COVID-19 and Clinical Pastoral Education: How ACPE Educators Pivoted Amid the Pandemic

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Abstract
Clinical Pastoral Education (CPE) programs faced extraordinary challenges during the COVID-19 pandemic. We examined how ACPE-certified educators responded to maintain program delivery. Survey results ($n = 210$) suggested a substantial and abrupt increase in remote delivery for CPE instruction and supervised clinical practice, primarily driven by those previously fully in-person. Respondents reported abrupt changes impacted 1152 students. Participants rated their utilization and helpfulness of professional, organizational, and technology resources during the pivot and beyond.

Introduction

The COVID-19 pandemic in the United States has been an unprecedented event for our generation. It has had a tremendous impact on the landscape and delivery of higher education (Smalley, 2020). Institutions of higher learning were challenged to abruptly transition to remote learning, often without sufficient preparation or resources. Literature describing how universities and discipline-specific programs pivoted during this critical time continues to emerge (Armstrong-Mensah et al., 2020; Govindarajan & Srivastava, 2020; Marinoni et al., 2020; Quezada et al., 2020; Savard et al., 2020). Although the disruption resulted in a break from more traditional education models of

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knowledge transmission and assessment of student learning, it accelerated the need for educational innovation and transformation (García-Morales et al., 2021; Mishra et al., 2020).

The impact was particularly challenging for health profession education programs (Brady & Pradhan, 2020; Giddens, 2020; Mahdy, 2020; Morin, 2020; Rabe et al., 2020; Theoret & Ming, 2020; Volkers, 2020). Faced with the need to balance public safety with the provision of clinical services, organizations providing education for healthcare trainees were challenged to ensure the safety of faculty, trainees, and patients while maintaining program integrity (Bell et al., 2020). Institutional decisions about the status of trainees as students or employees often determined who was considered essential. Even employees such as chaplains had to be assessed for whether and how they would have direct patient access, and to which patients. Alternatives to face-to-face contact with patients and families required consideration (Snowden, 2021; Vandenhoeck et al., 2021). With the potential for reduced access to clinical hours, program accrediting bodies needed to determine their level of flexibility in enforcing established standards.

In the wake of these determinations, educators experienced an unprecedented reliance on technology. Content lectures readily shifted to remote platforms such as Zoom or Microsoft Teams, while case-based learning and the practice of clinical skills shifted to virtual settings where possible (Scott, 2020). Healthcare education that traditionally involved hands-on clinical opportunities for learners required a shift from person-to-person to online or remote delivery in both speed and scope (Çoruh, 2020; Diaz & Walsh, 2021; Hannon et al., 2020; Hofmann et al., 2020; Jonuscheit et al., 2021; Seymour-Walsh et al., 2020; Sunavala-Dossabhoy & Spielman, 2020). Due to the extended pandemic crisis, what began as an emergency pivot now required changes of long-term consequence.

The use of simulation, a key but supplemental method of teaching, became the virtual tool of choice for some programs, especially for early learners in medicine and counseling (Brydges et al., 2020; Donn et al., 2021; Hannon et al., 2020; Phillips et al., 2021; Yang et al., 2021). In other training programs, this transition took several forms, including shifting case-based learning to remote formats, virtual bedside teaching rounds employing videoconferencing, and increased use of telehealth (Chandra et al., 2020; Diaz & Walsh, 2021; Hofmann et al., 2020; Keegan & Bannister, 2021; Sunavala-Dossabhoy & Spielman, 2020).

Clinical Pastoral Education (CPE) is a central training for spiritual care professionals and is required by national chaplaincy certifying bodies utilizing the Common Qualifications and Competencies for Professional Chaplains (APC, 2017). A recent special edition of the Journal of Pastoral Care and Counseling included an international study on the impact of COVID-19 on professional chaplaincy, with one article focused on continuing education and training (Flynn et al., 2021). Recommendations from the study focused more on how leaders and professional organizations shifted to remote use of technology for supervision and continuing education and did not specifically address programs of CPE. However, anecdotal reports tell us that CPE centers and educators faced similar challenges—and potential opportunities. Rapid paradigm shifts have affected the educational, organizational, and economic realities of CPE centers and the ACPE: The Standard for Spiritual Care & Education (ACPE).[1] Despite the pandemic, 7209 ACPE-accredited CPE student units were completed in the calendar year 2020 (ACPE, 2021). Although a growing literature now exists detailing the impact and resulting changes to health professions education, no study has been published on how ACPE-accredited programs of CPE have responded to the COVID-19 pandemic. We have yet to employ systematic ways to examine what these shifts look like in CPE. We recognized this time as an important window of opportunity to capture and critically reflect on how spiritual care education has been changing and evolving through the pandemic.

Purpose of the Study

The goal of this study was to describe how ACPE-accredited CPE pivoted and adapted in response to the COVID-19 pandemic. The specific aims were (a) to describe the extent to which educators pivoted to remote CPE delivery, and (b) to describe the changes ACPE educators made, as well as the strategies and resources employed in the pivot to remote learning.

Methods

Design and Participants

The study entailed a cross-sectional design and an online survey. We recruited spiritual care education professionals who were either certified by or in the certification process of ACPE. Eligible participants included ACPE Certified Educators, ACPE Associate Certified Educators, or Certified Educator Candidates who served as the primary educator responsible for at least one Level 1 or Level 2 CPE unit that was completed or in process between March and August 2020, during the initial acute phase of the COVID-19 pandemic in the United States.

Survey

Five ACPE educators and a research chaplain designed, developed, and tested the online survey. The online survey was further tested by four other educators selected by the authors and refined based on reported needs for clarity. Test data were not retained. Testing respondents were included in broader recruitment efforts and therefore had the opportunity to complete the final survey anonymously, if desired. We recruited potential participants via email

sent by ACPE to certified educators and certified educator candidates in their database. Additionally, ACPE publicized a link to the survey through online publications and email reminders until the period of data collection ended. Educators and other related organizations were also encouraged to share the survey information with potential participants via email or social media. Participants provided informed consent electronically at the start of the survey.

Survey data were gathered anonymously between December 2020 and January 2021 using REDCap (Research Electronic Data Capture), a secure survey and database application hosted by Johns Hopkins University. The survey elicited educator-level information by prompting participants to respond based on their own educational practices, views, and experiences and not to speak for their CPE center broadly or for other educators. The study protocol was reviewed and acknowledged as exempt from full review by the Johns Hopkins Medicine Institutional Review Board (IRB00271136).

Measurements

Overall, the survey involved questions regarding remote and in-person CPE delivery before and after the onset of the COVID-19 pandemic, the impact of COVID-19 on CPE units, trainees, and supervised clinical practice, and the resources participants utilized and found helpful, or anticipated finding helpful in the future. We gathered information about participants' demographic and professional backgrounds and CPE center types (using center types listed in the ACPE-accredited center public directory on www.acpe.edu), with multiple descriptors allowable for each center.

Before and After the Onset of COVID-19. Four paired pre-post questions measured the nature and extent of remote and in-person CPE delivery before and after the onset of the pandemic. Pre-COVID questions asked participants to consider the typical delivery methods for their CPE units in 2019 and up until February 2020. Post-COVID questions prompted educators to consider the CPE units they led since the onset of COVID-19, capturing the initial phase of the pandemic. These may have been CPE units that were completed, in progress, or beginning in this time frame. Three of the four pre-post question pairs inquired about remote and in-person delivery of structured group and individual instruction in CPE units. One question pair asked about CPE students' remote and in-person supervised clinical practice.

To indicate the typical ratio of in-person and remote CPE delivery across their CPE units, respondents chose from these options: (1) all in-person (100%), (2) some remote (less than 25%), (3) moderate amount remote (25%–50%), (4) significant amount remote (more than 50%), or (5) all remote (100%). Those who indicated at least some remote

delivery were asked about the typical ratio of synchronous versus asynchronous learning activities and the specific curriculum components within remote portions of CPE. Participants selected which educational components they delivered remotely from a list, including didactics, case conferences or verbatim seminars, IPR (interpersonal relations group seminars), individual supervision, and a text box to specify others not listed.

To identify what percent (%) of students' supervised clinical practice was done via remote means (e.g., telephone or virtual visits with spiritual care recipients), respondents selected one of these choices: (1) none (0%), (2) some (less than 25%), (3) moderate amount (25%–50%), (4) significant amount (more than 50%), or (5) all (100%) remote clinical practice.

Changes and Resources. These items explored the changes educators made in delivering CPE units due to COVID-19. We asked about unit cancelations and contributing factors, as well as abrupt changes to in-progress CPE units. We further inquired about the shift to remote spiritual care practice modalities for CPE students partially or fully and the strategies utilized to evaluate students' remote clinical practice learning in CPE. Specific questions were asked about educators' use of asynchronous learning activities and any Learning Management System (LMS).

The survey identified (a) what resources educators took advantage of and how helpful they found them during the pivot and (b) which resources would be helpful for the delivery of remote CPE in the future. Participants rated the degree to which each of 11 potential resources was helpful as they pivoted to remote CPE, using a five-point scale, where 1 meant not helpful at all and 5 most helpful, or N/A if they did not utilize a resource. Participants rated the same 11 resources on how helpful they would be if they delivered CPE remotely in the future, using the same five-point scale. There was a free-text box inviting responders to describe other not-listed resources at the end of each list.

Statistical Analysis

Basic descriptive statistics were generated using SAS v9.4 (SAS Institute, Cary, NC). Categorical data are presented as frequencies (percentages) and continuous data as means (standard deviations [SDs]), with ranges. These descriptive statistics were also used to generate the figures. No analytic assumptions needed to be verified, as no inferential statistics were performed.

Results

Participant Characteristics

The survey was submitted by 210 eligible participants, of which 197 were ACPE Certified Educators or ACPE

Associate Certified Educators. Direct communication with ACPE indicated that 356 educators in these certification categories reported CPE units during the eligibility time frame. This yielded a response rate of educators in these categories of 55.3%. Data on how many Certified Educator Candidates had primary responsibility for a unit were not available, and therefore response rate for this group could not be calculated.

The mean participant age was 55.3 (SD = 10.9) years. The majority of the sample was female (63.0%) and white (74.0%), with black or African American representing the next-largest racial category (10.1%). A large majority of the participants were certified educators (91.9%). Respondents had a wide range of length of experience since first getting certified as an ACPE Associate Certified Educator, including 23.0% > 20 years, 30.1% 11–20 years, 23.0% 5–10 years, and 18.7% < 5 years.

The three most frequent CPE center types describing participants' settings (with more than one descriptor possible for each center) were Academic Medical Center (47.1%), General Hospital (43.8%), and Level 1 Trauma Center (28.6%). The wide range of settings was notable since 19 of 20 center types were represented by at least one participant. Respondents reported living in 38 U.S. states and territories, with 2.5% living outside of the United States. Participant characteristics are shown in Table 1.

CPE Delivery Before and After the Onset of COVID-19

Remote Delivery of CPE. Examining the sample overall, a large majority of respondents (82.3%) reported delivering CPE instruction fully in person (no remote portion) before COVID-19, with the remainder delivering at least some portion remotely and only 5.3% delivering CPE that was significantly or fully remote. After the onset of the pandemic, fully in-person delivery dropped to 12.9%, while a notable 65.7% pivoted to delivery that was significantly or fully remote (Figure 1).

This shift toward increasingly remote delivery was largely driven by those who had been fully in person before COVID-19, which comprised the largest part of our sample, with 84.9% of them incorporating some remote since the onset of COVID-19. A similar shift was seen among those who were already using some degree of remote CPE delivery. Among those 37 respondents, 67.6% increased their use of remote, often pivoting to significantly or fully remote, while 24.3% continued with the same degree of remote delivery.

Synchronous and Asynchronous Learning Activities. Among those who were already delivering at least some remote CPE instruction pre-COVID-19, 52.9% employed fully and 41.2% mostly synchronous learning activities, with a modest shift to mostly synchronous after the onset of the pandemic (50% each, mostly and fully synchronous). In comparison, among those who were new to using remote delivery after the onset of COVID-19, 77.4% utilized fully synchronous and 21.2% mostly synchronous learning. In both groups, very few people (<6%) used remote learning that was substantially (at least half) asynchronous. Both groups favored fully or mostly synchronous remote learning.

Among those who reported any degree of asynchronous learning, 76.5% made use of prerecorded presentations, videos, or webinars; 38.2% discussion forums or boards; 38.2% written peer feedback or review; 25.0% portfolios, journals, or wikis; and 17.6% quizzes, surveys, or assessments. Free-text responses identified asynchronous activities such as a self-care log, podcast episodes, YouTube videos, research journal club, research literature review, and independent study (e.g., reading assignments and board certification preparation).

Remote Curriculum Components in CPE. Educators already using some degree of remote instruction before COVID-19 were heavily relying on the remote delivery of all curriculum components, ranging from 57.9% for IPR to 81.6% for supervision. These educators increased the prevalence of remote delivery of all curriculum components since the onset of the pandemic to a range of 92.1% (IPR) to 97.4%

Table 1. Participant Characteristics (N = 210).

Age, mean (SD) range	55.3 (10.9); 31–77
Gender, N (%)[a]	
Female	131 (63.0)
Male	68 (32.7)
Non-binary/third gender	2 (1.0)
Prefer to self-describe	3 (1.4)
Prefer not to say	4 (1.9)
Hispanic, N (%)	6 (2.9)
Race, N (%)[a]	
American Indian or Alaskan Native	3 (1.4)
Asian	7 (3.4)
Black or African American	21 (10.1)
Native Hawaiian or Other Pacific Islander	0 (0)
White	154 (74.0)
More than one race	9 (4.3)
Other, prefer to self-describe	5 (2.4)
Prefer not to say	9 (4.3)
Level of ACPE Certification, N (%)	
ACPE Certified Educator	193 (91.9)
ACPE Associate Certified Educator	4 (1.9)
Certified Educator Candidate (CEC)	13 (6.2)
Years of Experience, N (%)[a]	
Less than 5 years	39 (18.7)
5–10 years	48 (23.0)
11–20 years	63 (30.1)
More than 20 years	48 (23.0)
Certified Educator Candidate (CEC)	11 (5.3)

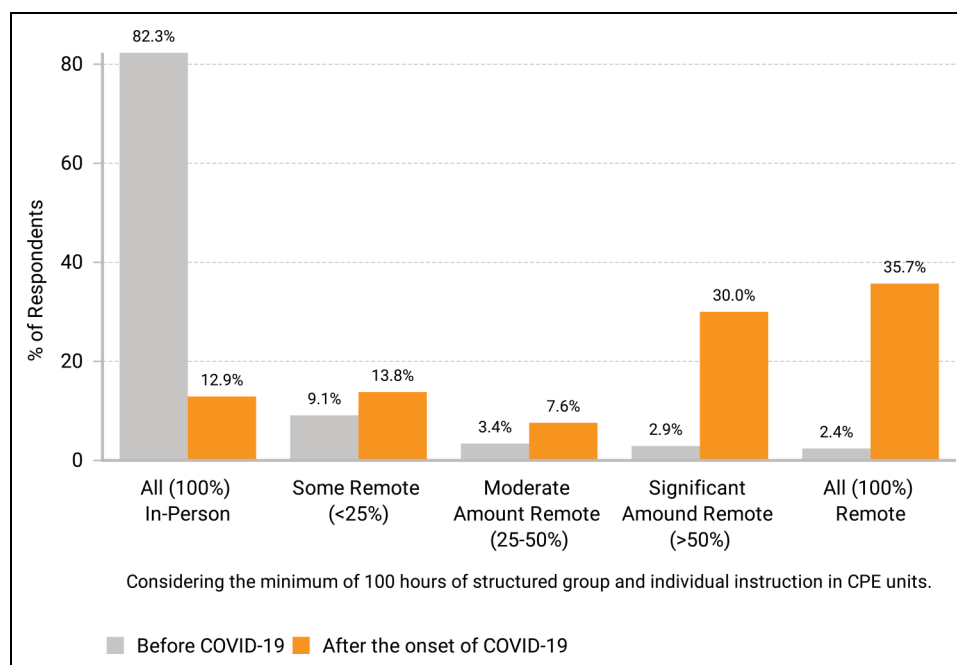[a]Missing data are less than 1% of the total sample.

Figure 1. Remote Clinical Pastoral Education (CPE) Delivery Pre- and Post-COVID-19.

(verbatims and individual supervision), with IPR showing the most gain (Table 2). Respondents new to remote learning (reporting no remote CPE at all before COVID-19) also relied heavily on remote delivery of each component but to a lesser degree, ranging from 72.7% for supervision to 81.4% for verbatims. However, many of them are likely utilizing remote methodologies to deliver these components for the first time.

Free-text responses highlighted additional remote learning activities such as book discussions, theological reflection seminars, final evaluations, graduations, retreats, worship, meditation, Level 2 or midyear student consultations, system orientation, independent study, and weekly reflection.

Remote Supervised Clinical Practice in CPE. Results revealed a major pivot toward trainees completing their supervised clinical practice via remote means such as telephone or virtual visits with spiritual care recipients, with 83.8% of participants reporting at least some remote clinical practice since the onset of the pandemic compared to 17.3% before. The prevalence of all-in-person clinical practice for trainees fell from 82.7% to 16.2% (Figure 2).

A large majority (82%) of those who reported that students engaged in fully in-person supervised clinical practice before COVID-19 switched, in varying degrees, to remote spiritual care practice. Most of them (41.9%) incorporated remote modalities for up to 25% of trainees' clinical care, and only 8.1% shifted to fully remote care. Similarly, while half (49.9%) of those who reported some remote clinical practice prior to the pandemic increased the proportion

of remote clinical care, most retained a substantial degree of in-person practice, and few switched entirely to remote (7.1%).

Those participants who switched from none to some degree of remote clinical practice or increased their use of remote, involving modalities such as telechaplaincy or virtual spiritual care, employed various strategies for evaluating trainees (Figure 3): 50.9% utilized roleplay with students or standardized patient simulation in class; 17% listened in on students' calls or virtual visits with care recipients; and 14.5% had students listen in on each other's spiritual care visits and provide peer feedback as evaluation strategies. Although most (83.6%) used the same verbatim or case presentation template as before COVID-19, 19.5% incorporated a format adjusted for virtual or telechaplaincy. Free-text responses added the use of feedback from peers, preceptors, and others, and the review of chart notes and clinical communications.

CPE Unit Cancelations and Changes Due to COVID-19

About a third of the participants (34.8%; $n = 73$) reported canceling a total of 93 CPE units due to COVID-19. Of these, 75.3% said the inability to complete CPE clinical practice hours and 11% the inability to deliver CPE remotely were significant factors in canceling.

Regarding abrupt changes in the midst of in-progress CPE units, 73.7% of participants indicated moving from in-person to at least some degree of remote delivery and 6.7% from partially remote to more or fully remote delivery due to

Table 2. CPE Curriculum Components Delivered Remotely Before and After COVID-19.

	Pre-COVID-19 frequencies among those *already* providing at least some remote pre-pandemic (n = 37)	Post-COVID-19 frequencies among those *already* providing at least some remote pre-pandemic (n = 37)	Post-COVID-19 frequencies among those *new* to remote since the pandemic (n = 172)
Individual Supervision	83.8%	97.3%	72.7%
Didactic Seminars	78.4%	94.6%	80.8%
Case Conferences or Verbatim Seminars	67.6%	97.3%	81.4%
IPR (Interpersonal Relations Group Seminars)	59.5%	91.9%	79.7%
Other	10.8%	8.1%	12.8%

Abbreviations: CPE, Clinical Pastoral Education; IPR, interpersonal relations group seminar.
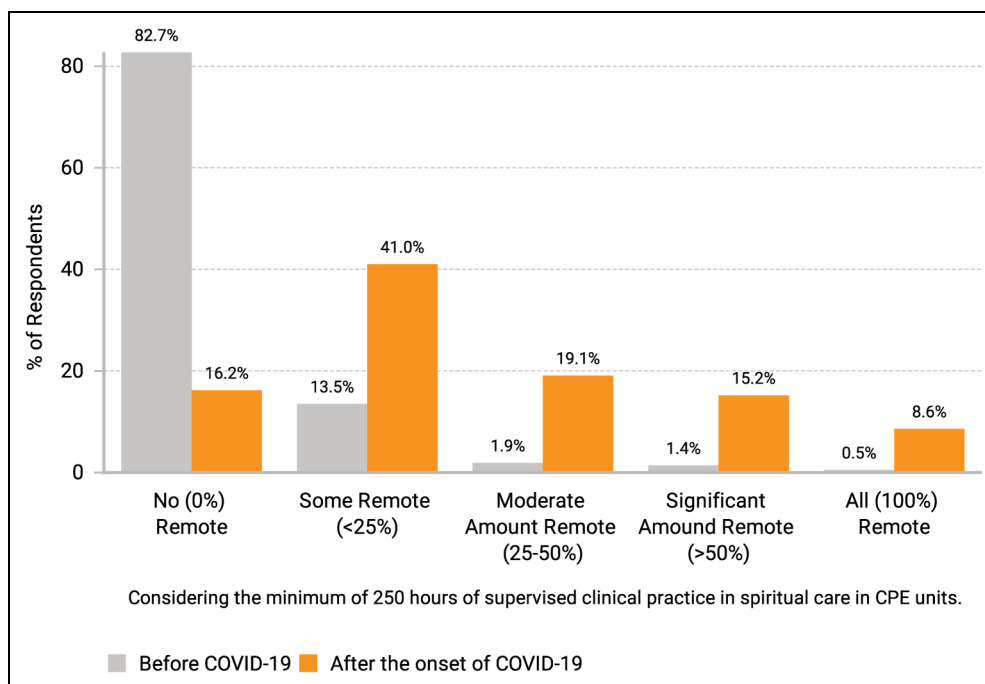
Figure 2. Remote Supervised Clinical Practice in Clinical Pastoral Education (CPE) Pre- and Post-COVID-19.

COVID-19. They reported a total of 1068 CPE students being affected by abruptly moving from in-person to some degree of remote and 84 CPE students by moving from partially remote to fully remote within an ongoing CPE unit. Overall, most participants (84.2%) had to make some type of pivot to remote CPE due to COVID-19 for either a unit-in-progress or subsequent units.

LMS Use

Only 22.9% of participants said they used a LMS or software to create, manage, and deliver course materials for remote CPE, with 43.8% using Microsoft Teams, 31.3% Google Classroom, 18.8% Canvas, 4.2% Moodle, and 2.1%

Blackboard. While not a fully integrated LMS, 13 free-text responses mentioned using video conferencing tools (e.g., Zoom, WebEx, Google Hangout, Jitsi, or Vidyo) and online collaboration tools, document management, and file sharing (e.g., Microsoft OneNote, Box, or Google Documents) for remote CPE.

Resources During the Pivot and in the Future

For each resource discussed below, we examined (a) the extent to which it was utilized by those who made a pivot to remote CPE, (b) how helpful it was perceived by those who utilized it, and (c) how helpful participants would find the resource in the future as they may continue remote delivery.
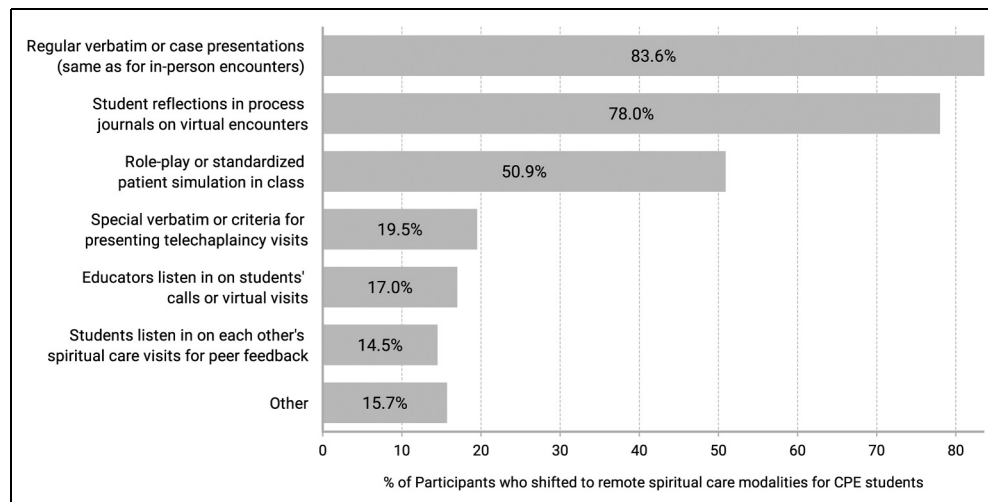
Figure 3. Strategies to Evaluate Remote Clinical Practice Learning in Spiritual Care.
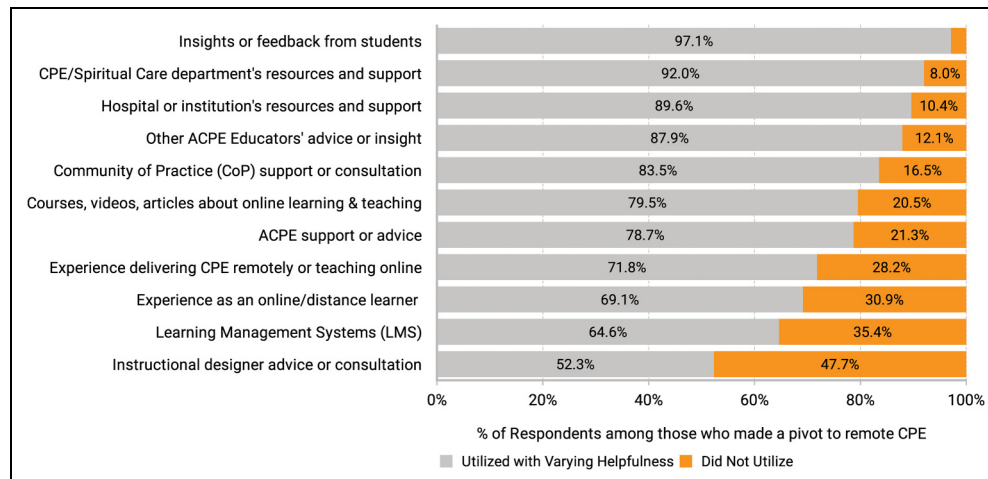

Figure 4. Resources Utilized Versus Not Utilized During the Pivot to Remote.

Utilization of Resources During the Pivot to Remote CPE. Among those who had to make some kind of a pivot to remote learning, the most commonly utilized resources included: insights or feedback from students; resources and support from the CPE or Spiritual Care department; resources and support from the hospital or institution; and advice or insight from other ACPE educators. The least-frequently cited resources by participants during their shift to remote CPE were advice or consultation from an instructional designer or a similar expert in remote learning; LMS, online learning platforms, and classroom solutions (e.g., Blackboard, Canvas, Google Classroom, Microsoft Teams, Moodle, etc.); and previous experience taking or delivering remote classes (Figure 4).

Helpfulness of Resources in Delivering Remote CPE. We measured participants' ratings of the helpfulness of select resources during the pivot among those who utilized them. We also asked all participants about the anticipated helpfulness of the same resources to promote successful remote delivery in the future (Figure 5). Insights or feedback from students were not only the most utilized resource but also was seen as the most helpful by those who utilized it (79.3% rated it highly helpful: 4 or 5 on a five-point scale where 1 meant not helpful at all and 5 meant most helpful). Even more participants (89.9%) evaluated the potential future helpfulness of this resource as highly helpful. Advice or insight from other ACPE educators was another markedly useful resource with high ratings on both helpfulness during the pivot and future helpfulness (68.6% and 83.6%).

We observed varying degrees of differences in how helpful a resource was for those who utilized it during *pivot* and how helpful all participants would find it in the *future*. The widest gap was revealed regarding support or advice from
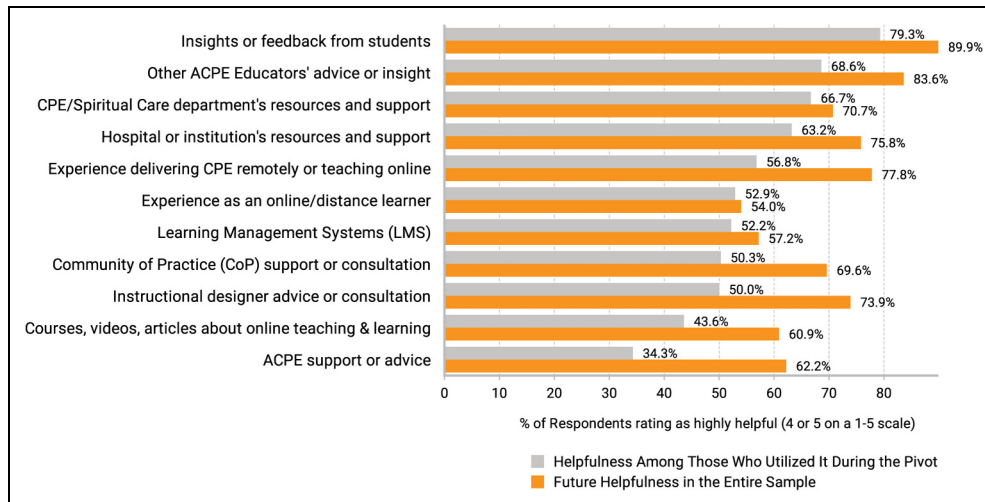
Figure 5. Helpfulness of Resources: During the Pivot and in the Future.

ACPE, with 34.3% perceiving it highly helpful among those who drew on it as a resource during the pivot, and 62.2% rating it as a highly helpful source of support as they may continue remote CPE in the future. Support or consultation in one's Community of Practice (CoP—self-organized communities of ACPE members around an area of shared interest to foster relationships, promote best practices, and provide ongoing professional development) showed a similar discrepancy in perception with 50.4% versus 69.6% rating it highly helpful during the pivot versus in the future. Advice or consultation from an instructional designer or a similar expert in remote learning was the least utilized resource with only 50.0% of educators rating it highly and 73.9% rating it to be a highly helpful resource in the future.

In free-text responses, participants highlighted resources they found most helpful while shifting to remote. These included video conferencing tools (e.g., Zoom, WebEx, or Skype), receiving advice from colleagues with remote teaching experiences, the action-reflection-action learning model, the Chaplaincy Innovation Lab, asynchronous video resources, ACPE guidelines, personal creativity, innovation, courage, and other resources from one's department, organization, or denomination.

Participants also commented on those resources they viewed most helpful for remote CPE in the future. They articulated the importance of ACPE and CoPs to endorse the value of remote learning, greater clarity on accreditation, bringing together educators to exchange ideas and support, and LMS provided by ACPE. Others reiterated the usefulness of technology, such as Zoom, WebEx, or OneNote, and the need for institutional support and resources such as laptops going forward. The action-reflection-action learning model, consultation with and feedback from remote spiritual care recipients, and practical training with technology were also mentioned.

Discussion

Our study aimed to describe the impact of the COVID-19 pandemic on the delivery of CPE through the eyes of ACPE educators. Findings demonstrated a substantial and abrupt pivot from primarily in-person to considerable remote structured instruction and remote supervised clinical practice in CPE. Most educators incorporating remote delivery had not done so before the pandemic and needed to learn and deliver remote instruction and clinical care for the first time during a fast-moving crisis. These shifts were congruent with how education in other health and helping professions quickly adapted to the disruptions and limitations brought about by COVID-19 (Bell et al., 2020; Fox, Bryant, Lin, et al., 2020; Morin, 2020; Seymour-Walsh et al., 2020; Volkers, 2020). Most educators incorporated at least some remote clinical practice for their trainees and employed a broad range of supervisory and evaluation strategies. This is also consistent with the transition to virtual clinical experiences utilized by other health professions (Augusterfer et al., 2020; Chandra et al., 2020; Diaz & Walsh, 2021; Hannon et al., 2020). Not surprisingly, the significant transition from the use of in-person spiritual care delivered by CPE students paralleled the limited patient rounding and increased use of telechaplaincy for chaplains in general (Kwak et al., 2021; Snowden, 2021; Vandenhoeck et al., 2021).

A small body of pre-COVID-19 literature about the experiences of teaching spiritual care skills virtually already exists. For instance, Doehring (2011) described her use of student partnerships to produce roleplays using case-based scenarios and fictional short stories. Transcripts of these roleplays functioned in the same manner as the traditional verbatim/case study, and the critical reflection on the transcripts became developmental in preparing for subsequent sessions. Roleplays or simulations were incorporated by

half of our respondents, indicating some shift to remote clinical practice for their trainees.

McGarrah Sharp and Morris (2014) provided practical and successful methods of teaching spiritual care remotely while preserving the main learning outcomes of the traditional in-person method. Using asynchronous whole class discussion boards, one-on-one student practice labs with videotaped roleplays, and synchronous small group discussions, they discovered that these remote methods produced a new lens for observing group dynamics and more meaningful and coherent group discussions. They also found that the shared anxiety among the students over this unfamiliar mode of teaching deepened empathy. Through discussing challenging clinical case examples, Doehring (2018) similarly found that students were more interactive and self-reflexive in responses using online discussion boards. Slightly more than a third of our participants used discussion forums in remote CPE. It is unclear whether roleplays and discussion forums were utilized because of prior familiarity to educators as this specific evidence-base was not cited by respondents.

Participants perceived and rated the helpfulness of resources during the pivot generally lower than the same resources in the future. The reasons for these differences are unknown. The immediacy of what happened and the abrupt changes may have impeded educators' capacity to identify and utilize all the available resources at that moment. Upon reflection, they may have considered what would have been helpful back then and would be helpful in the future.

Our study shows markedly low rates of utilizing LMS, asynchronous learning activities, and consultation with instructional designers. In comparison, faculty in higher education tended to use and benefit from these resources to a higher degree, and even more so when transitioning to online during COVID-19 (Fox, Bryant, Lin, et al., 2020; Fox, Bryant, Srinivasan, et al., 2020; Jaschik & Lederman, 2019). This raises the question as to whether CPE educators relied heavily on synchronous modalities such as live videoconferencing in order to maintain the more familiar model of face-to-face interaction and to more effectively foster interpersonal learning. Alternatively, it may suggest a gap in familiarity with the potential applications, benefits, and limitations of asynchronous learning and LMS. CPE educators may benefit from building the capacity to skillfully and creatively combine a range of synchronous and asynchronous as well as remote and in-person elements. Utilizing multiple and diverse online instructional practices was found to be associated with more positive learning outcomes during COVID-19 in higher education (Fox, Bryant, Lin, et al., 2020; Means et al., 2020). Our study participants see the importance and potential of these resources in the future. This may suggest an opportunity for educators to close this gap.

Professional associations have played a significant role in supporting spiritual care and higher education professionals navigating the pandemic and in professional development (Fox, Bryant, Lin, et al., 2020; Fox, Bryant, Srinivasan, et al., 2020; Snowden, 2021). Although most participants in our study reported drawing on ACPE and CoPs, about a third and a half, respectively, perceived these as particularly helpful resources, which is markedly higher than what higher education faculty reported regarding the perceived helpfulness of their professional associations during COVID-19 (Fox et al., 2020). Notably, our respondents expressed an even greater desire for meaningful support from ACPE and CoPs when looking to the future.

Respondents considered insights from students, advice from other ACPE educators, resources and support from their department and institution as the most helpful resources during the pivot. This is in part similar to higher education faculty involved with designing and teaching online courses, who identified advice from colleagues as the most helpful resource, followed by insights from students, instructional designers, and IT support staff (Jaschik & Lederman, 2019). Faculty transitioning online due to COVID-19 also viewed institutional support as their most helpful resource (Fox et al., 2020).

This study may be somewhat limited by its descriptive and largely exploratory nature, based on a cross-sectional survey analyzing data from CPE educators at a specific point in time. Our self-report method of data collection is subject to potential social desirability and recall bias. Despite this limitation, we believe this initial mapping of educators' pivot to remote CPE delivery during the early stages of the COVID-19 pandemic provides an important benchmark of educators' practices, resources, and needs.

Conclusion

Results have shown substantial and rapid shifts toward remote learning in CPE as an immediate response to COVID-19. They call for attentive, strategic, and practical responses to the seismic changes occurring and the resource needs among ACPE educators and stakeholders. There is a clear need to develop and adopt evidence-based practices for remote learning in CPE and enhance competencies to use them effectively, creatively, and relationally in the context of ACPE spiritual care education. These findings have significant implications for understanding how spiritual care education may thrive amid and beyond the pandemic in an increasingly digital world.

Future research should focus on the acceptability and feasibility of remote learning in CPE both from the students' and educators' points of view and examine the effectiveness of remote versus in-person instructional strategies in CPE. Further research is warranted on CPE students' experiences during COVID-19, with particular attention to the shift to remote learning and the use of telechaplaincy. Additional qualitative approaches could be used to explore ACPE educators' lived experience and professional well-being during the pandemic.

Declaration of Conflicting Interests

Funding

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Note

1. ACPE: The Standard for Spiritual Care & Education (formerly known as the Association for Clinical Pastoral Education) is the premier, U.S. Department of Education recognized, organization that provides a rigorous accreditation and certification process for centers and educators that provide CPE.

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