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Clinical Pastoral Education

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In 1925, Richard C. Cabot, M.D., noted Boston physician, author, and part-time teacher at Harvard Divinity School published an article in the *Survey Graphic* in which he proposed that something radical be done about the need for better prepared pastors. He suggested that every student for the ministry be given clinical training for pastoral work similar to the clinical training a medical student receives during his internship.

Behind Dr. Cabot's proposal lay not only his medical experience but his acquaintance with the work already begun by Anton T. Boisen, a middle-aged Presbyterian minister who had come through a serious nervous breakdown that had confined him for several months to a mental hospital. Boisen's ancestral family tree was heavy with college teachers and presidents, he himself being a graduate of Indiana University, Yale Forestry School, and Union Theological Seminary. He had also received a Master's degree from Harvard University and had been a sociological investigator for the Presbyterian Department of Country Church Work, doing extensive surveys for the Interchurch World Movement, the collapse of which brought his enterprise to an end and precipitated a nervous breakdown.

Being a genuine scholar, Boisen studied his own case and those of his fellow patients, and, upon his release from hospital, he enroled in Harvard University to study further the problem that had confronted him. There he found a group of men admirably suited to his thinking — Richard Cabot, Macfie Campbell, William MacDougall, and Elwood Worcester — all deeply interested in the vagaries of the mind. With their help he prepared himself for a ministry to the mentally ill and, at the same time, for further researches which would be foundational for more effective training of future ministers. Subsequently, as Chaplain of Worcester State Hospital with its twenty-two hundred mental patients, Boisen demonstrated that a Chaplain giving full time to an intelligent, day-in day-out ministry to mental patients individually and in groups was more effective than the plan in most hospitals of simply having pastors of local churches come in on Sundays to conduct a worship service. In the summer of 1926, he introduced four theological students, one each from Harvard, Boston, Union, and Chicago, as hospital orderlies on the wards who worked overtime reading up psychology, psychiatry, and religion, and discussing their work and their observations with Boisen and the medical staff. Thus began "Clinical Pastoral Education". Annual summer courses continued and still continue, and in many institutions today all the year round training is offered.**

While Boisen was developing his pioneer work at Worcester, Richard Cabot, supported by a group of distinguished Boston ministers, moved towards the foundation of an organization which would promote and support clinical training, enlisting the co-operation of theological seminaries, doctors and ministers. On January 21, 1930, incorporation papers for the Council for Clinical Training of Theological Students were signed, Philip Guiles being made Executive Secretary and Helen Flanders Dunbar (a pioneer in the field of psychosomatic medicine) the Medical Director.

An important fact needs stressing at this point. The founders made it clear to every student that he must not think of himself as under training to become a psychoanalyst or psychiatrist. That would take years of specialized training in the proper institutions. The Council aimed only at bringing the minister-to-be face to face with human misery in various institutions, and there, under competent supervision, to accomplish three things:

(1) to open the student's eyes to the real problems of men and women and to develop in him methods of observation which would make him competent as an instigator of the forces with which religion has to do and the laws which govern these forces;

(2) to train him in the art of helping people out of trouble and enabling them to find spiritual health;

(3) to bring about a greater degree of mutual understanding among the professional groups which are concerned with the personal problems of human beings.

In spite of these declared aims there were some who felt that the training was too clinical and insufficiently pastoral. They were in general agreement with the principle of learning from the "human documents" prior to academic reflection thereon, but they wanted a different balance of emphases in the training program. Differences of opinion also arose concerning the relative merits of training centered in a mental hospital and training in a general hospital. Other organizations, representing these concerns, arose to sponsor clinical training. Notable were "The Institute of Pastoral Care" and denominational associations set up by the Lutherans and by the Southern Baptists. This had a positive result in spreading clinical pastoral education across the United States, diversifying programs, and

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**"The 1973 Directory of the Association for Clinical Pastoral Education lists 306 accredited centres in the U.S., 24 in Canada, and 9 overseas. These include General and Psychiatric Hospitals, Penal and Correctional Institutions, and Centres for Juvenile Treatment, Handicapped Children, Geriatric Care, Rehabilitation, Community Mental Health, Inner-City Ministries, and Parish Mission. The Association's address is 475 Riverside Drive, New York, N.Y. 10027, U.S.A.

enriching options. It was against such a background that the Movement spread into Canada, brought into the Maritimes by the Rev. Prof. Charles Taylor of Acadia University who conducted a course in 1951 at the Victoria General Hospital but subsequently concentrated his efforts at the Nova Scotia Sanatorium in Kentville. His pioneer work received substantial impetus with the incorporation by the Nova Scotia Legislature in 1958 of "The Institute of Pastoral Training" (on the Council of which Dalhousie Medical Faculty had and continues to have representation) a body whose efforts presently include the promotion of Clinical Pastoral Education at the Nova Scotia Sanatorium, the Nova Scotia Hospital, the Victoria General Hospital, King's County Hospital, and Springhill Medium Security Correctional Institution.

Clinical Pastoral Education had attracted the interest of theological educators in Canada and Charles Feilding, then Dean of Trinity College, Toronto, led or supported a number of national consultations which led to the founding in 1965 of the Canadian Council for Supervised Pastoral Education. The adjective *supervised* was chosen not to reject *clinical,* or to be different from the Americans, but to provide a description covering a wider variety of training methodologies. Soon after this successful emergence of Clinical Pastoral Education in Canada, the hitherto fragmented movement in the United States achieved unity and tremendous new impetus by amalgamation in 1967 into the "Association for Clinical Pastoral Education" (head office in New York) setting the pace for higher standards, closer relationships with theological seminaries and universities, and taking over the publication of the movement's professional quarterly — "The Journal of Pastoral Care". An extensive literature has also grown out of the movement, some of the more outstanding publications being mentioned in the bibliography at the end of this article.

Having outlined the history, and indicated the prolonged incubation period which together issued in modern clinical pastoral education, now a sophisticated discipline increasingly recognized for course credit towards divinity degrees, it is now time to take a look at the methodology of training. Programs vary from locality to locality, training center to training center, supervisor to supervisor, but certain elements in a certain combination have emerged as characteristic of any program which is certified as meeting the standards set by the Canadian Council for Supervised Pastoral Education. These elements in order of priority, are as follows: —

FIRST. The students face-to-face encounter with another human being who is in a crisis situation. The frequency and intensity of such exposures is gradually stepped up to levels commensurate with that required of other helping professions.

SECOND. The students own retrospective consideration of his encounter culminating in committing to paper a detailed report which gives attention to his own feelings as well as to the implications (sociological, psychological, and theological) of what happened.

THIRD. The student's sharing of his anxieties (so far as he is able) with his fellow students in a peer group, meeting at least every other day. The supervisor is present but his participation growingly confined to facilitating communication. He may occasionally offer interpretations of dynamics which are causing persistent hangups, or share his own feelings if to do so is helpfully relevant and timely.

FOURTH. The student's personal regular encounter with his supervisor during which his pastoral relationships with patients, as evidenced in his reports and supplementary remarks, is the primary focus of the supervisor's concern, but the actual agenda and pace follow the needs expressed by the student.

FIFTH. The student's opportunity to acquire information *relevant to what he is experiencing* from lectures and directed reading.

SIXTH. The student's opportunity to *give* information by presenting a review of his work with one patient (or with several patients suffering from the same illness) together with relevant research reading, at regular clinical seminars.

I would like to make some comments on this methodology to bring out certain points of significance. The reader will have noted that each of the steps which I itemized in the methodology begins with the words "The student". This is not just a literary device. It expresses the fact that the personal and professional development of each individual student is central to the supervisor's task. This is why no staff member is allowed to supervise more than six students for the duration of a course. This is why supervision begins, before the course itself commences, with the careful screening of the applicant, designation of supervisory goals, and an appropriate assignment of chaplaincy responsibility for him to undertake. Furthermore, contrary to much of the rest of the student's education, this methodology starts from the student's experience and moves toward the interpretation of that experience, and its assimilation as consciously understood and helpful learning. In a word the methodology is inductive rather than deductive.

The feelings of the student are given as much attention, sometimes more, than what he thinks or says. This is very important in two ways. First the student is made conscious of his own previously unconscious contribution to the outcome of a pastoral encounter. Secondly the supervisor's understanding handling of the student's feelings is instinctively incorporated as a model for the latter's own pastoral encounter with others.

The priority given to experience and peer discussion over lecturing is in accord with research findings about how people actually learn. What is caught from one's companions sticks more than what is taught from on high! Moreover peer sharing of experiences-in-common engenders a team spirit and habit of co-operative working for lack of which many older clergy today suffer agonies of anxiety

and isolation. The team spirit goes well beyond any sectarian spirit because Clinical Pastoral Education courses normally enrol students of various religious communions and the ecumenical friendships which usually result are lasting and fruitful in the on-going ministry of the Church.

Appropriate use is made in our methodology of audio-visual aids and of role-playing. We are very happy when our clinical seminars can become inter-disciplinary by the presence of doctors, interns, nurses, para-medical staff, etc. Interested professional readers who have access to any of our training centers would readily receive an invitation to attend if they asked for one.

As in all forms of education, the worth and effectiveness of the training depends on the maintenance of high standards and constant self-evaluation. The primary purpose of the national professional organizations is to uphold such standards. Certain requirements must be met before an institution can be accredited for clinical pastoral education. In the process of achieving such accreditation, the visit of an accreditation team is mandatory. Stiff requirements must also be met before a man (or woman) can be approved as a certified supervisor of Clinical Pastoral Education (sometimes referred to by the misnomer-"Chaplain Supervisor"). These requirements include university and seminary graduation, substantial post-graduate clinical training, and periodical oral examinations by duly appointed Accreditation and Certification Committees.

Clinical Pastoral Education is slowly producing a growing number of practitioners of religious ministry who are trained and competent to be part of "the healing team" or to function more effectively in the parishes and congregations of our churches. I must emphasize however that Clinical Pastoral Education is not yet mandatory for all theological students. Some have had it, some have not, and, of those who have, some have had no more than an introductory course. As in other disciplines undergoing rapid change, one of the chief difficulties of Clinical Pastoral Education graduates is the image or stereotype put upon them by members of their own as well as other professions. Even their use of the word "professional" to describe their education is suspect in spite of the opinion of the great majority, and the official standpoint of the movement, that the training is essentially pastoral, preparing men for all kinds of religious ministry, although a clinical methodology in an institutional setting has been found the most propitious for that preparation.

What may the medical practitioner expect of a clinically trained pastor, or to a less extent of a theological student undergoing clinical pastoral education? First of all, he may expect a readiness to cooperate and an above average ability to understand the doctor's efforts in the care of a patient. Secondly he may be assured that the clinically trained pastor is not out to reprimand or proselytize his patient, or to be a "do-gooder" (in the pejorative sense), but to help his patient ventilate his fears, find solace in his religion if he has one, and find meaning and opportunity for personal growth in his experience in so far as he is capable. While doctors may readily see the usefulness of a clinically trained pastor in the care of the dying or the uncooperative patient, ' they should not overlook the medically beneficial aspects of a reduction of the patient's anxiety in many other situations where death is not anticipated or indeed likely. Furthermore, some doctors have also found significant personal help through consultation with a clinically trained pastor, help which they might just as well have obtained from any wise experienced clergyman, but was easier to seek from a man who could speak some of "the same language". ❑

Bibliography

Thornton, Edward E. Professional Education for Ministry; A History of Clinical Pastoral Education (Nashville & New York: Abingdon, 1970)

Feilding, Charles Education for Ministry (Dayton, Ohio: American Association of Theological Schools, 1966)

Oglesby, William B. The New Shape of Pastoral Theology (New York: Abingdon Press, 1969)

Cabot, **R. C.** and Dicks, R. L. *The Art of Ministering to the Sick* (New York: Macmillan, 1951) (and numerous others on the same broad topic or special aspects of it such as Ministry to the Dying, to the Hospitalized Child, in psychosomatic illnesses, in Grief, and in a variety of crisis syndromes).

Sharpe, W. D. Medicine and the Ministry (New York: Appleton-Century, 1966)

Westberg, G. S. Minister and Doctor Meet (New York: Harper Bros., 1961) (and several other modern examinations of inter-professional relationships and common concerns).

Caplan, Ruth B. Helping the Helpers to Help (New York: Seabury Press, 1972) (Experience and assessment of a Mental Health Consultation scheme to aid clergymen in pastoral work.)

Journals

The Journal of Pastoral Care Published by the Association for Clinical Pastoral Education, Suite 450, 475 Riverside Drive, New York, New York 10027. Quarterly @ $8.00 p.a.

Journal of Religion & Health Published by Institutes of Religion and Health, 3 West 29th Street, New York, New York 10001. Quarterly $8.50 p.a.

All the above and more are available in the libraries of the University of King's College and the Atlantic School of Theology both in Halifax, Nova Scotia. The author of this article is indebted to Fred Eastman's "The Man and the Movement", *Journal of Pastoral Care* Vol. 5, No. 1, for material on Anton Boisen and the early days of the Clinical Pastoral Education Movement.