviews of chaplains at *The Christ Hospital* namely the meaning of *presence*

for the care-giver and the *experience of suffering* of patients in HCOs from the aftermath of surgery. One abstract will be in the form of a verbatim interview followed by Moutakas's (1994) analysis of the data using horizonalization, and the second will be a composite of verbatim transcripts of 14 patients Moustakas (1994) calls "co-researchers" who experience the coronary artery bypass surgery. The objective of his phenomenological reduction analysis is to demonstrate how to acquire (using verbatim) a *cluster of horizons* then organize them into themes, and then organize the acquired themes into a *composite and coherent set of textual descriptions.* Moustakas (1994) summarizes his phenomenological reduction method as follows:

> *Bracketing*, in which the focus of the research is placed in brackets, everything else is set aside so that the entire research process is rooted solely on the topic and question; *horizonalizing*, every statement initially is treated as having equal value. Later, statements irrelevant to the topic and question as well as those that are repetitive or overlapping are deleted, leaving only the *Horizons* (the textual meanings and invariant constituents of the phenomenon); *Clustering the Horizons Into Themes*; and *Organizing the Horizons and Themes Into a Coherent Textual Description* of the phenomenon. (Moustakas, 1994, p. 97).

Stage I of *horizonalization* process of analysis is uncovering *horizons*, that is, "textual meanings and invariant constituents of the phenomenon" under consideration derived from the raw individual verbatim long interviews. **Stage II** of *horizonalization* process is to then *cluster* the *horizons* into *composite themes* derived from the raw interview data, and then finally **Stage III** of the *horizonalization* process is to organize the horizons and themes discovered or that emerge into a composite coherent textual

descriptive statement of the phenomenon under consideration. Moustakas (1994) uses this Phenomenological Reduction analysis and process of horizonalization gathered from verbatim interviews that contain statements he calls "invariant constituents" or "horizons" of specific experiences of phenomenon being as the primary mode of phenomenological inquiry (p. 129). Moustakas (1994) does so because he believes using this mode of research inquiry achieves a deeper understanding of the emerging themes related to the phenomenon experienced, even though he admits all such themes are subject to *epoche* or *bracketing* for purposes of analysis because some life experiences "are so severe, intense, and telling" that they cannot be merely "bracketed" or analyzed using Husserl's phenomenological reduction methods, which include horizonalization (Moustakas, 1994, p. 90).

Clinical Pastoral Education (CPE) has so far not recognized, ignored, or trivialized the immense value that the verbatim has for advancing its project of *caring for* and *curing soul* using both *head and heart* by limiting this reflective/reflexive learning tool of analysis to merely way to achieve pastoral and clinical formation of students CPE Level I and II in an attempt to improve clinical praxis. It is generally gone unnoticed that CPE students soon put aside this valuable learning tool of analysis once they become chaplains and achieve professional board certification, and see no need of it as a way of gathering clinical data not only for improved praxis but for scholarly research in this CPE human science discipline.

I argue that a *phenomenology of suffering* that naturally incorporates Phenomenological Reduction and other phenomenological methods of inquiry engages CPE student's *head and heart* in the kind of phenomenological analysis that will allow

CPE educators and practitioners to advance the use of verbatim to a higher purpose beyond CPE Level I and II and Supervisory components of training in order to advance the CPE project of caring for and curing the soul. Once this kind of analysis becomes a normal part of didactic and clinical training then this store of gathered knowledge can become the basis of qualitative research studies and enhance CPE literature that can be used by other CPE educators and practitioners in similarly situated hospital clinical organizations (HCOs).

Using the CPE verbatim to capture the experiences of clinical pastoral care practitioners and actually the writing process itself was the vision that Russell L. Dicks had in 1933 who wanted to see to it that the verbatim became the primary reflective/reflexive learning tool for CPE. Hall (1992) states:

> Dicks . . . originated the verbatim of pastoral conversations as the chief learning tool for clinical training students. Describing this technique he wrote, "When we reproduce in writing a contact, and interview, a working relationship, we do not merely record it, we rethink it and so develop its meaning, *not while we are seeing a patients but as soon after as possible*. . . . It is a check upon one's work; it is a clarifying and developing process; it relieves emotional strain for the writer . . . and stands as a record of one's work . . . It is a new creation of ideas which reveals lacks in what we have done. It is a fresh application of ideals to criticize what was done. It traces out the implications of what we have seen and heard. . . . It is self-criticism. It is self-evaluation. It is preparation for self-improvement. (Hall, 1992, p. 23).

This shows that Russell Dicks as one of the pioneers of CPE wanted the verbatim to be used as more than a tool for pastoral clinical formation of students but to go beyond that to discovering as he said *develop meaning of experiences* the pastoral care practitioners has in verbatim pastoral conversations with patients. Dick's critical analytical research focus is clear when he talks about using the verbatim to "create new ideas" and developing a "fresh application of ideals to criticize what was done" (p. 23). What Dicks did not have in 1933 to realize this vision for the verbatim was Moustakas's (1994) Phenomenological Reduction analytical method applied to verbatim interview that would advance it to and beyond Dick's vision for this CPE learning tool. I argue here that Moustakas's (1994) data analysis contribution to the CPE project will be to renew and refocus CPE's lost emphasis of using both *head and heart* in its primary project of *caring for* and *curing souls* that Russell Dicks wanted to achieve using the verbatim for its maximum value.

This dissertation holds that Moustakas's (1994) phenomenological method of analysis of the long interview if applied to CPE verbatims will advance CPE's educational and pastoral clinical tool from its current limited didactic application for CPE Level I and II training to become an ongoing clinical research tool for phenomenological research and scholarship that can be shared with other pastoral practitioners to improve learning and praxis. Moustakas's (1994) *horizonalization analysis* is an original contribution to learning and knowledge, since this dissertation has shown how it benefits CPE's human science discipline advance its project of *caring for* and *curing souls*. This dissertation uses Moustakas's (1994) Phenomenological Reduction methodology. This method is used, in order to demonstrate the process of how I analyzed my interview raw

datum and so demonstrate the value this kind of phenomenological analysis has for daily CPE clinical praxis, didactic learning, research inquiry, scholarly research and writing.

The raw data gathered ins this dissertation is *composite textural descriptions* of the *emerging themes* that combine the insights of the interviewees with Moustakas's (1994) Phenomenological Reduction playing a major role in the outcomes. Some direct quotes from the participants, however, must be included from the raw datum in order to see first-hand what the interviewee actually said that support the emerging themes suggested by the composite textual descriptions.

Moustakas (1994) presents a verbatim interview from Fraelich's (1989) study in which he "investigated the experience of psychologist-psycho-therapist "presence" in relationship to the client" (p. 107). The theme of *presence* came up time and time again in my own verbatim interviews with chaplains at The Christ Hospital with the same thematic descriptions of this phenomenon by chaplains in respect to caring for those who are suffering. Fraelich's (1989) verbatim follows:

R = Researcher

P = Participant

R: What I'd like you to do is, as fully as possible, describe in your own words how you experience presence as a therapist. Would you just start with getting into that experience . . . . Take your time; when you're ready, begin.

P: Well, when you read the description of presence . . . I realized that one of the things I do---I try to do---like if It's seeing a number of people, is to have enough space in-between so that there's some kind of preparation beforehand. This is more inner preparation. The fellow I'm thinking of comes once a week. . . . I

picture him in his situation . . . and I just kind of take that in so I feel I begin presence already. Just taking him into my consciousness before he comes. So that's one aspect.

R: . . . kind of a preparation, setting at tone.

P: Setting of a tone that puts me in relationship to him and . . . where I'm just bringing everything to rest. You know, If I've been working all morning long, or been in conversation with somebody just trying to let all that drop away so that I can have as open a consciousness as possible.

R: So the outside world gets put away.

P: Yes, just leave that behind. The kind of preparation for just being there with him.

R: Do you have any other experience that's a part of this preparation time?

P: Well no I don't. . . .

R: Now, I have a fairly clear sense of what that's like for you. You're wanting to be close to the person. You're ready and there waiting for him.

P: Yes, you're right.

R: Can you tell me more about what it's like?

P: Well, it's like wanting to know and caring about who he is. It comes to me as a kind of question that I don't know who he is. . . . "Bill, who really is this person, who is this struggling, individual manifesting his various feelings and thoughts, experiences of life. Who is really there?"

R: Which is interest and concern?

> **P:** Yeah. Caring about him, caring about where he's going, that I've made an alliance with him. I've taken some kind of responsibility for helping him get a sense of who he is and where he's going. (Moustakas, 1994, pp. 123-124).

Moustakas's (1994) application of horizonalization to Fraelich's verbatim resulted in a description of what *presence* means to this care-giver. This is Phenomenological Reduction Stage I where *horizons* of textual meanings and invariant constituents of the phenomenon emerge from the raw verbatim interview data. Moustakas (1995) describes the horizons of meaning from the phenomenon of *presence* stating: "The research participant describes *presence* as inner preparation, internal awareness of space, and imaginative readiness as ways of entering into the therapeutic encounter, setting the tone, and conveying an alertness, receptiveness, and attunement to listening, hearing, and responding to whatever the person-in-therapy presents. Each statement in *horizonalizing* holds equal value and contributes to an understanding of the nature of meaning of therapist presence" (p. 123).

The subject of the Fraelich's (1989) verbatim is the psychotherapist and his experience of the phenomenon of presence. At this point his patient "Bill" is paradoxically not really the subject of presence yet the phenomenon of presence is invoked by the psychotherapist's encounter with "Bill." The psychotherapist is the one experiencing presence in respect to his care for or caring for "Bill." The sub-themes surrounding the experience of presence are *preparation, being there, inner consciousness, bracketing* (the outside world so that the focus is on presence), *being close to the other* ("Bill"), *wanting to really know the other, sharing in the others life experiences, caring for, being responsible for, helping the other, thinking about the other*,

etc. all of which goes into what presence means for this psychotherapist. This is precisely the kinds of feelings the chaplains interviewees felt, as a result of their encounters with patients that were suffering. This is a demonstration of what emerges from the Phenomenological Reduction at **Stage I** of the process of *horizonalization*.

Now this dissertation presents two other examples from Moustakas's (1994) process of *horizonalization*, which is in the form of the **Stage II** of *horizonalization* in Phenomenological Reduction, where the *clusters of meaning* or *horizons* discovered are organized into *composite themes* from the raw interview data, followed by **Stage III** of *horizonalization*, which is organizing the horizons and themes into a *coherent textual description* of the phenomenon under consideration.

Stage II: Example of *Invariant Constituents or* Horizons: Bypass Surgery

According to Moustakas (1994) "Trumbull (1993) analyzed the verbatim transcripts of all 14 of his co-researcher' experiences of undergoing coronary artery bypass surgery in order to determine the significant, relevant, and invariant meanings that provide living descriptions or highlights of the experience. He derived 44 invariant constituents and clustered them into eight themes, as follows:

I. Relationship with Medical Personnel, Information, Process, and Interventions
    A. Relationships with medical staff
    B. The first signs and symptoms of the development of heart problems
    C. Undergoing a series of medical tests
    D. The Cost of coronary artery bypass surgery
    E. Being informed by the medical staff about the events, test and procedures
    F. Thoughts and memories and actually hearing of the surgical procedures

G. The medical preparation that were necessary for coronary artery bypass surgery

II. Bodily Pain and Concerns Related to CABG Surgery

A. Waking up after surgery with tubes protruding from one's body

B. Being extremely thirsty but only allowed minimal amount of fluids

C. The recovery process at home

D. Involvement in exercise programs and developing regular exercise

E. Perception of time as healer

F. Chest pain

G. Incision

H. Leg pain

I. Fear of continued heart problems and possible heart attack or having to undergo coronary artery bypass surgery again

J. Regaining body functions after surgery

K. Increased awareness of one's heart, and exercise, diet

L. Being hooked up to machines

M. Return to one's usual activities

N. Hallucinations

O. An awareness of the co-researcher's improvement after having coronary artery bypass surgery

III. Feelings and Memories Connected to the Surgery

A. Disbelief that the co-researcher was experiencing heart problems that required heart surgery

B. Feelings about how the physician and medical personnel took control of the person's life

C. Anticipating the surgery

D. Increased awareness of feelings

E. The negative impact of surgery

F. Feeling vulnerable

G. Feeling that life or God or the world was unjust in that they should have heart problems

H. Dealing with the physical pain

I. A sense that the person has lost control of what was happening to him/her.

J. A feeling of being safe in the hospital

K. Last memories just prior to having heart bypass surgery

L. First memories after surgery

IV. Significance of Family and Friends

A. Relationships with Family and Friends

B. Relationships with friends

V. Impact of Time on Undergoing CABG Surgery

A. Perception of time

B. Experiences that reminded the individual of earlier times

VI. Visions of Death Connected to CABG Surgery

A. Thoughts of one's own death

VII. Awakening or Confirming Religious Beliefs

A. Impact of surgery on the individual's religious beliefs

VIII. Horizons of New Life Following CABG Surgery

A. Importance of meaning of the surgery

B. A sense of new life

C. Making diet changes

D. Changing smoking habits. (Trumbull, 1993, 00. 121-122). (Moustakas, 1994, pp. 129-131).

Stage III: Composite Thematic Description of Horizons: Bypass Surgery

What emerges from **Stage II** horizonalization analysis of 14 co-researchers (i.e. heart bypass surgery patients) are "44 invariant constituents . . . clustered into eight themes" (Moustakas, 1994, p. 130). I have gathered from these horizons or invariant constituents provided by Trumbull (1003) and included in Moustakas's (1994) *horizonalization* analysis **Stage II** above that Stage III analysis would look something like the following: The researcher using phenomenological reflections and imaginative variation on the themes can reconstruct meaning of the experience of the trauma related to bypass surgery from these respondents.

The eight themes in short have to do with concerns about (1) what the medical staff is doing and related concerns about procedures and costs of surgery, (2) impact of the surgery on the person's body in respect to suffering various forms of pain (e.g. chest pain, leg pain, incisions, etc.), including perceptions about healing in respect to time (i.e. how long will it take to get back to normal) and fear of continued heart problems, that is, things related to the aftermath of bypass surgery, (3) Reflections on feelings before and after surgery in regard to losing personal autonomy, control over one's body and very life to medical staff in the hospital, feeling vulnerable to forces beyond ones control,

including disbelief that the person is even in just a predicament, and blaming life, God, or the world for this unjust situation (i.e. “What have I done to deserve this?” “Why is life so unfair when I was just at the top of my game?” Or “Why did God allow this to happen to me since God is good. Why would God allow me to suffer like this?”, (5) concerns about family and friends, (6) concerns about one’s own mortality and thoughts about the end of life, (7) reflections one’s religious beliefs and what those belief have to do with this situation of suffering and pain, and (8) regaining hope through new horizons through thinking about these concerns and coming to a new horizon of understanding that life is not over because one has had bypass surgery. There is an awareness that there is “life after” surgery and the pain of suffering analogous to the religious belief of some people that there is “life after” death, which is a belief that affirms life with future hope.

The conclusion is that it was necessary for these 14 co-researchers to go through the reflective thought process of horizons that emerged in themes 1 through 7 in order to arrive at horizons located in clustered theme 8, which resulted in a *new horizon of understanding* surrounding the *invariant constituents of hope* for a *continued and more healthful life* after bypass surgery. Suffering and pain can be bridged but experiencing doubt, blame, anxiety, and even fear are natural human responses to this *phenomenon of bypass surgery*, which includes real pain, imagined continued pain, lost of personal autonomy and control over one’s life, and concerns about ones mortality, including existential concerns about negation being (i.e. death of the physical body and the Self).

Now that I have given these two examples based on Moustakas’s (1994) understanding of the *horizonalization* process in Phenomenological Reduction, I feel able to move into my own interviews using **Stage II** and **Stage III** to reveal the themes and

horizons that emerged. It is to be understood that I have not passed over **Stage I**, but bridged this first step in the process, since it would be impractical to include all ten verbatim interviews in raw form. However, I will present parts of at least one or two verbatim interviews so that it can be clearly seen that the basis for **Stage II and III** composite statements on horizons and themes are derived from the actual collectives statements of the interviewees. This will illustrate how **Stage II and III** proceeds from the development of horizons and themes discovered in **Stage I** from their descriptions of experiences with the phenomenon of suffering.

Finally, what is incorporated and revealed in **Stage II** and **Stage III** will be the composite themes derived from individual verbatim data from **Stage I** so that the gathered data from that source (i.e. the individual verbatim long interviews) are transparent to the reader. The **Stage II** and **Stage III** data is organized around the four primary research questions to provide a more coherent analysis. After the *horizonalization* analysis my ten interviews are complete in its composite form, I will handle other *similarly situated human textual witnesses* using Van Manen's (1990) *hermeneutical phenomenological approach* in an effort to further uncover clusters of meaning and themes from these human textual statements in order to understand how to experience the phenomenon of suffering. This data will deepen and thicken my research efforts and hopefully validate, that is, give to support to my data analysis coming from the verbatim interviews. Taken together this two part analysis using both transcendental and hermeneutic phenomenological methods will demonstrate CPE can use these phenomenological methods of research to understand suffering and therefore further

advance its educational and pastoral clinical project of *caring for* and *curing souls* using both *head and heart.*

Horizons and Themes: Research Question One

How do chaplains within the context of their life world and lived experience as pastoral care practitioners experience the phenomenon of suffering of patient/clients domiciled in Hospital Clinical Organizations (HCOs)?

What follows are verbatim from three of ten interviews I had with chaplains in various disciplinary specialties at The Christ Hospital, including *critical care chaplains*, *surgical chaplains*, *palliative care chaplains*, *Eucharistic chaplains*, and *grief chaplains*. The three verbatim interviews are from a *critical care chaplain* , a *surgical chaplain*, and a *palliative care chaplain*. However, the whole interview for each will not be presented, because each interview averages one hour and fifteen minutes and the transcript for *critical care chaplain* by itself was fourteen pages long. However, a sufficient number of statements from each one of these interviews will demonstrate how *horizonalization* from **Stage I** is achieved. Thereafter the reader can expect that **Stage II** and **III** horizons and clusters of themes are a composite of interviews related to each research questioned.

Verbatim Interview: Critical Care Chaplain

This interview was conducted on January 11, 2012 at the Christ Hospital and lasted for approximately one hour and fifteen minutes, with digital numeration preceding the comments, where 001 PI = *Principle Investigator*, and 003 CC = *Critical Care Chaplain,* with the appropriate digital numeration appended:

001 PI: Interview taking place with Chaplain CC at Christ Hospital on January 11, 2012 . . . . OK, one of the questions I have in terms of . . . . it says: How do you as chaplain or

pastoral [care] educator within your lived experience deal with the phenomenon of suffering with patients in the hospital? . . . . what I am looking for with this question is [this]: What is your felt experience in dealing with patients that are suffering in the hospital as a chaplain?

003 CC: There are two perspectives that comes up whenever I am thinking about dealing with the phenomenon of suffering. One perspective is from the patient's point of view, and the other perspective is from my point of view. So both of them are what you are looking for?

005 PI: Yes, because actually when you say from their point of view what they say impacts your feelings. It is not just a matter of you going in there and feeling something. Obviously, they are saying things to you in the context of their suffering. So yes that would be very important.

007 CC: It is pretty difficult in looking at both senses. Whenever the patient is suffering there is so many questions that have a spiritual connotation. The main question that seems to be resonating between the person and persons is framed in such a way as: "Why God?, " "Why me?," "Why am I going through this?," "Why have I been chosen to suffer in this way?" And that very typically leads to the individual experiencing differing types of emotions directed toward God. Sometimes they have anger that . . . I had one person not long ago speak to me and said: "I use to be a very spiritual person, but that was many years ago, I have experienced suffering, after suffering, after suffering, and because of that it has arisen up so much anger and animosity. It has just been recently that I have been able to reconnect with the spiritual aspect of who I am, and begin the process, the healing process that goes on, because it was such an in-depth and personalized assault

that came upon me that there was no framework that I had of why a just and loving God would allow me to go through something like that.

009 PI: Now when they say those kinds of things to you. . . when they frame it in that way what is your felt experience?

011 CC: My felt experience is that I can go back in my life where I went through something very similar to them. . . .

015 CC: . . . . and had to process for myself my feeling of anger toward God. It help them to normalize that these are very normal feelings that you have and God is not shaken up because: "On no, somebody is mad at me!" Uh, it is just out of personality, out of our perspectives, out of our expectations, out of many different mechanisms that we use to process this information. We begin that and it really takes me back to the time that. . . . and it does not seem to matter how frequently I am exposed to it, it always takes me back to that . . . and I can really connect with them.

017 PI: When you are reflecting with a person and you are talking right in front of them about it you are experiencing that with them, you are experiencing their feelings; do you have any . . . do you share your reflective experience on that or do you let them . . .?

019 CC: If something I perceive will benefit them and keep the focus on them I will. I have learned over the years that whenever my issues rise up that those are my issues. I don't necessarily need to bring them into the interaction with the patient. . . . For the most part being acquainted and interacting with many form the Catholic faith talking about their Catholic guilt, and how their guilt gets to them so much and one of the things in that guilt process is the inability for them to give themselves permission to be angry at God. And that is something that causes further suffering and further pain for them, because

now they have to deny the feelings that they are having, and ignore or avoid the conflict that is at hand, because their spiritual values will not permit them to go to that place.

021 PI: But you don't want to share experience unless you feel it going to benefit them?

023 CC: That's correct.

033 PI: But in what situation would you think you could share your feelings of suffering, say like anger at God?

035 CC: I feel like there are indications after assessing the patient; if there are indications that the patient is feeling "I am on an island by myself" then to normalize it for them I will bring in my own.

041 PI: OK, I understand. That's good. Are there any other ways that you deal with the phenomenon of suffering? . . . . one of the things you mentioned was that sometimes when they are sharing with you, you can reflect back on how you felt the same way. . . Is there anything else that goes into how you feel when you are dealing with patients actually depending on what they say and the context and how they are feeling. I guess you would be kind of assessing how helpful you can be to them after listening to them?. . . . When you are listening to them are you trying at the same time trying to see what it is you could do to help them? Do you feel . . . initially helpless or do you feel like you are going to be of any help or does that depend on the context?

043 CC: Sometimes it depends on the context. Most times when I go in it almost always is an initial response . . . . that comes to mind. I don't what I have that can help these people. But after I have dispelled that thought and get that out of the way I am able to connect with the other skills that I know that are present that can help that person either walk through the suffering or make meaning out of that suffering, or find a place of

solace in the midst of that suffering. For me personally some of the things. . . . strategies that I have found with suffering, and engaging people in their suffering . . . . if you walk with people in suffering long enough then it can have a tendency to take your energy. It can begin to wear on you. I can begin to really take your perspective, and all you see is the negative things of life.

045 PI: How do you deal with that?

047 CC: There are a couple of ways that I deal with it. One is that I attempt to go into each encounter, understanding that this is theirs; it's not mine. So the interventions I going to bring in are going to end when the conversations ends, unless it dictates that I need to follow-up with them or do some further research to understanding a little bit more about what they are doing (i.e. experiencing): But understanding that this is not mine. It is their suffering. It is their journey. I have come in . . . It's a part of my theology of pastoral care. It's an "Emmaus Road Theology", where I come along side for just a short period of time, then I go away. And whenever I go away this is their journey, this is. . . . I am not responsible.

049 PI: When you walk away are you able to come out of that deep experience? . . . As you exit out do you feel?

051 CC: Sometimes I can just leave it there. Other times I need to sit down with colleagues and just process, and figure it out: Why have I carried this with me. It is speaking to some unresolved issues or grief that is in my life that I have not come to a resolution with; that I have not accepted yet?

053 PI: So does the reflective process help you expiate that, because if you don't you are going to be cripple for the next [encounter]. . . . You are not going to be help to other

people if you keep carrying someone else's issue. . . You know, carrying it form one [hospital] room to the other.

055 CC: There are time that I recognized the felt experience; that I recognize behavioral changes in myself. And it I don't re-expose myself then I will intentionally take another path . . . I know a patient is in a certain room. I want to go down that side of the hall. I will go down the other side of the hall. And when I do that I recognize within myself: "Ok, this is getting to me. This is something I need to process . . .

061 PI: Well, let me ask: Do you feel any guilt?

063 CC: The times I feel guilty are times that the behavior is accompanied with exhaustion. If I am not exhausted and I do something like that then there is no guilt. But if am entering into an exhausting zone, which can be easily entered into then there are feelings of guilt. There are feelings of paranoia. There are different feelings.

065 PI: But . . . could feel exhausted one day for no reason, and just feel like [you are] spiritually burdened?

067 CC: Huh, huh, yes.

073 PI: OK. Just let me ask you a question [coming from that] one. Is prayer helpful?

075 CC: Most definitely. I really adhere to the Scripture that says: "Pray without ceasing." I have a private prayer time, but I also a continuous prayer that whenever I am getting ready to go into a room it's the whispered prayer, and even while I am having conversation with patients I ask [the Lord] to open my mind, open my eyes so I can see where this is going, and see what interventions and tools [I need] to help this individual.

081 PI: Uh, do you feel that there are any spiritual impediments outside yourself involved keeping you from doing that? . . . . If that happens how do you deal with that?

How do you overcome that? Or is it possible to overcome that? Or do you just say: "Well, I won't be able to do anything here?"

083 CC: Sometimes you can, sometimes you can't overcome it [i.e. the barrier between the care giver and the patient]. If there is a definite statement like: Thank you for coming, but we would like to go through this ourselves. That wall is not worth scaling. . . . . (Critical Care Chaplain, 2012, Folder 01-P2:110105).

Verbatim Interview: Surgical Chaplain

This interview was conducted on January 13, 2012 at the Christ Hospital and lasted for approximately one hour and fifteen minutes, with digital numeration preceding the comments, where **01 PI =** *Principle Investigator*, and **03 SC =** *Surgical Chaplain,* with the appropriate digital numeration appended:

03 PI: I know this is an open ended question but you got to start somewhere: "So what is your felt experience in dealing with suffering? And if you have to use an example with no patient names it might help you but I don't know . . . how do you approach it and how do you deal with it as a chaplain in your area [i.e. surgical chaplaincy]?

05 SC: I believe that the whole area of suffering [is important] . . . . seeing patients that are suffering . . . I think over the years I have to some extent have learned how to handle it better myself than years ago. When I was first in chaplaincy ministry and even before chaplaincy ministry, as a minister visiting people in the hospital and nursing homes, uh. .

07 PI: Hold on a minute . . . Let me check this (i.e. digital recorder settings).

09 PI: Sorry for the interruption.

11 SC: Being involved in pastoral care ministry even before I was a chaplain, as a pastor, visiting people in nursing homes, hospitals, things such as hat where I was exposed to a

lot of suffering. In the early days of ministry I would see suffering and it would be hard for me the rest of the day to get that out of my mind. And it was hard for me to walk out of a door where you've seen suffering and forget about it. And . . . . I would try to literally forget about it to the point where it does not consume your thoughts the rest of the day. Over the years I think by being exposed to more and more perhaps you lose. . . I guess [it's not as] frightening to me to see anymore. It still touches me. It still bothers me to a certain extent, but in most cases I am able to walk away from the experience and not have it continue to come up throughout the day. That being said there are some situations that are so disturbing that I see that I am involved in that sometimes it is hard to walk away from it. Still that has always been a challenge for me: How do you not be so sensitive to what you see and still stay sensitive to the situation to be able to provide care for people and to not . . . to just become hardened to where it does not bother you anymore? And that has always been . . . that is kind of difficult balance for me to figure that out.

13 PI: In this balance and this . . . you touched on something that I heard before, but it is critical to try to get an understanding about how a chaplain would feel. Do you have a sense that on the one hand you are there to help that person, but on the other hand you feel like there is a need to protect yourself in a way? I don't know if I'm going in the right direction with this . . . with the question I mean. (i.e. Introspective notation on *empathic inversion*).

15 SC: I think dealing with what you see and trying to learn how to process what you've seen, or what you've heard, or what you have even experienced with other senses . . . sometimes people who are suffering. . . you are in a room where somebody is just

suffering horribly and even your sense of smell is effected in certain situations. So there are all different ways you can feel this or experience suffering; and trying to find a way to balance your life so that . . . I think it is called "caring for the care-giver." You have to be in a difficult situation, but you also (like you said) somewhat protect yourself and deal with what you see, hear, smell . . .

17 PI: Healthcare is double-edge. It has to be . . . in order for you to continue doing what you are doing, you have to not only have a sense of caring for the patient, but for yourself as well in order for to continue to do the work.

19 SC: Right! I think being able to process what you've seen, what you have heard with other people, and things like that. There are certain things you can do or that the caregiver can do for the caregiver. Now the hard part sometimes for me is to be able to realize I'm to do something to care for me or protect me but not let that hinder me from being able to care for or give all my attentions to the patient at the same time.

21 PI: Because that's important for you to be able to do that or otherwise you would not be doing chaplaincy.

23 SC: That's right! That's why we're here.

25 PI: Do you uh . . . along those lines in caring for yourself . . . . so much that you know you have to do that balance . . . fell any guild for having to take care of yourself? If you don't fully give yourself to that situation and help the patient and you have to withdraw for some reason . . . because it's effecting you, do you feel any sense of guilt for having to do what you know you need to do in order to take care of yourself?

27 SC: Yes! This is very common at least with me. The thing of it is that a lot of the people that are colleagues here at the hospital whether they be chaplains or nurses or

whatever we tend to be somewhat sensitive people or caring people and that is what brought us into this field (i.e. healthcare), but that same caring attitude or that same sensitivity can also . . . . cut you because you are a caring, compassionate person, and *you want to be there* (*Introspective notation*: Heidegger's (1953) notion of *being there*) to help people get through the difficult times but at the same time that type of an attitude, that type of person or make-up can be really difficult. I call it compassion fatigue, which is a term that is out there and used quite a bit. Caregivers go through what is called "Compassionate Fatigue", where they feel like they have to give, give, and give, and they see some traumatic things, very, very horrible things in the human perspective and especially if you have several of these deeply, emotional type of encounters right in a row. It's very tiring and very draining. You don't want to be a cold clinician. You want to be able to put *heart and mind* into it (*introspective notation*: CPE notion of *head and heart*), put everything you have into it. But at the same time a very draining thing for the care giver. In my experience I feel the need after going through several very difficult, deeply emotionally difficult situations . . . I have to find a way to back away from it a little bit. And some of the things I do: I will sit down with colleagues and go through a debriefing process, and this is kind of what we learned in CPE [that is] being able to share your experiences with others, In my experience, I think I do that quite often for reassurance that I have been doing the right think . . . in caring for these people, these patients and things like that. But at the same time just to process what you have seen; to kind of not let it just stay pent up inside to where pressure can build.

29 PI: Do you. . . when you are dealing with those kinds of situations . . . is there a sense of helplessness in respect to, or any feeling that you are dealing with a situation, and you just don't know how you're [going to] be able to help that person?

31 SC: That comes up occasionally with me. After going through several deeply emotional situations to the point where you are fatigued, you're going home [and] you are thinking about the case all day, and you may even dream about that night. I am constantly concerned in thinking about that situation there are times when you are physically and emotionally tired, and sometimes spiritually tired. And all of a sudden your pager goes off and here is another similar or worst situation. And in my case there are times when I am walking toward that situation where it is taking place, wherever I am being paged to, and thinking in my mind: "I don't know if I can go through another day like it was yesterday." And at the same time I begin to pray for this situation, for the patient, for the family, for even the caregivers that we will be able to do what God has called us to do.

Verbatim Interview: Palliative Care Chaplain

Interview Legend: **PI =** Principle Investigator; **PC -1 =** Palliative Care Chaplain 1

PI: This is Dia Mari-Jata interviewing Chaplain PC-1 at The Christ Hospital on January 18, 2012. Involved with the TCH or Christ Hospital Study #11-85 approval date 12/20/11. The study title is *Phenomenology of Suffering in the Lived-Experience and Life-World of Pastoral Care Educators and Clinical Practitioners in Hospital Clinical Organizations*. We have spent time going over the Informed Consent as well as the Release of Copyright/Publication Rights by the interview subject. And Chaplain PC-! has so graciously agreed to participate in the study and we are beginning with the questions.

PI: The first general question [that is] the main one . . . and what I want to do is read the question first like it would appear in the dissertation and then restate is so it sounds a lot more human as to what it is [I am] exactly trying to get at. How do you as a chaplain or pastoral care educator and/or practitioner within the context of your *lived-experience* and *life-world* deal with the phenomenon of suffering of patients domiciled in your hospital clinical organization or HCO? Basically, the bottom line is that we just want to open it up for you to [talk about] your experience of human suffering in your work as a chaplain in hospital settings? And you can begin wherever you feel comfortable.

PC-1: Well I have learned that suffering . . . . I think of suffering as vulnerability, loss of control , loss of physical, emotional, and psychological health. I think it is very real and it varies for me from patient to patient. So I take each and every opportunity to try to *meet that person where they are*. That is what I am called to do; to try to get to a point where I can understand emotionally, psychologically, and physically where they are. I think as a chaplain my calling is to represent the *presence of God* in those situations, and by that I mean that . . . as a Christian I believe that *is a representation of hope*, where none seemingly exists, where often times fear is very rampant and very deep, and my job is just to be present with them and try to be there for them. It often times a very helpless role, meaning that you feel, I feel most of time inadequate in that role. I feel that I am searching, trying to feel the gap, trying to *be there*, and trying to meet the needs. And what I try to do is *observe, listen, and be discerning* of what is said, what isn't said. And trying to connect. . . . Now I'm not trying to say I feel pain. I do not. I try to identify where they are coming from. And at the same time recognize how significant and how important [the situation of suffering condition] is to that person, but at the same time set

that boundary for myself not joining them [in that]. . . and joining them in [my] presence but I not joining in the sense of taking on their pain or their fear.

PI: Now you mentioned really three significant ideas I thought were related: (1) presence, the presence of God, and your presence. I don't want to put words in your mouth, but being present with them in their suffering, and then (2) you talked about inadequacy, and then another thing would be. . . I guess maybe uh off of that (3) you are not there to take on their suffering, even though empathize with it. Is that that what you mean?

PC-1: Uh, uh, Yes.

PI: So let me ask you going back with presence first, the presence of God, and then I want to deal [with it] related to this question, because it is really fundamental what you have been saying, in regard to your feeling of inadequacy. Uh, I want to know the first part of coming out of this. . . what you are saying is the presence of God, and what does that mean to you in that [suffering] situation, with that patient? And I know you have said it already but I want to go just a little bit [more] on how you are feeling and then relate it too. . . It sounds like to me you are relating that to inadequacy, because you talked about it almost in the same breath [that is] the feeling of inadequacy, in a sense. So how do you relate those two? You are there present to help , and you are there present with God being present, but yet as a human person there is some feeling of inadequacy in dealing with the situation [of human suffering]. So I just want to know in feeling this way knowing that God is present, but having this feeling of inadequacy how deal with that in dealing with. . . ., because that is very important to know how you feeling in dealing with that. I know

you say you feel inadequate but how do you deal with that [feeling of inadequacy]? I guess that's what I'm trying to say.

PC-1: I think I deal with it and recognize and knowing that I am not God. I am only God's representative. I will give you a theological perspective. And this is the perspective that John the Baptist had, who was Baptizing many disciples and Jesus came along. John was the forerunner. He was a representative for Jesus. And when he was asked [by the] people. . . you know: "Well John you [are] over here baptizing but that man you talked about Jesus! He is baptizing more than you. He is doing a better job than you in drawing more people!" John's response was: I'm just the forerunner. I said that someone would come after me that is truly representative [of God] and that can do a better job [than me]. I'm just a representative [voice crying in the wilderness]. And that's how I feel about it [my role]. That being said, and recognizing, knowing that I am not capable of being God, but I am capable of representing [God]. And that really is [how it is]. I can do nothing my own.

PI: That's very powerful, yes.

PC-1: And I think about that. . . for instance, I do this. . . . I think I told that sometimes I work as a Chaplain at Children's [Hospital]. When I'm there I'm on call. I'm the only chaplain there and I only respond to traumas, or medical teams, or codes, so in other words things that are very critical, and uh, just me. I have a telephone backup I can call, but it is just me. And every time I get page for those, and if I get paged . . .

PI: Is that a different role than palliative [care] here? That's critical care [isn't it]?

PC-1: Yes, that's critical care. Children's Hospital is a trauma hospital. You know gunshot wounds, those kinds of things happen there. As an on call chaplain I am only

there typically for the critical calls and deaths. Every time I get a page I'm praying as I go to the call: OK God help me to remember that He goes before. He goes in front of me. I His representative, because you never know what you are going to walk into, and it's very traumatic many times to walk into a situation with a child in the emergency room that could be dying. You are dealing mostly with the parents in that situation. They are distraught because . . . .

PI: What do you . . . when you ask God to go before you what are you asking Him to do?

PC-1: Speak through me. Tell me what to do. I actually do not know what I'm going to say, because it's not about me, so I ask God to guide me. That's my approach when I go even with patients here. And I will say that my work at Children's prepared me for what I do here [TCH] in palliative care. Here I have the other end of the spectrum in geriatrics from dealing with babies to everything in between that I deal with here. Children's is from infancy to new born. . . could be up to 25 because people have been in the system for a long time. From here they are adults. I have patients in their 30's. I have one now that I think is 98 years. So I have a full range [of people that suffer]. I count it to be blessing to be present for those here. . . the families in palliative care. But I say that I am going praying all of the time, particularly alone. It is just me. I am the chaplain going into the situation. You are responsible not only for patient but the whole room, the doctors, [just] everybody in your presence. You are observing all of this. That has taught me a lot for palliative care, for watching and observing, because we do a lot of family stuff, you know.

PI: Now that sounds like a heavy responsibility for one chaplain and that's a big hospital [Children's].

PC-1: That's why it's not [just] me. [We have a laugh]. That's why it's not me!

PI: From a [mere] human being it would be too much!

PC-1: I can do it but you really have to be clear. It's not about you. And it's not . . . it's for you to be a representative of [the] Presence. It's the Presence of God.

Stage I - *Horizonalization* Data Analysis:

Emerging Composite Horizons for Research Question One

The two verbatim interviews in transcript form above from a Critical Care Chaplain (CC) and a Surgical Chaplain are given in order for the reader to see the dynamic interchange of the dialogue between these pastoral care givers (i.e. chaplains) and myself, the Principle Investigator (PI). These two verbatim or long interviews were also given so that the reader could see the raw data from which the horizons and themes emerged. The long verbatims that are digitized will not be given in transcript form for the remainder of the data analysis but are a sufficient sample of the ten verbatim interviews to allow the reader the confidence that the following *horizonalization* analysis in **Steps I, II, and III** following each research question is grounded in the actual field interview data acquired The Christ Hospital (TCH).

The following 114 composite *horizonalization* markers emerged from the interviews for **Step I *horizonalization*** for **research question one**: (1) empathic inversion, (2) offering solace, (3) avoidance, (4) re-exposure, (5) taking another path, (6) intentionality, (7) felt experience, (8) lack of skills, (9) negative things of life, (10) suffering and helping, (11) lost of energy, (12) meaning of the experience, (13) being there for the Other, (14) being there for the Self, (15) embodiment of suffering, (16) guilt, (17) helplessness, (18) being present, (19) Presence of God, (20) coming alongside the Other . . . .

(21) fatigue and spiritual exhaustion (22) feeling the need to pray, (23) feeling the need to walk toward the suffering situation, (24) feeling the need to walk away from the suffering situation, (25) listening to the Other in their suffering situation, (26) different perspectives on the phenomenon of suffering (i.e. patient vs. caregiver), (27) questions with spiritual connotations and implications, (28) main resonating question: Why God? Why me?, Why have I been chosen to suffer this way?, (29) brings forward the "Problem of Evil": Why do bad things happen to good people?, (30) emotions: anger toward God . .

(31) being able to reconnect spiritual with the Self, (32) spiritual process of healing, (33) suffering seen as in-depth/assault on the person, (34) how can a loving God allow suffering?, (35) brings up existential questions about existence, (36) suffering of others brings forward caregivers shared experience of similar suffering, (37) process of the caregivers shared experience of being angry toward God, (38) brings about empathic inversion because of shared experience, (39) learn that angry about the situation or toward God looked as spiritual "Next-of-Kin," (40) normalization of emotional feelings of anger: It's OK to be angry there is hope at the end of the process. . . .

(41) realization that God is not shaken up by human anger: does not mean God does not care that is why the caregiver is called by God *along-side* to help, (42) caregiver along-side reflecting with the person suffering, (43) caregiver experiencing with the one who is suffering, (44) reflexive experience of suffering, (45) experiencing their feelings, (46) guilt process of forgiveness, (47) inability to give oneself permission to be angry with God or the suffering situation, (48) ignore or avoid the spiritual conflict being angry would bring, (49) help the one suffering flush out their own experience with suffering, (50) appropriate spiritual assessment and conditions that permit it and those that don't;

(51) patient feeling they are on an island all by themselves, (52) feeling of isolation a part of normalization process leading to hope, (53) feeling of helplessness to help the one who is suffering, (55) caregiver's doubt of being able to help, (56) remembering CPE acquired skills after initial doubt, (57) giving solace in the midst of suffering, (58) walking through suffering with others, (59) helping others to make meaning out of the suffering situation, (60) walking with others who are suffering depletes caregivers energies . . .

(61) can change your positive perspective and all you see are negative things of life, (62) recognition by the empathic care-giver that the suffering is not their reality but the patients, (63) Empathic caregiver not responsible: must learn to live it there, (64) must learn to just leave it there, (65) defense of your own spirit and feeling guilty for doing so, (66) exhaustion zone a dangerous place for the caregiver, (67) feelings of paranoia, (68) prayer is a helpful response to the negativity and exhaustion, (69) overcoming spiritual impediments outside the Self, (70) whispered prayer to God for insight into the situation . . . .

(71) time is needed to help caregiver learn to deal with suffering, (72) for beginning chaplain dealing with suffering may be difficult, (73) hard to walk out the door where you see suffering, (74) suffering can consume your thoughts, (75) over years not as frightened to see suffering but still touched by it, (76) still some suffering situations are disturbing no matter how long you have been a caregiver, (77) it is possible to be hardened to suffering of others, (78) it is difficult to balance being sensitive and being hardened to suffering, (79) critical to understand your role as chaplain, (80) have to learn to process suffering situation you have seen, (81) there are different ways suffering is experienced, (82) need perspective on "care" for the "caregiver," (83) hard to balance

protecting oneself while helping others who are suffering, (84) must have a sense of caring for the patient as well as yourself, (85) caring is a double-edge sword, (86) caring subjects one to "Compassionate Fatigue," that is, give, give and give some more, (87) care giving drains the care giver, (88) cannot allow suffering situation stay pent up inside, (89) some suffering situation are deeply emotional, (90) feeling of not wanting to go through another suffering situation . . . .

(91) prayer as the key to knowing you are called and enabled by God to do this work of caring for those who are suffering, (92) suffering as vulnerability, (93) lost of control, (94) lost of physical, emotional, and psychological health, (95) suffering is very real, (96) meeting people where there are in their suffering, (97) called to represent the presence of God to those suffering, (98) presence is a representation of hope, (99) representation of hope that replaces deep fears, (100) feel times chaplaincy is a very helpless role, (101) feeling of inadequacy despite CPE training, (102) feel like I am searching trying to fill in the gap, (103) trying to be there for the one who is suffering, (104) trying to meet spiritual needs of the patient who is suffering, (105) being there to listen, observe, and be discerning, (106) trying to connect to the Other, (107) not trying to say I feel the pain, (108) try to identify where the one who is suffering is coming from, (109) recognize how important this suffering situation is to the one who is suffering, (110) however, setting the boundary for myself and not joining with them in that suffering, (111) not taking on their pain or fear [e. g empathic inversion], (112) I am not God, (113) I am God's representative, (114) I am not capable of being God, but am capable or representing God in human suffering situations.

Stage II - *Horizonalization* Data Analysis:
Clustering the Horizons into Themes for Research Question One

There were 114 horizons that are organized into six thematic clusters: (1) General and Functional Aspects of Caring for Someone Who is Suffering; (2) Empathic Inversion: Paradoxical Feeling to Care For but Defend the Empathic Caregiver; (3) Emotional/Psychic Issues for the Pastoral Care Giver; (4) Spiritual Dimensions of Pastoral Caregiving; (5) Spiritual Presence of Chaplain with the One Who is Suffering; and (6) Reflective/Reflexive Praxis of the Pastoral Care Giver, as follows:

1. General and Functional Aspects of Caring for Someone Who is Suffering
    a) Offering solace to the patient who is suffering
    b) Intentionality: "My existence and the Other's existence are copresent and intentional communion" vs. "my own intentional consciousness" (Moustakas, 1994, p. 37)
    c) *Being there* for the Other in axiomatic Heidegger's (1953) concept of "Two beings which are objectively present within the world and are, moreover, *worldless* in themselves, can never "touch" each other, neither can *"be" "together with"* the other" (p. 52), unless they become part of the Other's *life-world* and share their *lived-experience*.
    d) Embodiment of suffering
    e) meeting people where they are in their suffering
    f) called to represent the presence of God to those suffering
    g) presence is a representation of hope
    h) Being present with the one who is suffering

i) Presence of God in the situation of human suffering

j) representation of hope that replaces deep fears

k) Coming alongside the Other

l) Feeling the need to walk toward the suffering situation

m) Listening to the Other in their suffering situation is part of being present

n) Suffering of others brings forward caregivers shared experience of the same

o) Process of the caregivers shared experience of being angry toward God

p) Brings about empathic inversion because of shared experience

q) Caregiver along-side reflecting with the person suffering

r) Caregiver experiencing with the one who is suffering

s) Experiencing the Other's feelings in suffering

t) Help the one suffering flush out their own experience with suffering

u) Finding appropriate spiritual assessment conditions of healing

v) Giving solace in the midst of suffering

w) Walking through suffering with others

x) Helping others to make meaning out of the suffering situation

2. *Empathic Inversion*: Paradoxical Feeling to Care For but Defend the Empathic Caregiver

a) Avoidance of suffering situations

b) Fear of re-exposure to suffering situations

c) Taking another path rather than deal with suffering situation

d) Being there for the Self

e) Feeling the need to walk away from the suffering situation

f) Caregivers shared experience of similar suffering

g) Brings about empathic inversion because of shared experience

h) Experiencing their feelings but there are different ways suffering is experienced

i) Need perspective on “care” for the “caregiver,”

j) Hard to balance protecting oneself while helping others who are suffering

k) Must have a sense of caring for the patient as well as yourself

l) Caring for others is a double-edge sword

m) Feeling of not wanting to go through another suffering situation

n) Not saying I feel the pain

o) Try to identify where the one who is suffering is coming from

p) Recognize how important this suffering situation is to the one who is suffering

q) Setting the boundary for myself and not joining with them in that suffering

r) Not taking on their pain or fear [e. g empathic inversion]

s) I am not God. I am only God’s representative

t) I am not capable of being God, but capable of representing God in suffering

u) Need to set the boundary for myself and not joining with them in that suffering,

3. Emotional/Psychic Issues for the Pastoral Care Giver

a) Felt experience of human suffering

b) Lack of confidence in CPE acquired skills to deal with suffering

c) Beginning to see negative things of life when dealing with suffering all the time

d) Tension between dealing with suffering and helping alleviate it

e) Losing the necessary energy to deal with suffering

f) Feeling of guilt in dealing with suffering and not wanting to deal with it

g) Feeling inadequate and helplessness despite CPE training

h) Feeling fatigue and emotional exhaustion

i) Shared feeling with patient who feel they are on an island all by themselves

j) Shared feeling of isolation a part of normalization process leading to hope

k) Pastoral caregiver's doubt of being able to help spiritually or otherwise

l) Remembering CPE acquired skills after initial doubt

m) Walking with others who are suffering depletes caregivers energies

n) Can change your positive perspective on life

o) Recognition by care-giver that suffering is not their reality but the patients

p) Empathic caregiver not responsible: must learn to live it there

q) Must learn to just leave it there

r) Defense of your own spirit and feeling guilt for doing so

s) Exhaustion zone a dangerous place for the caregiver

t) Feelings of paranoia

u) Feel at times chaplaincy is a very helpless role

v) Feeling of inadequacy despite CPE training,

4. Spiritual Dimensions of Pastoral Care Giving

a) Meaning of the experience

b) Being spiritual present for the Other

c) Feeling the Presence of God in the suffering situation

d) Fatigue and spiritual exhaustion

e) Feeling the need to pray

f) Knowing there are different spiritual perspectives on the phenomenon of suffering

g) Questions with spiritual connotations and implications

h) Main resonating question: Why God? Why me?, Why have I been chosen to suffer
i) Brings forward the "Problem of Evil": Why do bad things happen to good people
j) Emotions: anger toward God
k) Being able to reconnect spiritual with the Self
l) Spiritual process of healing
m) Suffering seen as in-depth/assault on the person
n) How can a loving God allow suffering?
o) Brings up existential questions about existence
p) Process of the caregivers shared experience of being angry toward God
q) Accept anger about situation. See God as spiritual "Next-of-Kin,"
r) Normalization of emotional feelings of anger
s) Learning it's OK to be angry and there is hope at the end of the process
t) Realization that God is not shaken up by human anger
u) Does not mean God does not care/why the caregiver is called by God *along-side*
v) Going through the guilt process of forgiveness
w) inability to give oneself permission to be angry with God or the suffering situation
x) Can try to ignore or avoid the spiritual conflict
y) Appropriate spiritual assessment and conditions that permit it and those that don't
z) Prayer is a helpful response to negativity/overcoming outside spiritual impediments

5. Spiritual Presence of Chaplain with the One Who is Suffering
    a) Feel like I am searching trying to fill in the gap

b) Trying to be there for the one who is suffering

c) Trying to meet spiritual needs of the patient who is suffering

d) Being there to listen, observe, and be discerning

e) Trying to connect to the Other

f) Not trying to say I feel the pain

g) Try to identify where the one who is suffering is coming from, (109) recognize how important this suffering situation is to the one who is suffering,

6. Reflective/Reflexive Praxis of the Pastoral Care Giver

a) Meaning of the experience of suffering

b) Remembering CPE acquired skills that help in dealing with suffering

c) Suffering can consume your thoughts

d) Reflexive experience of suffering

e) Experiencing their feelings

f) Making meaning out of suffering

Stage III – Horizonalization Data Analysis:

Horizons/Themes into Coherent Textual Descriptions Research Question One

From the interviews with chaplains at The Christ Hospital (TCH) this researcher was able to organize the one hundred and seven (107) of the one hundred and fourteen (114) *horizonalization* markers as shown above from interviews with chaplains at The Christ Hospital (TCH) into six clusters of themes on how pastoral care givers experience the phenomenon of human suffering within The Christ Hospital acute care organizational setting as follows: **(1)** General and Functional Aspects of Caring for Someone who is Suffering with a cluster of 24 horizonal markers; **(2)** Empathic Inversion: Paradoxical

Feeling to Care For but Defend the Empathic Caregiver with a cluster of 21 horizonal markers; **(3)** Emotional/Psychic Issues for the Pastoral Caregiver with a cluster of 22 horizonal markers; **(4)** Spiritual Dimensions of Pastoral Care giving with a cluster of 26 horizonal markers; (**5)** Spiritual Presence of Chaplains with the One who is Suffering with a cluster of 8 horizonal markers; and (6) Reflective/Reflexive Praxis of the Pastoral Caregiver with cluster of 6 horizonal markers. These numbers are associated with these thematic horizontal markers of meaning to show their relative importance and meaning to the chaplains that were interviewed. It is apparent that the chaplains interviewed were overwhelmingly concerned about the spiritual dimensions of clinical pastoral care followed by aspects of general and functional aspects of daily clinical praxis along with emotional and psychic stresses of chaplaincy.

Very revealing was the relative unimportance or emphasis put on reflective/reflexive praxis. I had suspected that this was the case based on my year-long observations of chaplains in the pastoral clinical at The Christ Hospital Pastoral Care Department. What I did not know at the time was why. I now know that the verbatim interview with patients is the center piece in CPE clinical and didactic training, which requires doing both reflective and reflexive thinking as an essential educational activity. However once CPE students complete Level I and Level II training they go into professional chaplaincy seeking ACPE certification and the didactic instrument that got them there is thought to be no longer useful.

This dissertation pointed out earlier that this is a mistaken idea and that Russell L. Dicks one of the pioneers of CPE designed the verbatim for use in the general hospital in 1933 and intended it not only for didactic and clinical CPE training but as educational

tool for reflective/reflexive practice throughout ones chaplaincy career. Not only that but he meant for it to be a valuable research tool stating that the verbatim "is a new creation of ideas which reveals lacks in what we have done. It is a fresh application of ideals to criticize what was done. It traces out the implication of what we have seen and heard. . . . It is self-criticism. It is self-evaluation. It is preparation for self-improvement." (Hall, 1992, p. 23). Once this education and professional tool that was designed by Dicks to improve clinical pastoral praxis and advance CPE reflective/reflexive horizons of understanding is merely seen as a didactic instrument for formal CPE education alone then it is understandable why reflective/reflexive praxis appears to be of little importance in the daily routine of chaplaincy and clinical pastoral care. As I have already explained this is where a phenomenology of suffering will make important contribution to Clinical Pastoral Education as a human science discipline.

A phenomenology of suffering will encourage the use of Phenomenological Reduction that uses the *horizonalization* to examine thematic clusters of meaning within long verbatim interviews that allow either the CPE educator/researcher or clinical practitioner to gain reflective/reflexive insights into clinical praxis and so new horizons of understanding that an advance the CPE project of caring for and curing souls, that is, assessing spiritual needs to alleviate spiritual suffering.

What is most interesting is the emergence of the unexpected theme of *empathetic inversion* and the number of *horizonal markers* associated with this phenomenon in their life-world and lived experience. This was an unanticipated discovery and I could not make any sense out of the apparent aversion that nearly all of the chaplains interviewed had with entering into the *life-world* and *lived-experience* of their patients except in very

controlled conditions. Pondering the question this researcher was finally able to give a name to this perplexing phenomenon where the professional life of the chaplain seems to call them toward the life-world of a patient and at least temporarily enter into the *lived-experience* of the person suffering. The question was this: How can they assess spiritual needs and deal with a person's spiritual suffering without entering into as fully as is possible that person's *life-world* and *lived-experience of suffering*? This researcher explored all kinds of understandings in order to answer this question including the notion from several researchers that "knowing is not purely cognitive act" but rather "love is foundational for all knowing of human existence", where according to Van Manen (1990) "We can only understand something or someone for whom we care" (p. 6). Based on this understanding this researcher found the interview statements and discussion on this topic both disturbing and paradoxical.

One interviewee described it not as just an attitude but as part of his clinical theology. Chaplain CC (2012) said: "But understanding that this is not mine. It is their suffering. It is their journey. I have come in. . . . It's a part of my theology of pastoral care. It's an Emmaus Road Theology, where I come along side for just a short period of time, then I go away. And when I go away this is their journey, this . . . I am not responsible." (Chaplain CC, 2012, digital paragraph 047). I began to think then that on one level this is all one can do for the other is to "come along side" or as Heidegger (1953) said "be" "together with" which cannot be done without entering into the life-world of the other to the fullest extent possible (p. 52). Without the other Heidegger (1953) states that two being are only objectively present if they are in the same world and

that without this manifestation of objective presence both by them remain "worldless" (p. 52).

This researcher discovered an introspective notation he had made thinking about this paradoxical phenomenon and mused over the word *empathetic.* This researcher wanted to know what an *empathic person* was. This is what these chaplains were trying to say to me but empathy did not quite explain the aversion most them had to immersing themselves into the life-world and lived-experience of patients who were suffering in order to advance the CPE project they all claimed was their spiritual calling.

An empathic person is one who takes on the malady of another person as if it was their own, whether it is physical or spiritual in nature. But this researcher discovered that after awhile they develop an aversion to dealing with another person's malady or illness so closely, especially if it is for any long duration and so an empathic will seek safety and avoid and/or go to great lengths to avoid the situation. This feeling appears to be related to the concept of *empathetic inversion*, which is the tension between extending sympathy and care toward the patient and at the same time extending sympathy to the Self or empathic imperfect care giver (i.e. would be healer of the soul).

Research Question Two

How does life-world and lived experience inform your clinical practice, education, and research within the context of this human science discipline?

Stage I - Horizonalization Data Analysis:

Emerging Composite Horizons for Research Question Two

The following horizonalizational markers emerged from the interviews for research question two: (1) lived-experience of Clinical Pastoral Education very valuable,

(2) both didactic work and clinical work were incorporated in CPE training, (3) able to use didactic teaching in CPE and apply it to clinical practice of chaplaincy, (4) chaplaincy work now has a close tie to CPE educational experience then, (5) Both experiences of didactic and clinical experiences has informed life-world and lived experience of chaplains, (6) In practice however one of these experiences speaks louder than the other depending on the situation, (7) whether teaching CPE students or helping patients it is made clear that practical experience and life experience is coming from the opinion of one person that has lived it, (8) Sometimes life experiences as chaplain contradict and supersede CPE theoretical education and training, (9) lived-experience can transform and enhance theoretical understanding, (10) Lived-experience breaks down tunnel vision and changes parameters of understanding (i.e. new horizons of understanding);

(11) Lived-experience is viewed as more authentic than theoretical understanding or experience even though you need both, (12) Live-experience expands the realm of your perspectives on situations and phenomenon, (13) Cognitive theory that concentrates on thoughts and experiential theory that concentrates on live-experience should not be validated one over the other, (14) All of these experiences should be incorporated together in order to find meaning, (15) the CPE clinical model is “Action, Reflection, New Action” and still serves as a professional chaplaincy model used daily, (16) A new action is brought forth after a reflection on an old action, (17) the CPE focus is experiential based on the above pastoral clinical model, (18) Reflection is central and definitely not tangential, (19) Reflection becomes reflexive, (20) there is a swing hermeneutic process between theoretical experience and lived-experience or experiential

knowledge based on the phenomenon experienced, (21) CPE education is more oriented toward clinical practice than theory in the classroom, (22) didactic studies after you become a professional chaplain are not prominent but attending lecture and seminars related to specific healthcare issues is still important to attend, (23) Experiential learning through contact with medical staff, nurses and surgeons is very important in expanding knowledge in the role of chaplain, (24) Each CPE center has its own flavor and even though it is governed by ACPE standards each CPE supervisor designs the CPE curriculum to fit the needs of a unique pastoral department and to fit the needs of the HCO.

Stage II - *Horizonalization* Data Analysis:

Clustering the Horizons into Themes for Research Question Two

1. Value of Clinical Pastoral Education
    a) Lived-experience of Clinical Pastoral Education very valuable
    b) Both didactic work and clinical work were incorporated in CPE training
    c) Able to use didactic teaching in CPE and apply it to clinical practice of chaplaincy
    d) Chaplaincy work now has a close tie to CPE educational experience then
    e) CPE clinical model is “Action, Reflection, New Action” and still serves as a professional chaplaincy model used daily
    f) A new action is brought forth after a reflection on an old action
    g) Didactic studies after you become a professional chaplain are not prominent but attending lecture and seminars related to specific healthcare issues is still important to attend

h) Experiential learning through contact with medical staff, nurses and surgeons is very important in expanding knowledge in the role of chaplain

i) Each CPE center has its own flavor and even though it is governed by ACPE standards each CPE supervisor designs the CPE curriculum to fit the needs of a unique pastoral department and to fit the needs of the HCO

2. Clinical Pastoral Education and Lived-Experience

a) Both experiences of didactic and clinical experiences have informed life-world and lived experience of chaplains

b) In practice however one of these experiences speaks louder than the other depending on the situation

c) Whether teaching CPE students or helping patients it is made clear that practical experience and life experience is coming from the opinion of one person who has lived it

d) Live-experience breaks down tunnel vision and changes parameters of understanding (i.e. new horizons of understanding)

e) Lived-experience is viewed as more authentic than theoretical understanding or experience even though you need both

f) Live-experience expands the realm of your perspectives on situations and phenomenon,

3. CPE and *Swing Hermeneutic Process*: Theory vs. Praxis

a) Sometimes life experiences as chaplain contradicts and supersedes CPE theoretical education and training.

b) Lived-experience can transform and enhance theoretical understanding.

c) Cognitive theory that concentrates on thoughts and experiential theory that concentrates on live-experience should not be validated one over the other.

d) All of these experiences should be incorporated together in order to find meaning.

e) CPE clinical model is "Action, Reflection, New Action" and still serves as a professional chaplaincy model used daily.

f) A new action is brought forth after a reflection on an old action.

g) CPE focus is experiential based on the above pastoral clinical model.

h) There is a swing hermeneutic process between theoretical experience and lived-experience or experiential knowledge based on the phenomenon experienced.

i) CPE education is more oriented toward clinical practice than theory in the classroom.

4. CPE Clinical Model: Reflection/Reflective Action

a) Reflection is central and definitely not tangential

b) Reflection becomes reflexive

Stage III – *Horizonalization* Data Analysis:

Organization of Horizons into Thematic Descriptions/Research Question Two

Four thematic *horizonalizonal* clusters emerged from the interviews on research question two with 22 horizon markers. The four themes are: (1) Value of Clinical Pastoral Education, (2) Clinical Pastoral Education and Lived-Experience (Relationship between them), (3) Swing Hermeneutic Process: Theory vs. Praxis, and (4) Reflective/Reflexive Praxis. Again reflective/reflexive praxis ends up in minority of thematic clusters with only two horizon markers and I have already explained above what I believe the reasons are for this and the cure.

There emerged 8 horizon markers for the thematic cluster value of clinical pastoral education to chaplains, and 9 horizon markers for theory vs. clinical praxis. The theme cluster Clinical Pastoral Education and lived-experience claimed 4 horizon markers. It seems clear that Clinical Pastoral Education has significant meaning for the chaplains interviewed and that they have definite ideas about role that theory and experiential learning (clinical praxis) has for their education and professional chaplaincy practice.

This researcher finds it very instructive the surgical chaplain's view in respect to how CPE centers are organized in respect to their curriculum as they relate to ACPE educational standards for certification. Chaplain SC (2012) states: "Each CPE center has somewhat of its own flavor." (Chaplain SC, 2012, Memo-P4-110107). What he is referring to is the near independent way CPE supervisors are able to design curriculums as long as they adhere to the basic educational standards laid out by the Association of Clinical Pastoral Education (ACPE). Its "own flavor" seems to mean the education one received will be based in part on the way the CPE educator sees and understands clinical and didactic processes so that the education process takes on the "flavor" or let us say the educational philosophy of the CPE supervisor. If a new supervisor comes on the scene then the educational philosophy in the CPE center could radically change.

In addition to that the curriculum is built around the student's perceived needs and goals, even though the Supervisor will include core material that must be learned and addressed in both the clinical and didactic seminar settings. There is no standard curriculum per se and much of the Pastoral Care libraries are filled with studies from allied human science fields and studies done that are not prepared or done by pastoral

clinical practitioners. This dissertation claims that it is their educational experiences that ought to inform the CPE curriculum designs and CPE literature, but that experience is for the most part not captured in every day setting as Russell Dicks (one of the founders of CPE) proposes. Russell Dicks introduced the verbatim interview in 1933 to advance this educational research purpose.

Pastoral clinical practice should be captured in the quarterly journals by those pastoral care professionals that have moved into practice from Level I and Level II CPE. However within the CPE curriculum as the surgical chaplain in my interview affirmed the emphasis is more on clinical aspects of praxis rather than theoretical knowledge.

As far as transcendental phenomenology is concern I have taken the "final step in the phenomenological research process" being "the intuitive integration of the fundamental textual and structural descriptions into a unified statement of the essences of the experience of the phenomenon as a whole" (Moustakas, 1994, p. 100). Nevertheless, This dissertation proposal for constructing a *phenomenon of suffering* looks dim when you consider the current CPE emphasis on experiential learning over that of theoretical learning. It is certain that a phenomenological focus that incorporates a swing hermeneutic between these two poles of learning is needed in CPE. This dissertation wants to say that the experiences that are lost should be the basis of reflective/reflexive theoretical learning that leads to an informed and enhanced CPE education that is capable of advancing the CPE historical project of *caring for* and *curing souls*.

However, some hope yet exists for dialogical conversations to open up on my proposal with *hermeneutical phenomenology* as understood by Van Manen (1990), which is more *open ended* and less encumbered with methodology than the methodological

approach of Moustakas (1994) Of course this is not to devalue the contributions of Moustakas (1994) in the least since his phenomenological methodology has revealed some serious deficiencies in the CPE clinical and didactic model of education as I already have shown but will again revisit in Chapter 5 summarizing my research findings.

Hermeneutical Phenomenological Research Methods

Applied to the Similarly Situated Human Textual Documents

This researcher stated earlier that he does not feel that Moustakas's (1994) *Phenomenological Reduction* is applicable to all kinds of gathered data from qualitative sources and this dissertation already showed that Moustakas (1994) agrees that this is the case. Moustakas (1994) admits that the "essences of any experience are never totally exhausted. The fundamental textual-structural synthesis represents the essences at a particular time and place from the vantage point of an individual researcher following an exhaustive imaginative and reflective study of the phenomenon." (Moustakas, 1994, p. 100). Further Moustakas (1994) states: "Despite practice, some entities are simply not "bracketable" (i.e. subject to *Phenomenological Reduction*). (Moustakas, 1994, p. 90).

That being said, this researcher thinks it would be good idea to look at Van Manen's (1990) hermeneutic methodologies from selected similar situated human textual sources in order to deepen the research and see if a similar cluster of meanings emerge from these sources as they have from my interviews from participants interviewed at The Christ Hospital. Van Manen (1990) includes in hermeneutic phenomenology as extraordinarily rich array of data sources that may be researched in order to obtain descriptions of meaning or phenomenological experiences, and his approach is more intuitive and less methodological but no less grounded in theoretical foundations of both

philosophy (Husserl and Gadamer) and educational pedagogy guided by hermeneutical phenomenological methods and assumptions.

Van Manen (1990) states: "What first of all characterizes phenomenological research is that it always begins in the lifeworld" (p. 7) is willing to go beyond the *long interview* or *verbatim* to gather data, because the *life-world* in *hermeneutic phenomenology* goes beyond the phenomenological experience of *just things* in the world, but includes a subconscious *life-world* of *conceptualizations, perceptions,* and *symbols* that while unseen are nevertheless just as real to the human person that experiences them. So these kinds of experiences cannot be counted as *things* as a more empirical methodological approach would be inclined to do and even demand. Van Manen (1990) states that data gathered to investigate *lived-experience* in phenomenological research can come from a variety of sources, including:

(1) Etymological sources that trace the origin and meaning of "Words that once could reverberate with lived meaning and reveal a living world now have become lame, limp, mute, emptied, and forgetful of their past power . . . . words such as "earth" or "water," "happiness" or "hope". . . . (P. 58).

(2) Sources of meaning that contain idiomatic phrases because they "largely proceed phenomenologically: they are born out of lived experience. For example, we say, 'every child needs a home.' In the concept of home or dwelling, there is strong sense of watching over something, preserving a space in which the human being can feel sheltered, protected, and what is thus preserved in the idea of a house. . . is safekeeping, holding, or bearing of something that needs to be watcher over. This caring modality . . . is something primordial which defies literal language and precise definition." (Van

Manen, 1990, pp. 60-61). Van Manen's (1990) thinks that such idiomatic phrases are*primordial* and this notion is similar to Husserl's (1999) description of the *life-world* and the *lived-experience* as *pregiven*, and therefore idiomatic phrases are assumed to just be objectively there as a descriptor of the phenomenon that people experience. They are not the phenomenon itself but without them being there nothing would be available to the person to describe the meaning of it to himself or herself or another person.

Husserl (1999) in his essay "Elements of a Science of the Life-World" states: "If we have made this clear to ourselves, then obviously an explicit elucidation of the objective validity and of the whole task of science requires that we first inquire back into the pregiven world. It is pregiven to us all quite naturally, as persons within the horizon of our fellow men, i.e. in every actual connection with others, as 'the' world common to us all." (Husserl, 1999, p. 363). Van Manen (1990), therefore, regards "Ordinary language" as a "huge reservoir in which the incredible variety of richness of human experience is deposited," however, "The problem often is that these deposits have silted, crusted, or fossilized in such a way that the original contact with our primordial experiences is broken." (p. 61).

This is why phenomenological thematic meanings are so rich and cannot be exhausted because the meaning behind the primordial phrases that carry the meaning change over time and with each new phenomenological experience. That is why Moustakas (1994) is not willing to say that that the researcher has uncovered as meaning today will be the same tomorrow, and so again "essences of any experience are never totally exhausted. The fundamental textual-structural synthesis represents the essences at a particular time and place from the vantage point of an individual researcher following

an exhaustive imaginative and reflective study of the phenomenon." (Moustakas, 1994, p. 100); (3) Van Manen (1990) also uses protocol writing where individuals are not interviewed but ask to write down descriptions of their lived experience of the phenomenon under consideration, including; (4) Interviewing the personal life story of the subject of the research (p. 63).

Literally for Van Manen (1990) any textually based source has a vast array of meaning and richness that may be explored over and over again. Van Manen (1990) states: "The problem of phenomenology inquiry is not always that we know too little about the phenomenon we wish to investigate, but that we know too much" (p. 47). This is one reason he does not agree with the notion of *bracketing* in Phenomenological Reduction and so states:

> How do we best suspend or bracket these beliefs? Husserl, who was at first a mathematician, used the term "bracketing" to describe how one must take hold of the phenomenon and then place outside of it one's knowledge about the phenomenon (1970b, pp. 33-42). But how does one put out of play everything one knows about an experience that one has selected for study? If we simply try to forget or ignore what we already "know," we find that the presumptions persistently creep back into our reflections. It is better to make explicit our understandings, beliefs, biases, assumptions, presuppositions, and theories. (Van Manen, 1990, p. 47).

Van Manen (1990) therefore takes an open ended approach to research inquiry he calls the human science of *lived-experience* or *hermeneutic phenomenology*. This is a research approach without a methodology, which is textually based and so allows a rich

array of interpretative meaning or new horizons of understanding to emerge from these kinds of sources. In this regard Van Manen (1990) states:

> Lived experience is the starting point and end point of phenomenological research. The aim of phenomenology is to transform lived experience into a textual expression of its essence---in such a way that the effect of the text is at once a reflexive re-living and a reflective appropriation of something meaningful: a notion by which a reader is powerfully animated in his or own lived experience. (Van Manen, 1990, p. 36).

This understanding by Van Manen (1990) means that I can open-ended examine of meaning of *lived-experience* of pastoral clinical practitioners (i.e. chaplains) focused on their experience of the *phenomenon of suffering* that have been captured in verbatims or other *textual based sources*. For Van Manen (1990): "Lived experiences gather hermeneutic significance as we (reflectively) gather them by giving memory to them" (p. 37). In this "reflective act" is embedded in consciousness and in consciousness phenomenological experience takes shape and form. However words are used to give expression to the experience and those that are written down may be researched for meaning without applying to restricted approach like Phenomenological Reduction that brackets the phenomenon without out consideration of related clusters of meaning.

According to Van Manen (1990) then, *Phenomenological Reduction* and *horizonalization* are not necessary and may even side-track this research project because "We try to come to terms with our assumptions, not in order to forget them again, but rather to hold them deliberately at bay and even to turn this knowledge against itself, as it were, thereby exposing its shallow or concealing character" (p. 47). All you need is the

textually based source to discover the array of possible meanings that related to any particular phenomenon such as suffering and what it means either to the one suffering or the one caring for the one suffering such as chaplains, but Van Manen is not just talking about scholar books and research journals, but *human persons as texts* whose experiences of phenomenon may be explored form an array of research sources With this understanding Van Manen (1990) states:

> In one sense the notion of textuality becomes a fruitfully metaphoric device for analyzing meaning. If all experience is like a text then we need to examine how these texts are socially constructed. Interpretation that aims at explication the various meanings embedded in a text may then take the form of socially analyzing or deconstructing the text and this exploding its meanings. We must not forget, however, that human actions and experiences are precisely that: actions and experiences. To reduce the world to text and to treat all experience textually is to be forgetful of the metaphoric origin of one's methodology. (Van Manen, 1990, p. 39)

Certainly this is a caution to CPE proposals that would reduce its education praxis to mere didactic study based on theoretical considerations and methodologies such as *Phenomenological Reduction* that might actually conceal meaning rather than allow meaning to emerge from lived-experience. If CPE did this then it too would forget that it began with a human science project governed by *head and heart* as it was constructing its clinical theology, so and held to the notion that the people it was *caring for* were considered *living human documents*. (Hall, 1992, p. 12).

This will allow this researcher to analyze *a similarly situated source* using Van Manen's (1990) open ended understanding of *hermeneutic phenomenology*, that is, textually based sources that describe chaplains dealing with the phenomenon of suffering. I will do this while keeping in mind that behind the textual source is a human being, that is, chaplains, who are dealing with the *phenomenon of suffering* and what meaning this *lived-experience* has for them. One source to illustrate Van Manen's hermeneutical phenomenological "method" is all that is necessary, because this researcher will be able to bring out the essential thematic clusters of meaning that point to my findings for Clinical Pastoral Education.

In her article "When a Chaplain Needs a Chaplain" Denise Giacomozzi May (2008) writes about her experience dealing with her father's suffering and the last two weeks of his life and how that experience of suffering affected her and what it meant for her. May (2008) states:

> As his condition worsened, I called my husband, Jan, from the hospital lobby. I was worried that my father would die any time and I did not know what to do. Jan, using his typical low-key human and indirect style that comes naturally to him, said that he heard they have chaplains in hospitals. Perhaps it is inconceivable, but I had not even thought about seeking out a chaplain, even though I am a Board certified chaplain and have served many years in hospitals! (May, 2008, p. 391).

May (2008) almost immediately reveals the paradox of *empathetic inversion*, which this dissertation already discovered about chaplains in my verbatim interviews. May (2008) states: "The next day I went to check out the chaplain. I knew that,

depending on their personality and ministry style, there are some chaplains that I would not be able to bear to talk to about this most powerful or impending loss. I decided that I would just walk by the chaplain's office and see when his or her hours were." (p. 391).

It is apparent that May (2008) is inferring that some chaplains (as contradictory as that sounds considering their CPE project of *caring for* and *curing the soul*) do not relate well to ministering to people who are suffering these kinds of losses. Somehow they have a professional aversion to dealing with, in this case, end-of-life situations and therefore May (2008) finds herself cautiously approaching the pastoral care departments offices for assistance in her time of need. Fortunately, she met Chaplain Louise Kingston, who remarkably was suffering not only her physical pain, but also loss of some self esteem, status and position. May (2008) explains:

> Chaplain Louise Kingston was an appalling sight to behold. Her face was severely disfigured. She insisted that I come in and talk to her. I told her my story, including the fact that I was a chaplain myself. I said that I did not want to take up her time and kept asking if she really has time to talk. It was then she told me about her face. She had recently been in a terrible car accident. An older woman, she had stepped down from her full-time position as head of the pastoral department and had switched positions with the younger chaplain who had been part-time. They had discussed that morning, Louise's first day back after her accident, that it would be best if she remained in the office so as to not frighten the patients. Before I had dashed by she had been sitting at her desk wondering what use she was ever going to be that day. All of that explained her eagerness to help. (May, 2008, p. 391).

The *textual horizons* immediately jump from the page in respect to suffering of Chaplain Louise Kingston, such as, *"her face being horribly disfigured,"* being *"an older woman,"* the loss of status and position and having to *"step down from her full-time departmental position,"* and if that was not bad enough having to turn her position over to a "younger chaplain" who was part-time and apparently with no experience in running a full pastoral department. What a stroke of luck for this "younger chaplain" then adds insult to injury by suggesting very emphatically that Chaplain Kingston not leave the office because she might "frighten the patients" with the assumption that patients who are suffering would not understand someone else's suffering. It is very unlikely that Chaplain Kingston did not know the underlying reason for this "suggestion" that likely has something to do with not embarrassing the pastoral department.

A number of related themes emerge from this encounter: (1) *physical pain*, (2) *emotional pain*, (3) *loss of self-esteem*, (4) *humiliation*, (5) *lost of employment status*, (6) wondering about one's self-worth, and even so, (7) *desperately wanting to help someone else who is suffering.* There are at least four thematic clusters suggested by these horizons that have to do with suffering: (A) *Physical Suffering* (facial disfigurement); (B) *Emotional Suffering* (humiliation, self-esteem); (C) *Psychic Suffering* (desperation in wanting to help); and (D) *Spiritual Suffering* (wondering about self-worth). It turns out that Chaplain Kingston was a tremendous help despite her own suffering that is now shared in a revealing therapeutic way with Chaplain May, which reminds me of Heidegger's (1953) view that two beings must be "objectively present within the" same world in order to have *Da-Sein* (to be a *human being*) and without the other being face to

face in the same world being "together with" they are in and of themselves "worldless." (Heidegger, 1953, p. 52).

My face is not just *my face*. My made for me because I cannot see it with a mirror, so that my face must be made for the *Other* in order to *reflect* my own being through their reflexive actions/reactions; through their understanding, compassion, or love. In short the meaning of my life comes through the created meaning via other's Da-Sein (i.e. human beings) that I see in their face in a *swing hermeneutic process* of acquiring who I am and who they are, ever discovering new horizons of meaning. The *Other* then is the embodiment of my own being and that is how we perceive and conceive one the other through embodied consciousness we call superficially call communication. Something more dynamic is going on than the mere exchange of words between two Da-Sein that are not Da-Sein without the *Other*.

Merleau-Ponty's (1945) work *Phenomenology of Perception* points out that embodiment of acquired meaning is physical (as it must be), as well as psychic, emotional and spiritual, as well. Merleau-Ponty (1945) states:

> What matters is the manner in which they make use of their body, the simultaneous articulation of their body and their world in the emotion. The psycho-physical equipment leaves so many possibilities open, and here we see that—just as the domain of instincts—there is no human nature given once and for all. The use that a man makes of his body is transcendent with regard to that body as a mere biological being. It is no more natural and no less conventional to cry out in anger or to express love through the kiss than it is to call a table a "table." Just like words, passionate feelings and behaviors are invented. Even the

> ones that seem inscribed in the human body, such as paternity, are in fact institutions. It is impossible to superimpose upon man both a primary layer of behaviors that could be called "natural" and a constructed cultural or spiritual world. For man, everything is constructed and everything is natural, in the sense that there is no single word or behavior that does not owe something to mere biological being . . . . Already the mere presence of a living being transforms the physical world, makes "food" appear over here and a "hiding place" over there, and gives to "stimuli" a sense that they did not have. This is even more the case of the presence of a man in the animal world. (Merleau-Ponty, 1945, p. 195)

All of this points to something more dynamic and transcendent occurring between Chaplain Kingston and Chaplain May dealing with the phenomenon of suffering that they both are dealing with and through which both are trying to acquire meaning (i.e. what it all means) through being face to face with each the Other as they create for each the Other Da-Sein (i.e. human being), becoming for each the Other human documents through which meaning about the phenomenon of suffering may be read. Chaplain May coming *face to face* with Chaplain Kingston was able to look beyond (not past) her disfigurement to see who Chaplain Kingston really was and is (i.e. Da-Sein). Chaplain Kingston not merely came along side, she entered the life-world of Chaplain May's pain and suffering surrounding her father's end of life situation. According to May (2008):

> And help she did. She was truly the most wonderful chaplain. She did everything chaplains are trained to do. Not only was she compassionate, but she also helped me in very practical ways. One of those ways included something I had been agonizing over: how to handle my father's funeral. My father long since stopped

> practicing Catholicism, and my mother, outraged over the cover-up of pedophilia in the Church, had stopped attending Mass. Thus neither of my parents was known to any parish. Complicating matters more, my father was adamant that he did not want a funeral. He just wanted the family present: but he had not defined "family." Did he mean only my mother, daughter, and husband? Or did he mean also his siblings? Or did he mean our large extended family included people he did not want to see in life? My father did not want a viewing of his body: rather, he told me to have a memorial service a month after his death. While I tried to convince him how depressing it would be if just my mother, Jan, Kristen, and I were the only ones at the funeral, he would have none of the discussion. I know from my training that, for the family's sake, ideally a funeral or memorial service should be held within a month after the death. When I had tried to talk to him about how the funeral was sometimes for the living, I had not gotten anywhere. (May, 2008, pp. 391-392).

A number of *horizons of meaning* and questions suggest themselves here in Chaplain Mays predicament: (1) *What does family mean to her father?*: (2) *agony of decision*: (3) *How to honor her father's autonomy and last wishes and still care for the feelings of Others in the situation?*: (4) *How to reconcile her one clinical theology grounded in her faith that end-of-life situations are not just about the dying person but about the living, who are dealing with the phenomenon of both dying and grief*. Other questions are evident as well: (5) *Feeling of helplessness*, (6) *Doubt about CPE pastoral care training that has left the chaplain without an immediate solution in dealing with grief and death*; (7) *Finding the proper way to say good-bye for the last time;* and

perhaps (8) *"Why me?" "I'm just his daughter" "Why am I the only one responsible for figuring this out?"*

All of these questions for meaning this dissertation suggests are *necessary and natural* to the human person in order to arrive to *a place of hope* and *a new horizon of understanding* about our own being and the existential situations we find ourselves in when faced with extraordinary phenomenon of suffering. This kind of deep grief and suffering has in some Catholic faith traditions something do with the notion presented to me in my interview with the Eucharist Chaplain at the Christ Hospital, whom this researcher discovered is a Franciscan and entertains the idea (because of his faith tradition) that suffering ought to be accepted and/or endured and that one can have "Joy in our suffering" expressed by the Franciscan dictum: "Joyful Sorrow" (Eucharistic Chaplain, 2012 Digital voice tape, P11:110221_001.MP3).

However, this Catholic notion, which may have more to do with a theologically predetermined way of dealing with *empathic inversion*, often cannot bring one to come to hope or a new horizon of understanding alone. This undoubtedly is why Chaplain May needs Chaplain Kingston, whom she now calls "Chaplain Louise" who has is helping her transcend her *agony, pain, doubt, and grief*. For the moment (by herself) all Chaplain May can come up with was a solution that would interject more problems than those presented to her by her stubborn father facing his own mortality, perhaps because of his own anger with God, with the church, with his family, etc. His wife was at the same place spiritually and apparently they left the church behind for the same reasons. The phenomenon of death, questions about human mortality, grief and *ways to say good-bye*

for the final time only add to the human predicament of *being and nothingness*, which we will address in Chapter 5 of my findings.

May (2008) in trying to find a solution by herself to the problem presented by her father's attitude and last wishes states:

> When visits to see my parents had included a Sunday morning, my mother would accompany me, Jan, and Kristen to the service at the church in their retirement community. I had been thinking I could ask their minister if we could have a memorial service there, but I was quite concerned how the extended family, particularly my very religious aunt Pat, would feel. (After my wedding where my United Church of Christ pastor used the UCC marriage ceremony, Aunt Pat's response was, "What kind of a cult was that?" (May, 2008, p. 392).

However, *being together with* the *Other*, Chaplain Kingston, now referred to endearingly as "Chaplain Louise," suggested the following solution:

> Here Chaplain Louise guided me with extreme practical suggestions. Since my father was clear in his wishes that his remains be interred at a particular military cemetery, I could have the funeral director request a Catholic priest for the cemetery service and then ask the retirement church pastor to conduct the memorial service. It is hard to convey the weight that was lifted off my shoulders. Knowing that there was very little left for me to do to honor my father, I had been determined throughout this ordeal to make sure his wishes were carried out. Chaplain Louise enabled me to see that having a memorial service shortly after the private funeral, which would include only Aunt Pat and Uncle Leo, in addition

> to my mother, Jan, Kristen, and me, would honor the spirit of his wishes. (May, 2008, p. 392).

Seemingly Chaplain Louise has helped Chaplain May resolve her difficulty with a practical solution. But death, dying and grief is not that simple For Chaplain May (2008) a whole new horizon of understanding the situation has occurred and new meaning is given to replace the old perceived situation as hopeless: (1) *a new vision of hope has come*; (2) *a heavy weight has been lifted*, (3) *the ability to honor her father is made possible*, (4) *a way to respect the Catholic religious feelings and sensibilities of other family members*; and (5) *keeping faith with her own Protestant tradition is also respected*. These are the horizons that appear to resolve all of the issues that Chaplain May has to deal with. It seems like all is well. *But is it?* Death and dying often have deeper spiritual implications than is apparent to the eye, as is further observed in this story. Chaplain May (2008) goes on with her story:

> Chaplain Louise's pastoral care did not end there. She listened to not only what I said through my teas about the life-long conflicted relationship I had had with my father, but she also gently raised the notion that perhaps I might consider shedding these tears in my father's presence. It is part of our training as chaplains to learn about the loses and grief that not only family members go through surrounding their loved one's dying, but also those grief's that the person is dying is going through as well. While family members are losing one beloved person, the person who is dying is losing everyone and everything. And, despite my expertise, in my own grief I had lost sight of that truth until Chaplain Louise brought it to the forefront. It can be an exceedingly lonely experience to die. While I had at least

> been speaking openly with my father about his dying, I had not shed a tear in his presence. Louise wondered out loud if I had told him how much I would miss him. After an hour, Chaplain Louise ended our visit with a promise to stop by to see my father; I made it clear to her that my father did not want to see a priest. During one of the days I returned home, Louise did visit him. I learned from my mother that my father, in his typical no-holds barred fashion, had asked her what happened to her face—something I cannot imagine anyone else doing. I consider it an example of what others have called a "God-incident," as distinct from a co-incidence, to have met Chaplain Louise the way I did. My whole life has been replaced with such "God-incidences" and in the events surrounding my father's death, when I needed reassurances of our Creator's loving intervention in our lives, such God-incidences came on like a flood. (May, 2008, pp. 392-392).

It is apparent with the help of Chaplain Louise (i.e. the *Other* in the *Da-Sein* relationship that makes being human what it is and gives it meaning) Chaplain May was able to *reflexively reflect* theologically on the deeper meaning of her relationship with her father, and come to *new horizon of understanding* about her own faith about the care and love of God. This phenomenon of love that arises out of struggling with the phenomenon of suffering she now describes as *"God-incidents"* which holds more meaning than *natural occurrences* we ordinarily call co-incidences that do not need to acknowledge the presence of God in the suffering situation.

Merleau-Ponty (1945) has something to say about "naturalistic conceptions" that somehow trivializes meaning in a reductionist fashion so that spiritual implication or horizons of meaning are eliminated from consideration when such deep phenomenon

surrounding suffering is involved. For Merleau-Ponty (1945) something more significant is happening than mere expression of language to describe meaning of any particular phenomenon and remember as Van Manen (1990) has said that words are only expressions of phenomenological meaning; they are not the phenomenon itself, but *only its sign*, where meaning may change with every new experience, even of the same phenomenon. This is why Van-Manen (1990) regards phenomenology as a rich "method" for extracting meaning but he at the same time insists that this kind of research remain open-ended in order not to eliminate or mistakenly *bracket out* essential horizons.

In this regard to phenomenological research of meaning through words used by human documents, Van Manen (1990) states: "Indeed it has been said that *the method of phenomenology and hermeneutics is that there is no method!* (Gadamer, 1975; Rorty, 1979). (Van-Manen, 1990, pp. 29-30). Merleau-Ponty (1945) wants to go behind language to discover meaning, as well, and states:

> But as we have said the clarity of language is in fact established against an obscure background, and, if we push the research far enough, we find that language itself, in the end, says nothing other than itself, or that its sense is not separated from it. We must, then, seek the first hints of language in the emotional gesticulation by which man superimposes upon the given world the world according to man. This is completely different from the famous naturalistic conceptions that reduce the artificial sign to the natural sign and attempt to reduce language to the expression of the emotions. The artificial sign does not reduce to the natural sign because there are no natural signs for man. Nor do we compromise what is specific to language by bringing language and emotional

> expressions together, so long as it is true that the emotion, as a variation of our being in the world, is already contingent with regard to the mechanical resources contained in our body, and manifests the same powers of articulation stimuli and situations that are at their height in language. . . . It is not merely the gesture that is contingent with regard to bodily organization, it is the very manner of meeting the situation and of living it. (Merleau-Ponty, 1945, pp. 194-195).

Chaplain May (2008) went through some kind of embodiment of her experience with the death of her father. This was her victory over grief where she reconciled with the situation with her father. Her long-standing grief experienced in their relationship was finally given expression in the language sign "God-incident." This allow her to find deeper meaning in her experience of the phenomenon of death and grief.

For Chaplain May (2008) she found a positive why through use of signs to the phenomenon to deal with suffering without bowing to *empathetic inversion*. We have already explained this concept that allows one *paradoxically* to both participate in the suffering of the *Other* and yet find a way *in desperation* to escape and not actually face the situation with the *Other*. My interviews with chaplains at The Christ Hospital (TCH) revealed this phenomenon time and time again, and I believe it does not advance the CPE project of *caring for* and *curing souls*, especially using the CPE clinical model of "Action, Reflection, New Action" that more than one chaplain mentioned as one of the learning's from the CPE education.

It is apparent to me that when this model is coupled with the very human feeling of empathetic inversion it allows the chaplain to easily escape from being there with the one who is suffering in order to assess spiritual needs and determine the particular form

of spiritual suffering a person is going through. This likely was the approach coupled with feelings of empathetic inversion that Chaplain May (2008) was taking when Chaplain Louise suggested that she shed tears in the presence of her father, in other words that she not merely come along side her father as she had been trained to do in CPE but to be together with and take the risk joining with him in his dying process, recognizing that he was losing more than she or anyone else left behind was losing.

Of course this brings up questions about the meaning of death, grief and existentially the question of non-existence as an embodied being. We note that it is embodiment that gives meaning to experiences, according to Merleau-Ponty (1945). Embodiment gives more power to experiencing the phenomenon of death and while contemplating its reality. It also gives power to the phenomenon of grief in the lived-experience of the situation.

Phenomenological Reduction is capable of bracketing all but the essential aspects of it since *everything matters* when one is facing death, down to the idea: “I wish I had finished fixing up the house like I promised I would to my wife for years. Now I won’t be able to keep my promise.” This is not a trivial thought or concern to the dying but essential to their being that they are or should have been for the Other.

How essential is the thought of *non-being* or *non-existence*? For Jean-Paul Sartre the thoughts surrounding *non-being* are very essential indeed a necessary question that must be faced if the nature of being or being human is to be understood. We must face it. Sartre (1984) states:

> In order for negation to exist in the world and in order that we may consequently raise questions concerning Being, it is necessary that in some way Nothingness be

> given. We perceive then that Nothingness can be conceived neither *outside* being, nor as a complementary, abstract notion, nor as an infinite milieu where being is suspended. Nothingness must be given at the heart of Being, in order for us to be able to apprehend that particular type of realities which we have called *negatites*. . . . Hence the question which is put to us now with this particular urgency: if Nothingness can be conceived neither outside of Being, nor in terms of Being, and if on the other hand, since it is non-being, it can not derive from itself the necessary force to "nihilate itself," *where does Nothingness come from?* . . . . Nothingness "is made-to-be," Nothingness does not nihilate itself: . . . It follows therefore that there must exist a Being . . . of which the property is to nihilate Nothingness, to support it in its being, to sustain it perpetually in its very existence, *a being by which nothingness come to things*. (Sartre, 1984).

It is the *persistence* of these kinds of thoughts in the mind of humans that in fact give non-being or Nothingness its very life, but we have no way to expiate the anxiety and even grief that comes from it as it *comes to things*, that is, to us or others we love, and seem to be every present to threaten Being itself. Superficially, some people including chaplains have sought to expiate by feelings of empathetic inversion, but other more positive responses and attitudes toward death and grief have been suggested. Therese A. Rando (1984) has suggested the following positive outlook on death, dying and grief in her book *Grief, Dying, and Death: Clinical Interventions for Caregivers*. Rando (1984) states in Chapter 1, "Our Attitudes Towards Death":

> Throughout history, humanity has been concerned with mortality. Philosophy, religion, and science have all been employed in an attempt to understand and

> control death. However, death continues to be inevitable, and this knowledge determines much of how we look at life. Life as we know it is inconceivable without the tacit assumption that it must end. . . . The very fact that we are finite and have only limited time makes life all the more poignant and meaningful. If we were immortal there would be no reason for aspiring, hoping, striving and attempting to make meaning out of life; our experiences would pale in intensity if there were an endless supply of tomorrows with limitless opportunities Death affects our perceptions of life in many beneficial ways (Koestenbaum, 1976):

- It helps us savor life.
- It provides an opposite by which to judge being alive.
- It gives us a sense of a real, individual existence.
- It gives meaning to courage and integrity, allowing us to effectively express our convictions.
- It provides us with the strength to make major decisions.
- It reveals the importance of intimacy in our lives.
- It helps us ascribe meaning to our lives retrospectively, which is especially useful for older people.
- It shows us the importance of ego-transcending achievements
- It allows us to see our achievements as having significance.

However, according to Rando (1984) death also threatens us with the negation of ourselves and all that we value and so her cluster of positive meaning derived from experiencing the phenomenon of death begs the question raised by non-existence and so I contend this is one of the reasons people grieve and perhaps why pastoral clinical

practitioners attempt to avoid the question they are faced with everyday by some mechanism of escape that I have described as *empathetic inversion*. My interviews confirmed this feeling on their part and Worden (1984) has provided a strong hint as to the reasons and why grief training to make care-givers aware of their own feelings that make them less capable of helping the dying patient and grieving family. Worden states in the forward to Rando's (1984) book that:

> In 1974 Elisabeth Ross and I asked 6,000 health care providers if working with the dying presented any difficulties for them. Of the 98% who experienced difficulty, many said it was because the dying patient confronted them with their own mortality. I believe this same phenomena exists today. To develop skills in terminal illness care without addressing the issue of personal death awareness is to miss an important dimension, and Dr. Rando has recognized this. Therefore the book opens by addressing our society's attitude toward death and the issue of our own personal death awareness, which can make working with the dying and bereaved difficult. . . . She offers many practical suggestions for the caregiver who is working with both individuals and families. (Rando, 1984, p. vii).

With this last notion or understanding I believe I have demonstrated that both transcendental (Moustakas) and hermeneutical (Van Manen) phenomenology gave complementary value for deriving meaning from horizons associated with any particular phenomena. While this is true I prefer the open-ended phenomenological analysis of Van Manen (1990) that I believe offers a broader and more richer opportunity to derive clusters of thematic meanings than does Phenomenological Reduction data analysis of Moustakas (1994) that carries with it the possibility of closing the door to rich horizons

of meaning that his horizonalization methods may exclude (i.e. mistakenly bracket) or trivialize as being tangential. More importantly I think I have identified at least four deficiencies uncovered in CPE education and clinical praxis in my verbatim interviews that I believe a phenomenology of suffering would correct and so better help CPE advance its historical and traditional project of caring for and curing souls. I will describe these deficiencies and the proposed phenomenological solution these deficiencies in CPE education and clinical practice in my findings in Chapter 5 that follows.

CHAPTER 5 - FINDINGS

In this chapter this dissertation describes this researchers findings from the data analysis. This dissertation began with two basic questions that are summarize as follows: (1) This dissertation wanted to know how clinical pastoral care practitioners (i.e. chaplains) experience the phenomenon in hospital clinical organizations (HCOs)? and (2) since this was an higher education project this dissertation wanted to know how CPE education prepared these clinical pastoral care practitioners to deal with the phenomena of suffering that they encounter in hospital clinical organization in their day to day work?

However, now based on the findings from my interviews, which are supported by the findings in the literature review this dissertation can now reframe the research questions for further study as follows: *How do pastoral care practitioners experience the phenomenon of human suffering in its didactic and clinical forms within hospital acute care organizations?* From the primary research questions can be formulated for further study as follows:

1. How have you experienced human suffering in respect to your didactic training and clinical practice at your hospital acute care organization?
2. What situations and experiences with human suffering within the context of the hospital have affected your views on your CPE training, as it relates to your actual clinical practice?

What ethical and/or social justice experiences have you had in respect human suffering, and how has your didactic and clinical training in CPE prepared you for dealing with these situations in respect bio-ethical concerns about human autonomy

subject to heurist claims and demands over the human person in hospital clinical organizations?

Based on this researcher's year long internship at The Christ Hospital (TCH) Pastoral Department (2010/2011) where he did the same didactic and clinical work as the professional chaplains and also did countless hours of observation of their daily pastoral activities. This researcher, therefore, felt confident enough to make the claim that CPE needed a phenomenology of suffering in order to advance its long standing and traditional pastoral care project of *caring for* and *curing souls*. Earlier in This dissertation, I explained that this project refers to learning how to do spiritual needs assessment in order to provide intervention for spiritual suffering of patient in hospital clinical organizational settings.

What this dissertation has discovered are four primary CPE educational and learning deficiencies related to clinical praxis that hampers the CPE project described above and elsewhere in this dissertation. This dissertation holds that there is a solution for each CPE educational and/or learning deficiency if CPE would focus on a phenomenology of suffering and adopt phenomenological methods of acquiring the meaning of these experiences. This researcher discovered the following CPE educational and learning deficiencies in This dissertation research:

(1) The CPE learning model of *Action/Reflection/New Action* is impeded by the wide-spread phenomena of *empathetic inversion* that allows chaplains to use theological and methodological thought patterns to avoid taking actions or new actions that could lead understanding a patient's spiritual needs and providing workable interventions for specific varieties of spiritual suffering; (2) Both CPE clinical praxis and research that

could benefit CPE students and pastoral clinical professionals already doing the work of caring for and curing souls is impeded because CPE verbatim clinical praxis has been limited to Level I and Level II training only and its potential for improving daily clinical practice and as an educational research tool to advance knowledge about this human science discipline has been lost along with the knowledge that this was the original intent of the founders and pioneers of the CPE Movement; (3) Reflective/reflexive praxis while given lip service by CPE practitioners is no longer at the center of CPE's clinical theology or its learning and teaching focus, and (4) Spiritual needs assessment and providing interventions for spiritual suffering has been largely replaced by psychoanalytical counseling methods and techniques that are better suited for dealing with emotions and other psychic problems.

If this dissertation can show that these educational learning deficiencies are real and also demonstrate how a new educational focus on phenomenology of suffering provides a solution for each one then it will have adequately proved this dissertation's claim that CPE needs phenomenology of suffering in order to advance its *human science* goal of *caring for* and *curing souls*.

Clinical Pastoral Education Deficiencies: CPE Learning Model

It might be helpful to understand what human science is in respect to phenomenology before describing this CPE deficiencies and other that follow. Considering this first deficiency surrounding CPE day to day clinical practice described as *Action/Reflection/New Action* it is important to know what impedes it as a framework for clinical praxis and why it is not phenomenological human science as presently constituted and practiced.

First this model in and of itself is inadequate to the task of caring for and curing souls because it does not fully qualify as a human science phenomenological methodology for clinical pastoral praxis. Secondly, this CPE clinical model is impeded and superseded by a general feeling of *empathetic inversion* that allows chaplains to use various theological and methodological constructs to *avoid* taking new actions based on reflective/reflexive praxis. First, why does this CPE educational model not fully qualify as a phenomenological human science? Van Manen (1990) states:

> Phenomenological human science is the study of lived or existential meanings; it attempts to describe and interpret these meanings to a certain degree of depth and richness. In this focus upon meaning, phenomenology differs from some other social or human sciences which may focus not on meanings but on statistical relationships among variables, on the predominance of social opinions, or on the occurrence or frequency of certain behaviors, etc. And phenomenology differs from other disciplines in that it does not aim to explicate meanings specific to particular cultures (ethnography), to certain social groups (sociology), to historical periods (history), to mental types (psychology), or to an individual's personal life history (biography). Rather, phenomenology attempts to explicate the meanings as we live them in our everyday existence, our lifeworld . . . . The term "science" derives from *sientia* which means to know. Phenomenology claims to be scientific in a broad sense, since it is a systematic, explicit, self-critical, and intersubjective study of its subject matter, our lived experience. (Van Manen, 1990, p. 11).

The CPE model is firmly wedded (at least at The Christ Hospital) to quantitative research method and interventions based on psychological methods and techniques. I participated a full year in The Christ Hospital's "Spirituality Research Pilot Program," which was designed to "establish a Standard Spiritual Assessment to be use by clinicians in EPIC." EPIC is a computer software platform that allows medical staff and pastoral staff to enter medical and spiritual assessment of patients. The pilot study itself gathered the data necessary using primarily quantitative data, even though I was given the nod to use the same interview data and apply qualitative methods using a qualitative program called ATLAS.ti.

The qualitative data was never to be seriously considered as the primary means of making a decision on which questions related to patient spirituality that would be added to EPIC, but was used for triangulation purposes as a check on the quantitative data. I discovered in meeting with medical staff that only one physician had pushed to seriously use the qualitative data, but the Pastoral Services department bowed to the majority of medical staff that felt more comfortable with the "scientific" data acquired by quantitative methods. I saw right away that the decision on which spiritual assessment questions would go into EPIC would be based on frequency data.

What was paradoxical about this is that what the pilot project was after was *what did these spiritual questions mean to the patients and how important were they to the patient as ways to assess their spiritual needs, so that appropriate "interventions" could guide both the clinicians and even medical staff on the spiritual needs of the patients.* This pilot program was one concrete expression of the CPE model of *Action/Reflection/New Action* at the institutional level that demonstrates a focus that does

not meet Van Manen's (1990) definition of a phenomenological human science that seeks to uncover meaning. Uncovering thematic clusters of meaning are necessary if appropriate interventions expressed in the CPE model are to be carried out in an attempt to advance the CPE project of *caring for* and *curing souls*.

However, this researcher discovered a more disturbing problem related to this CPE model that lay hidden until he conducted my verbatim interviews with chaplains at The Christ Hospital (TCH). This was the *feeling of avoidance* that this researcher began to describe as empathetic inversion that was introduced in Chapter 4. What then is empathetic inversion and how does it impede the CPE model of *Action/Reflection/New Action*?

This feeling by chaplains is the tension between extending sympathy and care toward the patient *and at the same time* extending sympathy to the Self or *empathic imperfect care giver* (i.e. the would be healer of the soul). It also describes in some cases the tension that comes from trying to participate in *narrative life-world of the patient* while at the same needing to *reject that narrative life-world* in order to protect one's own *narrative life-world* by refusing to blend the two worlds. To truly accomplish this requires a new horizon of understanding to emerge related to spiritual needs of the patient and the risk of being an *empathic care giver*.

Philip J. Deloria (2004) brought out this idea of *empathetic inversion* in an essay on historiography in an edited work on the Native America People and how during the Jacksonian Presidency Americans wanted to *at one and the same time* "participate in an Indian world" (i.e. safely contain and preserve it) and paradoxically destroy this Native American narrative world (which necessarily included the Native American People in

this empathic destruction if need be) because their narrative world posed a threat to the narrative world Americans had written for themselves. (Deloria & Salisbury, 2004, p. 14).

What are the perspectives chaplains have used at The Christ Hospital (TCH) to *affirm, justify,* and even accept as *normal* feelings *empathic inversion*? Two perspectives were theological grounded and one was methodologically grounded. The first perspective we already came across in Chapter 4 – Data Analysis, where the Critical Care Chaplain (2012) stated:

> So the interventions I am going to bring in will end when the conversations ends, unless it dictates that I need to follow-up with them or do some further research to understand a little bit more about what they are doing (i.e. experiencing): But understanding that this is not mine. It is their suffering. It is their journey. I have come in . . . It's a part of my theology of pastoral care. It's an *"Emmaus Road Theology"*, where I come along side for just a short period of time; then I go away. And whenever I go away this is their journey, this is. . . . I am not responsible. (Critical Care Chaplain, 2012, Transcription Folder 01-P2:110105).

More telling is the interview with the Eucharistic Chaplain (2012), whose faith in the Franciscan religious tradition leads him to try and superimpose his belief in "Joyful Sorrow" which is part of his life-world and lived experience but not necessarily not that of his patients, even though they are Catholic as he is. He explained this theology to me in the following interview:

Interview with Eucharistic Chaplain

PI = Principle Investigator; **EC =** Eucharistic Chaplain

PI: How do you as a Catholic Chaplain deal with the phenomenon of suffering?

EC: I do it from a Catholic perspective and of course I do not expect anyone else to agree with my perspective based on my faith.

PI: Of course. This is about how you deal with suffering.

EC: Some patients and/or the families think they are too good to suffer. Suffering is being a follower of Christ. If you wish to be a follower of Christ then you must take up your cross daily . . . . So suffering is part of being a follower of Christ. It must be accepted in that healing way. Once we accept the fact that I am not being punished by suffering . . . it's just a part of being a follower of Christ. . . . We are so used to alleviating suffering but we never think of just accepting it as part of following Christ. Some of the greatest saints in the history of the church suffered tremendously. I'm a Franciscan and St. Francis of Assisi received the *Stigmata of Christ*, that is, the *actual wounds of Christ his body that bled*, and were very painful. . . .

PI: Even though your patients are Catholics, do they understand what you are saying about suffering?

EC: Most of the time. I am mostly addressing the families. Like the case I had today. The patient is in a coma. So it was his wife that said that is such a good guy and that he should not be suffering.

PI: So she is looking at it as punishment and you have turned it in the other direction and made it part of the spiritual or natural process of healing?

EC: It's a spiritual process absolutely. When I left the situation with the family they said to me that I really helped them deal with the situation. They had never thought of suffering in the light I had put it.

PI: This is very insightful. You used the words *acceptance* rather than *endure* suffering. How would you look at enduring suffering?

EC: One of the beatitudes states: "Blessed are they who mourn. They shall be comforted. Christ did not say that what is causing them to mourn will be taken away, but that they will find comfort in their mourning; and so I like the expression of "Joyful sorry!" [It means] having *joy in our suffering.*

It is very clear that this chaplain is convinced that his patients must enter his spiritual life-world with his Franciscan perspective on accepting suffering as a follower of Christ and actually being joyful in suffering. It is also clear that he accepts suffering as a "natural" spiritual condition of being human and that the only way to overcome the feeling of wanting suffering alleviated is to accept it as a follower of Christ. The patient in order to be healed spiritually must come along side the chaplain into his life world and he not into their life world and lived experience.

This chaplain also understood quite well what *empathic inversion* was, because in describing his perspective on suffering he describe St. Francis of Assisi as an empathic person who was apparently identified with Christ's suffering to the extent that he took on the actual pain of Christ and received the same cuts that Christ received in his body, so that St. Francis bled like Christ, therefore, receiving supernaturally the *Stigmata of Christ* (i.e. stigmatism).

Ironically he describes St Francis of Assisi as a true empathic person that accepts the pain of the one he loves, that is, the Christ in that this saint *accepts the suffering* to the extent of receiving the same marks of suffering that Christ himself did. However, this chaplain himself is not an empathic person but actually using this theological notion to engage in empathic inversion, that is, a theological perspective that allows him to avoid entering into the life-world and lived experience of suffering with the patient as Heidegger (1943) might say must be done if we are "be together" with the Other in their pain and suffering to affect an intervention that addresses their spiritual needs.

However, Heidegger's (1943) phenomenological stance in real life it still begs the question of how a chaplain who has normal feeling wanting to somehow avoid participating in the *stigmata of the person who is suffering*. What can phenomenology offer as a way to overcome this natural fear of the caregiver so that they may confidently pursue the CPE project of *caring for* and *curing souls*? The phenomenological solution is that the caregiver must have sufficient love for the patient in their life-world and lived-experience to take the risk of entering into that life-world and lived-experience to the extent humanly possible. In other words the chaplain or clinical pastoral caregiver must overcome their natural fear and aversion to human suffering in all of its forms, including death in order to *care for* and affect (where possible) a *cure of the soul* of the person suffering.

This would seem to be guided by some ill-advised theology, but it comes directly out of phenomenological considerations, and is not considered a theological notion at all but a way of knowing the Other person, which cannot fully be done without sufficient love for the Other in order to understanding the meaning of suffering for them. Van

Manen (1990) and other scholars are saying the same thing and strange as it might seem on the surface see love as a way of knowing, understanding and arriving at a new horizon of understanding about the meaning of any phenomenon that human's experience.

Hermeneutic phenomenology claims that one can only truly know that which you love and that love and care is the foundation of true human science research, which studies the lived experience of a person in their life world. (Van Manen, 1990, pp. 6-7). However, the research challenge lays in the fact that phenomenology, where hermeneutic or transcendental in approach only describes or reveals clusters of meaning and themes around a person's experience of any particular phenomenon being examined for meaning. Therefore, it does not by itself allow a researcher to get at the kernel of the meaning of the human experience but merely opens the door to allow entry into the experience as the research comes with life-world and lived-experience as a contributor to a new horizon of understanding. Van Manen (1990) is not the only phenomenologist to suggest that *love and caring* is the entrance to knowing the *Other* and understanding human meaning behind the experience of phenomena.

Here and there you will find a study similar to the one I am suggesting, such as Kahane's (2001) dissertation on "A phenomenological study of therapists' experiences of love for their clients." Interestingly, Kahane (2001) explores this theme along with whole clusters of other themes that are relevant, including the phenomenon of suffering. Kahane (2001) too uses hermeneutic phenomenology as the approach for her dissertation and states:

> This dissertation explores the experience of psychotherapists' love for their clients. A review of the literature examines definitions and forms of love as well

> as countertransference love according to psychoanalytic, object relations, self psychology, Jungian, existential, and feminist theories. . . . Nowhere has it been named and explored explicitly, thoroughly, and phenomenologically. (Kahane, 2001, *Abstract*).

Kahane (2001) however explores each theme in the cluster surrounding her concern to understanding the *phenomenology of love.* One theme category that she is particularly interested in is human suffering and so explores the phenomenology and theology of suffering presented by Pope John Paul II (1984) in his Apostolic Letter *Salvifici* and lectures on the "Theology of the Body." Kahane (2001) states:

> Pope John Paul II's 1984 Apostolic Letter *Salvifici* doloris shares a common anthropology with his "Theology of the Body" audiences delivered between 1979 and 1984. In them, drawing on his work in phenomenology as a professional philosopher, he discusses the revelatory potential of the human body. His method of inquiry into man's self-understanding of his nature and the struggles he faces invites academic investigation of both issues of human sexuality and human suffering. Analogous to his description of man's coming to understand a language of the body between spouses, there is also the potential for a communion of persons to be released in the experience of the mystery of human suffering by both the suffering person and the one who cares for him. This dissertation investigates the themes addressed in Wojityula/John Paul's teaching, particularly in the "Theology of the Body" with the purpose of synthesizing an anthropology found there in order to present an expanded theology of suffering . . . . Wojityula/John Paul's view will be shown to counteract this mindset, treating the

> experiences of suffering, though an evil in itself, as uniquely affording the potential to release love and hope in the suffering person's relationship with God and others, as well as . . . for those who care for him. (Kahane, 2001, *Abstract*).

Certainly, Kahane (2001) is important for my own study based on the phenomenological method she has chosen and the emphasis she places on fleshing out the meaning of human suffering, in her case to understand better the phenomenon of human love. Van Manen (1990) also speaks of love in relationship to the object of research and states:

> We can only understand something or someone for whom we care. In this sense of how we come to know a human being, the words of Goethe are especially valid: "One learns to know only what one loves, and the deeper and fuller the knowledge is to be, the more powerful and vivid must be the love, indeed the passion" (1963, p. 83) I do not suggest that love or care itself is a way or method of knowing, but as Frederik Buytendijk said in his 1947 inaugural lecture, love is foundational for all knowing of human existence. That knowing is not a purely cognitive act is a principle to which we nod occasionally in educational research." (Van Manen, 1990, p. 6).

This dissertations acknowledges that knowing the human person is not a mere act of the mind, but one of the heart as well should not merely be a nod in educational research but should be taken seriously as does CPE whose motto has been the employment of *head and heart* in *caring for* and the *cure of souls* since its founding in 1925. Bentz and Shapiro ((1998) certainly takes love in relationship to the object of one's

ultimate concern seriously and suggests the following about the importance of love in mindful inquiry in social research using a Buddhist perspective:

> Buddhism, too, preaches the ultimate unity of all beings and the illusion of duality---- of the distinction between self and other, even the existence of self at all. But this unity is attained through increased mindfulness rather than mindlessness; but it is one that is attained through mindfulness and through compassion for and love of all things. . . . With regard to inquiry, this can be taken to imply that love and compassion are the underlying attitude that we should take toward all beings: that our knowledge that this advocacy of love occurs in a passage devoted to the attainment of calm. It is followed almost immediately by the statement "whether one stands, walks, sits or lies down, as long as one is awake, one should maintain this mindfulness" (Rahula, 1974, p. 98). (Bentz & Shapiro, 1998, p. 167).

Van Manen (1990) also suggests that love is important in understanding the lived experience and life world of a human person that is the object of our ultimate concern. Van Manen (1990) states:

> We can only understand something or someone for whom we care. In this sense of how we come to know a human being, the words of Goethe are especially valid: "One learns to know only what one loves, and the deeper and fuller the knowledge is to be, the more powerful and vivid must be the love, indeed the passion" (1963, p. 83). I do not suggest that love or care itself is a way or method for knowing, but Frederik Buytenmdijk said in his 1947 inaugural lecture, love is foundational for all knowing of human existence. That knowing is not a purely

> cognitive act is a principle to which we nod occasionally in educational research. . . . . When I love a person (a child or adult) I want to know what contributes toward the good of that person. So the principle that guides my actions is a sense of the pedagogic Good (van Manen, 1982d); at the same time I remain sensitive to the uniqueness of the person in this particular situation. (Van Manen, 1990, p. 6).

According to Van Manen (1990) then a person involved in either the cure of souls or understanding how this cure is obtained or its meaning must be a participant in the lived experience of the one suffering. The human person who is suffering is not merely an object or object of study but love would direct the human person who is suffering be their ultimate concern in the moment in which they share the experience of suffering. This ultimate concern through shared experience would then call on the person concerned with curing the soul or understanding what it means to do so to take an action respective to each of their participatory roles in helping the person who is suffering to transcend their phenomenological situation of life.

Clinical Pastoral Education Deficiencies: Verbatim Clinical Praxis

Another deficiency in CPE education where a focus on phenomenology of suffering would provide a solution is the CPE's emphasis on verbatim clinical praxis during Level I and Level II didactic and clinical praxis, where this valuable educational tool has been relegated to being just an instructional tool and not a clinical praxis and research tool the founders of CPE originally designed it to be. I offer Moustakas's (1994) Phenomenological Reduction as the means of overcoming this educational deficiency.

Lived-experience where "life experiences" become so "severe, intense, and telling" describes the daily *life-world* of CPE educators and practitioners dealing with the

phenomenon of suffering as they try to effectively achieve the CPE project of *caring for* and *curing the soul*. CPE very early began using the verbatim as an educational tool but not without debate about its usefulness in CPE training and achieving the CPE project. Certainly CPE literature shows that it's educators, researchers and practitioners have not come close to understanding the value of the verbatim as tool to analysis clusters of meaning surrounding the phenomenon of suffering similar to the analytical use Moustakas (1994) has had for the verbatim or long interview, that is, used as a way to gather data on meaning of phenomenon using horizonalization.

CPE has failed to use this kind of analytical tool in its educational curriculum and in its practice, but remarkable it has continued to use the verbatim as its primary training tool in didactic training, but sadly does not use it often enough in clinical practice as it was first introduced by Russell L. Dicks in 1933, as a regular tool to clinical praxis. For sure it uses the verbatim but not as a research tool and not as a means of deriving clusters of meaning to get access spiritual needs and understand spiritual suffering, but rather to as a reflective/reflexive too o improve pastoral clinical practice, which my thesis claims does not go far enough to get to the core of spiritual suffering and needs.

The use of the verbatim in CPE as the primary educational tool and as competitor of qualitative case study has not been without its critics within the CPE Movement. According to Hall (1992) it was Russell L. Dicks one of the early pioneers of the CPE Movement that developed the verbatim around 1933 for use by chaplains in general hospitals were the case study method was used in mental hospitals where patients were domiciled longer. In acute care or critical care HCOs the case study became impractical in Dicks view. Hall (1992) states:

Dicks became chaplain of Massachusetts General Hospital in Boston. After his first summer at Massachusetts General, 1933, Dr. Richard Cabot said to Miss Ida Cannon, Chief of the Social Service Department, "Here is a man that writes down the conversation and prayers he has with a dying man. That is the craziest thing I ever heard of. We'd better ask him to stay on here. We might learn something. With this beginning, it is understandable that Russell Dicks created a learning method for students in clinical training which is still used today, the verbatim. This is a written account of the pastoral conversation with a patient. . . . Discussing verbatim was the primary method Dicks used in supervision. It was a method of understanding what the patient was experiencing and of understanding the meaning of the pastoral relationship with the patient. . . . Dicks has experienced the case study in his CPE at Worcester. . . . Dicks did not find this a useful method for students in the general hospital. Instead, he originated the verbatim of pastoral conversation as the chief learning tool for clinical training students. Describing this technique he wrote, "When we reproduce in writing a contact, and interview, a working relationship, we do not merely record it, we rethink it and so develop its meaning, *not while we are seeing a patient but as soon after as possible* . . . . It is a check upon one's work; it is a clarifying and developing process; it relieves emotional strain for the writer. . . and stands as a record of one's work. . . . It is a new creation of ideas which reveals lacks in what we have done. It is a fresh application of ideals to criticize what was done. It traces out the implications of what we have seen and heard. . . . It is self-criticism.

> It is self-evaluation. It is preparation for self-improvement. (Hall, 1992, pp. 22-23).

Dicks therefore saw the verbatim interview as a reflective/reflexive educational tool for CPE training and improving pastoral clinical praxis. Advocates of CPE case study methods did not rave over Dick's introduction and use of verbatim interviews even in the general hospital. Anton T. Boisen, one of the founders of CPE was a vocal critic and believed that verbatim interviews did not focus "deeply enough on the problems of patients" and so Hall (1992) states that Boisen remarked once that "Dicks students at the Massachusetts General Hospital do not keep records. They only write down pleasant conversations they have with patients" (p. 25).

My critique of the current CPE use of verbatim interviews is far more fundamental than Boisen's sarcastic remarks reveal.

This dissertation claims that the verbatim has all but become a useless tool for analysis at any level in CPE since its use as reflective/reflexive tool is soon forgotten at the end of Level I and Level II training, and certainly after board certification as a professional chaplain. This situation exists because there is no phenomenology of suffering that would allow a new horizon of understanding on the value of the verbatim interview for research and pastoral clinical praxis. CPE educators, practitioners and researchers do not yet understand the value of verbatim interviews for both clinical praxis and CPE research, and so has trivialized the value of this reflective/reflexive learning tool by failing to expand its use into the area of phenomenological methodological analysis as Moustakas (1994) has done.

Clinical Pastoral Education Deficiencies: Reflective/Reflexive Learning

CPE is also deficient in its reflective/reflexive learning praxis. I could not help but notice that the horizons of meaning in my horizonalization analysis showed reflective/reflexive praxis or learning to be less significant in meaning to the chaplains than all other horizonal markers that emerged. Of course CPE has no monopoly on reflection/reflexive learning and praxis. This kind of reflection has been applied to case study methods used in medicine that practices the art of reflecting on patients and their case history in order to learn why they are suffering so that a cure can be prescribed.

In higher education reflective practice has been used in order to enhance its practitioner's ability to understand how students learn so that an educational philosophy and pedagogy can be devised, which allows the practitioner to advance learning in his/her educational discipline. From this educational philosophy that is grounded on reflective/reflexive praxis a relevant curriculum can be designed and developed that guarantees the desired learning outcomes for the students.

Reflection is an important aspect of educational research that allows you to stand back to see what you are doing and/or are looking at. It helps the researcher to refocus so that one can see more of the ideas that emerge from the phenomena under study. I have been participating in The Christ Hospital (TCH) Pastoral Department as a graduate intern and volunteer chaplain since 2010. I began my training at TCH in *grief chaplaincy* in 2012 where I learned about the dying process and end-of-life ethics from Chaplain Tim Waithatka, a *hospice chaplain* from Kenya, Africa, and other seminar presenters. This was the fruitful end of nearly two-year period of being introduced to various specialty areas of chaplaincy so that I can now say I have an *insider's view* of CPE and have a

fairly good idea of its educational strengths and weaknesses. This dissertation study from beginning to end has been a pedagogical exploration into how chaplains deal with the phenomenon of human suffering and how well their clinical and educational human science discipline within the Clinical Pastoral Education (CPE) Movement has prepared them to deal with the phenomenon human suffering as they pursue the CPE project of *caring for* and *curing souls*.

In order to pursue this pedagogical interest in CPE, I have had to become conversant in both hermeneutic and relevant aspects of philosophical traditions (e.g. Husserl, Heidegger, Gadamer, Merleau-Ponty, Sartre, Ricoeur, Hegel, etc.) without forgetting for one moment that this was an educational pedagogical project in higher education. The philosophical and theoretical foundations for this pedagogical project could not be superficially past over because phenomenology in both its transcendental and hermeneutic forms are based on philosophical and theoretical conceptions and horizons of understanding in regard to both theory and methodology.

Van Manen (1990), who is an educator and researcher, certainly understands this necessary connection that needed in order to achieve pedagogical competence within the phenomenological area under study. Van Manen (1990) states:

> Research and writing are aspects of one process. In a later chapter the pedagogical significance of the reflective nature of writing is explored and articulated. Hermeneutics and phenomenology are human science approaches which are rooted in philosophy; they are philosophies, reflective disciplines. Therefore, it is important for the human science researcher in education to know something of the philosophic traditions. This does not mean, however, that one must become a

> professional philosopher in an academic sense. It means that one should know enough to be able to articulate the epistemological or theoretical implications of doing phenomenology and hermeneutics---not losing sight of the fact that one is interested in the pedagogic praxis of this research; more accurately, it means that human science research practiced by an educator is a pedagogic human science. (Van Manen, 1990, pp. 7-8).

Therefore, knowing that phenomenology and hermeneutics are reflective disciplines and when applied reflective/reflexive praxis in CPE becomes a pedagogic human science project. So I begin with the experience I had taking a photography class that opened my eyes as to the deeper meaning behind reflection/reflexive praxis. It supplied with a metaphor for this praxis, which I began to call a *box frame* horizon of understanding phenomena. “Once I used a box frame (close up) shot on a set of toy trains in my photography class. I used the open door of one of the toy boxcars that would lead the eye of the person to see the other trains in the toy train yard. Remarkably when the photo came out the trains looked real and like they were sitting in a train yard ready to be loaded with goods and products.” (Mari-Jata, 2011, p. 2).

This is the metaphor used to describe my understanding of reflective/reflective praxis. The *box frame shot* of the phenomenon under consideration allows one to see several vistas, images or horizons that are seen within the main frame shot (i.e. initial understanding of the phenomenon) through to the other images (i.e. successive new vistas, images, horizons of understanding) that could not be seen before without the focused *box frame shot*. The reflexive image off the main box frame, therefore, allows other ideas to germinate that may offer a different story, different meaning, another vista,

or cluster of thematic ideas seen in the reflected/reflexive categories of thought. If CPE is not doing this kind of reflective/reflexive learning then I don't believe it can advance very far toward its long cherished project of *caring for* and *curing souls*. I submit that CPE needs a *box frame focus* on the phenomenon of suffering, which allows its educators and clinical practitioners to peer through several vistas, or horizons of new understanding on how to improve its curriculum designs that support its pastoral clinical practice in respect to this human phenomenon.

This reflective/reflexive process would be like looking through the lens of a camera that in turn shoots through the frame an open window that then moves through the living room through the patio door to the backyard. The camera has gone through several vistas of visual meaning and taking in more than the eye can immediately see. Phenomenology in generally has the ability to move a person seeking to understand the meaning of phenomenon through several new horizons of understanding. This researcher sees that he has had to approach this journey toward the dissertation through a *box frame view*. This understanding has allowed this researcher to focus on one central idea within the higher education discipline of clinical pastoral education (CPE) practiced within hospital clinical organizations (HCOs). In this researcher's doctoral Essay III (2011) he stated:

> In part my photo box frame focus can be seen in my dissertation title: *Phenomenology of Suffering in the Lived Experience and Life World of Pastoral Care Educators and Clinical Practitioners in Hospital Clinical Organizational Settings*. This dissertation focus is on the phenomenon of human suffering that takes place in HCOs and looks at how CPE educators and practitioners experience

> this phenomenon in their educational and clinical *life world*. The answers to the questions that this research focus suggests will allow CPE educators to design curriculums that will help practitioners of this human science discipline *learn to learn*, that is, help them to discover what kind of learning will help them deal with the phenomenon of suffering, which is their daily companion and the object of their clinical practice in seeking the physical, emotional, and spiritual wellbeing, rapid healing, and flourishing of human persons that suffer. One of the horizons of learning I gained through my seminars has been to focus my ideas in a *box frame view*. Obviously, the danger here is that the *box frame view* only allows you to go through (or so it would seem) one window to see one idea. There are two ways to avoid missing other ideas that the box frame photo leaves out. Pull back to a larger frame, which will then open new ideas or else shoot through more than one frame . . . I think I can do the same thing with the work on my dissertation based on the vistas of learning I have received in a number of seminars . . . . My year-long internship allowed me to integrate most of my seminar learning with a real community of CPE educators and clinical practitioners at The Christ Hospital (TCH). (Mari-Jata, 2011, pp. 2-3).

Another way "I have learned another way to overcome the box frame photo dilemma other than creating a shot that allows you to see through more than one frame to capture a series of anticipated, remembered, or vistas of ideas. One of the greatest learning outcomes I have achieved or acquired, other than being able to *focus* on one fundamental idea is the increased ability to sit back and *reflect on the box frame* itself and see where it might lead me before fully entering in the box frame of ideas. In the

disciplinary fields of higher education and medicine this kind of learning is called *reflective practice* or *reflective learning.*" (Mari-Jata, 2011, p. 4)

In this researcher's doctoral Essay III he stated the following: "I really began to do reflective practice without knowing what I was doing as I was lead into the box frame of ideas. My box frame focus allowed me to determine if the vista of ideas presented by a particular source would or would not answer the research questions I had formulated for my dissertation. Reflecting on the box frame of ideas of the source, coupled with my research focus allowed me either to enter into the framework of ideas presented by the source reviewed or reframe from doing so. In a sort of *swing hermeneutic process* I went back and forth with the ideas presented by the source against my dissertation focus. This allowed me to conserve valuable time that I would have lost because of the inviting nature of the ideas presented by the box framed sources that however interesting would not help me answer my research questions." (Mari-Jata, 2011, p. 5).

This researcher also said that "Chris Hart's (1998) work on *Doing a Literature Review: Releasing the Social Science Research Imagination* avoids the allurement of sources that could take you away from your research focus in his discussion on mapping and analyzing ideas, where mapping allows for clear focus, and reflection on what is being mapped or classified, allowing the researcher to select those sources most appropriate for his or her purpose. Interestingly enough Hart (1998) believes the *reflective approach* to the literature review is the best way to ferret out the ideas that surround your research focus in the process of classification. (Mari-Jata, 2011, p. 5). Hart (1998) states:

> As a researcher, the aim of your review is to extract, to an extent appropriate to your degree (master's, doctorate), those methodological assumptions. This means you need to elicit from the literature the ways in which core ideas, concepts and methodologies have been employed in argument and how they have been operationalized for empirical work. This process forms another part of the analysis element of the review and is essential if core ideas and concepts are to be properly identified from individual items and thereby used to produce a map of the knowledge on a phenomenon, topic or problem. . . . In everyday life we tend to classify things quite routinely as we encounter them without giving much thought to the process of how we typify things. There is nothing that we, as humans, do not place into some category or other. . . . we are sometimes required to give descriptions that have increasing depth and/or breadth. . . . This involves taking a reflexive approach to how we are classifying. It means seeking to evaluate the ways in which ideas on the topic have been conventionally organized. (Hart, 1998, pp. 142-143).

What Hart (1998) means by *reflective* is thinking process of *reflecting on reflection*. It is the process of thinking on reflection as a phenomenon in and of itself. *Reflection* itself is looking backward on an occurrence of a phenomenological experience in order to understand its meaning. *Reflexive* on the other hand is looking inward to examine how one is thinking about the phenomenological occurrence, that is, the actual character and nature of the reflective process and how that process allow one to arrive at meaning and clusters of thematic horizons richly embedded in any particular phenomena.

According to Van Manen (1990) the purpose of hermeneutic phenomenological reflection "is to try to grasp the essential meaning of something" (p. 77). He states further:

> Phenomenological reflection is both easy and difficult. It is easy because, as Husserl (1980) showed, to see the meaning or essence of a phenomenon is something everyone does constantly in everyday life. . . . I, as everybody else, have a notion of what a teacher is. But what is much more difficult is to come to a reflective determination and explication of what a teacher is. This determination and explication of meaning then is the more difficult task of phenomenological reflection. A more famous philosophical example concerns the experience of time. What could be more easily grasped than time? We regulate our lives by time. We carry time around on our wrist. We divide the day into morning, afternoon, evening and night time. And we reflect on past time and anticipate the time to come. We even talk about the time going by, sometimes fast, and at other times more slowly. And yet when someone asks us "what is time anyway?" we are quickly at our wit's end to describe it. What is it that goes by fast or slowly when we say that the time is elapsing? So there is a difference between our pre-reflective lived understanding of the meaning of time and our reflective grasp of the phenomenological structure of the lived meaning of time. To get at the latter is a difficult and often laborious task. The insight into the essence of a phenomenon involves a process of reflectively appropriating, of clarifying, and of making explicit the structure of meaning of the lived experience. (Van Manen, 1990, p. 77).

Van Manen (1990) admits understanding the reflective process is "a difficult and often laborious task" but I submit that this difficulty can be surmounted if reflexivity is taken into account and that the "pre-reflective lived understanding" of a phenomenon is what I described as looking backwards on an observed phenomenon is what reflection is, while on the other hand "our reflective grasp of the phenomenological structure of the lived meaning" of something is what should be regarded as the *reflexive process* of understanding what you are reflecting on, which in this example is the phenomenon of time. It is begging the question and really a circular argument to try to describe what reflection on something is by using the word reflection to define itself as applied to the phenomenon.

This is really the difficulty in looking at phenomenological occurrences. It is a two-step process of reflecting on the "pre-reflective lived understanding" of something. It calls for a reflexive process of grasping the phenomenological structure of those thoughts as it is applied simultaneously to the phenomenon that at first was grasped in the "pre-reflective lived understanding." That pre-reflective understanding must necessarily change as it goes through the sieve of the reflexive process aimed at assessing meaning. This presents particular problems when trying to organize a whole cluster of thematic horizons to come to a new horizon of understanding about any phenomenon, such as *time* or *suffering*, or *love* that is in the life-world and come in view of the perceptive lived-experience of a human person. This researcher stated in his doctoral Essay III (2011) in respect to my metaphoric box frame view of phenomenon that:

> To look at how ideas have been "conventionally organized" is really to look at how some human persons (e.g. social researchers, educators, medical researchers,

> etc.) have classified ideas related to their discipline into *box frame shots*; so that when you look through the theoretical and methodological framework they have erected you must do so carefully keeping a focus on your purpose and questions, using your ability to do reflective practice, so you include or not include a particular vitas or set of ideas as appropriate to that focus or purposes. My work in *EDU 705 – Issues in Higher Education* took me further into this process of reflective practice and learning that came out of the seminar project requiring a focused critical annotated bibliography on one general idea or notion that could be related to this dissertation research. This critical annotated bibliography was far more than a mere literature review. The goal was to critically discuss and annotate a number of sources around one central idea that could be used to advance your focused learning or dissertation focus. This project did both of these things for me. This kind of in-depth study of sources focused on one normative idea forced me into both a reflexive contemplative mode of thought as well as introduce me to *reflective practice and learning*, which fortunately had always been part of the clinical pastoral education experience for CPE practitioners. Now however, I had a name for what they do in clinical pastoral practice and what I was doing in researching what they do and how they feel in respect to the phenomenon of human suffering. (Mari-Jata, 2011, pp. 6-7).

EDU 705 allowed this researcher to frame and reframe his own set of ideas that met my acquired box frame horizon of understanding the nature of reflective/reflexive praxis. In this seminar paper (2011) this researcher stated:

> I hit on two ideas that (1) phenomenology is a reflective methodology, and (2) that clinical pastoral educators and practitioners use reflective methodology in their daily work in HCOs. I therefore did a seminar project on *reflective practice and learning*, which I believe will be invaluable to advancing this dissertation. I have been looking for a methodological key that would allow me to bridge the conceptual gap between hermeneutic and transcendental phenomenology on how the life world and lived experienced of the researcher should be treated within the research project. I think I have found the answer in a well-known methodology used in both higher education and the medical profession disciplines (e.g. among physicians and nurses, etc.), which is called reflective practice or reflective learning. This methodological link between educational and medical disciplines is an opportune interdisciplinary marriage, since this dissertation deals with clinical pastoral education (CPE) within hospital clinical organizations (HCOs). (Mari-Jata, 2011, p. 3-4).

This researcher further stated:

> According to Karen Lorraine Milheim (2008), in her dissertation for the doctor of education degree at Pennsylvania State University Graduate School of Education, reflective practice began its development for practitioners and professionals in two disciplines, which were higher education and medical practice. Later other professions took up the method and applied it to their fields of practice, such as human resources, etc. (Milheim, 2008, p. 22-23). Milheim (2008) states: “The idea of reflection as a method to develop professionals within practice, referred to as ‘reflective practice,’ is prevalent in the literature, with a particular focus on the

development of educators . . . and medical professionals. . .” (p. 23). Although Milheim (2008) does not believe that there is one single definition of reflective practice, she states that “in essence reflective practice involves consideration of both ‘seeing’ and ‘action’ to enhance possibilities of learning through experience (Loughran, 2002). Also, ‘reflective practice allows one to make judgments in complex and murky situations – judgments based on experience and prior knowledge . . .” (Milheim, 2008, p. 22). Milheim’s (2008) observations as to what reflective practice is about includes “seeing,” “action,” and using “judgments” about complex human phenomenon, whose meaning has to be accessed based on both experience and prior knowledge of the human situation, predicament, or in short the phenomenon experienced. This method gains the researcher access into the human phenomenon by being both engaged within the experience and standing back to examine what was experienced and its meaning based on the knowledge gained or prior knowledge of similar situations. I can find a way to use reflective practice with both Moustakas’s (1994) and Van Manen’s (1990) conceptual notions of reflection in phenomenology. I can see how the researcher could use his or her prior knowledge of one’s own bracketed experiences with a phenomenon and then later apply them through a process of intentional analogy to situation of the human subject being studied in relationship to the phenomenon (e.g. suffering, etc.) as Moustakas (1994) suggests should be done. I also can see how the researcher could come along side (or be present in the moment of) the human subject in an act of seeing firsthand what and how they experience by

means of empathic intentionality, as Van Manen (1990) suggests should be done. (Mari-Jata, 2011, p. 3-4).

Now this dissertation can hold hat reflective/reflexive praxis is the methodological means by which clinical pastoral education is wedded to medical human science disciplines in hospital clinical organizations. In respect to this researcher said in his EDU 705 critical annotation paper that:

> According to Jones (2006) learning in CPE is achieved by (1) actual clinical practice in helping the human person who is suffering, and then (2) reflecting upon the meaning of that human encounter and effort in order to improve understanding of this human phenomenon, where improved understanding through reflection will lead to further improved clinical practice. But what is this paradox of learning that Jones (2006) refers to? Jones (2006) relies on Donald Schon (1987) in his book Educating the reflective practitioner to described the predicament as follows: "The paradox of learning a really new competence is this: that a student cannot at first understand what he needs to learn, can learn it only by educating himself, and can educate himself only by beginning to what he does not yet understand. (Schon, 1987, p. 93)." . . . . Jones (2006) concludes that in order to achieve this transformation of the CPE practitioner in their human science discipline they must actually write down their thoughts using the verbatims we will discuss below in respect to the phenomenon of each encounter with patient/clients who are experiencing suffering and so "reflect on these distinct aspects of the encounter in a brief paragraph. . . . these required analytical paragraphs serves to challenge the student to move deeper into reflective process.

> For instance, the reflective analysis of The Person invites the student to explore his or her understanding of the patient and the issues involved. This reflection may involve some insights or interpretation of the meaning of the illness." (Jones, 2006, p. 134). (Mari-Jata, 2011, p. 8).

Active engagement with this clinical pastoral community for a two-year period has demonstrated to me that *reflective practice and learning* is of paramount importance in the human science CPE higher education discipline but that there are no deep reflexive understanding of this praxis based on the horizonal outcomes of my interviews at TCH with chaplains. A deep understanding of reflective/reflexive practice would allow this clinical pastoral community to examine any phenomenological experience, whether it be suffering, various horizons associated with spiritual needs assessment such as love, faith, hope, virtue, beauty as delineated by Bartel (2004) in his essay "What is Spiritual? What is Spiritual Suffering" (pp. 187-186). Nothing within the perceptive phenomenological understanding of the human person is beyond reflective/reflexive praxis, including thematic clusters that surround the *meaning of community* itself and constituent horizons of meaning surrounding concepts like *social justice* related to questions concerning what community is and means.

For example, going through the process of reflective/reflexive praxis allowed me to understand that the chaplains at The Christ Hospital (TCH) are a community dedicated to a particular educational discipline that is both clinical and didactic in nature. Further reflective/reflexive praxis gave me insight on how to engage this community in action plans that involved social justice issues and medical ethical issues related to healthcare sustainability initiatives. Healthcare sustainability is a social justice concern, because

requires an HCO institution like TCH to improve the physical, emotional, and spiritual wellbeing of its patients, who must be thought of as part of the larger TCH community. This focus requires pastoral care clinical practitioners and other caregivers to *reflect reflexively* on what community means. Community then becomes a phenomenological question, since it has to do with how its members experience the phenomenon of suffering in a caring community with each other. This experience of community in the HCO involves medical doctors, nurses, clinical pastoral care practitioners, and other professional staff. This focus on the TCH community gave me an opportunity to use hermeneutic phenomenological reflection to uncover the constituent meaning of community in relationship to social justice.

This researcher read Dianne Gereluk's (2006) work *Education and Community* for EDU 825 in order to examine what community is and is not. This researcher learned that its members define the meaning of community. However, one community can allow or be forces to allow another community to define that community, because of imbalances in power differentials. The social justice concern is that the community with the most power can write rewrite the other community's narrative (i.e. history, defining it social and moral values), which is oftentimes a *false narrative* of that community. This is especially true if the said *other* community is perceived as a threat. Of course this a social justice concern.

Because of these facts Gereluk (2006) does not give a definition of community for that would be to superimpose what community means to the constituent human elements that make up that community. In other words community and what it means is conceptualized by the perspectives of those participating as members on a daily basis.

However, from a theoretical point of view Gereluk (2006) states: “Communities are constitutive of the self and, as such, are to be embraced and accepted as a necessary condition of human life (p. 9).

There are different views on what community means depending on the individual or community’s views of the individual or collective self. These views determine how the community participants understand social justice that is grounded in the ethical norms within the community or by how persons in the community feel they ought to be treated by other communities and individuals. The feminist community represents just one example. Gereluk (2006) states:

> Feminist perspectives on community tend to address two main themes. The first prominent theme addresses the internal dynamics of community, particularly concerning substantive inequalities in communities. Notions of exclusivity, lack of voice, minority rights and the positioning of individuals are prominent themes in these readings (Fraser 1999, Okin 1999, Knight-Abowitz 2000, Fendler 2011). The second dominant theme considers the instrumental value that communities can possess by having a collective voice for political action (Fraser and Lacey 1993, Phillips 1995, Mouffe 2000, Young 2000). Though recognizing power differentials in communities, having representation through a collective voice may be a more effective way to change substantive inequalities in society, rather than by individual representation. The focus in both strands of feminist readings relies on dominant discourses of power in communities. The former is a critique of internal mechanisms that marginalize and suppress individual interests through

> community dynamics. The latter considers the potential to alter the substantive inequalities of society through collective action. (Gereluk, 2006, p. 10).
>
> Gereluk (2006)

One problem that Gereluk (2006) sees is that there is no meta-theoretical understanding of what a community is other than the bewildering array of different perspective on how members of this communities think that are and how they describe themselves, and what others think of them and how these others describe them. (Gereluk, 2006, p. 13).

After reading Gereluk (2006) I began thinking about what community means to CPE educators and practitioners at The Christ Hospital and how they see themselves in this complex healthcare organization. Do they see themselves as a community that is capable of assessing various horizons of spiritual suffering, such as despair, anguish, depression, discouragement, disappointment, meaninglessness, painlessness, drifting, emptiness, lack of vision, which they can counterpoise these spiritual needs with positive spiritual thematic horizons, such as, hope, vision, meaning, purpose, courage, perseverance, perspective, etc.? (Bartel, 2004, p. 195). I wrote about my learning on the meaning of community in my doctoral Essay III (2011) where I stated:

> By now I was immersed in this community, which gave me an insider's perspective with the obvious danger that my judgment might be clouded, because of my desire to be an integral part of its *life world* and it's *lived experience*. Gereluk (2006) allowed me to take a step back and look at this community of pastoral practitioners from the *box frame view* that I described earlier in this paper. By doing so I began to see that the clinical pastoral educators and

practitioners see themselves as a special community of pastoral spiritual leaders that engage in advocacy on behalf of ill persons with physical, emotional and spiritual needs, including also in this advocacy medical professionals and hospital staff who are all member of the larger TCH community. This advocacy has both ethical and social justice implications that are the box frame for daily action by this clinical pastoral group of educators and practitioners. My immersion into the TCH clinical pastoral community has allowed me to see that they do not see themselves as a community in the same way as most minority community would, such as feminist, gays, and racial minorities might that often see themselves in terms of their community of interests *over against* that of other more powerful social communities of interest, where they might as individuals and/or as a group be treated *differently*, and so suffer social injustice because of these differences. I have learned that the TCH clinical pastoral community sees itself as a *functional minority* or a *functional constituency* working within the TCH larger community and among associated constituencies, primarily on behalf of a voiceless community of patient/clients, who are incorporated into the TCH community for purposes of healing; but who are sometimes subject to very powerful institutional forces within the hospital that could overlook their rights to autonomous decisions over their own bodies, minds and spirits. My immersion into the *life world* of this pastoral community has been huge in my increased understanding of what community is and perhaps should be. Based on my reading of Gereluk (2006) and my *lived experience* within the *life world* of this community of clinical pastoral educators and practitioners, I now am able to identify this community as an

> *associative/supportive community* that *reflects* on their institutional role as "deliberative democracy advocates" within an institutional setting dedicated to human healing, wellbeing and flourishing (p. 63) (Mari-Jata, 2011, p. 12-13).

The Christ Hospital clinical pastoral community does not view itself above or *over against* other HCO constituencies in the hospital but rather seeks to collaborate with other TCH constituencies on mutual goals and aims in providing a healthcare environment conducive to assessing various maladies, illness and suffering. The TCH pastoral department has the objective goal to advance human wellbeing by providing for their spiritual needs of love, faith, hope, virtue, and beauty (Bartel, 2004, pp. 188-189), but the larger question is how well are they doing that without having a phenomenology of suffering and the attending hermeneutical phenomenological reflective/reflexive methods needed to more effectively do what they attempt doing daily? Van Manen (1990) states: "The purpose of phenomenological reflection is to try to grasp the essential meaning of something" (p. 77). This dissertation concluded that chaplains at TCH while they use theological reflection to help assess spiritual needs the reflection done is not rigorous enough to meet the demands of phenomenological human science reflective practice. Van Manen (1990) states:

> Contrary to what some think, phenomenological human science is a form of qualitative research that is extraordinarily demanding of its practitioners. Unless the researcher remains strong in his or her orientation to the fundamental question or notion, there will be many temptations to get side-tracked or to wander aimlessly and indulge in wishy-washy speculations, to settle for preconceived opinions and conceptions, to become enchanted with narcissistic reflections or

> self-indulgent preoccupations, or to fall back onto taxonomic concepts or abstracting theories. To establish a strong relation with a certain question, phenomenon, or notion, the researcher cannot afford to adopt an attitude of so-called scientific disinterestedness. (Van Manen, 1990, p. 33)

This argument goes for clinical pastoral care practitioners whom I submit should be researchers in their human science field but who so often are side-tracked and attracted to allied human science fields like psychology, because this field can make positivistic claims to being a science of the mind. These kind of focus can become "indulgent preoccupations" that side-track CPE educations and clinical practitioners from engaging in a hermeneutic human science of their own that uses reflective/reflexive praxis to understand the horizons of meaning associated with the phenomenon of suffering.

This researcher had other concerns involving CPE's special area of theological reflection, which is part of their use of verbatims in Level I and II. This researcher considered theological reflection a special area of reflective/reflexive learning and praxis. The problem for CPE is that when the use of verbatims end at the close of professionals training the systematic theological reflection also ends. Killen and De Beer (2011) in *The Art of Theological Reflection* discuss experience and meaning of various horizons of understanding that are arrived at through theological reflection. Killen and De Beer (2011) state:

> For human beings the drive for meaning, the drive to have what we encounter, endure, create, feel, and think in our lives make sense in an integrated manner, rivals the drive for physical survival. When we reflect on, muse over, ponder, or analyze events we are engaged in the process of making meaning. The process of

> making meaning has a structure to it, though most of us move through the process without noticing its structure. This is because our drive is to find meaning in our lives. Asking how we do so is a different kind of activity. . . . The movement flows through five parts: experience, feelings, images, insight, and action. Think of them as related in a circular spiral: action, by leading to new experiences in our lives, propels us back to experience. The movement is this: When we enter our **experience,** we encounter our **feelings.** When we pay attention to those **feelings, images** arrive. Considering and questioning those **images** may spark **insight. Insight** leads, if we are willing and ready, to action. Becoming aware of this movement in our own lives can strengthen and refine our habit of reflection. It puts us in touch with how, at times in our lives, we have come to significant understandings that allowed us to choose more freely among options or that strengthened or shifted our sense of who we are in relationship to God, self, other, and the world. (Killen & De Beer, 2011, pp. 20-21).

This researcher did not observe this kind of deep reflection/reflexive search for meaning while working as an insider volunteer grief chaplain or in my ten interviews with professional chaplains at TCH. Killen and De Beer (2011) demonstrate clearly there is a *swing hermeneutic process* that leads to movement toward insight" (p. 20). Killen and De Beer (2011) describe this process as "a circular spiral" that leads eventually to action, but appears adaptable to Gadamer's (2002) understanding of the hermeneutic circle that leads to every new horizons of understanding as reflective/reflexive praxis is engaged in. That this hermeneutic reflective/reflexive process leads to action could be incorporated into CPE's educational model *Action/Reflection/New Action*.

However, it is to be noted that Killen and De Beer (2011) actually uncover the problem with this CPE model in respect to the proper order of engagement. According to Killen and De Beer (2011) the model should be *Reflection/Action/Reflexive New Action* by the hermeneutic circle that goes from **experience** then to **feelings,** then to **images,** then to **insight**, then finally to **action**, where then action/reflection/new action might have more substance.

It is apparent then that CPE is putting the cart before the horse in giving priority to action followed by reflection. This may because CPE confuses the two level of meaning that exist between reflection and reflexive praxis. Actually Killen and De Beer (2011) spell this out without using the word reflexive when they state: "When we reflect on, muse over, ponder, or analyze events we are engaged in the process of making meaning. The process of making meaning has a structure to it, though most of us move through the process without noticing its structure. This is because our drive is to find meaning in our lives. Asking how we do so is a different kind of activity" (p. 20). The two levels of the process of making meaning are (1) reflection, where we "muse over, ponder, or analyze events [e.g. phenomenon], and the (2) reflexivity, where we ask the meta-theoretical question: How do we reflect on meaning? I have explained above that reflection/reflexive praxis it at two levels and I believe that CPE only practices the first level of the process that leads to making meaning. So when this deficiency is applied to the phenomenology of suffering and discovering the cluster of thematic horizons that would allow CPE to advance its own project of caring for and curing souls it is likely to come up short in determining levels of spiritual suffering and assessing spiritual needs to

alleviate that kind of human suffering. This researcher stated in his doctoral Essay III (2011):

> With this link [i.e. understanding reflection/reflexive praxis] the circle of understanding is complete where theological perspective and reflection is provided by . . . . pastoral care advocates. The interdisciplinary circle is complete that could provide medical healthcare science, practiced in HCOs, with the rational to pursue healthcare sustainability grounded in theological reflections, which claim that there is a direct relationship between human health, its environments, and its physical, emotional and spiritual wellbeing, leading to the good life. (Mari-Jata, 2011, p. 18).

Clinical Pastoral Education Deficiencies: CPE Spiritual Assessment

You certainly would not expect that CPE would be deficient in its CPE model of Action/Reflection/New Action; in the effective use of it primary educational and research tool the verbatim and in reflective/reflexive learning and praxis itself would be able to effectively do *spiritual needs* assessment well that is required in order to apply the appropriate intervention for patients that are *spiritually suffering*. These accumulating deficiencies obviously impact this central focus of the CPE project that is given expression by the traditional language of *caring for* and *curing souls*. Fortunately, Mark Bartel (2004) who has asked the vital question "What is Spiritual? What is Spiritual Suffering?" has gone beyond this question to supply the horizons of meaning to first address what are the *basic spiritual needs* of a person who is suffering. Bartel (2008) breaks out these horizons into five thematic clusters, as follows:

A. Love (Community, Connection)

Love, affections, commitment, compassion, relationships, community, fellowship, companionship, esteem from others

B. Faith (Worldview)

Faith, worldview, personal philosophy, worship, awe, wonder, reverence, humility, transcendent, prayer, contact

C. Hope (Vision)

Hope, meaning and purpose, courage, perseverance, perspective, vision,

D. Virtue (Ethics)

Virtue, integrity, morality, ethics, consistency, character, loyalty, goodness, kindness, patience, honesty, wisdom, justice, gratitude

E. Beauty (Renewal)

Beauty, art, music, aesthetics, balance, elegance, nature, creativity, expression, imagination, curiosity, exploration, renewal, rest, quiet, meditation, humor, diversion, fun, play, laughter, joy. (Bartel, 2008, pp. 188-189).

Bartel (2008) then provides an incredibly detailed chart of these horizonal relationships that cannot be included in this dissertation, and also a table of opposing horizons representing spiritual suffering to each one of the horizons of spiritual needs (Bartel, 2008, p. 195). As an example of the *Table 2* he opposes the horizons under the thematic cluster for love with spiritual suffering horizons such as *separation, loneliness, alienation, isolation, withdrawal, avoidance, disconnection, anger, hatred, rage, bitterness, revenge, grudges, despising, contempt, betrayal, abuse, lust, selfishness, self-*

centeredness, apathy, insecurity, self-loathing, toxic guilt, remorse, shame. (Bartel, 2008, p. 195). It is easy to see that these kinds of horizons and thematic clusters are or should be the stock and trade of chaplains, CPE educators and pastoral clinical practitioner. However, my claim is that these educators and practitioners cannot take full advantage of this learning unless construct a phenomenology of suffering along with its methods for accessing meaning from these kinds of horizonal markers of human meaning. It is my belief that this is achievable for CPE which has most of the positive elements in place but which lain dormant in some cases and underdeveloped. Once these deficiencies are resolved then CPE will be able to effective advance its CPE project of *caring* for and *curing souls*.

Clinical Pastoral Education Deficiencies: Social Justice Focus

This dissertation does not make the claim that The Christ Hospital (TCH) or the CPE supervisory leadership of its Pastoral Services Department do not have a focus on the implications of the health of its patient/clients in relationship to the impact that *institutional social justice* dimensions can have on patient's *eudemonia*, that is, on their *rapid healing*, overall *well-being* and *human flourishing*. That would be far from the truth. During my internship at TCH I participated in the monthly Ethics Committee meetings, which include medical staff (i.e. doctors and nurses), professional staff (IRB, legal counsel) and supervisory leadership of the Pastoral Services Department, where ethical issues involving the wellbeing of patients are taken seriously and actions are taken to protect and defend their human autonomy while they are being treated for their illnesses.

At TCH there is a general awareness among the medical staff, professional staff and CPE leadership of the negative impact that a large health organization and its medical staff in particular can have on a patient's general welfare in respect to their ethical, moral and human rights to their individuality, autonomy and wellbeing. For example their right not to receive specific types of blood products; their right to participate in their plan of health; their right to have equal access to medical and other services provided by the HCO; their right to bloodless surgery; their right not to have religion imposed upon them without their consent; their right to include spiritual needs as part of their plan of heath care. This last right is encoded in the Joint Commission on the Accreditation of Health Care Organizations (JCAHO), which states: "All patients have the right to have their spiritual needs addressed as part of their overall treatment plan." (Cleveland Clinic Clinical Pastoral Education, 2012, p. 1).

Well if all of this is true then what is the social justice deficiency for pastoral care practitioners and CPE at The Christ Hospital (TCH)? The deficiency is not that the chaplain's do not care about their patients or respect their autonomy as persons. In fact they do as the interviews them can attest to. The deficiency is the informed awareness of the profound moral/ethical issues associated with institutional social justice and a requirement in the CPE curriculum that students and pastoral professional practitioners have so many didactic hours in seminar related experiences dealing with moral/ethical issues, which might include attending (as this researcher had done) TCH Ethics Committee meetings followed by writing papers on these experiences.

This researcher attended these ethics meetings with the Director of Pastoral Services as part of my internship, but he noticed that the rank and file CPE students and

professional chaplains were never in attendance. This lack of formal training means that CPE students and professional chaplains are not as well informed as they should be in dealing with ethical issues that impact their patients general health and wellbeing. This situation is only exacerbated by the other deficiencies, including empathic inversion, because awareness of what ethical issues related to their care might negatively impact the patient's life-world and lived-experience is crucial to assessing their spiritual needs.

Reflective/reflexive praxis also comes into play. You cannot reflect on or gain insight into what you are not aware of. Therefore, the CPE curriculum is seriously deficient in this respect and may in addition have something to do with its emphasis on achieving an inordinate amount of clinical hours over didactic hours devoted to seminar and research. Even when didactic seminars are engage in they are more devoted to the student's being aware of themselves as chaplains than being aware of the ethical issues surrounding patient autonomy and why that is equally important if not more than discovering the CPE student's character flaws that prevent proper clinical assessments.

The *Association Clinical Pastoral Education Standards & Manuals* (2010) is not as specific as it might be on the amount of hours that should be devoted to ethical issues involving social justice. To be sure there is a **Code of Professional Ethics for ACPE Members (Standard 100)**, as follows:

> **101.1** affirm and respect the human dignity and individual worth of each person.
>
> **101.2** do not discriminate again anyone because of race, gender, age, and faith group, national origin, sexual orientation, or disability.

101.3 respect the integrity and welfare of those served or supervised, refraining from disparagement and avoiding emotional exploitation, sexual exploitation, or any other kind of exploitation.

101.4 approach the religious convictions of a person, group and/or CPE student with respect and sensitivity; avoid the imposition of their theology or cultural values on those served or supervised.

101.5 respect confidentiality to the extent permitted by law, regulations or other applicable rules.

101.6 follow nationally established guidelines in the design of research involving human subjects and gain approval from a recognized institutional review board before conducting such research. (ACPE Standards & Manuals, 2010, p. 2).

This is all well and good for guiding the professional ethics of both the CPE student and professional chaplain training or working in HCOs. However, there is paucity of didactic training the ethical implications of these standards in CPE curriculums and virtually nothing said about institutional social justice issues. ACPE (2010) recommends that the typical CPE curriculum include the following category of courses for CPE trainee supervisors, as follows: (1) history of CPE, (2) theology, (3) educational theory, (4) behavioral sciences, (5) multicultural theory, (6) management/administration of educational programs, (6) group theory, (7) supervisory theory, and (8) personal and professional ethics. (ACPE Standards & Manuals, 2010, p. 12).

This recommended outline for CPE courses is the same for Level I and II with the exception of supervisory theory. The inclusion of personal and professional ethics is needed but shows that CPE is not focused in on institutional social justice issues

necessarily associated with large human science institutions like hospital clinical organizations (HCOs) such as The Christ Hospital. In addition to this deficiency the amount of recommended clinical hours over the hours dedicated to didactic course study is not balance in favor of clinical praxis over that of didactic study and research. For example, at least 400 hours are needed to complete CPE Level I and additional 400 hours to complete CPE Level II. Of the hours needed for each level only 100 hours are devoted to didactic study and research. The other 300 hours per unit are devoted to clinical praxis. This is the same when student who have completed CPE Level I and II begin in their third year to train as CPE supervisors.

It is apparent that the CPE curriculum does not focus its students on institutional social justice or are made aware of the significance of such studies in respect to human autonomy and how negative aspects adds to the suffering of patients. However, even if CPE students were made aware of institutional social justice issues there currently is an insufficient amount of didactic study and research to cover the courses already outlined for its curriculum.

This dissertation suggests that a new focus a phenomenology of suffering that puts a high premium on theoretical knowledge, methodology and research might encourage a change of focus in the current CPE curriculum. One practical step would be for CPE centers such The Christ Hospital Pastoral Services Department to collaborate with local colleges and universities that could offer CPE student a more broaden view of social justice that goes beyond professional and personal ethics.

One such course would be seminar EDU 700 *Education and Social Justice*, which prepared me to discuss this CPE deficiency. This seminar taught a broad range of ethical

concepts needed for proper social justice integration: (1) An ethic of individual choice and justice as equal opportunity and procedural fairness, (2) An ethic of virtue and justice as community obligation, (3) And ethic of care and justice as close attentiveness to Others, and (4) An ethic of identity and justice as affirmation of difference and social transformation.

While all these ethical perspective have some significance CPE as I learned about it at The Christ Hospital the ethic of care and justice as close attentiveness to Others has more significance for the focus of my study on how pastoral clinical practitioners (i.e. chaplains) experience the phenomenon of suffering in the praxis within the context of The Christ Hospital. The care and close attentiveness chaplains have must extend to institutional social justice issues if they are to effectively assess the spiritual needs of patients who are negatively impacted in some way by the very HCO that is dedicated to their care. This ethical perspective states:

> By an ethic of care, social justice requires an acknowledgement of the complexities that attend individuals within any given circumstance and the *democratic and participatory structures* that encourage involvement, discussion, and a willingness to delay decisions until the *needs and circumstances of a community's or organization's members* are quite full known. In terms of education, an ethic of care implies an openness to challenging the meanings associated with established social roles (gender, to be sure, but also race, class, ethnicity) as well as valorization of and support for the needs and concerns of those place in these roles. More than this, education guided by an ethic of care would reexamine and refashion established roles and role definitions---including

> the definitions that apply to single parents, to individuals with different gender orientations, to the underemployed and unemployed, and to *those with an array of special needs*. (EDU 700, 2009, Handout, p. 2).

The key concepts for this dissertation derived from this ethical perspective close attentiveness to Others is the institutional nature of the association of human needs with democratic and participatory structures that are willing to recognize in the case of an HCO the right of patient to participate in their own plan of care, and not to unilaterally impose treatments or cures when the special needs of the members of the organizations (e.g. patients and their families) have not been fully considered. This imposition of institutional power over the individual would constitute institutional injustice. How would a chaplain be able to address this kind of injustice that very well may add to their patients spiritual suffering if they are not trained and aware of the social justice implications of institutional power, even if that power is benevolent such as HCOs are expected to be. It is paramount for chaplains to understand HCOs impact their patients. To do that they must be educated in how hospital as institutions operate and also social justice implications of public health policy that HCOs follow in trying to achieve their goal of providing health care to people who are ill and suffering.

Public health policy has as direct relationship to human wellbeing as argued by Powers and Faden (2006) in their book *Social Justice: The Moral Foundations of Public Health and Health Policy*. Powers and Faden (2006) state:

> Arguably, a central social role of public health, grounded in social justice, is to draw attention to any aspect of this social structure that exerts a pervasive and profound effect on the development and preservation of health. At the same time,

> however, health is one of the six different lenses through which the justice of social institutions practices, and policies are to be evaluated. In some cases, the effects on other dimensions of well-being may be as or more important in making determinations about injustice as the effects on health. . . . Public health and health policy have a unique relation to one dimension of well-being. Arguably, educational institutions and policy have a similarly unique relation to the dimension of reasoning. These institutions have stewardship over particular determinants that have special strategic effect on health and reasoning, respectively. However, we know that determinants such as access to primary medical care and schooling have pervasive effects on well-being that go far beyond their impact on health and reasoning. Just as public health has an obligation to call attention to any aspect of the social structure that has a significant effect on health, so too must public health evaluate the impact of its policies and practices, not only on health, but on all the dimensions of well-being. . . . Justice in health policy does not rest solely on its implications for health but on the totality of its effects on well-being in a particular context in which people likely vary in how well their lives are going, generally. (Powers & Faden, 2006, pp. 83-84).

There are two major points that Powers and Faden (2006) make that are related to social justice concerns that chaplains should be aware and have at HCOs such as The Christ Hospital (TCH): (1) Public health policy (in this case made by administrative leaders at TCH) has a social role grounded in social justice. That role requires these leaders have a moral duty to “draw attention to any aspect of this social structure that

exerts a pervasive and profound effect on the development and preservation of health" (Powers & Faden, 2006, p. 83). It follows that if they do not then pastoral and even medical staff have a moral duty grounded in social justice concerns related to the patients health to draw the attention of the administrators to the institutional social injustice situations that is impacted the well-being of the patients and their families.

According to Marshall and Oliva (2010) in their book Leadership for Social Justice: Making Revolutions in Education, social justice and moral transformative leadership go together. Educational leaders must recognize that institutions "regularly generate and produce power inequities" (p. 20). Quoting Foster (1986), Marshall and Oliva (2010) state through him that transformative leaders must be "critically educative" by looking at the conditions and situation people live in and "decide how to change them" (p. 20).

How are chaplains going to act out this social justice role if they are unaware and untrained for the task at hand?; and (2) While HCOs such The Christ Hospital have stewardship over strategic decisions involving the health of patients, Powers and Faden (2006) claim that the health of the patient is only one of six dimensions that impact the overall wellbeing of patients and HCOs such as The Christ Hospital must consider. Some dimensions have to do with equal access to care but Powers and Faden (2006) talk about effects on "all dimensions" of a patients well being (p. 84). This certainly can and should include the patient spiritual wellbeing, all the more since the JACHO requires all HCOs that are accredited through them to recognize the patients "right to have their spiritual needs addressed as part of their overall treatment plan" (Cleveland Clinic (2012), p. 1).

Are these two dimensions part of the chaplains business? I mean do that have the same moral stewardship for the care of patients as the HCO administrative leadership? From a moral/ethical standpoint it is very much their business. This is because HCO institutional structures can exert tremendous impact on patient's health and overall wellbeing through health policies that violate social justice normative practices that should rather be the interest of preservation of human overall wellbeing. That overall wellbeing includes the spiritual wellbeing and needs of the patient as well as their mental and physical wellbeing. This includes the patient's right to participate in decisions about their health or end of life decisions and having equal access to healthcare and healthcare services.

Dena Seiden (1995) in her essay "Health Care Ethics" suggest that there are a number of important dimensions of social justice related to health care that must be considered by leaders (e.g. administrative, medical, pastoral, professional, etc.) in HCOs in respect to patient wellbeing. All of these dimensions are necessarily in favor of patient wellbeing. Some of them even represents a threat to patient overall wellbeing and are in favor of the care giver, as follows:

(1) *Patient autonomy* - where according to Seiden (1995) "Currently, the most important issue within health care ethics is that of individual autonomy. What this has come to mean is that the patient is the chief decision maker in all situations, regarding her/his medical care" (Seiden, 1995, p. 495);

(2) *The doctrine of professional beneficence* - makes healing a "priestly function" and puts the decision to heal or not heal in the hands of the physician of the body (i.e. medical doctors) and/or physicians of the soul (i.e. chaplains and/or other pastoral clinical

practitioners). Sometimes this doctrine directly is in opposition to patient autonomy, where "the patient makes the decision, up to and including the rejection of all forms of treatment, including life-saving treatment. The professional must abide by the patient's wishes" (p. 495), as opposed to the doctrine of professional beneficence, which "is deeply embedded in medical history. It is part of the Hippocratic Oath. The Oath sates on part, "The regimen I adopt shall be for the benefit of my patients according to *my* (emphasis added) ability and judgment, and not for their hurt or for nay wrong." Not that the patient has no say in the regimen adopted. The physician decides alone" (Seiden, 1995, p. 497);

(3) *Professional autonomy* – "Given the struggle between individual and patient autonomy and professional beneficence, what balance can be achieved? Many ethicists, including this one, think that the answer lied in professional autonomy. In a sense, this is giving to the health care professional the same dignity and respect accorded to the patient. It takes into account that the health care professional has striven to master a body of knowledge which allows for informed, discrete judgments. It also allows for the fact of the health care professional as a human being, with feelings, beliefs, and values, not a technician who performs at the behest of patient, science, or employer. . . . By acknowledging that professionals have determining beliefs and values, and making sure that the arena is open for them to act on those beliefs and values, the practice of medicine may become more cooperative, less adversarial, and more humane. The patient or surrogate still decides, within the bounds of reason, what is done is with her or his mind and body. But the professional does not have to slavishly follow this dictate. In this view, the practice of health care also contains its own inherent values. (Seiden, 1995, pp. 498-499).

These are just three of the salient ethical understandings that pastoral clinical practitioners must be aware of and knowledgeable about if they are to engage in social justice reflection and actions that are for the spiritual wellbeing of their patients. These three ethical features that are foundational for institutional social justice in HCOs do not just belong to the medical staff but apply as well to the chaplain the erstwhile *physician of the soul*, charged by their human science discipline with *caring for* and *curing souls*.

How are they do that without a CPE curriculum that trains chaplains to use phenomenological methods that can uncover or reveal clusters of thematic horizons on how patients are experiencing the phenomenon of suffering? How will the chaplain by the same token come to this new horizon of understanding unless they understanding how they are experiencing the phenomenon of suffering as they take the risk of bringing their life-world and lived-experience of this phenomenon alongside the life-world and lived-experience of their patients? How will they access the spiritual needs of patients if they are not trained to understand all of those institutional structures and dimensions of social justice within HCOs that impact their overall wellbeing, not to mention the chaplains on proclivities to protect themselves because of feelings of *empathic inversion*?

Finally, Nel Noddings (1984) coming at the question of the ethics of care from a feminist perspective presents a passionate plea of caring and the risks involved in doing so. These risks are for the sake of the one who is suffering and calling for the help of one who cares and is able and willing to do so. Chaplains and other pastoral clinical practitioners would do well to reflect on her perspective in order to deal with any structural hindrances that had creped into clinical pastoral education (CPE) praxis that threaten its overall project to *care for* and *cure souls*. Noddings (1984) states:

> Caring preserves both the group and the individual and, as we have already seen, it limits our obligation so that it may realistically be met. It will not allow us to be distracted by visions of universal love, perfect justice, or a world unified under principle. It does not say, "Thou shalt not kill," and then seek other principles under which killing is, after all, justified. If the other is a clear and immediate danger to me or to my cared-fors, I must stop him, and I might need to kill him. But I cannot kill in the name of principle or justice. I must meet this other---even this evil other---as one-caring so long as caring itself is not endangered by my doing so. . . . I do not say, "Life is sacred," for I cannot name a source of sacredness. . . . My concern is for the ethical ideal, for my own ethical ideal and for whatever part of it others in my community may share. Ideally, another human being should be able to request, with expectation of positive response, my help and comfort. If I am not blinded by fear, or rage, or hatred, I should reach out as one-caring to the proximate stranger who entreats my help. This is the idea one-caring creates. I should be able to respond to the condemned man's entreaty, "Help me." . . . . The duty to enhance the ethical idea, the commitment to caring, invokes a duty to promote skepticism and noninstitutional affiliation. In a deep sense, no institution or nation can be ethical. It cannot meet the other as one-caring or as one trying to care. It can only capture in general terms what particular ones-caring would like to have done in well-described situations. Laws, manifestos, and proclamations are not, on this account, either empty or useless; but they are limited, and they may support immoral as well as moral actions. Only the individual can be truly called to ethical behavior, and the individual can never

> give way to encapsulated moral guides, although she may safely accept them in ordinary, untroubled times. Everything depends, then, upon the will to be good, to remain in caring relation to the other. How may we help ourselves and each other to sustain this will? (Noddings, 1984, pp. 27-29).

Noddings (1984) impassioned plea and insights into on the moral/ethical stance individuals within institutional structures of power must take to become and remain "ones-caring" for the "other" are well taken and advised for chaplains and other pastoral care clinical practitioners in order for he or she to sustain "the will to be good, to remain in caring relation to the other." (Noddings, 1984, p. 29). This of course requires CPE clinical and didactic training and skills that are focused on those who are suffering and needing care, and being very aware of institutional social justice issues and concerns since the pastoral care clinical praxis is necessarily done within HCO institutional structures of power and where power differentials are acutely in favor of the institution, which according to Noddings (1984) "may support immoral as well as moral actions" (p. 29).

The work of Dr. Howard Thurman, who was Dean of University Chaplains as both Howard University and Boston University is essential to CPE's understanding the relationship between human suffering, spiritual needs and social justice, or social change. Dr. Thurman (1979) fundamentally believed that the individual was the moral agent needed for social change, but still have faith in the church as an institution to help individual make the moral choice to act and so bring social change about. Thurman (1979) in his religious autobiography Head and Heart states:

> It was my conviction and determination that the church would be a resource for activists—a mission fundamentally perceived. To me it was important that individuals who were in the thick of the struggle for social change would be able to find renewal and fresh courage in the spiritual resources of the church. There must be provided a place, a moment, when a person could declare, "I choose!" (Thurman, 1979, p. 160).

CPE has always demanded that its practitioners remain connected and active in their faith institutions in order to participate in clinical pastoral education. The reasons have been provided in by Dr. Thurman. CPE is not only connected to the seminary but the church as well as the font of spiritual support for its practitioners. This spiritual source found in personal worship and reflection has allowed this practitioners to come back to there respective HCOs and share the courage and faith they have in God with those they are trying to heal. The courage that comes from this personal source of faith has also given them when needed the courage to deal directly with institutional social justice issues that arise at the CPE/HCO centers.

If one stays long enough at these CPE centers one will see clinical pastoral practitioners engaging medical, professional, administrative staff on issues impacting patients. They often have to stand as the patient and the families advocate in the sometimes too clinical environment where the human touch is missing and were no one seems to be listening. CPE pastoral clinicians are not just taught to listen to patient concerns when they are working on the hospital words but are trained to take immediate and appropriate actions with physicians, nurses and staff if they are not responding appropriately to patients needs. So it is not the clinical side of the CPE that is deficient in

understanding institutional social justice. The primary deficiency lies on the didactic side of their education, where CPE seminars do not focus sufficiently on social justice issues and learning in respect to how powerful institutions such HCOs through perhaps not purposely engage in unjust activities that impact the overall health of its patients. It goes without saying that if pastoral care practitioners had the advance training they needed in institutional social justice the would be willing to take actions to bring to light those issues and concerns that impact their patients. If they do not know what the social justice issues are related specifically to hospitals how are they to take social justices stances as spiritual advocates for patients and families? CPE educators and clinical practitioner's when well trained will be the first to recognized how suffering is related to inequities and power differentials.

Dr. Thurman (1963) has some interesting observations about suffering and the moral choice to do something about it concrete situations and how it related to the freedom of human persons. In his *Disciplines of the Spirit*, Thurman (1963) states:

> If suffering belongs, then does it go along for the ride, or must it carry its end of the stick? Does it have a function? What would life be like if there was no suffering, no pain? The startling discovery is made that if there were no suffering there would be no freedom. Men could make no mistakes, consciously or unconsciously. The race could make no mistakes. There would be no error. There would be no possibility of choice at any point, or in any sense whatsoever. It is irrelevant to suggest that there might be a more satisfactory way to guarantee this than to make human misery in some sense mandatory. This, then may be one of the ways in which suffering pays for its ride. . . . To say that man's spirit is driven

> to deal with the issue of death is equivalent to saying that man is driven to a face-to-face encounter with Life and its Creator, out of whom come life and death as experiences in Life. Death is seen as being an experience *within* Life, not happening *to* Life. Why do men suffer? They suffer as a part of the experience of freedom. They suffer as a part of the growth of life itself. They suffer as a part of life. . . . But at last we have a clue in the notion that without suffering there is no freedom fro man, ad that through it every man is faced with the necessity of experiencing in his being—not merely in his physical body---the meaning of death. (Thurman, 1963, pp. 80-81).

Final Remarks

We have taken a long, winding but necessary pathway to uncovering and/or revealing the five deficiencies within Clinical Pastoral Education and to show the reasons why a new focus on a phenomenology of suffering, including its methodologies (transcendental and hermeneutic) is the cure for these educational deficiencies. It is well understood that more work needs to done in this human science area of healthcare and so this dissertation does not claim that its findings are definitive. Yet this dissertation can certainly claim it has made a strong and valid nexus between CPE educational deficiencies and the need for a phenomenology of suffering. This dissertation has suggested throughout that CPE will need to refocus its learning, educational, and clinical praxis on the *phenomenon of suffering* to even begin to approximate this new horizon of understanding. This dissertation claims that CPE must do this if it wishes to improve its praxis within its human science discipline, and also achieve its long-standing CPE project to *care for* and *cure souls*.

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