# THE PASTORAL COUNSELOR ENTERS COMMUNITY MENTAL HEALTH

by

Robert E. Black

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C O N T E N T S

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## WHAT IS PASTORAL COUNSELING?

"Pastoral counseling is the helping approach, available to troubled people with social, emotional, and especially religious concerns, that combines the guidance of religion and the interviewing skills derived from social work, psychology, psychiatry, and psychoanalysis. It is practiced by a pastor, religious worker, or counselor in a religious setting."[1] This is one definition of pastoral counseling by Earl A. Loomis, Jr., a psychiatrist; it is serviceable. A certain dryness it has is relieved when its author adds that pastoral counseling differs from other therapies in that "the pastor overtly represents in his person, and sometimes through his words and acts, a church or congregation, a body of doctrine, and a moral code."[2]

Wayne E. Oates, venerable in the field, in 1959 described pastoral counseling as "a green twig on the venerable bough of the concern of the churches for needy people in the times of their turning for help from others,"[3] meaning turning to others for help, we are sure.

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1 Earl A. Loomis, Jr., M. D., in "Pastoral Counseling," The Encyclopedia of Mental Health, Franklin Watts, Inc., New York, New York 1963, Page 1449 (Vol. 4).

2 Ibid.

3 In a brief foreword to An Introduction to Pastoral Counseling, Broadman Press, Nashville, Tennessee, 1959.

Another definition is that of Howard J. Clinebell, Jr.: "Pastoral counseling is the utilization, by a minister, of a one-to-one or small group relationship to help people handle their problems of living more adequately and grow toward fulfilling their potentialities. This is achieved by helping them reduce the inner blocks which prevent them from relating in need-satisfying ways. . .relationship with God will become increasingly meaningful. (The counselee) . . . will become a renewal agent in his family, community, and church."[4]

The first definition's serviceability is attested in the fact that it dates from 1963 and in a fast-expanding discipline still was in regular use in almost identical form in 1967 by clinical psychologist and Lutheran minister John P. Kildahl in a clinical and academic program for clergy at the Postgraduate Center for Mental Health in New York City. And why are interviewing skills all that a pastoral counselor takes from the other disciplines? What is almost entirely missing, and missing from Clinebell's definition, are substantive words about the skills and knowledge brought to pastoral counseling by the clergyman. No mention of the wisdom of the ancient cure of souls, of the older and newer pastoral and systematic theology, or of the specific contributions of doctrines of creation, of man, and of God through the person of the counselor. Pastoral counseling seems little more than secular, clinical counseling done by a stick-figure called a "clergyman"; only Oates really indicates otherwise, and his "venerable bough" is more colorful than definitive.

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4 Basic Types of Pastoral Counseling, Abingdon Press, Nashville, Tennessee, 1966, Page 20.

Doubtless the psychologist, psychiatrist, social worker, and analyst might criticize the definition in the same vein from their knowledge of their own profession and could score the lack of rounding out of the five words listing their four professions. I plead guilty to a sensitivity about the clergy. This is because I am a priest and because an identity crisis is upon clergy more than any or all of the others at the moment; as part of this crisis, and perhaps because the impetus to be comprehensive and serve is so great among clergy, far more of us are learning of the other disciplines than vice versa.

Excepting the first, the above definitions are by ordained clergymen, so perhaps it could be said that it is because of familiarity that they omit substance from the "pastoral" part of pastoral counseling's definition. A clergyman can tell from these definitions what non-theological subjects he needs to know and know about to be a pastoral counselor, and if he has a sound theology he likely can remember where home is, so to speak. But what about the theologically naive, or the deficient clergyman or non-pastoral counselor or religious layman who turns to these deficient definitions? Can he tell what is to be learned in theology?

We suggest something more like the following: Pastoral counseling is a means of help available to people troubled with social, emotional, religious, or spiritual concerns through a concerned person who combines skills, insight, and knowledge derived from social work, psychiatry, psychology, and psychoanalysis with a theocentric humanist philosophy and experience in systematic, moral, and pastoral theology.

As a tentative re-definition the above is subject to amplification concerning the meanings of the words "systematic," "moral," and possibly "theology," but for the sake of brevity and to get on toward the purpose of this paper, I will let it stand now as it is above.[5]

The many formal and informal ways of pastoral counseling, some of them unique to pastoral counseling as distinct from other therapy and from guidance and plain or fancy advice, I will consider later. I turn now to some of the roots of pastoral counseling.

## DOES IT HAVE ITS OWN REAL HISTORY?

In the dimmer past, voluntary remission of illnesses, including mental illness, might well have been felt to come from nature at random and in some invisible or visible way. Later on, individuals interpreted and furthered the processes and we had the immemorial shaman, purveyor of all healing and counsel. Eventually "humors" were singled out for causes of illness of spirit or mind, and "demons" living in the spirit were blamed. The next step was to make the ill person guilty, illness being the punitive measure meted out to him for his guilt.

It is interesting to see in this history a change in man from passive object to active subject; the focus becomes sharper and more specific and the screen larger. The Talmudic literature dating from

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5 The limitations of psychological and medical models in training (and defining!) pastoral counselors are considered in an editorial by James H. Ashbrook in The Journal of Pastoral Care, Vol. XXII, No. 4, Pages 232-4.

200 B. C. to about 500 A. D. shows further great growth in a holistic attitude, as did Jesus' own teaching within the same time.

Ancient Judaism used the word etsah 84 times as a substantive in the Old Testament, and 23 times in the verb form yaatz. From this word comes the Hebrew word for counselor. Isaiah 9:6 in the Revised Standard Version of the Holy Bible is one example.

The Hebrew word sodh, as variously used in Proverbs 11:13; 15:22 and 55:14 is another word translated into English as "counsel." Various Old Testament figures can be seen embodying counseling as well as judgment and government in their persons. Moses, Samuel, Jeremiah and Ezekiel are examples.

For Christians, of course, the New Testament figure of Jesus stands out to the highest degree as a counselor. He "knew what was in man" (St. John 2:25), and in what has been called his inaugural address he said, at Nazareth: "The Spirit of the Lord is upon me, because he hath anointed me to preach the gospel to the poor; he hath sent me to heal the brokenhearted, to preach deliverance to the captives, and recovering of sight to the blind, to set at liberty them that are bruised" (St. Luke 4:18). His ministry to individuals and groups bore fruit showing the highest manner of pastoral counseling.

St. Paul, in his unique and directive (!) way did wonderful pastoral counseling. So did John Chrysostom and Ambrose. The history of confession, or penance, in the Christian Church is on its non-sacramental face a history of counseling --- first open and generally shared, and later private and between an instructed, prepared counselor and the counselee, penitent, or client.

In later times the Orthodox, Anglican, Roman and Protestant chapters of Church history all have their saints and traditions in the cure of souls, of which at least a considerable part is pastoral counseling.

Close to our time, Jonathan Edwards in the 18th Century wrote A Treatise Concerning the Religious Affections, a psychological approach to theology. E. D. Starbuck wrote The Psychology of Religion in 1899. Hartford Theological Seminary offered a course called "Psychology of Religion" in 1899-1900. In 1902 William James' The Varieties of Religious Experience was published.

In still more contemporary times, many things contribute to the development of pastoral counseling as an activity with special identity. "Life" can be credited or blamed for making it happen. Humanism, technology, social evolution, and religious crises internal and external all have much to do with it. But, in a more direct sense, it comes as a result of a revolution within medicine, psychology and religion started by Dr. Sigmund Freud. Again, man, knowing but unknown, focused on more and more sharply and with a larger and larger screen needed on which to reflect what is seen, is the subject. In his wake came Carl Jung, Alfred Adler, Harry S. Sullivan, Paul Tournier, Erich Fromm and many others.

In our own time, pastoral counseling still is much too busy becoming to write its own history, and too many things are too new to allow us much perspective. But let us see what we can. The Rev. Dr. Paul E. Johnson of Christian Theological Seminary recently delivered a summary of 50 years of clinical pastoral education in the

United States which is worthwhile.[6] For our purposes, his summary will serve well to provide a background, fragmentary though it may be. Dr. Johnson's history has both the value and the limitation of being personal and oriented in some ways to the Association for Clinical Pastoral Education.

By their nature, real beginnings are too fine to see and are lost in what they are not. Dr. Johnson points first to field work for Union Theological Seminary which Anton T. Boisen did in 1908-11 in lower Manhattan, New York, and further work by Boisen and Fred Eastman in surveys in Missouri, Tennessee, and Kentucky after their graduation in 1911. Johnson himself did work in "face-to-face encounter with the acute distress and social pathology of the slums" in New York's "dark and breathless tenements"[7] in 1917. To this point, pastoral counseling is indistinguishable from social service. After more social surveying, Boisen suffered a schizophrenic reaction and was in Westboro, Massachusetts, State Hospital for two years. Then he studied ethics and psychology, received pastoral counseling from The Rev. Elwood Worcester at Emmanuel Church, Boston, and did research in psychology and social work. One of his teachers in social ethics, Richard C. Cabot, at that time was espousing clinical training for theological students.

In 1925 Boisen already had four students taking clinical training at Worcester State Hospital, where he had become chaplain. Theology, ethics, and Boisen as a leading figure now are part of the history.

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6 In an address at Buffalo, New York, June 1967, on the tenth anniversary of what is now called the Association for Clinical Pastoral Education; it was adapted and published in The Journal of Pastoral Care, Vol. XXII, No. 4, December 1968, Pages 223-31.

7 Ibid., Page 224.

By 1927, medicine, psychiatry, psychology, theology, and social work together were sponsoring clinical pastoral education at Worcester State Hospital. Johnson first met Boisen in that year. In 1928 there were 12 students in the Worcester training group, including Carroll A. Wise, one of the later leaders. Mental health classes were added at Boston University. In 1930 a Council for Clinical Training of Theological Students was incorporated in Boston. Dr. Helen Dunbar was medical director, and continued to be for 12 years.

In 1931 the Worcester program had 20 students and training centers opened at Rhode Island State Hospital and Syracuse Psychopathic Hospital. Boston City Hospital developed a clinical training program between 1933 and 1936. Andover Newton Theological Seminary developed a pastoral psychology and clinical education program.

In 1938, Dr. Johnson relates, Council for Clinical Training executive secretary Seward Hiltner assumed the same post with the Department of Religion and Health of the Federal Council of Churches of Christ in America. Governmental institutions began requiring clinical training for their chaplains. The interworkings of clinics and seminaries increased. Boston and New England continued to be the most active in development. Theological schools in and near Boston in 1944 incorporated the Institute of Pastoral Care, and in 1947 its magazine, The Journal of Pastoral Care, first was published. 1944 also saw the first national conference of clinical pastoral education.

From his own experience in Boston, Dr. Johnson remembers and lists "a stream of capable men" who came from the Boston University doctoral program in psychology of religion and pastoral care in the 1940's and 1950's as a result of the clinical training started in the 1920's and 1930's: Seward Hiltner, Wayne Oates, Carroll Wise, Robert Leslie, Charles Stewart, Lowell Colston, Thomas Klink, Reuel Howe, Ernest Bruder, Rollin Fairbanks, Charles Fielding, Granger Westberg, William Hulme, and David Belgum.

Between 1957 and 1967 Dr. Johnson notes "a tremendous surge toward maturity." He mentions encouragement by the American Association of Theological Schools that seminaries include clinical training. Research studies and publications came in numbers. And not all of the growth was so closely related to clinical training as Dr. Johnson's view.

## PREPARATION IN THE SEMINARIES FOR PASTORAL COUNSELING

Theological schools always have prepared men to be pastoral counselors. But even the above capsule resumé from Dr. Johnson clearly implies great changes recently within the theological schools in the direction of more and hopefully better preparation. That this was more than mere implication is borne out in many ways.

The Resources Planning Commission of the American Association of Theological Schools in the summer of 1968 published a report on redeployment of resources for theological education in the 1970's. Arthur R. McKay, president of McCormick Theological Seminary, was chairman of the commission.

The report quotes a 1950 survey of Protestant seminaries by Liston Pope which concluded that "despite the tampering that has occurred around the edges, the theological curriculum is still largely medieval in structure and purpose" and the commission in 1968 judged that "The program of study required for most students (i. e., the first degree, normally the Bachelor of Divinity degree or its equivalent) remains highly stereotyped in content."[8]

The same commission observed "a proliferation of courses in the so-called practical/pastoral portion of the standard B. D. program at Protestant seminaries and similar developments at Roman Catholic seminarie." The commission was "skeptical, however, that a wider array of specialized courses represents a coherent response to the problems and needs posed by the actual and prospective diversification of ministerial functions and church-related occupations."[9]

This serves to establish the fact that, while theological school attention to pastoral counseling (among other things) increases, its place still is uncertain. Of course, not all of

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8 Theological Education, Vol. IV, No. 4, Summer, 1968, Page 777.

9 Ibid., Pages 779-80.

a student's organized experience fitting him for pastoral counseling takes place in or directly related to a theological school, but much of it does and probably shall continue to do so.

Dr. Johnson's 50-year history recalls the small beginnings of clinical pastoral education. Compare that with his report in mid-1967 that there were in the United States, Canada, the Philippines, and Australia 233 accredited training centers.[10] Yes, changes are taking place.

In October 1968, Dr. Charles E. Hall, executive director of the Association for Clinical Pastoral Education, reported that in 1968 more than 2,000 theological students and ministers received training in accredited centers.[11]

At the end of 1968, the National Council of Churches of Christ in the U. S. A. listed 251 accredited clinical pastoral education centers and 83 member seminaries in the United States alone.[12] The largest number of centers are located in mental and general hospitals. Others are in penal and correctional institutions, juvenile treatment centers, parishes and inner-city ministries, community mental health centers, counseling agencies and rehabilitation centers, children's homes, and convalescent centers for the aging.

The rapid increases in these numbers are significant in themselves. They suggest also that not only are seminaries offering more

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10 Op. cit., Page 231.

11 Ibid., Page 249.

12 Pastoral Psychology, Vol. 20, No. 190, January, 1969, Pages 8-20.

courses themselves in departments relating to pastoral counseling, but indicate that they are increasingly sending students "outside the walls" to the centers, streets, and storefronts for study and clinical experience. The inter-relationships are increasing.

The American Association of Theological Schools does not keep a list of the number of pastoral counseling, pastoral psychology, and clinical pastoral care courses offered, either by member or non-member schools or in undergraduate and postgraduate curricula. Nor do they measure what necessarily must be an increase in the number of faculty and in the financial support of faculty in these areas of learning. But Dr. Johnson's reference[13] to teaching leaders of his association in the field who came from one school in one short time-span is indicative of the increase and provides a baseline for wide speculation.

I remember that Bexley Hall, my own Episcopal seminary in Ohio, as late at 1957 offered only one elective in the field of clinical training. Eight of the eleven major Episcopal theological schools now require clinical training, whereas in 1957 only three did so. In 1922 the dean of Bexley Hall initiated a social service training group in Cincinnati which included clinical work and which grew into the Graduate School for Applied Religion and in 1944 united with the Episcopal Theological School in Cambridge, Massachusetts.

Many small seminaries, such as the very small Episcopal Theological Seminary in Lexington, Kentucky, require clinical training though they can offer little else in the field.

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13 Page 9 above.

Possibly the most startling development in pastoral counseling among the seminaries is the newly-formed Boston Theological Institute, incorporated in 1967. This is composed of Weston College and St. John's Seminary (both Roman Catholic), Harvard University Divinity School, Episcopal Theological School, Boston University School of Theology, Boston College Department of Theology (Roman Catholic), and Andover Newton Theological School. In the first catalog of the Institute, the seven institutions offer 35 pastoral counseling courses for the 1968-69 academic year; this is a considerable number. Cross-registration and extensive service to institutions and the community at large make this an outstanding offering.

In Berkeley, California, what was only an idea in 1958 became a corporation in 1962, and now has nine divinity schools and seminaries as members of what is known as the Graduate Theological Union.[14] The Pacific School of Religion, one member of G. T. U., has a Department of Pastoral Counseling, one of 14 departments in the school. The department has ten courses. Any Bachelor of Divinity degree there requires a course in Personality and Religion; a Bachelor of Divinity degree with a major in pastoral counseling recommends five theoretical courses and three clinical courses in the field. The Doctor of Theology degree in Theology and Personality Sciences includes several pastoral counseling courses. All G. T. U. offerings as such are graduate level.

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[14] See Theological Education, Vol. IV, No. 4, Summer 1968, Supplement 1, Pages 3-21, "Graduate Theological Union : A Descriptive-Evaluative Study," by David S. Schuller.

Another of the seminary clusters forming near or in metropolitan areas is the Rochester (New York) Center for Theological Studies. This was formed in 1968 by Colgate-Rochester Divinity School (Baptist), Bexley Hall (Episcopal), and St. Bernard's Seminary (Roman Catholic). Only clinical pastoral training, two other related courses, and a research course in pastoral psychology are offered in 1968-69. St. Bernard's has introduced a new department of pastoral psychology.

The Disciples of Christ Lexington (Kentucky) Theological Seminary in 1968-69 listed 14 pastoral counseling courses, including clinical pastoral training. The Southern California School of Theology at Claremont, a United Methodist school, also recognized by the Disciples of Christ, lists 12 courses. The Church of God Anderson (Indiana) School of Theology at Anderson College lists eight courses, including clinical pastoral training.

United (Methodist) Theological Seminary in Dayton, Ohio, in 1968-69 requires an introductory course in clinical pastoral care for the Master of Religious Education degree and a course in pastoral counseling for the Master of Divinity degree. It also offers a seminar in psychology and courses in clinical pastoral training, advanced training in clinical pastoral care, counseling theory in pastoral work, interpersonal psychology, religious personality, and psychology and religion. The list of courses offers an idea of the wide range of study offered. Degrees granted include Master of Divinity, Master of Religious Education, and Master of Sacred Theology. United has a cooperative relationship with four other theological schools.

New York Theological Seminary, an independent once-fundamentalist school adjusting to contemporary urban needs, in 1968 awarded its first Master of Sacred Theology degrees to clergymen in pastoral counseling, for which work was done primarily at an affiliated and large New York teaching clinic, the Postgraduate Center for Mental Health.

On the other hand, the United Theological Seminary of the Twin Cities in Brighton, Minnesota, a United Church of Christ school formed recently from existing upper Midwest theological schools, and with a revamping of departmental lines, offers nothing in the way of pastoral counseling or clinical courses. And, the advantageously located Philadelphia Divinity School (Episcopal) offers only clinical pastoral training and one related course.

Statistics about courses and faculty are difficult to obtain and of questionable value in the midst of such rapid development. Richard L. Rising of the American Association of Theological Schools could only say, early in 1969, that "There has been a real increase in both faculty and electives offered in seminaries in the counseling field, although we do not have statistics available. The development of experience-oriented programs in some institutions involves built-in pastoral programs as well as others."[15]

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15 In a letter to the author, January 31, 1969.

PREPARATION FOR COUNSELING OTHER THAN IN SEMINARIES

In another development, one of many separate from theological schools, Iona College of New Rochelle, New York, in 1963 inaugurated a Graduate Division of Pastoral Counseling, which grants a Master of Science in Education degree.

The course list at Iona is as follows: Principles of Personality Development (I and II), Dynamics of the Counseling Interview, Group Dynamics and Processes, Fundamental Concepts of Psychiatry (I and II), Supervised Case Seminar (I, II, and III), Theory and Techniques of Counseling (I and II), Mental Health and Religious Development, Psychology and Development of Religious Life, Mental Health and Religion, Tests, Measurements, and Statistical Approaches, The Counselor and Specialized Problems, Advanced Personality and Counseling Theory, Seminar - Integration of the Role of Religious and Psychological Concepts, and (third-year students only) Field Experience, an elective.

A three-year course in pastoral counseling leading to a certificate is offered by the American Foundation of Religion and Psychiatry, Inc., incorporated in 1951 in New York. This is described as a full-time program including academic courses, workshops, counseling, case supervision and conferences, and personal therapy. Two quarters of accredited clinical training is a prerequisite.

The Postgraduate Center for Mental Health, New York City, offers a two-year, one-day-a-week program leading to a certificate. The 32-credit hour program may be combined with additional work at

New York Theological Seminary for a Master of Sacred Theology degree from that school.

The training program deals with the clergyman's impact on the mental health of individual, family, and community, interviewing techniques, short-term counseling, applied psychopathology, group experience, clinical case conferences, and supervised counseling. The Postgraduate Center is one of the busiest clinics in the world; it accepts nearly 70,000 clients a year. It began in 1945 and has functioned from the outset as a community mental health center. Personal therapy is suggested, but not required. The pastoral counseling program began in September of 1965.

Since it is clergy who do pastoral counseling, and clergymen are prepared in theological schools and seminaries in many ways either before or at the same time as they receive training as pastoral counselors, we must seriously ask: what real effect have the psychological disciplines had so far on what happens to the man who is a minister undergoing further training or is preparing to be a minister?

We already know the great increase (though it is not universal) in clinical and psychological emphasis in Protestant and Anglican seminaries.

A National Institute of Mental Health grant to the Religion and Mental Health Project of Loyola University Seminary, Chicago, supported an interdisciplinary study of the role of religion in mental health and an attempt to make better use of the behavioral sciences in the training of priests and ministers. Projects were conducted at

Loyola by project director The Rev. Vincent V. Herr, S. J., and at Harvard Divinity School and Yeshiva University; the project began in 1956. A considerable number of other seminaries became involved in time, through efforts at the three project centers. A progress report was published in January 1962 in the Journal of Religion and Health of the Academy of Religion and Mental Health. It was brought up to date in January 1966 by Father Herr in the same publication (Vol. 5, No. 1). His remarks help to answer our question.

The mere fact of the project and its continuance for nine years at that time evidences active and serious study of the inter-relationships of the psychological disciplines with theology. The two aspects of the project further show a double interest on the part of seminaries: 1) in appropriating and using psychology and its companion studies in the seminaries and 2) understanding how what the seminary does affects mental health, both generally and among seminarians and clergy.

Rabbi I. Fred Hollander, director of the companion project at Yeshiva University, based on the same NIMH grant, has written: "The primary importance of this grant . . . lies in the fact that the clergy's role in mental health is considered specific enough to permit the development of a formal educational orientation based on their role."[16]

Father Herr's 1966 updating reported many things. A side effect at Loyola was closer collaboration between seminary and psychiatrist in screening candidates for the ministry and observation of personality changes in students while in seminary. In the main, Father Herr reports,

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16 "The Specific Nature of the Clergy's Role in Mental Health," Pastoral Psychology, Vol. 10, No. 98, November 1959, Page 11.

"a lively interest was shown in the newer trends in seminary education,"[17] specifically the use of the behavioral sciences. He writes of an almost unmanageable volume of correspondence asking for further information and guidance as a result of seminars and lectures. In January 1966, he wrote about Roman Catholic seminaries: "Seminars are currently being held in at least a dozen of the seminaries that cooperated with us in the original project"; and "In dozens of other schools of theology, group discussions take place."[18]

What he calls "multi-faith groups" in the project found themselves in long-term cooperation to learn what image the minister has of himself and what image the lay people have of him. This, the project director wrote, will be of both empirical and philosophical value. The minister's growing psychological self-knowledge is important throughout his report. Father Herr also reports more Roman Catholic seminaries inaugurating field-work programs with mental health agencies. This is the more significant because the Roman Catholic schools have been among the more conservative in accepting validity of the psychological disciplines.

Thirdly, he feels that the clinical pastoral training movement has furthered recognition of the clergyman as one with professional

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17 Herr, Vincent V., "Mental Health Training in Catholic Seminaries," Journal of Religion and Health, Vol. 5, No. 1, January 1966, Page 28.

18 Op. Cit., Pages 28-9.

skills and identity.[19] My understanding of what Dr. Pruyser says at this point is that his words apply to the person of the clinically-trained pastor as well in his function as prophet, teacher, administrator, and priest as in his specific tasks as a pastoral counselor. Lastly, he says there is a ". . .growing, and I hope felicitous, impact of psychological disciplines"[20] on the aspect of the personal identity of the man who becomes a clergyman. In other words, how well does he resolve or cope with or use his personal strengths and weaknesses, his own emotional health and history? What sort of a person is he? How well does he know himself as a person? This is important for one who will have the opportunity to touch other persons so deeply and meaningfully, for good or for ill, in the name of God.

Nothing in Dr. Pruyser's words suggests that an effect of the psychological on the theological through the clinical pastoral training movement or otherwise has been to make any part of the theological school discipline of none effect or to raise up a new animal, a new creature, neither ordinary man, nor psychologist/psychiatrist, nor clergyman, called Pastoral Counselor.

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19 Ibid., Page 29.

20 Ibid., Page 31.

THE PASTORAL COUNSELOR IN COMMUNITY MENTAL HEALTH

My understanding of "pastoral counselor" here is twofold. It includes, first of all, the person who is a pastor, a pastor with particular counseling understanding and skills; counseling for him is a development and a function of work as a clergyman. It also includes the person who is a counselor with theological training and orientation but is not working as a pastor and shepherd within a community of faith.

I myself am inclined to agree with Gibson Winter, who said some years ago that "Although the pastoral counselor may feel that he is operating in isolation from the fellowship and may, in fact, have to function independently at times, his counseling ministry has deep theological roots in the life of the parish fellowship."[21] Ultimately, for his freedom to listen, Winter said, "The pastor depends on his anchorage in the fellowship."[22] His remark came out of his need to define therapeutic counseling. He defined it as a process of resocialization through relationship. Relationship must be in particular and cannot be only in general. Hence the necessity of fellowship.

So pastoral counseling is and likely will continue to be practiced principally by clergymen related to some group of the Body Faithful. I can see, however, that one cannot by definition exclude the clinically-based or office-based pastoral counselor per se; his theological training

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21 "The Pastoral Counselor Within the Community of Faith," Pastoral Psychology, Vol. 10, No. 98, November 1959, Page 29.

22 Ibid., Page 27.

and/or experience could be sufficient for continuing pastoral orientation if he has a congregational relationship as a strong layman rather than pastor-shepherd.

Several forces are likely to work to make most pastoral counselors persons working somehow from within the religious system. Dr. Pruyser's analysis points this way. The surprising openness and flexibility of theological school thinking, even when seen only in the areas of our study already indicated, point this way. The varieties of this, however, may be more numerous and exciting than what we see now. The system will change. More about this later.

Now, how and where is the pastoral counselor in community mental health? As I write I have before me a Public Affairs Pamphlet, "Your Community and Mental Health."[23] A drawing shows a smiling group planning a local mental health association. The drawing includes seven figures. The clergyman is the one in the middle. He is the central figure. The 5,000-word text nowhere suggests any positive contribution he makes other than being one of the "opinion leaders." He is a symbol of religion and morality. Perhaps ethics, too. Apropos the professional health community this particular figure remains a strategically-placed layman, not a fellow-professional with skills and insights which can be shared with them and who is competent to share their knowledge.

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23 Elizabeth M. Dach, Public Affairs Committee, New York, 1958 (Sixth Printing, 1964).

I have been for two years vice-chairman of a regional mental health planning council, one of 14 established by statute in the state where I live. Although I was seriously interested in mental health, I had lived in my two-town region less than six months and was unknown when asked to join. Why was I asked? One reason was that my town was less-represented than the other on the council. The second reason was that I was a clergyman, and they had no clergyman on the council.

I sat for months at general and executive meetings, acting as business required, without ever learning any unique contribution I was expected to make or could make because of theology or pastoral experience. Psychiatrists, nurses, public health administrators, doctors, social workers, psychologists, and school men -- they turned at times one to the other for various contributions, but never to me. I was sure that it was not a conscious difference in treatment, or personal preference on their part. It was simply that they could relate to each other professionally or vocationally, and understood each other's language, but did not know how to communicate with me. They did not know what to say to me.

What I did about this is irrelevant here. The point is that the nominating committee wanted a clergyman as member, and I was welcomed as a religious member, but no one had any idea about specific contributions from me. They wanted religion represented but didn't know what for. They may have known in the cognitive sense, but did not possess either the theological, philosophical, or synthetic language for it.

There are many exceptions, and things are changing, but the above is fairly typical of a widespread, uncertain, and friendly aloofness now gradually dissipating. I realize that the above, while it can apply to the clergyman with community interests in the field of mental health, need not always apply to the pastoral counselor. But it is likely to happen even to him if he enters community mental health work while maintaining a distinct parish identity, and is not identified by those health workers he meets as a fellow "pro" through association with a clinic, center, or hospital.

Among more informed members and leaders of medical, psychiatric, and hospital communities it can be different. The clergyman-counselor is not always a stick-figure, a type./ Stanley F. Yolles, psychiatrist and Director of the National Institute of Mental Health, in 1965 spoke to the question: "It is apparent that, as community leaders, the clergy of all faiths have a very important part to play in developing and promoting the (community mental health) centers and the continuum of care they will provide."/ I could say the same for the businessmen of the community, for leaders in social welfare, teachers, elected officials, and, of course, for members of the medical profession. But what is unique about the role of religion in the new community approach to mental health? I would like to quote one comment from what to some would be an unexpected source: 'Only religion is able to answer the question of the purpose of life. One can hardly go wrong in concluding that the idea of a purpose of life stands and

falls with the religious system.'"[24] He was quoting none other than Sigmund Freud, who cannot be charged with favoring religion, but had to say what he did.

Counseling by pastors, or by clergymen who assist the religious role in health and well-being, or by any person with spiritual or theological orientation, is and always has been a vital factor in the mental health of people -- and if a factor in mental health, then a factor in health without the qualifying adjective. In certain historical ways, as has been shown, representatives of religion practiced these arts and skills long before the medical and psychological and psychiatric disciplines were abstracted, practiced, and professionalized. Counseling by pastors, or pastoral counseling as a particularly therapeutic set of skills assisting the process of greater personalization and of "resocialization through relationship" as Gibson Winter terms it, is a necessary part of any community's health (or mental health) effort. In these days of integration, inter-disciplinary courtships, and holism, the counseling clergyman, and particularly the one with special training, is a part of the team. Considerable literature exists about this.

Some of it is in the governments (e. g. National Institute of Mental Health publications; reports from Connecticut conferences on pastoral counseling held in 1958, 1960, 1963, and 1965 by the U. S. Public Health Service, the Department of Mental Health of the State

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24 Journal of Religion and Health, Vol. 4, No. 4, July 1965, Page 303.

of Connecticut); some of it comes from citizen associations (e. g. the Connecticut Association for Mental Health was a co-sponsor for the 1958, 1960, 1963, and 1965 conferences in Connecticut); some of it comes from professional and inter-disciplinary societies (e. g. publications, projects, and seminars of the American Psychiatric Association Group for the Advancement of Psychiatry, Academy of Religion and Mental Health, American Medical Association); some of it comes from independent periodicals (e. g. Pastoral Psychology); some of it comes from university and religious presses, foundations, institutes, and clinics (e. g. Westminster Press, Institute for Advanced Pastoral Studies, Menninger Foundation, Postgraduate Center for Mental Health); some of it comes from individuals. Many sources could be added to the few examples listed here.

But no general or widespread understanding or opinion yet exist as to exactly what his role is or how he fits in; perhaps none shall. Some clergy with counseling training certainly would not consider themselves as pastoral counselors in the growing interpretation of the term. The others have a variety of relationships to individual clients, congregations, denominations, communities, clinics, schools, and hospitals. The special developments of pastoral counseling are recent enough, different enough, and concern numbers of men still small enough that no "right" or "normal" relationships have yet been standardized. So, in what is our investigation here, no one can say what the pastoral counselor's relationship to community health agencies <u>should</u> be.

In passing, let me offer the opinion that this should not surprise or worry clergymen, because the roles and relationships of the physician, the psychiatrist, the social worker, and the osteopath are uncertainly defined among themselves and with others.

Since we cannot say in general what the role of the pastoral counselor is or should be with respect to groups and agencies of the several communities, let us look at a selection of instances of what relationships have been effected. How are pastoral counselors working out their role? What roles have they?

The Rev. Tom Jackson, after other schooling, seminary, and military service, became a clinical psychologist. He was, in 1967, senior minister in an Oregon church. Besides this over-all responsibility, he taught two different 12-week courses in personality structure and personal and social adjustment to laymen and another course to clergy. His forte is the group processes of helping relationships; he does one-to-one counseling in the course of normal pastoral duties, but bears down in teaching and enabling processes of interpersonal relationships in groups.[25]

It is not clear how Mr. Jackson makes pastoral counseling of what from the brief article's description might possibly be only group psychotherapy done by a minister in a church building but devoid of a theology and pastoral concern. He reports that group

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25 Associated Press "Religion Today" feature by Frank Wetzel, from (Meriden, Connecticut) Morning Record, December 22, 1967.

participants pay a nominal amount to the parish for materials and that the leadership is part of the parish ministry. "We are recognizing that the pain is inside, and that healing comes from inside out. It is exciting, creative, and makes a real thrill of being a pastor." He told the reporter: "God is sovereign of all life. That doesn't leave much out."[26] So much for any who would question the propriety of a minister doing such work.

The Greater Hartford (Connecticut) Council of Churches in September 1968 added The Rev. Thomas G. Campbell as assistant director of the Council's Pastoral Counseling Center. Many councils or associations of churches across the country are among those employing pastoral counselors. With one kind of support or another, centers were opening at the rate of one each week in 1967 and 1968.[27] Many employ counselors on a part-time basis; Mr. Campbell serves the Hartford Center eight hours a week.

The director of the same church-council-sponsored center in Hartford, The Rev. George R. Merrill, is a full-time non-parochial pastoral counselor; he serves the already-mentioned center in Hartford and is chaplain to Blue Hills Hospital in Hartford, an inpatient state institution for alcoholic and drug-dependent persons. The Hartford Pastoral Counseling Center is in the central city area in a church parish house (offices and activities building with its own street entrance).

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26 Ibid.

27 According to The Rev. Knox Kreutzer, Director of the Marriage and Family Institute in Washington, D. C., and treasurer of the American Association of Pastoral Counselors, in an interview.

Individual parish churches, usually large, affluent, and given a social conscience, but possibly smaller or possessed of special concern, sometimes support a pastoral counselor or counselors. Trinity Church, New York City, has for several years supported a multiple-staffed counseling service; much of the work is oriented largely to social service. Marble Collegiate Church, New York City, has for more than three decades offered counseling oriented toward the psychological disciplines; it was out of this beginning that Dr. Smiley Blanton and The Rev. Norman Vincent Peale conceived the American Foundation of Religion and Psychiatry, which trains professional counselors who have a theological background.

First Presbyterian Church of Evanston, Illinois, has a Pastoral Counseling Service. Psychiatric consultant to it is Elihu S. Howland, associate in psychiatry at Northwestern University and lecturer at Chicago Theological Seminary and McCormick Theological Seminary.[28]

In 1955 Congress established a Joint Commission on Mental Illness and Health to survey the nation's mental health needs and recommend new approaches to bring about better mental health care. In 1961 the Commission made its report. This helped enactment two years later of the landmark Community Mental Health Centers Act of 1963. One of many advances thereafter has been the development and improvement of a great number of community mental health centers and state services for them. With this background, I draw especial attention to the pastoral services

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28 See "The Challenge of Mental Health to the Christian Community" by Dr. Howland in Journal of Religion and Health, Vol. 5, No. 4, October 1966, Pages 314-23, an address delivered at the church.

to be provided the community mental health centers of South Carolina through the Division of Community Mental Health Services, South Carolina Department of Mental Health.

In South Carolina, The Rev. J. Obert Kempson is consultant for pastoral services to the South Carolina mental health centers and that state's Department of Mental Health. He also is regional supervisor for the Association for Clinical Pastoral Education and is chairman of the Committee on Community Mental Health and the Clergy, of the American Association of Pastoral Counselors. This is a strategic administrative and executive role for a pastoral counselor on the state level. What follows will show some of his work.

In 1968, the South Carolina Division of Community Mental Health Services, with the support of the National Institute of Mental Health, held a conference concerning pastoral services to people through the community mental health centers. Background included the fact that many pastors, counselors, and clergy groups were interested in the functioning of community clergymen through the centers and in clarifying and defining the role of staff clergymen in the centers. Other than a few scattered local and state attempts, little was understood about these two questions. Of the four conferences in Connecticut already referred to, three preceded the federal enabling act of 1963. They were concerned, admirably and successfully, with educating and encouraging clergymen in the field of mental health, particularly toward cooperation among the clergy and leadership in the community programs. Even the fourth of the Connecticut programs, in 1965, preceded the appearance of community mental health centers in numbers

and strength supported by the federal government, so pastoral services to such centers could not be analyzed, though again the clergyman was helped to take a leading role in community programs.

Of primary concern in the case of South Carolina is the fact that the conference was convened for the stated reasons. Also, that it was attended by national mental health leaders, of course, but also by nearly 50 interested clergy and health workers from the six states of Alabama, Florida, Georgia, Mississippi, Tennessee, and South Carolina. The proceedings developed what in their report was called a significant body of information for developing pastoral services in the comprehensive community mental health centers. Trained pastoral counselors in that region as elsewhere undoubtedly will serve in the community centers, likely in leadership and teaching roles as other responsibilities permit.

The South Carolina Division of Community Mental Health Services has job descriptions for two classes of pastoral service coordinators in the community mental health centers; they vary as more experience and training enable a coordinator to exercise more leadership.

General duties of any coordinator are, under general administrative direction, to

> plan, organize, and direct the overall program of pastoral services in the community mental health center; plan and supervise an approved clinical pastoral education program for theological students and ministers; provide consultation for local clergy about the pastoral care of emotionally troubled and ill; interpret to the church and civic groups the work of the center and the interrelationships of religion and the problems of mental health; perform related work; and functioning as a member of the multi-disciplinary team of the center.[29]

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29 Full job descriptions for the positions may be obtained by writing to: Department of Mental Health, State of South Carolina, 2214 Bull Street, Columbia, South Carolina 29201. They were adopted in July 1967.

Academic knowledge, abilities, and ecclesiastical endorsements for the two classes of coordinators are identical. Experience required for the lower class is "Two years of full-time paid employment as a minister of a church or its equivalent. Satisfactory completion of at least one year of approved Clinical Pastoral Education."[30] The second and higher class of coordinator requires as experience

> "Two years of full-time paid employment as a minister of a church or its equivalent. Satisfactory completion of at least one year of approved Clinical Pastoral Education of which six months must have been conducted in a mental health facility (preferably a mental health center). In addition to the aforementioned, a minimum of three months approved training as an Assistant Supervisor of Clinical Pastoral Training in a mental health facility."[31]

That section of the South Carolina conference proceedings which concerned the role and function of the staff clergyman seemed still to concern itself with an older style chaplain (although one with psychological training), and not with any noticeable formal pastoral counseling. One of the speakers said "A staff clergyman does more teaching and consulting and organizing than anything else," and will long for "the old days when chaplains just visited wards."[32]

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30 From "Coordinator, Pastoral Services I" job description. See footnote 29.

31 From "Coordinator, Pastoral Services II" job description. See footnote 29.

32 Chaplain Jack Slaughter, Fort Logan Mental Health Center, Denver, Colorado, proceedings of the South Carolina conference, Page 36.

Another speaker, however, cited several examples of trained counselors working part-time or as consultants in community centers while ministering to a congregation:

> "In a small city in the midwest, a long-established denominational hospital is planning new construction to house a mental health center. . . . Over a period of years, a group of clergymen established a marital counseling clinic which was housed at the hospital. . . . With the formation of the new center, the marriage counseling group will become part of the structure of the community mental health program and the marriage counseling clinic staffed by the clergymen will continue."
>
> "A general practicioner in Oregon. . . had taken training provided for non-psychiatric physicians and had become interested in helping his patients in the community with emotional and mental health related problems since no psychiatric assistance was available closer than 60 to 80 miles away. This doctor had learned something about group therapy and had set up. . . a group of patients who had returned from the state hospital. A community clergyman who had been trained as a pastoral counselor was co-therapist. . . . The clergyman had become interested because some of his parishioners had returned from a state hospital stay. The physician supervised the patients' medication and the clergyman took over if the doctor was called away."[33]

The speaker also mentioned a Kansas clergyman who divides his time between counseling in the new mental health center and acting as chaplain in the general hospital. She referred to several clergymen in another place who each assumed two or three hours of work weekly as therapists after the local mental health center expanded its program and case load.

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[33] Dr. Lucy Ozarin, National Institute of Mental Health, in the proceedings of the South Carolina conference, Page 20.

In another instance, known to this writer, a man ordained priest and very briefly in a parish ministry pursued full training short of a degree in medicine and a psychiatric license, and as a pastoral counselor is in private professional partnership with a clinical psychologist. He exercises his priesthood sufficiently to remain in the official directory of his communion of the Church and diocese on the list of "non-parochial clergy" but has (or had in 1965) no regular pastoral life with any congregation or institution of the Church. An undetermined number of men with theological training go this route through personal conviction or impatience with slowly-changing hierarchies and religious institutions and lack of medical degrees and psychiatric training. Partnerships of different kinds are forged. Many of these persons eventually lose their ecclesiastical accreditation.

Still another role-variation of the pastoral counselor is that represented by Protestant clergyman, Edward F. Dobihal, Jr., fully-accredited by his denomination and also by the American Association of Pastoral Counselors and the Association for Clinical Pastoral Education, who serves as full-time chaplain, pastoral counselor, and clinical supervisor at the large, university-related Yale-New Haven Hospital in Connecticut. He also teaches with sub-professorial rank in the Yale school of medicine. Again, here, I draw on my own acquaintanceship with counselors; search would show this counselor role as well as others mentioned and to be mentioned approximated many times over elsewhere.

In Washington, D. C., The Rev. Knox Kreutzer is a priest in good standing in his diocese. He also is a pastoral counselor of 20 years' experience who is administrative director of a staff of eight at the Marriage and Family Institute. Two psychiatrists, a person with a doctorate in social work, and Father Kreutzer are full-time, and two psychologists and two child psychiatrists are part-time. One of the full-time psychiatrists is medical director. The co-directors comprise "what is called the chief executive office and this office rather than a single individual is responsible to the Board of Directors for the operation of the Institute.[34]

Nearby in Washington is the Pastoral Consultation and Counseling Centers of Greater Washington. The Rev. Charles R. Jaekle is director. Of the organization it has been said: ". . . one of the financially most sensible and effectively organized of the pastoral counseling centers. The pattern of relationship between the various professional disciplines involved and with the community will be worth. . .study."[35] Father Jaekle is an Episcopal priest in good standing; at the same address, and listed in the Episcopal Church Annual[36] as an agency of the Episcopal Diocese of Washington is the Pastoral Institute, which offers alcoholic rehabilitation, counseling, diagnostic services, group work,

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34 Father Kreutzer, in a letter, December 10, 1968.

35 Ibid.

36 Edition of 1968, Morehouse-Barlow Company, New York, Page 50.

an outpatient clinic, referral services and a training school. Father Jaekle formerly was director of the Pastoral Institute, and now directs the further-evolved complex of centers. He is a member of the American Association of Pastoral Counselors. He thus is in intimate relationship with a center he helped establish in his own communion of the Church, is in good church standing and also has a broader ecumenical and community relationship, truly an admirable development.

We have already recognized four conferences on pastoral counseling in Connecticut between 1958 and 1965. After the last, and after two years of work to take advantage of the 1963 federal Mental Health Centers Act, a Committee for Connecticut Conference on Pastoral Counseling convened in Meriden, Connecticut, in June 1966. Significantly, The Rev. Jervis Zimmerman, an experienced pastor who was the first teaching chaplain in the state at Norwich Hospital, was chairman.

Dr. Abraham Zeichner, Chief of Psychological Services, Connecticut Department of Mental Health, traced the history of the conferences from initiative first taken by the Hartford Seminary Foundation. Minutes of the 1966 committee meeting say that he "laid stress on the changes in role perception among the clergy of Connecticut from an initial view of the clergyman as mainly a resource for counseling to an increasing awareness of leadership responsibility in the community, particularly in terms of planning. The big problem now is how to make clergymen more directly participant in the regional programs of mental health services at the community level." Particularly in his mind

and minds of others as concerns planning was the recent establishment in the state of 14 regional mental health planning councils. Unmentioned was any special significance of the specialty or subspecialty of pastoral counseling or particular leadership growing therefrom, distinct from what any concerned pastor might do.

I interviewed him about this early in 1969. Dr. Zeichner said: "Our aim at each of the conferences was to convene clergy in substantial numbers. The number of clergy at the four conferences ranged from 60 to 100." The approach at first centered on the clergyman as a counseling resource, because "he was already involved in counseling, whether he termed it that or not, and he was in a position to be a beneficiary to training in counseling methods and theories. We wanted to show him how he could extend counseling as a means of helping people within his pastoral role in the parish.

"At the outset we had trained mental health counselors as faculty and a very occasional clergyman who either was, in addition to being a clergyman, a trained mental health professional, or had received such training."

Dr. Zeichner's partial description of the 1958 scene suggests that the clergyman was held to be relatively ignorant of psychological literature and a person who would continue to work then and in the future within his parish pastoral role. The 1958 conference, he reports, produced resistances on the part of clergymen to the erroneous assumption on the part of the planners that clergymen (at least the selected ones invited to Hartford) were ignorant of psychological literature. They also sensed that they were to be made over in the image of some other profession.

Subsequent follow-ups at the local level explored the resistances and positive possibilities. In late 1958 and early 1959, at least three inter-professional groups were established where clergy and mental health people met at a nearly equal level. Mental health people learned that clergy did have assets besides piety and good manners, and many had extensive knowledge of pertinent literature; clergy learned that the health professionals were not by any means all bent on using clergy primarily as free referrals for case overloads. And, "clergy became less intimidated by notions of psychopathology and aware that they could offer very valid help to people besides recognizing cases to be referred."

Reports of the four conferences show the evolution of thought and relationships between the professional theological, medical, and other health people, and how they moved closer together, "at least among the members of each group who comprise the smaller universe, that is those who are active and not evasive."

Clergy rank very high, Dr. Zeichner said, among those who are natural community leaders. "We have to look for appropriate leadership, and we've been trying to make clergy aware of the possibilities of their leadership."

In 1958 the view among Connecticut Department of Mental Health officials and the small inter-disciplinary group in Hartford who planned the 1958 conference on pastoral counseling was that clergy were unknowing in psychology and related knowledge and that they would

(or were expected to continue to) counsel primarily within their congregational limits. From the viewpoint of the community they were "mainly a resource for counseling."

The same 1966 committee minutes, however, that reported the 1958 expectation expanded on by Dr. Zeichner also said that there has been "an increasing awareness of leadership responsibility in the community, particularly in terms of planning." What has happened between early 1958 and the end of 1968?

Dr. Zeichner's estimate in January 1969 is that at least 12 clergy in Connecticut "have emerged in distinct leadership roles in mental health planning," as chairmen or directors of local or regional committees, associations, or councils. Dr. Zeichner, who travels extensively in the state, says that an undetermined but great number of clergy have "modified the way they function" in their community. Many with greater than average counseling training are "associated with a clinic, formally or informally. Some have worked out a schedule of counseling in or beyond the church or synagogue. Some come together in groups to work out an approach to their own character structure that will help them in their person and in their counseling. Some have resumed clinical training, in chaplaincy or other programs."

He added that several pastoral counseling centers are functioning in Connecticut and there is interest in developing others. Talk is heard of establishing a permanent institute to train clergy in counseling. Are clergymen being lost to parishes and their people as a result of all this? Dr. Zeichner believes not. He believes, on

the contrary, that more clergymen are, as a result of mental health and counseling emphasis, more meaningfully related to their people, and helping more, and that the mutually helpful realtionships are stronger.

And how many inter-professional or inter-disciplinary groups of theologically-oriented and medically- or psychologically- or social work-oriented groups function in Connecticut in January 1969? No one can tell with exactness, but Dr. Zeichner believes that there are eight, each different but each made up of helpers who are in dialogue and increasing community. Clergy with pastoral counseling training are prominent in these groups.

Reference has been made to the 14 regional mental health planning councils established by statute in Connecticut; early in 1969 there were no fewer than 38 clergymen members on the nine councils for which rosters are available.[37]

The Connecticut Association for Mental Health in March 1969 reported 21 clergymen on 14 association boards in the state.[38]

Connecticut does not have an official consultant on pastoral services or coordinators of pastoral services in its community mental health centers; South Carolina does. Wide differences certainly exist in many respects among the states as concerns the functions of pastoral

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37 Information supplied by the Division of Community Affairs, Department of Mental Health, Hartford, Connecticut.

38 Information supplied by the Connecticut Association for Mental Health, Inc., Hartford, Connecticut.

counselors in all ways. The development outlined above from Connecticut may be typical of what is happening in many places. We should remember, when we consider all this, that most pastoral counseling, on a gradually more informed and skilled basis, is and may continue to be done by pastors working exclusively or largely within their own congregations.

I earlier described my own introduction to community mental health soon after arriving in Connecticut. I shall now add to the story -- not because I am singular, but because I feel I may be a typical pastor becoming a pastoral counselor in a contemporary development of the Christian ministry.

A leadership development officer in one communion of the Christian Church heard me out and then said "You're one of the pioneers for the next generation." I wish to disclaim any feeling of heroism at being called a pioneer; I feel that I am driven by my ministry, knowledge, and the world.

Outwardly, after learning the uncertainty of the mental health planning council about my role, I made it my business to learn what I could, and to speak positively but not dogmatically when I should. The nominal chairman of the council, a busy physician, began missing meetings. My council weight increased. I accepted an invitation to join an interdisciplinary group (a therapy group, one of those stimulated by Dr. Zeichner six years after the first Connecticut conference) of clergy, psychiatrists, psychologists, and social workers. This group eventually began offering counseling to the public, announced chiefly through the churches. Eventually, in 1968, the member psychiatrist began referring clients to clergy of the group. The psychiatrist

directs an adult outpatient clinic at a small general hospital as well as maintaining his own practice. I continue in the group, with the council, and now see clients regularly at the hospital clinic.

What kind of a parish do I have, you might ask, that allows me to devote so much time to community mental health and non-congregational counseling?

My parish is more than a century old, but a small and weak one within ten minutes easy driving time of four larger, well-led, and well-served parishes of my communion. Nor is the area otherwise unchurched or poorly served religiously; at least 30 other religious congregations are in it. As an independent parish it is vestigial from the generations before automobiles and before growth of the two surrounding, and I mean surrounding, towns.

My parishioners' later-20th Century wage-earning, social, and private lives are such that they do not welcome and scarcely would tolerate an old-fashioned minister dropping in to balance a coffee cup and make them late for their second job, or bowling, or night school, or dancing lessons, or any of several other things. They are disinterested in social life at church -- they have enough of this elsewhere, by choice or necessity. Education classes are severely limited.

The parish would likely be small in any event; it is as small and weak as it is because of the highly creditable parishes nearby, because it has had a pitifully broken and discouraging ministry through 100 years, and because of changing times. Its requirements of me are few, though essential. It is financially dependent in part on the Diocese of Connecticut, which chooses to continue to keep the parish

open. In my judgment, its only hope for vitality and purpose depends on a long, supportive, strengthening ministry, not in sudden expenditures of energy, public relations, or better organization. To serve this well and long (and service is the purpose of it all) a minister must, for his life's sake in every interpretation of the word, serve the community around and serve himself, as well as the congregation, in some continuing and mutually rewarding way. I think that pastoral counseling is such a way -- personal, pastoral, Christian.

I can visualize continuance in this parish with what I suspect are absolutely necessary roots in the ongoing, organic community of faith that its life would give me. I can visualize a pastoral relationship to fellow members within my own particular faith community referred to me from neighboring parishes, and to other Christians and humans in need.

At the same time I could support a vital pastoral relationship to the professional helping communities of persons around me and have an opportunity for leadership. These latter things would not be possible if the parish were of a size and type calling for a great amount of administrative time, constant money-raising, and great numbers of classes and social activities; impossible if I had to spend too much of my time "taking care of the store." Thus, in a small parish and supporting myself in part from work in the community, I could have a parish ministry and also a ministry of breadth and depth in the general community with other professional helping people. In the community, I would hope to add to mental health planning and service the contributions of a pastoral and theological view of man and the world.

This projection of possible development is only one possible growth. Others are equally feasible, for me and others.

I now cite one more type of participation toward helping people be whole. It involves counseling. In July 1967, the first Directory of Suicide Prevention Facilities appeared, published in the Bulletin of Suicidology.[39] It listed 47 programs in 16 states. Less than a year later a second edition listed 60 facilities in 22 states and the District of Columbia. In 45 of the 60, the professional background of the director is known. Seventeen of these programs are administered by clergy, 15 by physicians, eight by social workers, five by psychologists, and two by nurses.[40]

What may be called a reaching-out and holding-on orientation is termed "an important first step with character-disordered persons and, indeed, also with many so-called 'normal' persons when they are momentarily overwhelmed by a serious crisis or emergency."[41]

Certainly such programs are concerned with community mental health, and obviously both the crisis work and great amount of follow-up performed by clergy, especially clergy with some diagnostic and psychological training for counseling, is an important contribution.

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39 National Institute of Mental Health, Chevy Chase, Maryland, Volumes are unnumbered.

40 Bulletin of Suicidology, National Institute of Mental Health, Chevy Chase, Maryland, July 1968, Page 25.

41 Ibid., Page 29.

One such program is in existence in Connecticut, and the mental health planning council with which I am most familiar is taking the initiative to extend and support the "help-line" service through our 200,000-population region. In the preliminary stages, six clergy have indicated an interest in taking part.

Now to a survey which samples the relationships of a few trained pastoral counselors to community mental health.

At the end of 1968 I distributed a questionnaire to recipients of certificates from the Pastoral Counseling Program of the Postgraduate Center for Mental Health, New York City. The Center calls itself "the largest clinical facility of its type in the world" because of the "approximately 70,000 individual and group treatment sessions given during the year." Lewis R. Wolberg, M. D., is medical director and dean of the Center, which, besides massive therapeutic service and the Pastoral Counseling Program, has training programs in psychoanalysis, child therapy, research, group therapy, drug addiction and juvenile delinquency, office psychotherapy, psychiatric principles and practices for physicians, and psychiatric principles and practices for dentists.

Two classes have received certificates for completion of the two-year program for pastoral counselors. The first class was graduated in 1967 and the second in 1968. Each class had the maximum of 24 members at the outset. Of the 48 original members of the two classes, 36 were certified; 12, an average of six in each class, for one reason or another, did not satisfactorily complete the program.

One of my mentors has been Alfred McClung Lee, newspaperman, sociologist, author, opinion analyst, and onetime president of the

Institute for Propaganda Analysis. Emboldened by academic experience with him, I prepared my own brief questionnaire for the counseling program graduates. It contains one open-end and seven multiple-choice questions. A stamped, self-addressed envelope was enclosed with each questionnaire; the questionnaire was within the body of a one-page letter which identified me and made anonymity possible for the respondent.

Between January 1, 1969, and March 15, 1969, I received 23 replies from the 36 graduates, slightly less than 66-2/3 percent. Gross scoring of the 23 replies is shown on a copy of the questionnaire which is Page 47 of this paper, so I will neither repeat the questions nor list the scores here.

From my point of view, it is very pleasing that only one respondent counsels exclusively with his own congregation (the word "congregation" was prepared by me and understood by the respondents to mean any distinguishable or identified group regularly served, not only the traditional interpretation of those enrolled members of an incorporated group of a particular religious denomination or faith called a parish or congregation). One man did substitute "constituency" for "congregation.". . . And in the one case of exclusivity the congregation is made up of the inmates of two county jails, a child welfare home, a youth shelter, and ministry shared with two other chaplains for patients in a 12,000-bed general hospital.

The fact that two-thirds of the respondents counsel mostly in their own congregation or constituency agrees with the expectations

From: The Rev. Robert Black

Dear _____;

I am currently in the pastoral counseling program at the Postgraduate Center and New York Theological Seminary. For my thesis, I pose some questions below. Your reply will be most helpful. If you wish anonymity in your response, draw a line through your name above before returning your responses.

I am concerned particularly with how and whether you have recognized and special counselor status or function in your church's structure and/or in your relationships to community agencies and institutions and the professional health people in them. If you have effected either or both of these roles, how did you do it and what is the job description? If not, what are the main obstacles?

The questions:

1-I do my counseling all 1 with members of my congregation.
mostly 16
less than ½ 6

2-I am never 3 recipient of referrals from other clergy.
occasionally 14
frequently 5

3-I am never 9 recipient of referrals from mental health
occasionally 9 professionals and agencies.
frequently 3

4-I am 13 a staff member of a hospital, clinic or agency
am not 8 (public 9 or private 5 ) as a
want to be 4 counselor or pastoral consult-
do not want to be 2 ant with prescribed counseling duties.

5-(If answer to 4 was yes) This is full-time 4 .
part-time 11 .

6-I am pleased 22 with the use I am able to make of my
displeased ____ pastoral counseling training.

7-I expect 18 to be counseling primarily in parish work
expect not 4 five years from now.

I know the above questions do not meet your circumstances exactly, so I respectfully ask that you add whatever you feel will be helpful under question 8. Then return this sheet to me in the enclosed postpaid envelope.

8-I'd like to add this:

REB/1168

of the Postgraduate Center and probably most of the medical, psychiatric, and community health professionals. It suggests contributions in the areas of prevention and education, both of primary help.

One of the six who counsel less than one-half with their own congregation is working to help establish community mental health centers and hopes to work professionally with the centers when they are established, but also speaks feelingly of the proper use of group processes and counseling techniques "to make the Church a more viable institution" because "unless something is done soon to break down the barriers to communication the Church is destined to be left to a handful." Another in this group has left the parish ministry and works for a church insurance and pension company, but still receives referrals and feels his pastoral counseling training to be of value. A third who counsels little with his own congregation writes of the advisability of establishing a pastoral counseling center where he lives. The fourth of these six does considerable work at a local mental health clinic. The remaining two in the group offer no additional information about this division of their counseling time.

Fourteen, a significant number of the 23 respondents, occasionally receive referrals from other clergy. This is particularly encouraging because, in the face of several possible or real threats that the emergence of specialized counseling can present to other clergy, particularly older ones and any afraid of losing out, a particular competence is acknowledged and used. And this comes historically rather early in the impact of counseling studies and work on laity and the clergy at large.

Of the three who "never" receive referrals, one speaks of "jealousy and competition," but the conflict is that of "helping agents," not of clergy, and another is too busy with graduate work for very many clients.

Answers to Question 3 seem to me to reflect moderate but not great use of pastoral counselors by other professionals and agencies. I suspect that in some cases the other helping persons and agencies simply do not yet know enough about the competences or person of the pastoral counselor, or may have their own personal or professional barriers against him. It is not encouraging that only three of 21 persons who answered this question frequently receive referrals.

Against this are the 12 (more than one-half) respondents (Question 4) who are staff members of a hospital, clinic, or agency as counselors or pastoral counselors with prescribed counseling duties. This question was phrased as it was in order to distinguish unfailingly between counseling and older style chaplaincy, which might easily not include pastoral counseling.

In most cases the staff work is part-time (Question 5), because in most cases the counselor also serves a separate religious congregation. I interpret this, too, as a good thing, since it means that people at the congregational scene, too, are receiving the benefits of pastoral counseling. If this is then projected into the whole number of trained pastoral counselors, the clients and patients in as many as 1000 hospitals and clinics and agencies may already be benefitting from pastoral counselors, and many hundreds of religious congregations as well.

Everyone who answered Question 6 expressed pleasure with the use they are able to make of their pastoral counseling training. In retrospect, the question might be a poor one, since it easily is possible to be pleased with the use one makes of training without being satisfied or even feeling that it was worthwhile. But the answers may nevertheless mean general approval of what training institutions (in this case the Postgraduate Center) are doing, or of their general approach. Regardless of counseling, the increased sensitivity and psychic "nearness" to people helps the pastor.

I made reference earlier to alleged pressures within the ranks of clergymen somehow involved in pastoral counseling work or preparation -- pressures to separate out of congregational pastoral work into a group with its own professional initials, a shingle, and only an office address. I have seen a little of this -- but little. Contemporaneous with this, and related to it, is the religious identity problem of our time; religion itself often is questioned. Change has overtaken religion and ecclesiastical systems and institutions and mores as well as nearly all others in our society, and in religion as elsewhere, institutions change much more slowly than many people feel they should. Resistance to change is greater in churches than is inherently so in education, busines and social life in general, though not so great as its enemies charge. As a part of all this, many clergy now are questioning themselves and their work. One result of this is added reason to counsel in a pastoral way somewhere else than in the parish, be it a changing parish or not. So it is significant, even

surprising, that of 22 Postgraduate Center alumni who answered Question 7, some with Master of Sacred Theology degrees and some with certificates, 18 "expect to be counseling primarily in parish work five years from now.

Of the four who "expect not" to be so working in another five years, one already has left congregational-parish work and is in business, one has begun to consult and to counsel and refer fellow clergy of his denomination and expects this to become full-time work, one is taking further graduate work in counseling, expecting to do full-time non-parochial counseling, and the fourth has similar goals in a community mental health center.

The eighth and open-ended question brought a number of helpful replies. Excerpts, as long as necessary and as brief as possible, follow.

A man who expects to be counseling primarily in parish work five years from now but does less than one-half of his work in his parish now, seems happy in the use made of him by the local mental health clinic.

A nurse who is "not doing any counseling as such" and is the only unordained graduate of the course so far, is in nursing education at a large state hospital after several months at a small Roman Catholic-operated general hospital. She finds the state hospital "far more progressive in attitude and program." As concerns counseling, her training is "invaluable, not only in dealing with patients, but also with my students. And, of course, it was a help to me personally." Many religious conflicts, she reports, are in those who come to her for "talks."

One minister's sole comment is that "The course was helpful from the viewpoint of my own personal mental health."

A rabbi serving as a chaplain writes mainly of his own increased sensitivity to feelings in himself and his congregation.

Another man gained a position counseling for a juvenile court as a result of his training.

A pastor who counsels mainly with members of his own congregation explains that this is under a broad definition of "counseling" including many informal situations as well as formal settings.

Another graduate of the Postgraduate Center has since left his parish for clinical psychology study at a university.

One man's "parish" are the several institutions he serves as chaplain.

Counseling with planning goals for new ministries to urban complexes, more than individual problem counseling, was emphasized by one respondent.

One un-numbered and implied question in the paragraphs introductory to the questionnaire concerned acceptance by professional health people. An answer, the only one specifically concerning doctors of medicine, says that doctors are ready for clergymen as co-workers but few clergymen are prepared. "Professionals were willing to give me a try and finally to even welcome me as a clergyman who understood his relationship to the medical community; they are rare in most places. . . . I just believe that the medical profession (generally speaking) is ready to team up with the clergyman."

Another man wrote "I am recognized by other pastors and my congregation as one with counselor status," but did not mention other community health and personal helpers.

The questionnaire probably could be improved on, and it might prove worthwhile to repeat it on a broader basis a few years hence. One might interpret, from the paucity of direct answers, that few pastoral counselors have formally-recognized roles as such in their ecclesiastical structures. A typical counselor, judging from my questionnaire, might be a pastor who counsels mostly within his own congregation, occasionally has someone from another clergyman, has some part-time staff role at a local public hospital, enjoys his work and expects to remain in it. This is an encouraging profile.

What about the pastoral counselor's relationships with physicians, psychiatrists, psychologists, nurses, and social workers? The pastor who answered my question by saying that the medical profession is "ready to team up with the clergyman" but "few clergymen are prepared" may be correct, but precisely what does he mean? And, is he correct. What is happening in this relationship?

American Medical Association

Our brief glance at the history of the clinical training movement for clergy showed serious, organized efforts extending back at least 50 years; the board of trustees of the American Medical Association established a Department of Medicine and Religion only in 1961.

We are not prepared fully to consider why the A. M. A. established the medicine and religion department when they did. The Rev. Paul B.

McCleave, LL. D., director of the new Department of Medicine and Religion, said in 1963 that scientific and technical knowledge since World War II has made possible great advances in surgery, use of drugs and in diagnosis, and that "sometimes we have a sense of arrogance in all of this new knowledge."[42] He went on to picture the greater control over life now exercised by the physician. And, in what comes across as real humility on the part of the doctor, he said that the doctors are frightened by their re-awakening sense of the mysterious and intangible factors of life and death, and they need help from the clergyman.

Also, however, by 1963 the seemingly rocklike political position of the A. M. A. was changing. Medicare had to be coped with, and in the mental health field a 1955 joint commission established by Congress had led to the shocking 1961 report "Action for Mental Health," to President Kennedy's "bold new approach" message to Congress in 1963 and would result in the Community Mental Health Centers Act of 1963. Pressures too many and too great no longer could be minimized. Because of the unique and traditionally strong position of clergy with respect to patients and the communities, and with an eye to the steadily growing clinical training movement, it may have seemed expedient to the A. M. A. to bend a little and establish the Department of Medicine and Religion.

The olympian, protectionist attitude of the A. M. A. as a whole is too well known in too many regards to need recounting here. Recent

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42 "Medicine Seeks the Clergy," Journal of Religion and Health, Vol. 2, No. 3, April 1963, Page 239.

applied science and technology have favored the growth of this gargantuan health power, and the A. M. A. does not listen well. But it does listen.

What about the Department of Medicine and Religion? The department as such is not within our view, but one project of the department is of interest. A publication of the department[43] says that it considers the four phases of total health to be the physical, spiritual, emotional, and social. To further its relationship with the clergy in the area of patient care, the A. M. A. in 1962 appointed a committee of ten doctors (including one psychiatrist) and ten clergymen to assist the department.

In 1963, four areas of interest were listed by the A. M. A. department for study: hospital chaplaincy; pastoral clinical training centers; studies in medical schools, nursing schools, and theological seminaries; and faith and healing.[44]

In 1965 a research project was developed in one of those interest areas to help answer the question: "How can organized medicine be of assistance to the individual seminary?"[45] Since then, approximately one-third of the county medical societies across the country have had joint programs in which physicians and clergy discuss problems of patient

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43 "The Physician, the Clergy and the Whole Man."

44 Paul B. McCleave, Op. cit. Page 245.

45 "A Program Guide for County Medical Societies and Theological Seminaries," American Medical Association, Page 1.

care. A major conclusion was that communication between the two should begin at the medical school and seminary level.[46] A survey sent to 269 seminaries in 1965 was answered by 199 of the seminaries, of which 162 favored pastoral-clinical training and 87 were then participating in such training. The pastoral care courses were being taught in 102 cases by chaplains, 69 by clinical psychologists, and only 59 by physicians. In 134 schools a pastoral psychology course was offered. An A. M. A. teaching manual would have been welcomed by 188 of the seminaries (out of 199), and 150 wanted to discuss such a teaching program with an A. M. A. representative. It may be safe to conclude that the seminaries welcomed anything to do with help from the A. M. A. toward pastoral-clinical training.

Twenty seminaries later were selected for pilot projects to develop an A. M. A. manual for a teaching program in seminaries. Dr. McCleave spoke on behalf of the A. M. A. about medicine "taking this lead,"[47] but it seems to me that the initiative of the A. M. A., worthy though it is, was limited to its degree and mode of organizing for participation in something that had been going on for some 40 or more years. I am sure that their efforts now will be greatly rewarding.

The actual meetings of 20 seminaries with their respective county medical societies began in 1966. A total of 30 physicians took part, and 255 seminary faculty and students -- more than eight seminary

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46 Op. Cit., Page 2.

47 "Medicine Seeks the Clergy," Journal of Religion and Health, Vol. 2, No. 3, April 1963, Page 245.

students or faculty for each doctor attending. An unspecified number of medical society executives and non-medical hospital staff members also attended. The response of the seminaries to the A. M. A. questionnaire and attendance at the meetings both indicate a lot more interest in the subject on the part of the seminary clergy and students than by doctors, despite the great effort of Dr. McCleave and his A. M. A. department. Dr. McCleave believes that "medicine seeks the clergy," but it seems that clergy seek the doctors, by eight to one.

The A. M. A. Program Guide resulting from the 20 seminary projects lists seven kinds of project subjects. They included: medical ethics, organization, and function of the hospital medical staff; function, administration, and physical plan of the hospital; treating the "whole" man (cooperation of physician and clergyman); mutual professional concerns with patients' psychology; counseling, including marital and family and co-counseling by physician and clergyman; values in medicine; and ethical medical practice, including telling patients the facts and norms of conduct.

The list is promising, especially so in the areas of ethics, counseling, values, cooperation, and the "whole" man. This is especially so if we take Dr. McCleave's title "Medicine Needs the Clergy" seriously. The seminaries showed throughout that they need and want what medicine knows, and the project subjects look very good. Comments from the seminaries' project reports show their plans to follow up.

But the Conclusion by the Guide at the end of the summary of results of the 20 projects is:

> "...that organized medicine can be of assistance to an individual seminary in training its students. The enthusiasm shown by both county medical societies and seminaries has proven the need to start and continue programming at the student level. The students also show great enthusiasm for this type of programming."[48]

So far as the Guide is concerned, it seems only that seminaries need knowledge and understanding of organized medicine.

It may not really be so bad. Seminary project reports speak of "an on-going committee . . . composed of about six of our faculty and six members of the medical society." They say that "informal faculty-physician contacts will continue through the summer."

All 50 states, the District of Columbia, and Puerto Rico have established state committees of medicine and religion through their state medical societies, the function of which is to encourage the local medical society to have dialogue with their clergy. Dr. McCleave says that "40 percent . . . are having these dialogues. We have found an enthusiastic reception on the part of both professions to meet together and discuss total patient care."

The University of Kansas Medical School has a 16-week course on medicine and religion. Dr. McCleave says that beyond the Kansas course "any curriculum is very limited."[50] He says that "some" medical schools are encouraging courses in the humanities and moral-ethical

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48 Page 12.

49 In a letter, February 4, 1969.

50 In a letter, February 18, 1969.

problems of modern medicine.

His department is anticipating a program in which "ten teaching hospitals will be invited to participate in a pilot study in which interns and resident students will be given an opportunity for discussion in the areas of physician-clergy relations -- "what should I know about faith other than my own that involves my medical practice, and certain moral-ethical problems that arise in modern medicine?"[51]

Consideration of the American Medical Association department and committee and projects and studies is an attempt to see something of the organized, professional relationships of doctors and clergy, particularly clergy who are trained to some acceptable degree in pastoral counseling. With regard to pastoral counseling, per se, we encountered nothing; questions addressed to the A. M. A. Department of Medicine and Religion about clinical training and pastoral counseling vis a vis the medical community remain unanswered. The Program Guide studied cites interest at the seminary meetings in counseling, but mentions it only as a topic. No real recognition of counseling was apparent.

The Department of Medicine and Religion concluded that communication between physician and clergyman should begin at the medical school and seminary level; in 1969, though, Dr. McCleave lists only one course in one university medical school. Is it a matter of medical philosophy, or purely one of medical school conservatism? The attitude and commitment of an increasingly significant number of clergy (both in and out of school) is clear, and they are accomplishing this without

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51 Ibid.

loss of theology or faith. Physicians consider theology a discipline, I am told, and the A. M. A. Program Guide does refer to clergy as professionals. From my study, though, the A. M. A. wants to orient and educate the clergy to help the physician do his job in treating persons, but still can't bring itself to believe or accept that the minister, even the trained counselor, has something positive to teach the physician as a person, or that the physician might even, without loss, help the clergyman do the clergyman's work.

My purpose is not to attack the large and powerful A. M. A., but its degree of interest in the clergy (including pastoral counselors) other than as tools and helpers for the physician presents an obstacle in depth to the trained pastoral counselor's full participation in community health, including mental health. This is true though many physicians and clergy have developed and are developing close, trusting, helpful relationships on a one-to-one basis. Ultimately it must always be effected on this latter basis, of course. The A. M. A. could be a strong influence toward this, but seems to be doing little. Organized religion on its part is doing more.

Dr. Irving Berlin helps us understand something of the dynamics of what is going on in the A. M. A. and elsewhere apart from philosophy, theology, and administration. "Mental health professionals resist change because such change may reduce their status, financial return, sense of personal satisfaction, and feeling of competency. Learning new methods of working, and especially using new models like public health concepts, are threatening to our established and already learned theoretical frameworks and practices."[52]

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52 "Resistance to Change in Mental Health Professionals," American Journal of Orthopsychiatry, Vol. 39, No. 1, January 1969, Page 115. Dr. Berlin is professor of psychiatry and pediatrics, University of Washington School of Medicine, Seattle, Washington.

The American Psychological Association in 1966 said, in a consideration of manpower needs for community mental health: "New and important roles must be found for teachers, recreation workers, lawyers, clergymen. Consultation, in-service training, staff conferences, and supervision are all devices that can be used to extend resources without sacrificing the quality of service."[53] The means and ways of joint effort among clergy and psychologists are different than those open to clergy and physicians. Sharing among the latter two groups would need to be more consultative and educational, while clergy and psychologists can both treat the same client at the same time for the same illness; more shared work is possible here than between clergy and physician. Some psychologists and some clergy might feel that the above quotation speaks for a feeling that the clergy is valuable chiefly as a substitute psychologist, but if the competent counselor enters into this relationship he will prove himself to the psychologist and an equality relationship will exist. I will not quote chapter and verse from the American Psychiatric Association about clergy and clergy counselors, but I can report from personal experience that acceptance of each by the other is great, both locally and in associations such as the Academy of Religion and Mental Health. My own associations have been with the superintendents a state mental health center on a service and a planning level, and with the director of a general hospital outpatient psychiatric clinic on a consultative and service level.

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53 The Community and the Community Mental Health Center, American Psychological Association, Washington, D. C., 1966, Page 19.

Psychiatry, with its own roots in medicine and fully as many reasons as medicine for being at odds or distant from religion, nonetheless is much more open. An example is the Group for the Advancement of Psychiatry. Made up of approximately 185 psychiatrists now, it was formed in 1946 to study various aspects of psychiatry and its application to mental health and human relations. Since 1956, GAP, as it is known, has had a Committee on Psychiatry and Religion. GAP has published no fewer than ten reports of particular interest to those concerned with religion; the first was "Integration and Conflict in Family Behavior" in 1954 and the latest is "The Psychic Function of Religion in Mental Illness and Health" in 1968.

The second of the four Connecticut conferences on pastoral counseling was titled "The Partnership of Clergymen and Psychiatrists."

A challenging viewpoint of the role of the pastoral counselor is that of Dr. Gotthard Booth. He was for many years psychiatrist-consultant to General Theological Seminary, an Anglican theological school in New York City, and is the only psychiatrist member of the Committee of Medicine and Religion of the Board of Trustees of the American Medical Association. He has a private practice in New York, and has taught and written.

Dr. Booth feels that professionalization and technological development of pastoral counseling is wrong. He is in favor of clinical training and study of psychology but against such associations as the American Association of Pastoral Counselors and professional accrediting agencies for counselors. At a World Council of Churches

meeting he spoke against such specialization as has been favored by The Rev. George C. Anderson, president of the Academy of Religion and Mental Health, who himself is a moderate in this respect, compared with Frederick C. Kuether, secretary of the American Association of Pastoral Counselors.

It is no surprise, therefore, that Dr. Booth does not value highly the contributions of such as the American Foundation for Religion and Psychiatry. He believes that that institution bends clergymen away from their theological roots and planting in a community of faith, and gives them a lot of psychiatric and psychological orientation and knowledge (but still short of making them into psychiatrists), with the result that their students are neither psychiatrist, psychologist, nor pastor and hence in an uncertain relationship to the other professions, neither fish nor fowl.

It is his view that special studies and skills of pastoral counseling should be comprehended and practiced entirely within the Church or synagogue, and that psychiatry, after recovering from the falsity accepted through Sigmund Freud's prejudice against religion, now is attaining a balanced view. In other words, psychiatry is correcting itself and the Church was right in holding its ground against the falsity of what Dr. Booth calls "almost the double-religion" of Freud, the religion of psychiatry opposed to the religion of the Church.

There is a sound of wisdom in this view and it seems to have a perspective of centuries. It may be that what has happened in this area in the last eight decades may be only a historical convulsion or

explosion-implosion of insight in pastoral theology; this spasm, call it what you will, might be expressed as Freud -- anti-Freud -- un-Freud -- neo-Freudian -- eclectic -- neo-Christian.

But Dr. Booth's view considered in itself gives no consideration to other contemporary forces of society acting on and within the Christian Church today, and perhaps equally on and within Judaism. Philosophically and historically he can be right and still be wrong in terms of practical and pastoral theology. I feel that he may underestimate the forces acting on the minister today.

As concerns Dr. Booth's fears of pastoral counseling turning into a thing apart and its professionalization and accreditation aspects, attention to the Association for Clinical Pastoral Education and the American Association of Pastoral Counselors may be in order.

The first has programs "offered as part of theological degree and graduate degree programs, as continuing education for the ministry, as training for chaplaincy and pastoral counseling, and as training for certification as supervisor of clinical education."[54]

The constitution of the American Association of Pastoral Counselors makes clear its religious orientation in its preamble: "In the Judeo-Christian tradition there has always been concern for the ministry to the needs of troubled individuals and families. Pastoral counseling is one of the forms of response of the religious community to these needs. . . . The concern of this asscciation is with those clergymen who do counseling

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54 Accredited Clinical Pastoral Education Centers and Member Seminaries, (1969), a directory of the Association for Clinical Pastoral Education, Inc., 475 Riverside Drive, Interchurch Center, New York, New York, Page 2.

as part of their pastoral ministry and with those clergymen who have acquired specialized training and experience and have become identified as specialists."[55]

I will refer to two last items bearing on the many-sided and changing question of the relationship of the counselor clergyman to various organizations and agencies concerned with mental health in communities.

In May 1966, a conference on "Coordination and Integration of Community Resources: Toward Improved Mental Health Services in the Greater Bridgeport Region" was held in New Haven, Connecticut. The National Institute of Mental Health, state Department of Mental Health, and five Bridgeport and regional associations were sponsors. It was a three-day conference. Clergymen were active in the planning, on panels, as leader of one workshop, and were in the audience. One workshop leader was a graduate of the counseling program at the Postgraduate Center. But the 67-page report shows no impact of any clergyman or counselor or religious concern; in no way, apparently, did concerned clergymen or a pastoral counselor touch the thinking of the conference. Other professionals were there and were reported, but the clergyman-counselor was not. I don't know why; maybe it is a true record of a passivity reputedly common among clergy generally; maybe it is difficulty in being "heard" as a counselor by reporters and recorders used to "social workers," "ministers," and "psychiatrists," etc., as types;

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55 Manual and Directory, 1966-1968. The preamble and constitution are worth reading more thoroughly, and may be obtained from A.A.P.C. at 201 East 19th Street, New York, New York 10003.

maybe other disciplines are shy of the clergyman in a changed role. Maybe the pastoral counselor should speak out.

Lastly, in May 1965, the Meriden-Wallingford Mental Health Planning Council published its first annual report. For it, 34 clergymen in the service area of the council were surveyed; 20 replied. All of them reported engaging in pastoral counseling activities. Nearly all of this counseling was with persons church-centered or drawn to the church. The survey conception was not of high quality and the yield from it difficult to use, but it did show an absence of specialized pastoral counseling and apparently an absence of counseling outreach into the community. Nor was a need or desire to offer or receive such service reported. One clergyman was closely associated with one health agency; he expressed a desire for more staff and facilities for the agencies.[56]

## State and Church?

The United States Public Health Service, Department of Health, Education, and Welfare, in 1964 published the booklet "The Comprehensive Community Mental Health Center: Concept and Challenge."[57] It says that in the comprehensive community mental health center ". . .staff would provide consultation to professional personnel in the community such as non-psychiatrist physicians and clergymen. . . ."[58] Nothing is remarkable about this reference to clergy, and that is the reason I cite

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56 The Report of the Mental Health Planning Council of Meriden and Wallingford, Meriden, Connecticut, May 1965, 20 Pages.

57 Public Health Service Publication, No. 1137.

58 Ibid. Page 11.

it. In the publications I have encountered from the U. S. Public Health Service, National Institute of Mental Health, and the Department of Health, Education, and Welfare, "clergy" are spoken of, but pastoral counselors never.

As clergymen, pastoral counselors are among mental health leaders and resources in the community; as a specialization generally or widely recognized as frequently separate from leaders in the community a question regarding separation of church and state might arise. If pastoral counselors are considered by the governments in the same light as chaplains at state-supported institutions, then there would likely be no question. "Total patient care" and "comprehensive" might include recognition of a person's spiritual life or religious life as a health factor, necessitating special pastoral counseling. I am not forgetful of the federal grant to Yeshiva, Harvard, and Andover Newton for seminary pastoral counseling curriculum study, the state-supported pastoral services in South Carolina, NIMH director Stanley Yolles' remarks about the clergy, and federal support to pastoral counseling conferences in Connecticut. Each of these may have many counterparts elsewhere. I nonetheless remain puzzled by lack of reference to the specialty or sub-specialty of pastoral counseling in NIMH and HEW publications, or to religious counseling in a comprehensive way, just as I am pleased at acceptance of clergy in governmental health concepts, without "church-state" separation.

## Summary

What is the relationship of the pastoral counselor to community mental health?

First of all, the understanding of who is a pastoral counselor is broad. Any ordained pastor, and any concerned and listening religious person, who exercises sensitive religious care may be considered a pastoral counselor. Excluding the unordained from consideration here, however, the pastoral counselor may be considered to be the clergyman who takes the cure of souls seriously, the one who had a special course in seminary, the one who has taken clinical training for a semester or more, the one who has made the most of one or more conferences, the one who majored in counseling in one of the more progressive seminaries, the one who has read extensively in the field, the one who has gained either a certificate in training or a further degree in the subject, the one who is accredited by the Association for Clinical Pastoral Education, or the one who is a member of the American Association of Pastoral Counselors in either the division of parish ministries or the division of specialized ministries.

He might practice exclusively in his own parish or congregation, be an administrative director, be a chaplain, divide his time between a school or clinic and his congregation, work full-time in a clinic, function as a consultant only, or have a private practice. He is in good standing with his ecclesiastical jurisdiction, but might function in some instances without this approbation. Perhaps there are still more variations.

More properly understood, he sees himself as a pastor functioning with some uncommon degree of counseling skill and insight rather than

a counselor as such who happens to possess theological and pastoral knowledge; I speak, of course, of his principal and spiritual orientation.

The pastoral counselor comes on the scene without a place reserved for him. Ecclesiastical systems and community structures do not know exactly what to do with him or about him, and he has to make his own way by doing what he is, uncertain possibly because he cannot know what is taking place at the same time elsewhere and because each situation is at least a little different from all others. Is he as he was because he feels continuity and development? Or is he a new breed because something is changed?

The pastoral counselor's relationship to community health (or mental health) agencies, institutions, groups, forces, individuals, and influences in the present time of relative newness and increase of numbers depends on the strength and character of the individual counselor wherever he moves and practices. This gives him more freedom but calls for more responsibility than the older models of ministry. It can threaten his career, acceptance, and income.

There is more interest among clergy in doing and learning from others what is needed to help people through pastoral counseling than there is interest among others in doing and learning from clergy how they in their calling or profession can better help people. This may find its root in general uncertainty about religion. In this movement outward from the familiar religious ways, most clergy certainly will retain a basic theological rooting and remain pastoral counselors;

as a result, other helping disciplines in the community will learn much more than they previously knew about what a pastor is, knows, and does. One unanticipated outcome of this might be a much healthier respect for clergymen and their ways, indirectly helping the priest, rabbi, and minister remain what he is and be more sure of himself. Exposure will manifest him before others to better advantage and add to his self-knowledge and role-concept.

## THE PASTORAL COUNSELOR AND THE ECCLESIASTICAL SYSTEMS

Where does the clergyman-counselor stand in his own family? I mean the Church and church?

He has introduced himself in his new guise to congregations and ecclesiastical administrations and jurisdictions, most of whom are unprepared to treat him any differently than earlier. Never mind whether an individual has tried to announce his new role or not; by and large neither congregations and their boards nor diocesan offices and their counterparts disturb their other ways of life when clergymen become pastoral counselors and justify fresh consideration -- they wait until justification becomes necessity.

The time seems to have come.

Scheduled to assume work with the National Council of Churches Department of Ministry this year is The Rev. Dr. Berkeley C. Hathorne,

as director of a new division for Pastoral Care, Pastoral Counseling, and Community Mental Health Centers. Dr. Hathorne has worked extensively in organizing pastoral counseling services through churches, councils of churches, denominations, and independently. The denominations, at least several of those affiliated with the N. C. C., now are sufficiently concerned to contribute to the N. C. C. division. Dr. Hathorne comes to the N. C. C. post from the Washington (D. C.) Pastoral Counseling Service. Creation of his position means that noticeable pressure in the specific area of coordinating and administering pastoral counseling by the churches already is felt and indicates that pastoral counseling influence and education will become more widespread.

Financial support for the new division is coming from the denominations and from the National Task Force on Religious Participation in Community Mental Health, which is related to the Office of Citizen Participation, National Institute for Mental Health, according to the N. C. C. Department of Ministry.[59]

The president of the Academy of Religion and Mental Health, writing in that organization's newsletter, says:

> "Several Protestant denominations. . .have issued handbooks or guidelines for the clergy on relations between religion and health in which some of the theological problems are dealt with, but more so the practical approach of clergymen in dealing with emotional and health problems among their parishioners and others in the community. For example, the Episcopal Church in the United States has recently changed the name of. . .The Commission for the Ministry of Healing to a much broader term The Joint Commission for Religion and Health. The change in title reflects the widening concept of relations between

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59 Keith Wright, in an interview, March 25, 1969.

> religion and health since these relationships also involve problems of medical ethics such as euthanasia, abortion, drug addiction and transplants."[60]

A partial list of churches with recently-established divisions or departments for pastoral counseling includes: United Church of Christ, American Baptist Convention, Episcopal Church in the United States, United Methodist Church, Reformed Church, The Presbyterian Church (U. S.), and the Lutheran Council in the United States for the Lutheran Church in America, the American Lutheran Church, and the Lutheran Church - Missouri Synod.

Is the Roman Catholic Church doing the same? Information is more limited, but the answer seems to be affirmative. The national Bishops' Conference is very interested in the field, according to Wright, and Roman Catholic representatives are active in the NIMH-related National Task Force referred to above. The National Catholic Conference, with offices in Washington, D. C., has conducted national programs to study the effect and role of pastoral counseling in the Church. Earlier, we examined an NIMH project toward a model pastoral counseling curriculum at Loyola University of Chicago, a Roman Catholic institution. The Roman Catholic Paulist Press has published extensively in the pastoral counseling subject area.

Jurisdictions between the national and the local also show this development. In the Episcopal Church in Connecticut, for example, a changed emphasis became apparent several years ago when a license was granted a New York priest to officiate in Connecticut in his

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60 Academy Reporter, Vol. 14, No. 1, January 1969, Page 3.

capacities as chaplain at a Hartford Council of Churches Pastoral Counseling Center and a state hospital for alcoholics. In 1968 a priest who had been the first teaching chaplain in a state hospital and accredited by the Association for Clinical Pastoral Education as a training supervisor, became executive secretary of the Department of Christian Social Relations and renewed his supervisor status with A. C. P. E. A priest of the diocese who is canon counselor on the cathedral staff has been encouraged to pursue further education in counseling with homosexuals. Another was assisted financially in completing a curriculum in pastoral counseling. Two diocese-wide conferences on pastoral counseling have been held since September 1967 for the benefit of parish clergy.

A Disciples of Christ minister in Connecticut serving a Baptist congregation and training in pastoral counseling anticipates a special non-parochial ministry for himself counseling clergy. He came to see me in March 1969 about his further training, and said that his hopes were a result of observations and questions addressed to him at denominational clergy meetings.

The answer to the question about where the pastoral counselor stands in his church family depends on where the individual counselor insists on standing. Few parishioners have sufficient idea of what the ministry, including pastoral counseling, means and is. If a congregation were told that it had a paid parish physician, everyone would know to go to him for physical ailments; but tell many people that they have a pastoral counselor in the parish and they have little understanding of it

because they are not acutely conscious of what the community of faith is, of what a pastor really is, and therefore what a pastoral counselor might be. They are sharply individualistically oriented and actively supporting community groupings at large. They are coming to understand "community counseling," but do not yet accept the parish clergy as a competent professional counselor because of their stereotype of him as a general religious handyman. What I mean here is what is sometimes subsumed in the phrase "secularization of life." This is not to say that religion and theology can have nothing to do with this, but it is to describe one of the broader basic problems the specially-trained counselor encounters.

Dioceses and similar ecclesiastical jurisdictions as such are, of course, devoid of philosophies or theologies which could facilitate acceptance and employment of pastoral counselors. In our time they are administrative authoritative groupings whose function chiefly is to oversee and supervise collection and distribution of monies and relate congregations one to another through an organization and a titular head who may also be a spiritual head. They enforce discipline and help effect relationship to civic authority. Pastoral counseling, except in one way, is not likely to become a concern of dioceses or similar jurisdictions until and unless interest or work in the special area influences or threatens to influence government of the congregations in the jurisdiction. The one exception is that which happily is so much felt right now, community and secular government pressure to take an informed and active role in mental and total health of persons en masse.

One result of the relative lack of understanding of interest in pastoral counselors on the part of congregations and dioceses and their counterparts is that counselors are devising satisfying ministries across and outside denominational lines, and are seeking and finding financial support there. Partly because a clergyman's pastoral counseling emphasis may be seen theologically as almost totally a function within his ordained pastoral ministry, congregations, and jurisdictions unfortunately can be loathe to see anything new in it; this can mean that to them it is the "same old thing" with a few new words, for the same money.

Earlier sections of this paper reported local exceptions to this prevailing picture, which ultimately will have their good effect.

The congregation and diocese or corresponding religious jurisdiction at present are a source of frustration to the counselor because they usually do not reward him appropriately for the time and money spent on sharpening his skills and deepening his ministry. And he feels unrequited because it is for them in considerable part or under their granted authority that he makes the effort. And if they do not recognize or welcome his contributions it distresses him a little extra because other forces today also act to make him feel less needed than formerly in his official religious role.

Incorporation into the structure and its recognition and other rewards may all come, and in a number of ways, but chronologically almost certainly will come after the fact and the value of pastoral counseling as a sub-specialty of its own within the ministry already are established.

The ecclesiastical systems follow the fact, and at present are at their best (and then only in some places) acting to distribute within the "company" some of the skill and the impact that counselors are making in their communities and the governments are making on counselors and communities. As a person, the counselor in his communion is a more effective minister and thus more employable. Only very slowly, but surely, are the ecclesiastical jurisdictions making place for his special function.

## CONNECTING-LINK DEVELOPMENTS

Bridges, webs, or connecting-links, are being effected among public and private mental health groups and professionals, ecclesiastical and religious bodies, communities at large, government and the pastoral counselors, and among counseling groups. This is under pressure of the increasingly complex times and the increasingly apparent interdependent relationships of men, and can be only to the good, particularly as it is among helping people.

This is happening, as might be expected, because interested individuals (counselors in this instance) are putting themselves in a helping relationship to people where existing systems do not reach and are pulling them together; human need exists and counselors move in.

This is happening because a technologically-aided and computerized explosion of knowledge is providing a vast over-lay touching well

defined intellectual disciplines and "gray," ambiguous, areas alike. In the face of this, synthetic philosophies, economics, physics, biologies, and theologies alike seem more attractive.

Perhaps a common fear of inhuman systems pouring out data in overwhelming volume and speed is causing humans to draw together in common lot. We can expect the fears to lessen as further systems and the human mind and emotion cope with this progeny, but the common knowledge and unity thus discovered will not all be put into old categories. Of this we are confident.

Counseling and pastoral service desks are being added to local and state divisions and departments of hospitals or of mental health. Churches are staffing community pastoral counseling centers, and municipal or other governments are assisting financially and in consultative and enabling capacities. States are paying for pastoral counseling in churches and clinics. Foundations and the federal government are assisting urban counseling ministries on a comprehensive scale, sometimes with the assistance of state and private universities and colleges.

Seminaries are gathering in small or larger clusters in order better to prepare men for counseling ministries (among other things), and community mental health agencies are coming closer together to use counselors. Denominational headquarters are establishing pastoral counseling secretariats and expanding chaplaincy services and concepts. Many more clergymen are accepting leadership roles in community mental health work. Much of all this has been explicit or implicit in our foregoing examination of ways in which counselors are effecting and affecting the well-being of persons.

Out of this inevitably will come revised and deepened theologies of pastoral care, of moral theology, of practical theology, and systematic theology. New departments will emerge in seminaries and medical schools may erode some of their parochialism. Psychologists and psychiatrists may, in the altered relationships and freer association with clergy around the table, lose a defensiveness they sometimes manifest with respect to medicine. In keeping with other religious developments, ecumenism in pastoral care is on the scene, among people and among clergy associations.

A bridge, a connecting-link, of mankind is the common hurt, which most of us in the world now unpleasantly share. In response to this, help is more commonly shared than ever before, and helpers are more commonly shared than ever before; of necessity the philosophy and theology of this reflects the existential reality. The sum of the helpful or creative relationships that might come from this can be guessed at roughly by multiplying the number of responsive human beings in the world by their own number, times the mass of relevant knowledge.

GROWTH? GAIN? HOW SO?

Has there been growth in pastoral counseling? Unquestionably. Do I mean in sheer numbers of counselors? Yes. Do I mean in the quality of counseling help received by people? Yes. Is this all that needs to be said about it? No.

First, evidence abounds for an increased volume of counseling ------ in numbers of counselors, counselees, referrals, training institutions, and counseling centers.

Secondly, it is a far cry from Anton Boisen's first four seminarian clinical training students at Worcester State Hospital in the early 1920's to the 251 accredited clinical pastoral education centers in the United States of America in 1968, each providing training of varying lengths for either a few or many students. No one knows exactly how many seminarians or clergymen have taken clinical training; a stable, unified, national association which might soon be expected to know this came into being only in 1967 as the latest in a number of unifications. The annual number of clinical training students, it is safe to say, is in the thousands; we have seen that in 1968 it was 2000.

The thousands of clergy who have received clinical training is not the number who consider themselves pastoral counselors or who might be considered pastoral counselors by others; the latter number is much smaller than the former. All pastoral counselors must have clinical training, but not all clergy with clinical training are pastoral counselors. Today, a clergyman who has taken clinical training and read a counseling book in the course of seminary preparation for ordination and is asked

if he is a pastoral counselor is likely to say "I counsel, yes, but I'm not a pastoral counselor."

It is the estimate of the director of the Academy of Religion and Mental Health that less than 7 percent of the clergymen in the U. S. A. have "adequate knowledge of psychodynamics."[61]

Taking the Academy's figure of 350,000 clergymen in the country, this means that fewer than 24,500 ministers have adequate knowledge of psychodynamics. The Academy does not use the term "pastoral counselor"; only 218 clergy, plus a small number of student affiliates and professional (psychiatrist) associates are members of the American Association of Pastoral Counselors,[62] which uses the title in its own distinctive, professional way. The number of clergymen who know enough psychodynamics for their work certainly is more than the number of those who have the added knowledge and intensive practice of pastoral counselors.

So, we may look at the number of 218 who meet the exacting requirements of the A. A. P. C. and are members; or we may consider the estimated 24,500 who meet the Academy's minimum of "adequacy"; or we may accept the larger number who have learned what they could from a seminary pastoral care course, clinical training, and a conference sometime since ordination. By any standard, there is much more known and more people delivering it in pastoral counseling now than even a generation ago, to say nothing of the early systematic efforts after World War I.

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61 George C. Anderson, director of the Academy, in "Planning for Mental Health," American Psychiatric Association, Washington, D. C., 1965, Page 10. A summary of a conference for leaders in state mental health planning.

62 1966-1968 Manual and Directory.

There are numerous indications of the improving quality of pastoral counsel being offered and received. One obvious way is the increasing seriousness with which techniques and knowledge of the behavioral sciences are being employed by reputable theological schools in the preparation of persons for ministry, rabbinate, or priesthood. Another is the willingness to accept extra-theological professional standards for pastoral counseling along with high and continuing theological standards.

A third and most meaningful indication in the contemporary scene is the fact that other professional helping people, unknowing or even with some bias against the counseling clergyman only a few years ago, are accepting clergymen on clinical teams and community task forces. These people, looking for help from their point of view, would not accept clergymen if the clergyman did not pull his weight. For every psychologist, according to Rabbi Henry Kagan, there are 23 clergymen, and for every psychiatrist 43 clergymen.[63] Not all clergymen are trained or interested in this kind of work, but enough now are seriously to interest and encourage the other professions.

Countless numbers of persons in some kind of positive relationship to a religious congregation have been helped to find their way again to a meaningful and purposeful life because their minister with pastoral concern continued to learn and notice what is going on around him. Most ministers can provide examples of this and many laymen can testify to the same.

Something else needs to be recognized, though it is unmeasurable. Our time sees a smaller proportion of the population of the United States

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63 "Planning for Mental Health," American Psychiatric Association, Washington, D. C., 1965, Page 11.

of America in attendance at weekly religious services than a generation or two ago, and any year now the number of clergymen active may show a decline and church buildings begin to find other uses. Yet the number of counselors and the proportion of their time spent in counseling increases, which I take to include the fact that many of the oft-estimated 42 percent of the people who go first to their clergyman with serious problems go back again because he helps them.

It may, and I believe does, mean that the growth of special stipendary and non-stipendary ministries of pastoral counseling are in the stream of the Church moving into the world alongside those who go and serve as neighborhood political action leaders, guerrilla chiefs, and military strategists for the poor. In other words, pastoral counseling is pastoral far beyond the Church. Pastoral counselors may be bridges both ways between the religious institution and the health professionals and agencies, but even more profoundly, may speak for the soul of Christianity to needy people. In another way, this means that pastoral counseling doesn't depend on the religious institution.

If the theological schools whose catalogs I examined are at all typical, the proportion of ordained clergymen who receive a modern course in pastoral care and/or pastoral psychology, along with clinical training will continue to increase steadily. The number of counselors accredited by the A. A. P. C. is almost certain likewise to increase, though its percentage of members in relation to the total number of clergy likely will remain small.

This double development at two speeds in one direction I take to be good, because it would seem to me undesirable to have even several

thousand clergymen trained to the A. A. P. C. level if the great majority remaining were to remain unrelated and unknowing. I can imagine that in such a disparity of outlook and skill the clergymen in A. A. P. C. might feel and become so disoriented from their brothers that they would separate -- or be separated. If that happened, everyone and their churches and related people would suffer. And, if there were no leading edge of clergy more professionally-oriented to encourage others to higher standards, the larger number, in whatever state, might become self-satisfied. In addition, the close and in all ways beneficial peer-relationship with physicians, psychologists, and psychiatrists in the community now enjoyed by the better-trained counselors would disappear.

Another of the great gains and promises of growth is hidden. I refer to the effect of the knowledge and viewpoints that are gained in modern pastoral counseling returning on the other departments of theological school training to influence their mind and systems -- in effect, increased self-knowledge in the content of the disciplines and the persons of their leaders. This may well have radical consequences.

We studied earlier some aspects of the NIMH project jointly carried on by three theological schools including Yeshiva. Rabbi Fred Hollander of Yeshiva, project director there, has caused a stir with what are called radical ideas on theological schools as a result of project results. Remember that the purpose of the project was only to devise curricula for pastoral counseling.

Likewise, the study of pastoral counseling in continuing education after ordination can be expected to continue or increase. The knowledge explosion itself permits no clergyman to rest on three or four years of seminary learning and his subsequent rich experience.

It is not difficult to imagine that future clergy will have "worldly" professional standards to maintain as well as institutional standards, and that continuing education soon will be required of every man who wishes to achieve or remain "Grade 1." This may (among many possibilities) be in the form of so many credit hours every so many years, mainly in the person's major field.

Programs such as that at the Postgraduate Center for Mental Health have far more qualified applicants than the limited enrollment allows. The sometimes criticized American Foundation for Religion and Psychiatry seems not to be adversely affected by the criticism. Membership in the Academy of Religion and Mental Health, basically aimed at reconciling psychiatry and religion, continues to grow in numbers and stature (it recently added an executive for professional services and has been designated to assist the White House Conference on Children and Youth to be held in 1970).

Degree programs at colleges, universities, and theological schools increase; those at Iona College, New Rochelle, New York, and New York Theological Seminary are examples.

Although I have no way of knowing if it is exceptional, it is interesting to me that the "eclectic, neo-Freudian" Postgraduate Center, as it is described by pastoral counseling program director Manfred Hecht, M. D., now has academic status through incorporation of its certificate program into the Master of Sacred Theology degree program of New York Theological Seminary. Whether this was a goal of the Center I do not know, but psychiatric training clinics reportedly long have chafed over non-recognition from academic institutions. Teaching

members of the Center staff are considered adjunct professors of the seminary. A doctoral program in relation with another academic institution is a possibility for the Center, as well as broader and even more intense community ties in the form of counseling services for a New York City hospital with federal support.

The complexity and difficulty of human relationships and the persistence of the old questions of purpose and ultimate values make it more important now than ever before that men come to understand themselves better, as well as the material world around. Pastoral counseling seems to be of growing importance in this increasingly complex network of mutual awareness and relationship, because theology has a built-in way of dealing with the spiritual dimension of man's life in ways that have roots in the source of strength and concern.

SO --- WHAT?

Point with pride and view with alarm? Yes, a little, but mainly cock a quizzical head and squint a little at the scene. I will try to cast a rounder, fuller, light on the moving, hard-to-focus growth of pastoral counseling and more particularly the modes the counselor is using as he becomes part of the community mental health consortium.

We early examined the illustration in a mass-distributed booklet of the clergyman symbolically in the middle of a community group as a symbolic leader. We were somewhat critical of this, since his picture

was not filled out to show how he fulfilled the role. Since the educated and humanistically-oriented clergyman does have distinctive contributions to make, we felt that these should be more widely known, even by fellow professionals and even in our day of declining religious influence, if they expect him to speak their language. We felt that his presence as a symbol of morality, neutrality, and well-meaning was too small and too narrow.

We maintain, though, that even if organized religion is declining in influence, though the trained and educated clergyman's contributions are sometimes downgraded or little understood, and though he may be placed in the center of one citizen's health group or another for the wrong reasons, his orientation, his knowledge, and his experience nonetheless can be of great value. This can be especially so if he has made the effort to become a pastoral counselor or has studied in the health fields.

We didn't exactly answer the question "does pastoral counseling have itw own real history?"; we're not sure that it does. Dr. Paul Johnson's personally-tinged story principally is one of historical correctives exercised during a 50-year period within pastoral/practical theology. The story as he recalls it began in the Church and it now seems that it will continue therein, though with "doors" and "windows" open and a lot of visiting going on with the neighbors.

The many ways of pastoral counseling are increasing; we have identified several of them. The number and variety will increase, since pastoral counseling is a skill and orientation which can be practised in any number of environments and, happily, is not yet isolable

into a new niche. Neither church theology nor denomination, nor building, nor previous condition of professional separation nor size nor language serves to isolate it. It offers a means to greater service, more money if need be, more work "where the action is" if desired, and is a strength to all it affects in other activities of life, including fellow professionals.

As seen from the viewpoint of organized religion, many new and special kinds of "parishes" are appearing in our time, as they should when older functional lines based on geography, poor general education, agriculture, and town life are out of keeping with the time; special-service "parishes" where counselors function with breadth in the community of faith and also function as sub-specialists for brother clergy and congregations and extensively in the general community are forecast, for example by the Department of Ministry of the National Council of Churches of Christ in the U. S. A.[64] and at least one leadership development officer of my own Episcopal Church, The Rev. Dr. Robert Rodenmayer.[65]

Parishes for counselors can be seen, from a broader view, as among several special, new ministries appropriately developing in our time of change.

We quoted the Resources Planning Commission of the American Association of Theological Schools to the effect that it is skeptical that more and more specialized courses in pastoral counseling and other subjects

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64 In an interview, March 25, 1969.

65 In an interview, February 11, 1969.

is the best response to pressures being exerted on theological schools to change and be modern.[66] We also reported Keith Wright's recollection of one counselor-rabbi's "radical" ideas about seminary education, based in part on the rabbi's study and experience in counseling and with a counseling curriculum development research project. We suspect that the two, starting from different points, may agree in considerable detail and maybe for the same reasons. This would bear further study. Wright said that "The shape of pastoral counseling will be determined largely by strong forces outside it, including citizens and governments. The demand for decentralization and community participation will not let the churches bundle pastoral counseling into a seminary department or a church parish house. Even office practice of psychiatry is on the way out, for the same reasons. These services must center in the community."[67]

No doubt the growing need to plan in total community terms in order to participate in federal and state support for mental health centers and other projects is a strong incentive to think "community," but Wright's comment from his vantage point is a sign that service decentralization across institutional lines is even more than political and financial expediency. It seems a movement to meet human demands of the times -- and also makes for a better theology of pastoral care.

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66 Page 10.

67 In an interview, March 25, 1969.

Wright foresees trained counselors in the churches very soon training members of the congregations to minister in one-to-one counseling situations where one person with certain characteristics needs only certain training and counseling himself in order to be of lasting and great help to another person in the congregation. In other words, John Smith, with a little help, will be just the person to help William Jones to physical, mental, and spiritual health -- and the professional psychologist, psychiatrist, social worker, physician, and pastoral counselor might never need see him.

We gave attention earlier to results from an American Medical Association project. We seemed to be and are critical of a certain aura of untouchability unfortunately about the A. M. A. despite efforts of Dr. Paul McCleave and others. We do not want to make the mistake of thinking that the organization speaks for all doctors of medicine -- it doesn't. But the A. M. A. does represent the most powerful single voice of organized doctors. What affects the A. M. A. and also affects others in the health and mental health field, including clergy-counselors, is something studied by Howard E. Freeman, Ph. D., and Rosalind S. Gertner. They called it "The Changing Posture of the Mental Health Consortium."[68]

> "The continued trend toward equality and diffusion of the roles of the various subsets within the consortium of mental health practitioners, until there is one undividable ball of wax, is a remote possibility. Rather, a better guess is that new groups within the consortium will begin to seize dominance and control, and the field will return once again to a more vertical sorting of individuals and an increased specialization in task allotment.

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68 American Journal of Orthopsychiatry, Vol. 39, No. 1, January 1969, Pages 116-24.

> The ideology of American social life as well as the dynamics within the consortium will lead to the gradual assumption of increased power by professions now, or at least in the past, regarded as marginal in status and competency and denied the opportunity to participate fully within the consortium of health professions. As they legitimize their place and tighten requirements to obtain their credentials, they will render the traditionally superordinate groups illegitimate and, like the carpetbaggers of the Civil War era, will first infiltrate high society, and then capture it."[69]

The Freeman-Gertner study also is pertinent if we speculate that the 1967 merger which created the Association for Clinical Pastoral Education from related organizations will continue toward unification of the A. C. P. E. and the American Association of Pastoral Counselors a few years hence.

The fact that the A. M. A. cannot know all and say all on behalf of medicine and medical schools and their attitude and activities touching religion is borne out in an Academy of Religion and Mental Health report of a study by Milton O. Kepler, George Washington University School of Medicine. He was developing a new course of instruction in medicine, religion, and healing, and surveyed 100 medical schools in the United States and Canada. He learned that nine out of ten schools of medicine with religious affiliation had religion, medicine, and healing instruction, and that 18 out of 58 such schools without church affiliation had similar instruction.[70] The nature and quality of instruction varied.

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69 Ibid., Pages 122-3.

70 "Ethico-Religious Instruction in Medical Schools of the United States and Canada," Journal of Religion and Health, Vol. 7, No. 3, July 1968, Page 252.

All this, in distinction from Dr. McCleave's reports at the end of 1968. This serves to remind us at least that the A. M. A. does not and should not be expected to know all and be all for American medicine.

Though it is not pertinent to our main concern here, our quotation from Dr. Kepler reminds us of references we have seen in the literature of the field that it no longer is a necessary assumption that mental health centers must have a doctor of medicine as directing head. The Marriage and Family Institute in Washington, D. C., with a psychiatrist-M. D. medical director and priest-counselor as administrative director, working together as the executive office, is just one of a number of possible variations.

Particular attention was drawn to the "connecting-link" nature of developments in mental health, health, pastoral counseling, the churches, governments, and larger numbers of citizens was basically a way of reminding ourselves that nothing happens or exists, or acts, all by itself. Life is related, and ultimately one. So, the various activities and relationships involving pastoral counseling and pastoral counselors have many and profound effects.

Can there be any question of our use of the word "synthetic"? One may have the idea that a synthetic is artificial; I use the word, however, in the sense of that which is the result of synthesis, a marriage or a blending of two or more into one, and is in its resulting way just as genuine and real as anything imaginable which has not gone through synthesis. My use of the word was in connection with "philosophies, economics, physics, biologies, and theologies" and referred to the products of unitive evolution.

Dr. Lucy Ozarin, of the NIMH, was quoted as saying in South Carolina that more small-town clergy are, in her experience, involved as leaders in local mental health than are city clergy, with the implication that city clergy are laggard. I suggest that the average-trained counselors and clergy, as well as the more advanced man who happens to prefer the small town, simply has more opportunity to be in the forefront as a leader in a small town than he does in the city.

The fact that the development of pastoral counseling is contemporaneous with removal of some of our society's barriers between church and society and a movement of Christian ministry outward more toward people-in-their-situation strikes us as not accidental. That pastoral counseling is developing as it is within and out of Christian ministry as a whole has double import. First, it is concurrent with the movement away from obvious bases of vested Christian power and influence and toward the "unwashed" others, with a commitment to help shape better people in a better world. Secondly, in this movement the counselor has profound skills and a sense of the soul and spiritual dimension involved which everyone does not have; through his sensitive and skilled work many people at large will learn about religion and about clergy as well as about themselves, and religion will benefit greatly.

As it has been put most succinctly, "Contemporary theology considers human experience valid data for theological reflection."[71]

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71 Editorial, Association for Clinical Pastoral Education News, Vol. II, No. 1, January 1969, Page 3.

I feel I should introduce at this point a general observation by a well-qualified person referred to earlier in connection with the Marriage and Family Institute. The Rev. Knox Kreutzer says:

> "It is my experience over the past 20 years that collaboration between the pastoral counselor and the other professions in the mental health field, particularly the psychiatric, are furthered very little by the conference table. The conference table has provided mostly an opportunity for people to ascend their podiums and spout off their favorite notions. It has not resulted in any place that I know of in any significant real collaboration, though sometimes it may have been a door through which the professions could walk into some joint work.
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> "The only way in which real collaboration occurs and real respect grows between the pastoral counseling specialist and his colleagues on the mental health team is when they are together involved in common work through the sharing of cases either informally or through common involvement in a clinic. At this level respect tends to accrue to competence rather than to the alphabetical letters which follow one's name."[72]

At this point, Kreutzer says, it becomes not uncommon to find the psychiatrist seeking supervision at times from the pastoral counselor, and for psychiatrists and their wives to be in therapy with the pastoral counselor.

This is eminently worth keeping in mind since we are in a period of place-finding by the pastoral counselor on the organizational level and a period of rapid expansion of the number of counselors and their associations with other professionals in hundreds of communities.

I draw attention again in this closing section to the experience of the Connecticut conferences and Dr. Zeichner's comments. The enlightened change in emphasis (see Pages 37-40) and the measurable increase in the number of clergy in leadership roles in mental health in the state are encouraging.

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[72] In a letter, December 10, 1968.

By implication, showing the way many counselors individually have sought training, changed the emphasis in their parishes, affiliated with clinics or hospitals, and have opened or joined counseling centers, we have drawn a picture of the non-participation by denominations or districts, or dioceses as such in the pastoral counseling movement generally. Particularly, there has been noticeable a lack of contact between government and the churches in mental health. But this, too, is changing, partly as a result of church interest and partly as a result of governmental initiative. Since early 1967, a group called the Interfaith Committee on Community Health, along with the NIMH, has studied the church's involvement. A main objective is to make the churches active in the planning and governing of the local health "community" as well as in the functioning treatment teams. Dr. Berkley Hathorne has prepared material toward "guidelines for the development of relationships between local churches and clergy and local comprehensive community mental health centers."[73]

What the role of the pastoral counselor in the community mental health centers will be remains a question, because the centers are new and because the pastoral counselor and his discipline are still without general definition. But his role certainly will include consultation, treatment, education, planning, and illness prevention.

We have looked into many gains, growth, and problems of pastoral counselors. The Academy of Religion and Mental Health report on a three-year project in Philadelphia to acquaint clergymen with the principles

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73 "Community Mental Health Centers: Background Statement" by Walter J. Baepler, Lutheran Social Welfare, Vol. 8, No. 3, Fall 1968, Page 32.

of mental health and completed in 1965 was not encouraging: "The relations between psychiatry and religion have profound implications. But these implications have scarcely affected the beliefs and attitudes of organized religion and its clergy."[74] On the other hand, the number of clergymen now advanced counselors, the nature and number of different kinds of courses, the very real growth in membership on local mental health boards and clinics, and the volume of literature building up all are impressive, and their rates are likely to increase in the next years.

It may be true, as an Academy-sponsored conference of researchers, research directors, theologians, and behavioral scientists at Princeton, New Jersey, concluded in November 1968, that "for all practical purposes, a substantive field, adequately supported by acceptable scientific research procedures, does not exist," and that serious needs exist in terms of "encouragement, clarification, synthesis, coordination, and interpretation"[75] but hundreds of clergymen, most of them young, are becoming trained counselors each year and making their new presence felt. The work of many of these men and more, less-trained but with changed attitudes, goes unnoticed primarily because so much of it is primary and preventive.

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74 Impact in Understanding, Academy of Religion and Mental Health, New York, not dated.

75 Academy Reporter, Academy of Religion and Mental Health, Vol. 13, No. 9, December 1968, Page 2.

Our title is "The Pastoral Counselor Enters Community Mental Health." The first thing to be clear about is that he is entering, and in numbers; it is not a question or a likelihood, but a fact.

Secondly, the counselor's ways of entering community mental health are many; they depend on his individual needs, community needs, organizational and disciplinary structures of his church and local health groups, and the personal relationships of the people involved. In my own case, which is typical of the histories I know, I first made it known that I was interested in mental health work, then accepted membership and leadership (offered quickly since I had symbolic value) on the mental health planning council; I joined an inter-disciplinary training group. In all this I gained general knowledge and some acquaintance with area mental health organizations and their leaders. They learned to know me personally, concluded that I have theological and religious competency, and learned that I systematically increase my competency in psychology and related counseling knowledge and skills; a first client was referred to be for pastoral counseling. From that point, given the current climate generally and with continued good church standing, it was easy to begin seeing clients in a clinic as well as in the parish; I am called a pastoral counselor.

Thirdly, the pastoral counseling movement represents not only an addition of skills and a deepening of vocation and ordination to heal people for Christ's sake, but also represents participation in a broader movement of organized Christianity in our times out of itself and into the "world" with more relevance. Given the motivation

of the Gospel, this not only means "going out" to help and heal, but also to lift up, transcend, and prevent sickness of persons.

Fourthly, this is fraught with possibilities of misunderstanding on the part both of traditional religionists and anti-religionists, and new communication between educated men of good-will is necessary, as is actual experience working together.

But, fifthly, this also is filled with new opportunities for the humanitarian Gospel to come alive in a new way for many people who now see in it only stained-glass windows, plainsong chants, amateurish do-gooders, and fat clerics.

Lastly, it is an added way for great numbers of people to become more whole persons, even persons with an inter-related and healthily functioning body, mind -- and spirit.

For reasons of introducing himself more easily and generally into professional health community circles, the pastoral counselor could use sharper definition of role. I do not believe at this point, however, that he needs this as much as he needs high standards for service and training and needs a theology with elastic pockets, with adaptive vitality. Problems such as recognition and reward in the ecclesiastical structure and elsewhere, will solve themselves in time and in various ways.[76]

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76 In 1963, Drs. Emily Mudd and Hilda Goodwin, writing on marriage counseling in The Encyclopedia of Mental Health (Franklin Watts, Inc., New York, Vol. 3, Page 987), could say that in pastoral counseling no fee arrangement is made. By 1969, for reasons involving the individuals, involving non-stipendary priests, and involving community clinic administration, the absence of fees for pastoral counseling is not absolute. The base is changing; in 1963 Dr. E. Loomis, writing in the same Encyclopedia (Vol. 4, Page 1454), could say that only rarely is pastoral counseling undertaken in clinics or guidance centers, whereas in 1969 considerable pastoral counseling is undertaken in those places. Also,

The pastoral counselor is in community mental health, and in to stay -- because of likely trends in church history in the next several years, because he is a healer and helper by choice and gift, and because the community is where the people are. With a double education and commitment he will have to make his own way because some churchmen sometimes are not sure he remains in their family and "worldly" health professionals are unsure that he belongs with them. But we'll all learn.

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76 (continued)
the fees that Dr. Loomis in 1963 said might be charged in clinics (he also referred to gratuities in church-supported clinics) now often are for services involving pastoral counseling as a matter of course.

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