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REPORT

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Self-reflections of health care chaplain fellows: Development in self-attunement and compassion during engagement with Compassion-Centered Spiritual Health (CCSH)

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ABSTRACT

Clinical Pastoral Education (CPE) prepares health care chaplains to address the spiritual and emotional needs of diverse patients and staff by cultivating self-awareness, interpersonal and clinical skills, and resilient compassion. Some health care chaplains engage in structured fellowship activities after CPE to expand and improve their expertise in clinical spiritual care. We conducted a retrospective investigation of recurring consult case reflections from chaplain fellows ($n = 10$) enrolled in a 2-year Compassion-Centered Spiritual Health (CCSH) fellowship program. We compared the fellows' first and last 10 reflections to identify changes in the fellows' reported activities and in the language that they used to reflect on their attunement during the consults. In the last 10 reflections, fellows attributed patient distress to a wider array of sources and were more likely to report using mindful grounding and cultivating a warm-hearted presence with patients. When reflecting on their self-attunement, fellows used fewer discrepancy words (e.g., *would*) and more positive emotion language in the final 10 reflections. These results suggest that fellows diversified their activities with patients and used less dichotomous thinking to discuss their attunement as they became more experienced. This research provides insight into the cultivation of interpersonal and intrapersonal skills essential for high-quality chaplaincy care.

KEYWORDS

Clinical pastoral education; compassion; health care chaplains; LIWC; spiritual health

Introduction and background

Health care chaplains play a vital role in health care settings by supporting patients, their loved ones, and health care staff across diverse spiritual and religious affiliations. Chaplains address the holistic needs of patient care, including psychological, social, and spiritual needs (Cunningham et al., 2017; Handzo et al., 2023). Chaplains also provide

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specialized spiritual and emotional support to patients and families during times of distress through conversation, prayer, ritual, intervention, life review, advocacy, empathetic listening, and participation in care assessments (Gaines et al., 2023; Tartaglia et al., 2024). Health care chaplains provide expansive and varied care, supporting patients and their loved ones across a wide spectrum of clinical conditions, illness severities, and care trajectories. They work in diverse settings, such as inpatient, outpatient, and telehealth (Adams, 2019; Handzo et al., 2023). Although research increasingly highlights the benefits of chaplaincy care and characterizes the multifaceted role of health care chaplains, less is known about the emergent psychosocial skills and attributes cultivated during chaplaincy training. We addressed this gap by examining how chaplains' professional competencies and interpersonal skills changed across the course of a compassion-based fellowship program through their self-reported activities and linguistic choices, which seemed to support more sustainable and inclusive compassion.

Research consistently highlights the benefits of chaplaincy care on patient care and clinical outcomes. For example, most patients report meaningful benefits from chaplain consults (Pearce et al., 2012; Piderman et al., 2013), and patient satisfaction is higher when a chaplaincy consult is included in their care (Marin et al., 2015; Williams et al., 2011). By reducing anxiety and enhancing patients' feelings of alignment with their health care goals, chaplains can significantly improve the quality of care for patients in times of crisis (Flannelly et al., 2012). Moreover, collaborative care between physicians and chaplains has been shown to enhance patient and provider satisfaction, strengthen teamwork, and support provider well-being (Branney, 2012). Additional research has found that patients have lower rates of hospital deaths and higher rates of hospice enrollment when chaplaincy services are offered in hospitals (Flannelly et al., 2012). These findings reinforce health care chaplains' role not only in spiritual care but also in clinical patient care.

Health care chaplains train to deliver spiritual care in a clinical context through engagement with Clinical Pastoral Education (CPE), which involves supervised interactions with care receivers experiencing a crisis. CPE aims to help chaplains not only achieve clinical competencies but also develop psychosocial skills such as emotional awareness and compassion (Handzo et al., 2023). Training methods for CPE include an action/reflection method that teaches chaplains foundational knowledge on how to address clinical challenges, such as professional practice skills and organizational leadership (Clevenger et al., 2021; Jones et al., 2021). Educational components of CPE include peer group processes, supervised clinical consults, and didactic instruction (Cobb et al., 2012). Overall, CPE qualifications equip health care chaplains to be valuable assets in the skillful delivery of quality patient care (Potts et al., 2023). Following CPE, some chaplains may choose to pursue a fellowship in order to refine their skills with patient interactions.

Previous studies evaluating CPE have identified improvements in emotional intelligence and self-efficacy, self-reflection, and pastoral and clinical skills (Jankowski et al., 2008; Ragsdale, 2018; Szilagyi et al., 2024). CPE participation has also been shown to promote role clarity, which in turn cultivates self-confidence, teamwork, and leadership skills (den Toom et al., 2024; Szilagyi et al., 2024). These improvements are especially useful as researchers have found that a chaplain's confidence and ability to cultivate

trusting relationships with other health care members are associated with their integration and perceived value within the health care organization (Swift, 2019). Health care chaplain trainees typically complete four CPE units covering key competencies including the practice of ministry, evaluation and supervision, and theoretical perspectives on the program's elements (ACPE). Proficiency in chaplaincy care is further supported by board certification requirements. After completing a one-year CPE program and residency, some chaplains choose to pursue a fellowship, where they train more advanced skills and practice more independently than they did as residents (Swift, 2019).

Educators have emphasized the benefit of chaplains' competency to acknowledge the patient's whole personhood (Cadge et al., 2019). When evaluating important hiring criteria, health care institutions prioritize chaplains who exhibit strong interpersonal skills (i.e., warmth and compassion), effective communication, and a growth mindset for continuous learning and self-reflection (Fleenor et al., 2025). Chaplains' critical role in providing emotional support and cultivating a trusting environment underscores the importance of cultivating resilient and expansive compassion during CPE training. Chaplains' holistic care is especially important because they must also accommodate the diverse, continuously changing demographics in America. Approximately one-fifth of Americans report no religious affiliation (Cadge et al., 2019). Although CPE is widely regarded as essential for training spiritual care competency for diverse patients, research on its content and processes remains limited, leaving fundamental knowledge gaps (Cadge et al., 2019; Clevenger et al., 2021). The overall aim of this study was to describe change processes observed during chaplain training by exploring changes in chaplains' consult reflections with hospitalized in-patients in a metro-Atlanta hospital through the chaplains' reflections completed during a two-year post-CPE fellowship program. Specifically, we identified changes in fellows' self-reported activities and investigated how fellows' responses to open-ended prompts about attunement to themself and to care-seekers changed throughout the course of their first and last 10 reflections. Accordingly, this study was guided by the following questions. First, how do chaplain fellows' self-reported activities change during a compassion-centered fellowship program? Second, how does the language chaplains use in their self-reflections change during their fellowship?

Methods

Overview

This program evaluation examined chaplain fellows who were post-CPE learners and were enrolled in a two-year fellowship program that used The Compassion-Centered Spiritual Health (CCSH) model and curriculum (described in the following discussion) at the time of this study. To characterize chaplain fellows' activities with patients and explore changes in their activities and the language they used to describe their consults, we examined reflections completed throughout their fellowship. Chaplain fellows completed 60 total reflections over the course of their two-year fellowship. Four to five reflections were complete monthly on a subset of consults conducted with in-patients at a hospital in the metro Atlanta area, and fellows chose which consults on which they wrote their reflections. To identify changes in chaplain activities and the language used

in their reflections, we compared the first 10 and last 10 reflection forms completed by 10 chaplain fellows. The first 10 and last 10 consults were selected for each chaplain fellow to ensure a consistent within-participant comparison of early versus later reflections across all fellows. The consults were assessed to analyze whether there were changes in the types of language that chaplains used to describe their consults over the course of their fellowship. The dates ranged from November 2021 to August 2023. The institutional review board determined that institutional review and consent were not necessary because data were anonymized and gathered for program evaluation. No incentives were given for participation. One fellow was missing a single reflection, as they accidentally submitted the same reflection form twice. This form was counted as missing in the analyses. There were no other instances of missing data, and we did not conduct any imputation for missing data.

Compassion-Centered Spiritual Health (CCSH) model

The fellows examined in this program evaluation were trained in the CCSH Model,[1] an operationalized approach to spiritual health care that applies theory-driven research on compassion for both care receivers and caregivers. During their CCSH Fellowship, chaplains receive one-on-one mentoring using their written cases. They also participated in and presented at two Fellow group meetings each month with supervision. Throughout this process, chaplains followed the CCSH and CBCT manuals to fine-tune their use of CBCT practices and deepen their CCSH competencies. CCSH integrates insights from Cognitively-Based Compassion Training (CBCT), an Indo-Tibetan Buddhism-inspired training program designed for both religious and non-religious individuals, enhancing chaplains' ability to enhance resilience and well-being while reducing burnout and depression among health care professionals (Ash et al., 2021; Hofmann et al., 2011; LoParo et al., 2018; Mascaro et al., 2018). The training incorporates a range of meditative exercises aimed at stabilizing attention and fostering compassionate perspectives (Ash et al., 2021; Mascaro et al., 2022; Pace et al., 2009). For example, mindful grounding exercises such as mindfulness to the sensations of the breath aim to cultivate attentional and non-reactive awareness that facilitates the identification, acknowledgement, and allowing (sometimes referred to as *equanimity*) of emotional experience. Compassion-based practices are cognitive exercises to contemplate a deep sense of interconnectedness to cultivate affection and endearment and to facilitate a warmhearted presence (Brenden & Brooke, 2011).

Expanding upon CBCT, CCSH emphasizes compassion as a fundamental objective of spiritual care (Mascaro et al., 2024, 2025). This evidence-based model employs a structured, four-stage process that emphasizes the cultivation of compassion in the spiritual care of chaplains: (a) Prepare the Care Responder, (b) Attune to the Relationship, (c) Access compassion, and (d) Entrust the Care Seeker. In the Stage 1, chaplains prepare for an encounter with a care seeker by regulating their internal state and grounding their intention to offer care. In the second stage, the chaplain observes the care seeker's emotional state and evaluates how to proceed based on factors that may impact the care seeker's level of distress. Stage 2, "Attune to the Relationship" encompasses two overarching concepts: "Attune to Self" and "Attune to Other." This involves attuning both

to the care seeker and the external environment, discerning distress, and noticing emotional imbalance to help the care seeker return to a physiologically attuned state. The third stage encourages the chaplain to access their compassion and pinpoint care responses that could help the care-seeker cultivate compassion, warm connection, and resilience. In the final stage, the chaplain entrusts the care-seeker and acknowledges steps to move forward with compassion, hope, and resilience. This series of steps encourages the chaplain to regulate their own internal state first and then connect with care-seekers through a compassionate presence. Overall, the chaplain and care-seeker work as a team to explore their resources to move forward beyond the encounter.

Case reflections

The consult case reflection forms, which closely follow the CCSH model, were completed by the chaplain fellows and consisted of both "check all that apply" and open-ended reflection questions. In the reflections, fellows contextualized the current state of the care seeker's attitude and external/internal atmosphere, such as the involvement of family members and/or health care staff. Some fellows also elaborated on potential future steps for patient care. The remainder of the intervention form was categorized according to the four stages of the CCSH Model, followed by a final reflection. (The self-reflection form completed by the health care chaplains is presented in Online Supplemental Figure 1). The reflection forms represent the intrapersonal and interpersonal skills that CCSH aims to cultivate. Intrapersonal skills emphasize self-regulation and self-compassion to strengthen psychological resilience, while interpersonal skills involve extending compassion toward others (Ash et al., 2021).

To characterize fellows' activities, we analyzed how frequently they engaged in key tasks aligned with each stage of CCSH: first, preparing their mental and emotional state; second, building a connection with the patient and assessing sources of distress and resources of the care seeker; and third, providing a compassionate response tailored to the patient's specific needs. To examine fellows' open-ended reflections about their attunement during the consult, we investigated the language used in the free text of Stage 2: Attune to the Relationship. In the "Attune-to-Other" reflective statement, chaplain fellows described which aspects of their responses to patients were "acknowledged and allowed." In the "Attune-to-Self" reflective statement, they noted the CBCT skills or insights used to sustain empathetic balance. During this stage, chaplains closely observed the care-seeker's zone of well-being, including emotional state as well as behavioral and verbal cues.

Activities

To characterize chaplain self-reported activities and identify changes in their self-reported activities, we first generated frequency counts for each activity across all reflections. We then compared the frequency of each activity occurring in the first 10 consults to the frequency in the last 10 consults. Chi-Square tests were applied to determine whether the ratio of reported activities significantly differed between these two time points.

Language

We utilized Linguistic Inquiry and Word Count (LIWC) 2022 software, a comprehensive text analysis tool, to analyze changes in fellows' language in the open-ended prompts about their attunement (Pennebaker et al., 2015). Through its integration of over a hundred dictionaries, LIWC-22 compares each word to an internal dictionary category, generating a frequency count of major linguistic categories (e.g., pronouns), psychological processes (e.g., affective or emotional words), personal concerns (e.g. occupation), and others, and calculates the percentage of total words that fall into each category relative to the total word count. We were interested in fellows' use of language related to cognitive processes: causation (e.g., *how*, *because*, *make*, *why)*, tentative (e.g., *if*, *or*, *any*, *something)*, differentiation (e.g., *but*, *not*, *if*, *or*), insight (e.g., *know*, *how*, *think*, *feel*), discrepancy (e.g., *would*, *can*, *want*, *could*), and certitude (e.g., *really*, *actually*, *of course*, *real*).

In addition to frequency counts, LIWC assesses linguistic style through four summary variables: analytical thinking, clout, authenticity, and emotional tone. Given the focus of this study on chaplains' reflections, we examined clout and authenticity scores. Clout scores are interpreted as reflecting self-confidence and are generated using the formula: first person plural + second person + social processes – first person singular – swear words – negations – differentiation. Authenticity scores reflect the capacity to speak vulnerably without self-monitoring and are calculated as: authenticity = first person singular + third person singular + third person plural + differentiation – motion – negative emotions (Zhou et al., 2023).

Statistical analyses

All data were analyzed using the Statistical Package for the Social Sciences software, version 25.0. For activities, we used chi-squared tests to evaluate whether each activity was more or less common during the final 10 consults compared to the first 10. For language variables we compared the outputs of each LIWC output between the first and last 10 consults for both "attune to other" and "attune to self" texts using Wilcoxon signed-rank tests. Applying Wilcoxon signed-rank tests were necessary as the LIWC summary variables were not normally distributed, and measures were paired. An alpha level of 0.05 for all statistical tests (Kotz & Johnson, 1991).

Results

In our analysis of the frequency of activities outlined in the reflection forms, we found that five activities were significantly different when comparing the first 10 and last 10 consults. Chaplain fellows were more likely to attribute patient distress to exaggerated expectations of difficult emotions in the last 10 consults of their training ($\chi^2(1, N = 20) = 4.23$, $p = 0.040$) and less likely to link patient distress to excessive focus on personal shortcomings and overly harsh self-judgment ($\chi^2(1, N = 20) = 4.048$, $p = 0.044$). Chaplain fellows were less likely to associate patient distress with feelings of isolation and abandonment in the last 10 reflections ($\chi^2(1, N = 20) = 6.14$, $p = 0.013$). For Stage 3 of the chaplains' compassionate response, fellows were more likely to report that they

stabilized and mindfully grounding their attention ($\chi^2(1, N = 20) = 4.72$, $p = 0.030$) and more likely to report engaging in a warmhearted presence with their patients ($\chi^2(1, N = 20) = 14.38$, $p < 0.001$) during the end of their training. Individual fellows' activities are visualized in supplemental figures (Online Supplemental Figures 2–6).

With respect to the language used during the open-ended prompts about attunement, fellows used fewer discrepancy words (e.g., should, would, could, ought) when reflecting on attunement to themselves during their last 10 reflections ($Z = -2.71$; $p < 0.01$) (Table 1). Chaplains also used more positive emotion language, indicated by greater emotional tone scores in the final 10 reflections ($Z = -2.44$; $p < 0.05$), representing a greater ratio of positive to negative emotion language (Tables 1 and 2).

Discussion

Compassion is a central pillar of high-quality patient care, improving both health care personnel's well-being and patient outcomes. This is especially true for health care chaplains, which is why CPE programs strongly focus on cultivating compassion among chaplains. Compassion-based CPE programs have been shown to improve chaplains' psychosocial skills, equipping them to respond effectively to most emotionally taxing cases (Mascaro et al., 2025). Here, we compared the first and last 10 consults of chaplain fellows who had completed post-CPE and were now enrolled in a fellowship following the CCSH model, which is aimed at cultivating compassion. Over time, fellows diversified their attributions of patient distress and demonstrated deeper attunement to compassion by more frequently engaging in mindful grounding and a warmhearted presence. Chaplains also used fewer discrepancy words and more emotional tone words when writing self-reflections. Taken together, the results offer insights into how chaplain fellows who completed CCSH chose to engage in particular compassionate skills.

Compassionate care begins with recognizing the care recipient's suffering (Sinclair et al., 2018). In the CCSH model, chaplains initiated their compassionate response to the patient by first carefully assessing the sources of patient distress. With respect to chaplains' reports of patient distress, we found that chaplains were more likely to attribute patient distress to exaggerated expectations of being free from difficult emotions later in their fellowship. During CCSH training, chaplains learn to identify exaggerated expectations of being free from difficult emotions when patients voice, for example, being alone in their suffering or feeling that their suffering is result of being punished for a past action (Shelton et al., 2018). Chaplains were also less likely to link patient distress to the patient's narrow focus on perceived personal failures and overly harsh self-criticism. Furthermore, chaplains less frequently associated patient distress with feelings of isolation and abandonment (i.e., the patient feeling disconnected from their loved ones) during their last 10 consults. Taken together, these results indicate that chaplain fellows at an earlier stage of training may more readily attribute patient distress to feelings of isolation. With more experience, fellows may have become more sensitive to underlying existential struggles like excessive emotional expectations rather than interpreting distress as purely emotional. These findings align with previous studies that found that chaplains became better equipped with their spiritual assessment skills in honing in on patients' spiritual struggles, an explicit goal of CPE (Szilagyi et al., 2024).

Table 1. Comparison of health care chaplains' median LIWC scores reflecting their attunement to themselves during first versus last ten visits with patients.

Attune to Self				
Module	First 10 Visits	Last 10 Visits		
	M (*SD*)	*M* (*SD*)	Z	*p*
Analytic	68.71 (26.84)	64.21 (27.28)	−1.107	.287
Clout	8.80 (22.11)	8.37 (16.35)	−1.25	.213
Authentic	79.29 (27.65)	79.41 (27.45)	−0.68	.678
Tone	**34.77 (31.09)**	**53.42 (36.61)**	**−2.44**	**.015****
Cognitive process	11.28 (4.19)	11.40 (5.04)	−0.03	.975
Insight	3.28 (2.04)	3.59 (2.45)	−0.87	.384
Cause	1.48 (1.81)	1.87 (1.72)	−0.29	.771
Discrepancy	**1.36 (1.30)**	**0.84 (1.36)**	**−2.71**	**0.007*****
Tentative	1.17 (1.33)	1.07 (1.66)	−0.30	.767
Certitude	0.00 (0.56)	0.00 (0.40)	−0.13	.894
Difference	2.13 (1.85)	1.78 (2.07)	−0.09	.927

Note. Bold values indicate statistical significance. **Correlation is significant at the 0.05 level (2-tailed). ***Correlation is significant at the 0.005 level (2-tailed).

Table 2. Comparison of health care chaplains' median LIWC scores reflecting their attunement to the patients during the chaplains' first versus last ten visits.

Attune to Other				
Module	First 10 Visits	Last 10 Visits		
	M (*SD*)	*M* (*SD*)	Z	*p*
Analytic	54.70 (26.42)	47.48 (24.76)	−0.74	.460
Clout	66.61 (29.66)	65.16 (27.52)	−0.36	.719
Authentic	17.19 (28.38)	17.73 (35.31)	−0.91	.361
Tone	20.23 (31.22)	20.23 (32.40)	−0.91	.361
Cognitive process	10.31 (5.52)	9.92 (5.00)	−0.52	.604
Insight	2.64 (2.51)	2.62 (2.48)	−0.70	.482
Cause	1.40 (1.81)	1.86 (2.00)	−1.71	.088
Discrepancy	1.44 (2.03)	1.20 (1.48)	−1.79	.073
Tentative	1.40 (1.75)	1.58 (2.03)	−0.93	.351
Certitude	0.00 (0.83)	0.00 (0.93)	−0.57	.572
Difference	2.07 (2.26)	2.16 (2.28)	−0.10	.917

Note. Bold values indicate statistical significance. **Correlation is significant at the 0.05 level (2-tailed). ***Correlation is significant at the 0.005 level (2-tailed). LIWC = Linguistic Inquiry and Word Count.

By recognizing patients' struggles with heightened expectations related to difficult emotions, chaplains may be better able to anticipate potential threats to patients' self-worth, an issue that researchers highlight as a core hallmark of spiritual distress (Lee, 2002). CPE also encourages chaplains to go beyond surface-level emotional assessments toward more thoughtful evaluations that attend to patients' emotional, spiritual, and relational conflicts (Szilagyi et al., 2024). Thus, our findings align with the goals of CPE as the post-CPE chaplain fellows appeared more discerning of complex sources of distress and nuanced forms of suffering after training and experience with CCSH. Our finding that chaplain fellows reported a more frequent use of stabilizing and mindful grounding of their attention at the end of their training reveals other areas of growth, especially in engaging compassion. For example, during CCSH training chaplains learn to stabilize and ground their attention by directing their attention to their breath or to physical sensations such as colors, sounds, and touch (Shelton et al., 2018). A previous study found that mindfulness training may help cultivate compassion through a scalable

digital app-based mindfulness intervention (Lim et al., 2015). Our findings also invite a promising outlook for the CCSH model as previous research suggests a prioritization of an attentive and process-oriented intervention delivery method in chaplaincy care (Cadge & Sigalow, 2013; Lyndes et al., 2012). Similarly, chaplains reported cultivating a warmhearted presence with their patients more during their last 10 consult reflections. Within CCSH training, cultivating warmhearted presence involves intentional attunement with the care-seeker, balancing empathy for self and other while allowing and acknowledging distress and suffering. This cultivation may feel empowering, which can be actively practiced even when suffering could not be resolved. Unlike the traditional emphasis in CPE on sustaining a non-anxious presence, CCSH highlights cultivation of presence rather than avoidance. Warmhearted presence expands upon simple concern and recognizes the care-seeker as "like me" in seeking relief from distress (Shelton et al., 2018). The chaplains' response supports CBCT's integrative model's intent to enhance the caregiver's resilience by encouraging them to gain greater self-awareness of their thoughts and thus promoting resilience (Ash et al., 2021). These findings are promising, especially with growing evidence emphasizing the role of the chaplain's demeanor during patient interaction, specifically their gentleness, compassion, and calmness, in fostering a trusting relationship with patients (Cunningham et al., 2017; Flannelly et al., 2009; McCormick & Hildebrand, 2015). Furthermore, research increasingly recognizes spiritual care for encompassing more than simply religious engagement but also acknowledging a broader sense of purpose and connectedness with themselves and the external environment (de Brito Sena et al., 2021). If the reflections are indicative of chaplains' enhanced ability to remain present and self-regulate during crises, CPE and the CCSH model may be beneficial in their ability to provide quality spiritual care. In fact, previous research from our group has found that CCSH training is associated with improved patient outcomes (Mascaro et al., 2025). Our findings are also consistent with previous research on how short-term compassion training may enhance concern for others' well-being due to its pro-social structure compared to short-term instruction-based training of empathic concern (Leiberg et al., 2011).

We also found that chaplain fellows used fewer discrepancy words (e.g., should, would, could) when engaging in self-attunement in their last 10 reflections. Framed within the psychological processes domain under the cognitive processes subcategory of LIWC, discrepancy words are generally understood to reflect perceived gaps between one's current state versus their desired state (Pennebaker et al., 1997). Prior research correlates higher use of discrepancy words to more regret, uncertainty, and lower confidence (Moore et al., 2021) as well as increased maladaptive rumination if one reflects on unresolved internal conflict, especially when employed with negative emotion words (Watkins, 2004). In the context of chaplaincy, frequent use of discrepancy words may reveal heightened internal conflict, such as unresolved tension between chaplains' intentions and their perceived professional competence. A prior study found that greater use of discrepancy words in autobiographical narratives written by women who habitually experienced domestic violence could reflect a mismatch between their anticipated outcome and actual outcomes (Tani et al., 2016). Other literature has similarly noted that greater use of discrepancy words may suggest relatively more focus on gaps between their current state and a desired state. (Hevey & Wilczkiewicz, 2014; Pennebaker, 1993).

From this view, the use of relatively fewer discrepancy words by chaplains at the end of their fellowship may demonstrate growing internal resolution and confidence as fellows gain insight into how they may navigate patient encounters. However, the findings on discrepancy-word usage are nuanced and complex. Some studies suggest that lower usage of discrepancy words may also reflect reduced cognitive complexity with conflicting interpretations. For example, one study found that negative post-traumatic cognition (e.g., self-blame) among trauma-exposed individuals was associated with the use of fewer discrepancy words when they discussed distressing nightmares (Meador et al., 2022). Moreover, another study found that habitual liars used significantly fewer discrepancy words than those who told the truth in high-stakes cheating scenarios, a pattern interpreted as lower cognitive processing rather than increased clarity (Ali & Levine, 2008). However, the researchers in this study caution that the discrepancy word usage differences between liars and truth-tellers vary based on their context. Our findings are more plausibly understood as an indicator of changing internal conflict management rather than reduced honesty. As fellows progressed through their training, they may have become less preoccupied with perceived gaps in their skills and more grounded with presence. This interpretation is supported by parallel findings in the present study that fellows more frequently using mindful grounding and warmhearted presence at the end of their fellowship and used relatively more positive emotion language in their later reflections. Taken together, this study adds to what is known about discrepancy word usage in the context of health care chaplaincy and how chaplains may manage their internal conflict after patient interactions over time. The use of less discrepancy language may reflect processes of self-attunement and confidence, which are important competencies in spiritual care. Understanding this shift in discrepancy language may provide insight into how chaplains manage internal conflict as they progress through their fellowship.

Additionally, emotional tone scores increased in the final 10 reflections, indicative of a greater ratio of positive to negative emotion language. Additionally, emotional tone scores increased in the final 10 reflections, indicative of a greater ratio of positive to negative emotion language. Emotion tone scores reflect positive (e.g., happy, joy) and negative (e.g., sad, angry) emotion language as well as words related to those emotions (e.g., birthday, beautiful, funeral) (Boyd et al., 2022). For instance, one chaplain noted in a reflection at the end of their fellowship, "I felt like I was bearing witness to something beautiful and holy, and I felt grateful to be invited here." This shift may be especially beneficial for emotional processing and meaning-making. For instance, previous research found that individuals who employ more positive emotion tone words while writing about their past trauma possessed better health outcomes (Pennebaker et al., 1997). Another study found that higher usage of negative emotion tone words was significantly associated with higher momentary depression severity in patients with major depressive disorder (Hartnagel et al., 2025). Other studies suggest that communicating positive emotions can be a mechanism to enhance resilience from depression and to nurture connections (Askelund et al., 2018; Fredrickson et al., 2003). In clinical contexts, practitioners whose communication used positive messages had small measurable benefits in patients' perceived pain (Howick et al., 2018) and were associated with greater patient preference (Falkenstein et al., 2016). Although we are unable to

definitively link chaplains' use of relatively more positive emotion language with either chaplain or patient outcomes, one interpretation of our finding is that training may support chaplains' skills in engaging in greater self-attunement with a more emotionally regulated and positive stance. Furthermore, chaplains may have had increased capability of making visible more nuanced resources of the care-seeker in the present moment to help bring forward and to soften the source(s) of distress.

Although our findings may not be generalizable to other post-CPE programs, this program evaluation may inform what is known about the skills and attributes cultivated during chaplaincy training. Existing research indicates that organizations that oversee chaplaincy certification are separate from those accrediting CPE education, leading to some inconsistencies in chaplaincy preparation (Cadge et al., 2019; Clevenger et al., 2021). Moreover, CPE has been criticized for not keeping pace with the United States' emphasis on patient-centered outcomes in the health care setting due to CPE's heavy emphasis on didactic training and limited attention to propositional knowledge (i.e., facts, theories, and ideas) (Clevenger et al., 2021). Consequently, contemporary chaplaincy education has increasingly sought to place a greater emphasis on propositional knowledge into the existing curriculum, including formal instruction in ethics and evidence-based spiritual care development (Fleenor et al., 2022, 2025). However, Clevenger and colleagues (2021) note that there is little consensus among CPE educators regarding the inclusion criteria for CPE curriculum aside from a broader call for religious diversity. Furthermore, some leaders in the field advocate for the replacement of the second unit of chaplaincy education entirely with a second year of CPE residency or fellowship dedicated to specific clinical contexts (Cadge et al., 2019). These discussions regarding the CPE training process for health care chaplains underscore challenges in navigating the skills and professional competencies of CPE, especially in balancing approaches to didactic versus propositional education as well as regarding specific topics discussed in CPE, such as ethics, trauma, and organizational behavior (Clevenger et al., 2021). Moreover, our study identified changes in the way fellows interacted with and reflected on their interactions with patients, which may support the proposal to replace a traditional second unit with context-specific training.

Our findings may also provide insight into the concerning epidemic of burnout among frontline health care professionals (Dewa, 2014; Halbesleben & Rathert, 2008; Maslach & Leiter, 2016; Melnikow et al., 2022; Mufarrih et al., 2019; West et al., 2006, 2018). Burnout among health care workers is highly prevalent across licensure, specialization, and setting, burdening both patients and providers with significant cost and harm (Mohr et al., 2025). Neither are chaplains immune to burnout. One study reported that over 60% of palliative care chaplains experienced feeling worn out in the past three months due to their job (White et al., 2019). Moreover, the length of time chaplains work has also been shown to positively correlate with burnout (Galek et al., 2011). However, there is accumulating evidence that hospital chaplains may demonstrate an enhanced capacity to sustain compassion and may be relatively buffered from burnout despite routinely caring for patients in severe distress (Ash et al., 2021). Participation within CPE has also been shown to protect against burnout and compassion fatigue among chaplains (Flannelly et al., 2005). In a previous study, our team found that health care chaplains—many of whom were trained in the CCSH model—

were buffered from the impact of the pandemic on their well-being (Palmer et al., 2024). These findings align with broader evidence suggesting that compassion-based interventions may offer a promising approach in fostering resilience and reducing the risk for emotional exhaustion (Hotchkiss & Lesher, 2018; Lyon & Galbraith, 2023; Martins et al., 2025). Within this context, our findings that more experienced fellows reported generating warmhearted compassion more frequently at the end of the program may indicate the development tools and skills for a sustained capacity for compassion. As fellows gain more experience, increased use of warmhearted compassion may promote an increased capacity to remain present with patient suffering, which may in turn help lower burnout. Beyond sustaining presence, fellows may benefit more from forming genuine connection with the care-seeker and recognizing those interactions as nurturing moments that could be recalled during future challenging cases. This pattern suggests that sustained attunement to common humanity may help develop confidence in chaplains that they can still foster meaningful connection even in difficult circumstances.

Existing research highlights that clinical compassion facilitates engagement with patients and supports the delivery of highly adaptive care to evolving patient crises (Malenfant et al., 2022; Watts et al., 2023). Within the health care team, health care chaplains play a distinct role in alleviating patient distress as they co-navigate patients' concerns and formulate appropriate action plans for patient relief. Furthermore, chaplains' reflections vary based on the unique context of each crisis, often requiring chaplains to engage with complex emotional needs. Thus, chaplaincy training programs help facilitate not only clinical skills but also reflective practice and compassionate presence. As chaplains gain more experience through their training, they may develop the ability to sharply identify patients' distress, a skill especially desired by health care chaplaincy hiring managers (Fleenor et al., 2025). In this study, we found that chaplain fellows became more specific regarding which categorization they attributed patient distress to, thereby moving away from dichotomous thinking toward more nuanced insights into patient interactions. Taken together, our study investigates how CCSH-based CPE education may influence how health care chaplains navigate demanding patient crises as they gain more experience.

Limitations and future directions

Although this program evaluation reveals insights about changes evidenced by fellows' reflections, we cannot definitively generalize about CPE based on this study. A strength of this study was the longitudinal design, which allowed us to quantify changes in fellows' activities and the language they used in self-reflection; however, we are unable to examine which aspects of their training influenced these changes. As a program evaluation focused on a specific cohort of chaplain fellows, our results cannot be broadly applied to other populations or training programs. Moreover, because the data were collected through self-report, the findings reflect chaplains' perspectives and may not align with patient or observer reports of chaplain activities. While self-report measures are a common and valuable method for providing insights into compassion, they are inherently subjective. These self-reported measures are subject to social desirability bias,

which may compromise their accuracy (Dodd-McCue & Tartaglia, 2010; Sassenrath, 2020). Frequency counts of chaplains' activities also do not represent objective measures of their behavior. However, the chaplains completed these reflections as part of their training program and not in the context of a formal research evaluation. As such, the likelihood of bias may be reduced, and there was also a 100% attrition rate. Still, future research warrants more objective assessments to complement self-reported findings, and future studies could pair feedback from patients and interdisciplinary team members (e.g., nurses) with chaplain reports. Another potential limitation is that the design choice to compare the first and last 10 reflections reflects our a priori intuition that this comparison would yield the largest detectable changes. However, it is possible that other changes in activities or language that occurred during other stages in the fellowship may have been missed with this design. Additionally, our study's evaluation of the intervention may help refine and optimize specific skills that CCSH aims to develop, rather than simply evaluating its success or failure. This is especially beneficial as previous research suggests the call for a standard documentation tool in chaplain training to encourage inter-professional communication and collaborations between chaplains and patients (Tartaglia et al., 2016). Future research could also compare CCSH-trained fellows' adherence to that of fellows who exclusively followed other models of CPE training. In a future study, researchers could also diversify the sample by geographic location, religious affiliation, and varying levels of health care chaplain expertise and experience.

Our linguistic analysis is also limited by LIWC's inherent use of word counts and summary dimensions, which cannot fully consider the contexts or intents behind chaplains' language. Analysis using LIWC may have posed some contextual constraints because the unique structure or wording of each chaplain may have influenced their tone score. LIWC may have also misclassified certain words that otherwise embody compassion (e.g., "surrender" could have been misread as a negative word) (Moore et al., 2021; Tausczik & Pennebaker, 2010). Consequently, we cannot yet determine whether discrepancy word usage correlates with positive or negative outcomes without further analysis of the chaplains' well-being and performance outcomes. Our findings provide insight into how health care chaplains employ discrepancy words and what that may reveal about their internal conflict management. This program evaluation longitudinally examines chaplain fellows' consult activities and reflective language within a compassion-centered post-CPE fellowship. By highlighting the patterns across training, this study offers meaningful insights into this training program contribution to the development of clinical and interpersonal skills in chaplains. Ultimately, understanding how chaplains develop their skills through this CCSH-based CPE program provides insights into how to further refine the program to address the multi-factorial nature of compassion.

Note

1. Fellows in this study are building on their ACPE CPE Education in CCSH™: a program to bolster the well-being, resilience, and compassion of health care patients and staff. CCSH™ augments spiritual health education and best practices with CBCT®, a program developed at the Center for Contemplative Science and Compassion-Based Ethics at [Redacted] University.

CCSH™ interventions are delivered by spiritual care professionals trained in both CBCT® and ACPE: The Standard in Spiritual Care and Education.

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No potential conflict of interest was reported by the author(s).

Ethics statement

This program evaluation study was reviewed by the Emory University Institutional Review Board and determined to be exempt as it was not considered human subject research.

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Data availability request

The participants of this study did not give written consent for their data to be shared publicly, so due to the sensitive nature of the research supporting data is not available.

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