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ABSTRACT

Supported by the National Institue of Mental Health and Lilly Endowment, Inc., a demonstration program in continuing education for clergy and related professions in the field of mental health was conducted from 1964 to 1967. The purpose was to provide clinical pastoral education within the clergtman's home community where he could learn to work cooperatively with mental health resources. Administrative centers were set up in Fort Wayne, Muncie, New Castle, Lafayette, southeast Indianapolis, and Columbus (Indiana); each area provided urban, rural, and semi-rural communities. The fall-to-summer period was selected and community resources were mobilized to select enrollees (78 clergtmen and 18 others) and to continue local interdisciplinary relations and education after the program. A week spent at Indiana University Medical Center provided a core curriculum; it was followed by a series of tri-weekly seminars at which current pastoral cases were discussed and a second week at the Medical Center which focused on material current within the community. A followup was scheduled about six months after the curriculum phase. It was concluded that the clinical method is adaptable to continuing education for the clergy but it was recommended that a residential training center was necessary for continutiy. (EB)

A COMMUNITY PROJECT IN RELIGION AND MENTAL HEALTH

A Program in Continuing Education for Clergy
conducted at
Indiana University Medical Center
1100 West Michigan Street
Indianapolis, Indiana

FOREWORD

This is a report of a demonstration program in continuing education for clergy and related professions in the field of mental health conducted over a three year project period. Support for staff and traineeships during this period from 1964 to 1967 was provided by a grant from the National Institute of Mental Health. Support for local expenses for each program was provided by Lilly Endowment, Inc. The aim was to demonstrate that this program in continuing education was useful and could be duplicated elsewhere.

The scope of this report covers administration, methods, curricula materials and assessments of the program. Applications are shown for clergy in urban, semi-urban and rural communities. Conclusions and recommendations are given. A sampling of the many dynamic considerations incorporated by the staff from time to time is included in the supplemental material following the report.

Acknowledgements are due Chaplains Robert C. Alexander and Kenneth E. Reed respectively of Central State Hospital and Methodist Hospital of Indiana. Both are certified Chaplain Supervisors with considerable experience in a variety of educational programs for clergy. Each clinical educator served as associate director, contributing both guidance and educational supervision throughout the project period. Appreciation is also due to Chaplain Myron Ebersole who completed the first two and one-half years of the project in an associate position with the director. Special acknowledgement is due Chaplain Albert L. Galloway, who succeeded him and subsequently contributed to the

collection of data and writing the report.

John A. Whitesel, Ph.D.
Director
December, 1967

COMMUNITY PROJECTS IN RELIGION AND MENTAL HEALTH

Introduction

Adams suggests that "continuing education may be defined as a deliberately contrived program of learning which has its beginning at that point where study ceases to be the learners primary occupation".[1] Our community projects in religion and mental health meet both criteria. They are contrived as a program of continuing education at the point of primary problems for the practicing clergyman in meeting individual and community mental health needs. In retrospect, we found a significant number of clergy who enrolled had no additional training after formal studies required for ordination. In forethought we knew of their needs for continuing education in the field of mental health. These needs are well documented by congressional mental health studies, by clergy who enter clinical pastoral educational programs, and by other evidence.

An important factor in planning this project was the obvious need for a program related to the geographic community in which the clergyman works. At the time our project began none existed designed for interaction in the home community between clergymen, between them and related disciplines, and do so to the end that indigenous mental health problems

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[1] "The Emergence of Continuing Education", A Report of the Consultation on Continuing Education to the General Council, Philadelphia; (National Council of Churches, Department of Ministry, Vocation, and Pastoral Services: United Presbyterian Board of Christian Education, 1965), p. 16.

and resources would be better understood.[2] Stewart spoke broadly to this intention when he presented a paper during one of our programs. He said, "Individuals get well in communities and not in isolation."[3] A salient concept in our program of education for the clergyman is to assist him to new insights for preventive care as well as for follow-up in the community where he works.[4]

Two additional factors influenced the design and purposes for the project. The first concerns clinical pastoral education, as a form of continuing education for clergy, and the second arises from experiences of the project director in the field of counseling and mental health. Clinical pastoral education lends itself to adaptations for our program. However, very little direct effort has been made to adapt these clinical educational methods to a program for clergy within their home community. We were certain adaptations could and would affect mental health structures in that community. While an executive in a council of churches the project director observed that programmed interaction is required for clergy to learn how to work cooperatively with mental health resources within their community. Pastors were not taught effective methods and attitudes relating to these resources when formal theological studies

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[2]Reference is to programs developed in Columbus, Georgia, in Nebraska and later at Western Reserve University. While overlapping features occur, our project involved interaction between clergy and many segments of the community where their parishioners live and an academic center such as Indiana University Medical Center.

[3]Charles W. Stewart, Ph.D., "The Healing Church and the Community," The Journal of Pastoral Care, Vol. XXI, No. 1 (March, 1967), pp. 8-14.

[4]A more extensive statement of our philosophy is in Appendix A.

were their primary occupation. Once in parish work they rarely find a vehicle to learn about methods and attitudes, except on a case to case basis. A vehicle to systematize learning is needed, lest case to case experiences are lost among the other duties pastors are required to perform. The important ingredient for such a vehicle is both form and communication; between clergy, with related disciplines, with available agencies and with effective mental health practices.[5] The clergyman no longer can consider himself as a provider to meet all needs; rather as a consultant, a counselor and always as the director of an agency requiring access to other community agencies when dealing with human needs.

The second influence was the Evansville Project. Briefly, an interdisciplinary committee from this Indiana community requested of the director, and clinical training supervisor associates in Indianapolis, to conduct a program in religion and mental health. Upon termination of this program in 1962 several needs were evident as to design and purposes. New curriculum material was needed. Obviously this should include both elementary core curriculum and material drawn from current experiences of pastors. The emphasis on interaction with representatives from other disciplines should be a continuing feature. Learning about community agencies and interaction with their resources should be strengthened, as well as an investigative attitude for further self-directed studies.

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[5]See Adams, op. cit., who shows the need for dialogue between the academic and the practical communities. Linkage between the two is paramount to our philosophy. We designed our programs to combine substantive and facilitative learning; according to Adams. We combined in our design the "what" with the "how".

If possible, various assessments of learning shoulc be included, designed particularly with pastoral needs in mind. Such matters brought the design and purposes for future projects into focus.

Purposes

The pilot project supported by the National Institute of Mental Health from 1964 into 1967 proposed:

1. To promote acceptance of the mentally ill and relate them to the life of the community by developing an alliance between leaders in the fields of religion and health as a working group over a sustained period of time.

2. To develop an inquiring attitude and collaborative efforts among clergy toward individual and community mental health problems at the local level.

3. To sustain an educational relationship between disciplines related to the mental health fields for the exchange of theory, methods or prevention and treatment, and referrals for service.

4. To experiment with proven theory and methods in clinical pastoral training for application to such a community service educational program.

5. To initiate investigations into instruments for various assessments.

The Problem

The problem underlying these purposes was the question of designing a program which would demonstrate probability of duplication. Needs and feasibility both were documented from previous knowledge and experience.

Proposed Demonstration Design

The original design, given in our proposal for the project, divides

into four major sections.

First, selection of sites which, over a three year period, would show feasibility of the program for clergy in different localities.

Second, a presentation of educational experiences for the clergyman which take into account basic information, immediate mental health tasks and local community resources. This was the core of the design. The tasks here were to mobilize local planning for the program, enroll a cross section of clergy from different localities within and around the site selected, and include persons from the other helping disciplines as members of the program. Educational elements in this aspect of the design were contrived so as to get all persons involved in the study of immediate mental health problems, ranging from studies of needs in the community to individual needs requiring professional help. Implementation was planned to include preparation with responsible agents or agencies in the site selected; orientation of clergy and co-participants from other disciplines; a week of intensive studies at Indiana University Medical Center; approximately six months of seminars conducted by participants at a meeting place in the city selected; a second week at the medical center, followed by the final series of seminars in the community selected.

Third, assessments of clergy participants were planned to secure psychological profiles, general knowledge in the field of mental health, development in mental health casework practices and understanding of counseling. Three equivalent forms for psychological profiles and mental

health information were proposed and timed for administration at the outset of the program, after the second clinical week and approximately six months after completion of the program in which the clergyman was enrolled. Casework and counseling assessments were timed to be given in the initial seminars and after the second clinical week. Except for standardized psychological forms all others were considered to be teaching as well as assessment instruments.

Fourth, a traineeship was included each year during the project period. The design thus placed a trainee directly in contact with traditional clinical pastoral education and this pilot program in continuing education for clergy.

Summary of the Program and Methods

Prior to implementation certain steps were taken. These were intended to strengthen the probability of duplication. First, communities were selected so that the program could be demonstrated in a variety of environments throughout the project period. The concept of communities was broad and related to geographical areas which would coincide with divisions of the state in which Indiana State Mental Health Department institutions were located. Second, the selection of hub cities, or nexi, in such Mental Health Department divisions, was necessary to the project for administrative economics. Third, criteria for selection of these divisions should include local sophistication as to mental health organization and resources, concern about mental health problems, and the present stage of development for meeting mental health needs. Fourth,

preliminary consultations also included those with the Indiana State Council of Churches, and the Community Services Council of Metropolitan Indianapolis.[6]

These four considerations resulted in establishing administrative centers for the project period. The centers agreed upon were Fort Wayne, Muncie, New Castle, Lafayette (including West Lafayette), the southeast sector of Indianapolis, and Columbus. All met our criteria. They provided moderate, little, and high sophistication in mental health planning, respectively. Each nexus was located in a separate area of the state under the Indiana State Mental Health Department. Each afforded opportunity to reach clergy in urban, rural and semi-rural communities during the project period.

A final preliminary need also was accomplished. This consisted of assurances that resources were available at the center chosen for the clinical weeks. Several criteria were essential. First, faculties for each week should be composed of leaders in their professions. Second, they should be interested in interdisciplinary education which include clergy. Third, they should be oriented, or at least sympathetic, to clinical pastoral education. Fourth, they should be willing to serve as consultant to the program staff whenever needed. In sum, the center and the faculty for the clinical weeks each should have qualifications desired for an accredited clinical pastoral education program under a

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[6] The Community Service Council of Metropolitan Indianapolis, Inc., is the council of social agencies for Greater Indianapolis. Staff members served as consultants about comparable organizations throughout the state.

certified supervisor.[7]

The design of the program planned for each nexus took into account three administrative needs; development, curriculum, follow-up. Central to the problem of design was the time of year most conducive to a committee enrollment of clergy. Experience showed the Fall-to-Summer period best. Development was planned for a period up to three months prior to the curriculum phase. Follow-up for staff purposes and residual needs of participants in each program, could require up to six months. The core of the design for the presentation of educational experiences thus covered twelve months for development and an intensive curriculum. This was the primary focus of the demonstration. As an additional feature the design also included provisions for a traineeship connected with each program, hence add trained manpower to the field of continuing education for clergy.

The sequence for the program in each area selected was planned accordingly:[8]

1. Development of community resources or a committee to assist in promotion and selection of enrollees, and in the continuation of local interdisciplinary relations and education following the close of the program year. This phase included staff

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[7] While Indiana University Medical Center served as the center for each clinical week, other institutions were used. Each met the criteria given. Each was accredited for clinical pastoral education under the Institute of Pastoral Care. The other centers were Central State Hospital, and Methodist Hospital of Indiana. Appendix B gives a brief description of all centers.

[8] Appendix C contains exhibits of materials connected with development and curriculum.

orientation to the varieties and functions of community agencies, resources, and dominant mental health and sociological issues. The original design also included enrollment of the interdisciplinary panel of co-participants from the fields of psychiatry, psychology, internal medicine and social work.

2. The curriculum phase is in two major segments; seminars in the community selected as the meeting place for participants, and, clinical weeks for full time studies at the Indiana University Medical Center. Breakdown for the sequence is as follows:

   a. Orientation seminars for participants and for staff. The clergymen enrolled receive core curriculum textbooks, complete initial forms of assessment instruments, and discuss dominant mental health and pastoral work problems.[9] Staff for the program also become oriented to the needs and interests of the group members, and their concerns related to community problems.

   b. The first clinical week accomplished four purposes for the clergy and their co-participants from other disciplines. First they got to know each other as persons interested in common problems which override professional biases. Second,

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[9] Textbooks provided were: James C. Coleman, Abnormal Psychology and Modern Life, Third Edition (Chicago: Scott, Foresman and Co., 1964); Paul E. Johnson, Psychology of Pastoral Care (New York: Abingdon-Cokesbury Press, 1953). As local funds permitted special interest volumes were added. For example, when Roman Catholic priests were enrolled, additional texts were secured for their use.

they experienced a core curriculum structured by the staff on the basis of the common information deemed necessary, correlating information provided in the texts with clinical case records and observations. Third, the staff involved participants with clinical methods from traditional clinical pastoral education. Fourth, a seminar curriculum committee was elected by clergy members and subsequent seminars were planned.

c. A series of seminars then was conducted by the clergy seminar curriculum committee, with assistance by the staff and by consultation from co-participants from other disciplines. These were held on a tri-weekly schedule as nearly as possible. Topics finally settled on were selected by clergy members. The agenda for each seminar was presentation of a current pastoral case by a group member, discussion of related theoretical material and a review of community agencies or other resources needed to resolve the case problem presented. Whenever possible, these seminars were held in the facilities of an agency involved with people whose problems paralleled the case presentations.

d. The second clinical week curriculum at the medical center focuses mainly on material current within the community and provided by the clergy group. Four purposes were accomplished in the use of this material during the schedule for the week. First, training in consultation methods occurred as members

presented records of pastoral casework and counseling. Second, education in psychodynamics was reinforced as counseling problems were studied during presentations of live, taped and written client situations. Third, education in the evaluation of community problems was accomplished through role playing a current community concern demonstrated by the clergy and discussions about community power structure. Fourth, reinforcing motivation was added for continuing self-education in pastoral work and community mental health problems through planning for future seminar topics which combine pastoral concerns with community mental health needs.

e. The final series of seminars were conducted according to topics agreed upon by the group. The order of agenda remained the same as for previous seminars, except for completion of the second forms of assessment instruments. Administration of these forms were arranged by the staff at a time so as not to interfere with the seminar program.

3. Follow-up primarily provided for final administration of assessment instruments, scheduled approximately six months after the conclusion of the curriculum phase for each program. Follow-up also provided for consultations desired by individual clergymen or portions of the original group in each program.

4. Traineeships provided administrative assistance and contributed to the achievement of two purposes. First, they contributed trained workers to the field of continuing education for the

clergyman. Second, a traineeship in conjunction with traditional clinical pastoral education afforded an opportunity for him to learn adaptations applicable to new programs for clergy education. Both purposes were fruitful for the subsequent employment of trainees. Three were supported by the grant for this project. One obtained a position with a council of churches, which required qualifications for a chaplaincy service program and experience in education of clergy. The second trainee became associate director of the project during the concluding six months when the first associate director resigned to head a service and educational program for a hospital in another state. The third trainee entered advanced clinical pastoral education in another institution with several varieties of clergy educational programs both local and statewide.

Results

1. Six cities were selected as administrative centers for the program.
2. Preliminary steps in planning resulted in the enrollment of seventy-eight clergymen from twenty-three urban and rural communities. Eleven counties out of ninety-two in the state of Indiana were represented.
3. Eighteen persons from other professions were enrolled as co-participants during the project period.

4. Developmental educational efforts with responsible sponsoring committees or agencies (such as Ministerial Associations in rural areas) required two to three months. Up to four meetings were necessary to accomplish this step, including enrollment of clergymen.
5. Enrollment of co-participants from other disciplines required staff contacts in addition to meetings scheduled with potential sponsoring groups.
6. Orientation seminars ranged from one to three meetings with clergy enrollees prior to the first clinical week.
7. Absenteeism during seminars and the clinical weeks occurred only when emergencies arose, such as funerals, personal sickness or previous commitments.
8. Dropouts occurred only when employment changes were made.
9. Four hours were sufficient per seminar and thirty-five hours for each clinical week. The amount of time for each was compatible with schedules of most clergymen.
10. Subjective evaluational comments by all participants, written and taped, during the clinical weeks showed:
    a. Positive appreciation for the inductive learning method applied to case presentations, the interpersonal interactions afforded by all participants in residency at the clinical center each clinical week, by planning seminars around local needs, and the emphasis on curriculum material from current local problems during the second clinical week.

b. Negative evaluations resulted in expressions of the need for more individual supervision and consultation on casework, more time to interact with participants from other professions within their particular nexus community earlier in the program, and that experiences of the clergy with counterparts in other professions developed slowly during initial stages of the program.

c. Specific evaluations obtained from participants resulted in suggestions that discussion of the power structure for each community include participants from the nexus community and that personal material used in the second clinical week required more time for individual consultation regarding procedures and methods.

11. Objective results from the assessment instruments were compared according to the following sub-groupings:

a. Age (under 35 and over 36).
b. Denomination ("Mainstream" or Sectarian).
c. Present position (Pastor in charge, associate or assistant, director of religious education, church agency staff member).
d. Years in the ministry.
e. Years in current position.
f. Location of church facility (Inner-city, other city, suburban, village, open country).
g. Size of congregation (0-100, 101-200, 201-300, 301-400, 401-500, 501-750, 751-1000, 1001-1500, over 1500).
h. Size of town (open country, up to 250, 251-500, 501-1000, 1001-2500, 2501-10,000, 10,001-25,000, 25,001-100,000, above 100,000).
i. Years in formal education (High School, Bible School, Technical School, undergraduate, Institute, Accredited Seminary, Post graduate).
j. Clinical education (workshops, institutes, etc.).
k. Community agency activities.

Results considered by the staff to be significant are:

A. IPAT assessments placed clergy participants within the "normal" range for the population of standardization. Retesting resulted in changes toward more venturesomeness and tendermindedness, indicating to the project staff that interpersonal sensitivity and confidence increased during the programs. The under thirty-five group showed the greatest increase in venturesomeness and tendermindedness.

B. Assessments of retention of basic mental health information (based on the Library of Test Items for Coleman's textbook) showed the following sub-groupings retained the most information:

1. Clergy under thirty-five years of age.
2. Clergy with the least formal education.[10]
3. Clergy serving suburban congregations.
4. Clergy serving in towns with a population under 1000 persons.
5. Clergy responsible for congregations over 1500 members.

C. Assessments in counseling exercises according to aptness

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[10]This assessment is for the function of gain in information rather than determination of the level of initial information. It was assumed that to some extent modern education included mental health information and that our programs would provide a review for some and new information for others. The gain here, however, is important if the assumption can be made that the least educated (according to our sub-grouping) were the more motivated for "substantive" education.

of responses and according to perception of hypothetical client frames of reference showed the following results:

1. Changes in items recorded in the exercise in aptness (basic counseling attitudes) showed a greater degree of appropriateness: (a) Among pastors in "sectarian" denominations; (b) among pastors in suburban communities; (c) among clergy serving towns of 1000 or under; (d) and, among clergy having the least formal education.
2. Perceptions of parishioner frames of reference requiring greater sensitivity to hypothetical problems presented did not differentiate significantly.

D. The Parish Problems instrument showed significant increases in ability to recognize symptoms, and to discriminate the appropriate agency should referral or consultation be necessary. The clergyman's sensitivity toward family integrity was demonstrated in that participants showed the most gains in appropriateness of referral and consultation on the "Family Problem" test. The most significant gains were demonstrated by pastors under thirty-five years of age and by those serving mainstream protestant congregations.

E. Follow-up results are reflected in individual consultations or in planning future activities. Future planning at the close of one program took the form of continuing

seminars for an additional year. Another program continued in the form of influencing development of a counseling center, serving the community on an interdisciplinary basis. In general, all programs resulted in considerations for continuation either through the media of individual interests or group planning.

Individual follow-up resulted in six of the seventy-eight seeking advanced training in the field of mental health education. Each sought consultation with the staff in planning their programs for continuing education. More significant, in terms of the purposes for each program is the fact that ninety percent of all clergy enrolled remained in parish work where the program was designed to give assistance to individual and community mental health problems. Such a percentage is consistent with findings by clinical education supervisors as they receive and train parish clergy for pastoral work in community parishes.

CONCLUSIONS

1. The Clinical pastoral education method is adaptable to continuing educational programs for clergy. Adaptations can combine substantive and facilitative purposes by linking an academic center, which includes an accredited clinical pastoral education program, with local community groups motivated for continuing education.

2. Adaptation requires systematic organization of local groups,

construction of a core curriculum based on mental health educational needs of clergy, and continuous staff observation of parish work problems to be used as curriculum material. These three elements focus facilitative learning on current needs and resources.

3. Development requires supportive promotion by leaders of diverse elements within the community, whose followers accept the task to be achieved as a common denominator to their diverse local tensions.

4. Motivation of those enrolled is affected positively by opportunities to release shared negative elements in a permissive atmosphere and to express subsequent motives for the common denominator. Orientation seminars achieve motivation in proportion to staff preparation for the release of negatives and the use of skills to mobilize positive interests among participants.

5. Enabling functions by the staff during early stages also require careful attention to selections of participants from other disciplines. Staff efforts should be to motivate these persons to participate with the clergy as colleagues rather than becoming instructors with superior information.[11]

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[11] In our first program during the project period the local sponsoring committee secured these participants. The result was that the psychiatrist was "fired" by clergy enrollees. Staff members assumed the attitude that these enrollees should survey the community and secure a replacement compatible with purposes for the program. This episode reinforced indications that the staff should become active at the outset in selections of participants from other disciplines. Consequently selections were made for each program thereafter according to criteria which assured that the clergy enrollees respected the communicability of the person from the other discipline and that he wished to be a part of the group rather than direct his attention to instruction alone.

6. The program can be duplicated, and:

   a. Application is possible for clergy both in urban and rural settings where motivation for continuing education is present.

   b. A staff trained for accredited clinical pastoral education is essential to mobilize resources and implement a program.

   c. Staff acclimation requires experience in one program, or one year, to become efficient in administration. Preferably the staff should be headed by a certified clinical pastoral educator.

   d. Two programs can be conducted simultaneously when an experienced staff is available.

RECOMMENDATIONS

Based on our findings and conslusions, we recommend the following for duplication:

1. A training center is required for continuity of administration with resources for both substantive and facilitative educational faculties. Enrollees should be brought into and remain within such a center rather than distributed among several centers, as in our programs. Acquaintance with individual needs and maximal use of supervisory faculty members are more productive in one environment where consultations can occur momentarily regarding either core curriculum or follow-up on facilitation problems posed by clergy participants.

2. The ratio of clergy participants to clergy supervisory personnel

churches or the complex of sectarian agency leaders as the media. In any case sponsorship assuring a substantial following is recommended. It would be well to avoid utilizing local academic influences unless rapport is good between the "town and gown" communities.

8. Programming thus far suggests a Fall-to-Summer schedule because of changes in clergy appointments during the summer months.

9. Follow-up planning can be strengthened if staff observations about community needs are begun at the outset. The staff can utilize curriculum material arising from the clergy enrolled and from the seminar curriculum committee to suggest cooperative efforts between clergy and available community resources. Toward the end of the program the staff should raise specific questions about forms for continuance, based on observations gleaned from needs shown by enrollees and those evident in their community.