

THE CHAPLAIN
IN HEALTH AND WELFARE SERVICES

A Study of his Role in the General Hospital
with special reference to the Vancouver
General Hospital and recent developments in
the Clinical Pastoral Training Movement

by

ROBERT DANIEL MAC RAE

Thesis Submitted in Partial Fulfilment
of the Requirements for the Degree of
MASTER OF SOCIAL WORK
in the School of Social Work

Accepted as conforming to the standard
required for the degree of
Master of Social Work

School of Social Work

1962

The University of British Columbia

ABSTRACT

This study was undertaken (a) to examine some areas where the traditional role of the chaplain has undergone significant changes, (b) to determine the present role of the chaplain in a general hospital and (c) to study the Clinical Pastoral Training Movement, and its significance to the traditional chaplaincy and to social work.

After a discussion of the historical background of the chaplaincy in the Christian Church and in some selected social institutions, there is an examination of the role of the chaplain in the general hospital and a discussion of some religious needs of patients.

To gain information from chaplains at Vancouver General Hospital each was interviewed and a questionnaire was completed. The chaplains also kept statistics of some aspects of their work for a two-week period. There is an examination of the chaplain's backgrounds, their counselling practices and referral patterns. The latter are compared to referral patterns made by theological students and social work students in three brief case illustrations.

The Clinical Pastoral Training Movement, and its literature are examined in some detail. Standards and curriculum are outlined and references made to the rapid expansion of the movement.

Implications are drawn for the Churches, the Vancouver General Hospital and social work. Some specific suggestions are made for these three areas arising from these findings.

TABLE OF CONTENTS

Chapter 1. <u>The Emerging Role of the Chaplain</u>	Page
The Problem. The Development of the Chaplaincy in the Church. The Military Chaplain. The Chaplain in Correctional Institutions. The Chaplain in the Mental Institution. Other Areas of Specialized Ministry. The Chaplain in the General Hospital. The Chaplain and the religious needs of the Patient. The Scope of the Study.....	1.
Chapter 2. <u>A Case Study of the Chaplaincy at the Vancouver General Hospital</u>	
Hospital Procedures. Interpretation of the word 'Chaplain'. Denominational Practices. Preparation of the Chaplain. The Chaplain at Work. Counselling Practices. Referral Patterns with other Professions. Referral Patterns indicated in three case examples	28.
Chapter 3. <u>The Clinical Pastoral Training Movement</u>	
Origins and development. The Council for Clinical Training. Varying emphases. The Institute of Pastoral Care. Co-operation between the Council and the Institute. The Literature of Pastoral Care. Standards and Accreditations	53.
Chapter 4. <u>Implications of Recent Developments</u>	
Implications for the Churches. Implications for the Vancouver General Hospital. Implications for Social Work.....	85.
Appendices:	
A. Sample questionnaire to Hospital Chaplains and Official Visitors.	
B. Sample case histories.	
C. Statistical form.	
D. Sample Questionnaire of Student backgrounds.	
E. Sample application form for Visiting Chaplain.	
F. Standards for the Work of the Chaplain in the General Hospital. (American Protestant Hospital Association)	
G. Standards for Clinical Pastoral Education.	
H. Bibliography.	

TABLES IN THE TEXT

	Page
Table 1. Number of Patients by Religious Denomination Admitted to the Vancouver General Hospital For the two-week Period, March 11-24, 1962.....	38
Table 2. Number of Patient-Visits by Chaplains March 11-24, 1962.....	39
Table 3. Number of Referrals of Vancouver General Hospital Patients to Parish Clergy by Chaplains or Visitors, March 11-24, 1962.....	40
Table 4. Number of Working Hours of Chaplains at the Vancouver General Hospital March 11-24, 1962.....	41
Table 5. Number of Patients seen for Counselling by the Chaplains During two week period March 11-24, 1962.....	45

ACKNOWLEDGMENTS

To Dr. Leonard Marsh of the School of Social Work, University of British Columbia, who gave the encouragement needed to pursue this topic in the initial stages and to Professor William Dixon, Director of the School of Social Work, without whose help and constructive criticisms this study could not have been completed.

To the Reverend Canon T. D. Somerville for his ever present advice and help.

To the chaplains and official visitors at the Vancouver General Hospital who gave so freely of their time to answer questionnaires and participate in interviews.

THE CHAPLAIN

IN HEALTH AND WELFARE SERVICES

CHAPTER I

THE CHAPLAINCY OF THE CHRISTIAN CHURCH

The Problem

It is a favorite trick with those who pretend to read the palm or the handwriting to say, with special emphasis and secrecy to each customer: "I can see in your hand that the deepest and best of you has never yet found expression. Half unconsciously you are repressing a flood of power which pushes ever for freedom. To set it free will be the deepest joy of your life."¹

So observed Dr. Richard C. Cabot who, in 1905, had had the genius to introduce social workers to the Massachusetts General Hospital for the purpose of improving the over-all medical care of patients. Dr. Cabot went on to observe about the palmist that:

The beauty of this ever-successful trick is that what the sharper pretends to discover in this individual, he knows to be true of every living being. We are piteously unexpressed. We differ only in the means that can set us free.²

What Doctor Cabot had realized about social work in the medical setting was that the boundaries of professionalism had to be broken to let social work enter the medical setting and set it free to serve the patient. It was only twenty years later that this same man recognized the same principle

¹ Cabot, Richard C., What Men Live By, Houghton Mifflin: Boston and New York, 1914, p. 268.

² Ibid.

operative in the Christian ministry. He could see that a means to set it free was necessary. He wrote a plea for a clinical year in the course of theological study.¹ As he observed theological students he

wondered whether their call to the ministry has meant in every case a call to preach or whether to many it is not rather a call to carry the Gospel of Christ to fellow men in trouble of mind, body or spirit and if so, whether their future service to individuals in their parishes is not very like what the doctor actually does....when he visits a patient. 2

Considerations such as this led Dr. Cabot to speculate on the possibilities of ministers becoming "members of the health team" in a manner not unlike his pioneering in bringing the social worker into the staff of the hospital.³ His 'plea' did not go unanswered and today in Canada and the United States several thousand Ministers of Religion have benefited by "Clinical Pastoral Training" even as several thousand trained social workers are now employed in hospitals.

Each of the well-established professional disciplines accepted today as an essential member of the clinical team has had its unique struggle in attempting to establish the particular contribution it has to make in the total diagnosis and treatment of an ill person. This has been particularly

1 Cabot, Richard C., "Adventure on the Borderland of Ethics," The Survey, Vol. IV, No. 5, December 1, 1925.

2 Ibid., p. 275.

3 Belgum, David, Clinical Training for Pastoral Care, The Westminster Press: Philadelphia, 1956, p. 30.

true of clinical psychology, psychiatry and social work. Even today, however, these disciplines are not accepted to the same degree. Now another profession, the ministry, and particularly the institutional chaplaincy, which is also concerned with the adjustment of people, both emotional and social, has begun to extend its interests and contributions beyond its long-established role into clinical work.

With its introduction of medical social workers in 1912 the Vancouver General Hospital was a pioneer in British Columbia in making social work a partner of the healing professions.¹ By contrast the hospital chaplain, fifty years later, is not generally considered part of the hospital team. Today the chaplaincy comes to the Vancouver General Hospital as an outside 'auxiliary' service supported by various denominations.

The evolution of the chaplaincy since Dr. Cabot's inspiration has in many places been very remarkable. In countless ways the traditional role of the chaplain has been changed and modified. As a result, the chaplain in many general hospitals, as well as welfare institutions of various kinds, in the United States and to a limited extent in eastern Canada, has become an integral part of the healing team. It is of particular note that in British Columbia, medical and welfare agencies, as well as the Churches, have been among the last to

¹ See: Collier, Elizabeth A., The Social Service Department of the Vancouver General Hospital: Its History and Development, 1902-1949, Thesis for Masters Degree in Social Work, The University of British Columbia, 1950.

see the value of the recent developments in the training of the chaplaincy, particularly that arising out of the clinical pastoral training movement.

The Development of the Chaplaincy in the Church

The modern minister follows in a path marked out by religion's traditional concern for sickness and healing. Primitive societies, as well as the cultured Greeks, considered priest and medicine man synonymous. Healing was one of the priestly functions in Greek temples.

Although the Hebrews were a nomadic people, and therefore not inclined, as were the Greeks, to establish permanent temples in the early part of their history, there was a moral attitude toward the sick and the stranger which can be considered as antecedent to the institutional care of the sick in hospitals. The Jews were anxious to provide for the needy, such as the stranger, the fatherless and the widow. Often the sick were provided for by segregation; lepers were classified as "unclean" and lived in the hills. It was left for later times to integrate the idea of hospitality and segregation (that is "hospitalization"), with the needs of the sick, and combine the two elements into the hospital as an institution.

The healing miracles of Jesus indicate a change in attitude toward sickness. Instead of merely protecting the community by segregating the sick, the unfortunate victim was to be ministered to, healed and cared for. The parable of the

Good Samaritan portrays the wounded man treated with utmost consideration, brought to an inn, and cared for until he recovered.¹ When Jesus healed lepers, he sent them to the priests to have their healing certified. The Great Physician instituted healing as a regular part of the work of the disciples: "They shall lay their hands on the sick and they shall recover."² When Christ sent out the Seventy, he instructed them to "heal the sick that are in the way and say unto them, the Kingdom of God is come nigh unto you."³

Peter's reputation for healing became so great, "That they brought forth the sick into the streets and laid them on beds and couches, that at the least the shadow of Peter passing by might overshadow some of them."⁴ A method of caring for the sick, described in the Epistle of James 5, finally grew into the sacrament of unction.

Is any sick among you? Let him call for the elders of the church; and let them pray over him, anointing him with oil in the name of the Lord; And the prayer of faith shall save the sick, and the Lord shall raise him up; and if he have committed sins, they shall be forgiven him. ⁵

According to Talcott Parsons the most distinctive feature of early Christianity was its religious "individualism," its

1 St. Luke, 10:30-35. (King James Version used in all references.)

2 St. Mark, 16:18.

3 St. Luke, 10:9.

4 Acts of the Apostles, 5:15.

5 Epistle of James 5;14,15.

concern with the fate of the individual soul.

Since the problem of health is also--however much it is socially conditioned--a problem of the state of the individual, it is not surprising that early Christianity was permeated with concern with health, and that religious healing was one of its central bases of its validation. The impact of the Gospels would certainly have been greatly diminished had this element been removed.¹

As the Church became more completely organized, care of the sick was also institutionalized. It took a special crisis to bring the needs of the sick into the open. "Naturally it was travellers attacked by illness that called for the greatest pity and anxiety. This was the origin of hospitals....the first of which was founded in the last quarter of the fourth century, A. D., on account of a famine which had caused a deadly epidemic."²

About 400 A. D., Chrysostom established seven different hospitals which would be considered by modern welfare agencies to be quite comprehensive in their coverage of human needs. There was an inn for strangers and travellers, a hospital for the treatment of acute illness, another hospital for chronic patients, and homes for orphans, the aged, the reception of the poor, and another for all kinds of destitutes.

¹ Parsons, Talcott, "Mental Illness and 'Spiritual Malaise': The Role of the Psychiatrist and the Minister of Religion," in The Ministry and Mental Health, edited by Hans Hofman, Association Press: New York, 1960, p. 24.

² Bonet-Maury, G., "Hospitality (Christian)," in James Hastings, (ed.) Encyclopaedia of Religion and Ethics, Vol. VI, p. 804.

During the Middle Ages numerous monastic orders and lay brotherhoods cared for the sick.¹ Monastic orders were established to meet the health crises of the great crusades, and a series of migrant wars which left wounded along the way and spread disease. The Knights of St. John of Jerusalem (founded c.1210) established many hospitals and ministered to the sick along the way. John of Avila, in Spain, pioneered the work among the sick that became famous as the Hospitalers.

Sometimes a hospital would be founded by an order, and in other cases a religious order would be born from an unusually successful hospital program, so that branch hospitals would be sponsored by the mother institution.

It is illuminating to notice that the spiritual care of patients in the Hotel Dieu (a thirteenth century hospital in Paris) was quite complete and elaborate. Everything possible was done to maintain the patient's spiritual life.

On entering the hospital, the patient, if a Christian, went to confession and received Holy Communion, in order that peace of mind might benefit bodily health.... According to their ability, the sick performed the duties of prayer, attendance at Mass, and reception of the sacraments. They were especially recommended to pray for their benefactors, for the authorities, and for all who might be in distress. At nightfall a sort of litany was recited in the wards, each verse of which began: "Seignors malades, proies por," etc. They were often cheered by the visits of persons of high station or of noble rank and charitable disposition, like Catherine of Sweden; Margaret, Queen of Scotland; Margaret, Duchess of Lorraine; King Louis IX of France.²

¹ For example: The Order of Our Lady of Mercy, Spain (Founded 1218); The Hospitalers of St. John of God, Portugal (Founded 1537); The Congregation of Alexian Brothers, Germany (Founded c.1250).

² Walsh, James J., "Religion and Health," Catholic Encyclopaedia, 1910, Vol. VII, p. 486.

The two roles of 'physician to the body' and 'physician of the soul' were often combined in that of the priest or chaplain.¹ In many instances the roles would be difficult to distinguish.

With the advance of science in the 17th to 19th centuries and its application to the study and practice of medicine the two roles became more differentiated. The study of medicine became almost exclusively the concern of the laity and the "cure of souls" became the unique role of the hospital priests. The hospital was the chaplain's "parish" and the patients were his "parishioners." He ministered to the patients in a manner not unlike that of any parish priest.

The extra-parochial ministry in the hospital setting was not the only specialized ministry to evolve in the Church. There has developed a vast ministry pertaining to other institutions and organizations.

The Military Chaplain

The military chaplain today falls heir to an office of long tradition. The institution of the chaplaincy has a history as old as the story of military operations. The chaplain's title goes back to a legend concerning Martin of Tours (335-397 A. D.),² who gave half of his cloak, or mantle, to a shivering

1 Fox, A. H. Purcell, The Church's Ministry of Healing, Longmans: London, 1959, Chapter 19, "Co-operation Between Clergy and Doctors," pp. 101-107.

2 Oxford Dictionary of the Church, edited by F. L. Cross, Oxford University Press: London, 1958.

beggar. The half that he kept, known as "Capella," became an object of veneration at Court. French kings began to apply the title "Chappelains," keepers of the cloak, to the clergy who ministered to them. In centuries to follow, "chappelains" were found wherever kings went to war and soldiers fought battles. In times of peace they served at court, giving aid and comfort to all in need.

As history ran its course, new nations developed on this side of the Atlantic. Here, too, the tradition of service and sacrifice was carried on. In the United States there were chaplains attached to many of the forces engaged in struggles against the Indians and the French. In fact it was quite natural for the town clergyman to march off to battle with units of the revolutionary militia and become the chaplain. At the outset of the American Revolutionary War, each colony had a separate plan for procuring and maintaining the chaplain. The only consistent principle at the time was the belief that the chaplain should represent the religious sentiment of the troops he served. The legal origin of the chaplaincy as part of the American military service is found in a resolution of the Continental Congress, dated July 2, 1775.¹ An act of that date established the military chaplaincy. In time the Continental Army had hospital chaplains, a German chaplain-at-large, a chaplain-missionary to the friendly Indians, and one division

¹ The Air Force Chaplain, Air Force Manual Number 165-3, Department of the Air Force, Washington, D. C., March 1954, p. 1.

chaplain at Headquarters. During World War II there were 8,896 ministers, priests and rabbis serving as chaplains to United States forces.

In Great Britain and Canada, Army and Air Force chaplains are given permanent or temporary commissions, and rank equivalent to captain or above according to seniority; in the Navy they do not hold official rank. The chaplains are drawn from all the larger religious bodies. Chaplains appointed by the state are paid by the state. There are approximately 200 chaplains serving Canadian armed forces at the present time.

The Department of Veterans' Affairs in Canada attaches sufficient importance to patient care that they employ chaplains on a full-time basis.¹ Each of the D.V.A. hospitals in Canada has one or more chaplains.²

The Chaplain in Correctional Institutions

The chaplain also ministers in correctional institutions. Gaols, originally for the safe-keeping of prisoners awaiting trial--a function they still serve--and houses of correction, originally "for the setting of the Poore on Worke, and for the avoiding of ydleness," came into general use as places for the incarceration of convicted offenders early in the 17th century. However, as early as 1547 the Council of Orleans declared it the

¹ Kirk, T. E., "The Role of the Chaplain in a Hospital," Medical Services Journal, Vol. XVII, No. 10, November 1961, pp. 765-767.

² There are Roman Catholic, Anglican and United Church full-time chaplains at the Shaughnessy Military Hospital, Vancouver. One of them holds the degree M.S.S.W.

duty of archdeacons to visit all prisoners every Sunday.¹ Several religious brotherhoods were specifically organized to minister to criminal offenders. This interest is common to all religious denominations, each of which, with its own emphasis, recognizes a responsibility towards imprisoned offenders.

Mabel Elliott, a contemporary sociologist interested in criminology writes,

Religious leaders have supplied the basic concepts of modern penology...the dignity of human personality...the redemptive power of love and the futility of brutal and vindictive punishment...it is to the religious leadership within the prison that we must look to help the prisoners understand the creative and regenerative powers of love. ²

There are penal institutions where the one bright spot in an otherwise drab and hopeless situation is the office of the chaplain. There are others where the inadequacy and hypocrisy of the chaplain render his work worse than futile. In some the chaplain is about the only person who tries to gain the confidence of the inmates or interests himself in the welfare of their families or even in preparing the situation on the outside to which the inmate must return on release.³

The Director of the United States Federal Bureau of Prisons is reported to have stated at the Institute for

¹ Correction Research, edited by Albert Morris, A Publication of the United Prison Association of Massachusetts, November 1961, p. 2.

² Elliott, Mabel A., Crime in Modern Society, Harpers and Bros., 1952, p. 643.

³ Finnegan, Hugh, The Chaplain and His Work, American Prison Association Proceedings, 1934, pp. 261-265.

Catholic Prison Chaplains, held in 1940, in Washington, D. C., that

...frequently the chaplain is the one official who can establish a personal contact based on understanding and good will. He has no product to manufacture, no marks or grades to give, no demerits to assess, no pills to offer; his sole objective is the spiritual welfare of the prisoner. In an organized religious program, this relationship is based on the understanding engendered in the initial interview in which the chaplain carefully explores the attitudes, the religious convictions or philosophy, the motives and the goals which underlie not only the prisoner's criminal life, but his whole existence.¹

The ideal chaplain from some wardens' point of view is, among other things, a man who will not interfere with discipline.² Some chaplains have agreed that such matters are none of their business even if they think the punishments inflicted cruel or undeserved, while occasionally a courageous chaplain calls attention to abuses. Some chaplains cooperate effectively with other staff members in those modernized prisons where good classification and case work are being done. Others speak a language inconsistent with scientific methods in prisons.³

It is perhaps in the correctional setting that the new role of the chaplain has evolved to the greatest extent. A unique phase in this evolution has been described by Robert M.

1 Belanger, Rev. E. J., "Evaluation of the Initial Interview," Proceedings of the 83 Annual Congress of Correction, American Prison (now Correctional) Association, 1953.

2 Herron, James W., The Ideal Chaplain from the Superintendent's Point of View, American Prison Association Proceedings, 1928, p. 264.

3 Taft, Donald R., Criminology, A Cultural Interpretation, MacMillan: New York, Revised edition, 1950, p. 218.

Gluckman, psychiatrist at the Illinois State Training School for Boys.¹ It concerns the chaplain as a member of the diagnostic clinical team. This experiment has shown that the dual role of the chaplain as diagnostician and therapist, on the one hand, and religious leader on the other has not proved conflictive. On the contrary, this new role has been mutually beneficial to both aspects of the chaplain's work and the total treatment team.

The significant thing about Dr. Gluckman's article is that the administrative and clinical staff are aware that these additional members of the clinic team could not be just any graduate theologians. In addition to specialized clinical pastoral training, certain personality characteristics were necessary that would qualify the chaplain for the type of relationship needed. The most important thing, Dr. Gluckman claims, is intuitive understanding of the needs of the emotionally maladjusted boy.

Chaplains serving in Canadian prisons are often chosen on the basis of previous experience as chaplains in the military forces. None of the chaplains so employed in prisons in British Columbia has taken Clinical Pastoral Training.

In British Columbia there are two full-time chaplains on staff of the Department of the Attorney-General.² One of these

¹ Gluckman, Robert M., "The Chaplain as a Member of the Diagnostic Clinical Team," Mental Hygiene, Vol. 37, No. 2, April 1953, pp. 278-282.

² Annual Report of the Director of Corrections for the Year Ended March 31, 1961, British Columbia, Queen's Printer: Victoria, p. 179.

is the "Senior Chaplain" and the other, the chaplain at Haney Correctional Institution. Two part-time chaplains serve Oakalla Prison Farm, and the Prince George Gaol. Three voluntary chaplains (two of whom are theological students) serve at the Chilliwack Forestry Camp, Oakalla Prison and the Women's Gaol. At the federal level two full-time chaplains minister at the British Columbia Penitentiary, New Westminster, and two part-time chaplains minister at Agassiz and Williams Head.

The Chaplain in the Mental Institution

The twentieth century has brought something genuinely new into the relation of the Church to illness and health. Nowhere has this been more true than in the work of the mental hospital chaplain. The stimulus for this new awakening has been the tremendous growth in the psychological, psychiatric and social sciences. Although sharp differences continue to exist between psychiatrist and minister, the tension is waning as each comes to understand more fully the concepts and roles of each discipline. "It might be pointed out here that there is no more conflict between the concepts of psychology and those of theology than there is between certain schools of theology."¹ This has been one of the results of the development of the clinical pastoral training movement in the United States. The call for chaplains in state mental institutions represents the

¹ Wise, Carroll A., "The Place of Clinical Training in the Department of Pastoral Theology," The Journal of Pastoral Care, Spring 1951, Vol. V, No. 1, p. 48.

community's awareness that this role must become a part of the therapeutic community.

Chaplains are represented in most mental institutions in Canada. In British Columbia one Roman Catholic and one Protestant chaplain minister to the spiritual needs of the patients in Essondale and Crease Clinic. During 1961 another Protestant chaplain was appointed to minister to the patients in Valley View Hospital.¹ The "Ross Report" of 1961 recommends continued appointment of the chaplaincy at Essondale.²

The primary function of the mental hospital chaplain is to provide a spiritual ministry to patients; in addition he is expected to interpret the function of the chaplain in the hospital and the meaning of religion to other hospital personnel; to interpret to the community (church and civic groups) the work of the hospital and the relationship of religion to the problems of mental health; to encourage, where possible, programs for the clinical pastoral training of seminarians and clergy, and to offer opportunities for clergy to obtain specialized training in the ministry to the mentally ill person; and to utilize what community resources are available for the extension of this ministry.³

Among the standards for qualification as a mental hospital chaplain approved by the Association of Mental Hospital

¹ Mental Health Services Annual Report 1961, Department of Health Services and Hospital Insurance, Queen's Printer: Victoria, 1962.

² Survey of Mental Health Needs and Resources of British Columbia, Editor: Matthew Ross, Medical Director, American Psychiatric Association, 1961, p. 126.

³ Standards for Mental Hospital Chaplaincy, adopted by the Association of Mental Hospital Chaplains at their annual meeting in Washington, D.C., April 30, 1953. (A mimeographed brochure obtainable through the National Council of the Churches of Christ in the U.S.A.)

Chaplains is that he shall have completed a period of specialized training in Clinical Pastoral Training. None of the chaplains serving in British Columbia mental hospitals is so qualified.

Other Areas of Specialized Ministry

The foregoing discussion of the chaplaincy in various institutions does not describe all specialized ministries. Full-time and part-time chaplaincies are often assigned to church-sponsored homes for the aged, T.B. Sanitoria, universities,¹ missions to seamen,² treatment centers and clinics for alcoholics,³ institutions for the care of children, and homes for unmarried mothers. For example in a Lutheran maternity home in Minnesota:

...significant results are being demonstrated through close teamwork of chaplain, caseworker, and nurse.... Where guilt, anxiety, and hostility are present, redemptive religious faith with its restorative power is offered⁴ through individual pastoral care and group worship.

1 The University of British Columbia has four full-time chaplains (Anglican, Lutheran, Roman Catholic, United Church) and three part-time chaplains (Baptist, Presbyterian, Lutheran.) They are sponsored by their respective church authorities.

2 There are four full-time chaplains in Vancouver, North Vancouver, and New Westminster serving in "Mission to Seamen" hostels.

3 The Alcoholism Foundation of British Columbia hires a full-time Priest-Counsellor, and makes special referral to some city clergy on a part-time basis.

4 Whiting, Henry J., "Current Emphases in Casework under Religious Auspices: Integration of Casework and other Programmes," Social Welfare Forum, 1951, National Conference of Social Work, Columbia University Press, New York, p. 217.

The Chaplain in the General Hospital

Something of the Church's ministry to the physically ill has already been described under the development of hospitals and the hospital chaplain. Ministry to the sick has always been a primary obligation of the Christian Church, and in this it follows the example and charge of her Founder.¹ Visits to the sick in their homes are still one of the first charges upon the parish ministry, but today a vast portion of the people in serious illness are to be found in hospitals, so that inevitably the ministry to the sick is concentrated in the great network of hospitals throughout the country. The calling of the hospital chaplain is not new, but ministry to the sick in a large modern hospital involves a new approach to this whole question by the Church, the hospital and various levels of Government. In Britain the Ministry of Health recognizes the important part the chaplain has to play in the life of a hospital and in the whole work of healing, and provision for chaplains in all hospitals is insisted on by the Ministry.

The relevance of religion to the healing art is slowly, but steadily, gaining recognition. This has been marked by a statement approved by the British Medical Association in 1947, which recommends that there should be a closer cooperation between ministers of religion and medical practitioners.²

1 St. Matthew 4:23; St. Matthew 25:36; St. Mark 16:18.

2 "Medicine and the Church," a statement approved by the Council of the British Medical Association, British Medical Journal, November 8, 1947, Vol. ii, p. 112.

The Council of the British Medical Association is of the opinion that there is no ethical reason to prevent medical practitioners from cooperating with the clergy in all cases and more especially those in which the doctor in charge of the patient thinks that religious ministrations will conduce health and peace of mind or will lead to recovery. Such cooperation is often necessary and desirable, and would help to prevent abuses which have arisen through the activities of irresponsible and unqualified personnel.

Two movements have led to this recognition. On the one hand there has been a development of psychological medicine which has revealed the intimate relationship of mind, body and spirit, showing that underlying psychological and spiritual disorders frequently play a great part in the causation of many kinds of illness, physical and mental. On the other hand, there has been a re-awakening of the Churches to the full significance of the ministry to the sick and of their responsibilities to those in hospital. These two movements have developed simultaneously in the twentieth century and are finding a common meeting ground.

The functions of the minister are within certain areas overlapping those of the doctor and the social worker, and the problem is to find the most effective means of cooperation. The opportunity for this cooperation is nowhere better provided than in the modern hospital, where the chaplain finds himself working in close association with numbers of men and women devoted

to the service of the sick. The better he understands the functions and roles of other disciplines, the more intelligently will he be able to cooperate with them. But he will not, however, gain the respect and confidence of members of the health team unless he is himself as competent in his own sphere as they are in theirs. He must, therefore, be afforded the training necessary for this specialized work.

The Chaplain and the Religious Needs of the Patient

The chaplain no less than the social worker in the medical hospital often finds that questions and problems which clients have regarding themselves and others come to focus in the very process of admission to the hospital. If the problems are not discovered on admission, they may come to light during the patient's stay in hospital or just prior to discharge.¹ Illness presents unusual opportunities, too, for consideration of the spiritual needs of the patient, who is stripped of many of the interests that normally absorb his time and energy. His peculiar circumstances of isolation in a strange institution can be stressful for a patient and thus precipitate responses indicating deep spiritual needs.

One of the most common responses in illness is that of grief, either as a result of bereavement or as "anticipatory grief." The latter is a term used by Dr. Erich Lindemann, who

¹ Stroup, Herbert Hewitt, Social Work, an Introduction to the Field, American Book Company: New York, 1948, pp. 364-375.

has written a descriptive account of some of the dynamics of grief in a paper presented to the American Psychiatric Association in 1944. In his paper Dr. Lindemann says:

We were at first surprised to find genuine grief reactions in patients who had not experienced a bereavement but who had experienced separation, for instance, with the departure of a member of the family into the armed forces. Separation in this case is not due to death but is under the threat of death. ¹

There are many kinds of grief response. There is that which follows the loss of a member of the family by illness or fatal accident. This is especially severe when death comes without warning for there are many after effects. There is the grief response which comes from anticipation of possible death, as with the admission to the armed services during wartime. There is the more subtle grief response which is associated with the loss of love of husband or wife, even though they continue to live with each other. And there is the grief response which is caused by the concern of parents over a child who has got into trouble at school, or in social life, or with the law; and the response which accompanies loss of self-respect, prestige, status, income, or any other part of self or family which is held to be essential for life and well-being.

A great deal of life loses meaning when a loved one dies, and it is necessary to build new habits and new activities which are appropriate to the relationships that are still a part

¹ Lindemann, Erich, "Symptomatology and Management of Acute Grief," American Journal of Psychiatry, Vol. 101, 1944, pp. 141-148.

of life. The chaplain can help the patient to accept the pain and give support when a patient encounters some of the common fears that are a part of bereavement. He can give opportunity to confess where there was failure or hurt in the relation with the loved one, and assist in formulating what the future relation will be to the loved one. The chaplain has the resource of a vast number of parish clergy to which to refer a patient when discussing plans for the patient's continuing life and his moving back into the community.

Helping the dying patient and his family has long been a concern of many professions. Despite this, there is a dearth of literature on the topic within the various disciplines ministering to this need. The social worker, no less than the minister, must face the bereaved client. Helping the dying patient and his family can be a most distressing experience for the social caseworker.

It is an area of practice that demands the highest calibre of professional discipline and skill. Paradoxically, it can also be a most gratifying experience, since in offering this kind of help the caseworker is called upon to give as unselfishly of himself and his service as at any point in his professional life.¹

There are a number of patients who seem to be unable to return to their church or community until they have talked over

¹ Kennedy, Nathalie, Helping the Dying Patient and His Family, National Association of Social Workers: New York, 1960, p. 23. See also: Benda, Clemens E., "Bereavement and Grief Work," The Journal of Pastoral Care, Spring 1962, Vol. XVI, No. 1.

some of the things that are concerning them. The hospital chaplain is on the front lines of the church's ministry and is given an excellent opportunity to care for people who want to belong to the fellowship of the church and need it badly but are unable without help to take the steps toward belonging.

One of the chief purposes of the ministry is to nurture wholesome family life. It is often found that for some patients family difficulty is an even greater cause of anxiety than is the illness. Such anxiety often inhibits the patient's recovery. Discussion with the chaplain about family problems can bring relief to the anxious patient. The chaplain must be sensitive to this opportunity to enable the patient to view realistically the stresses in his home and his family life.

Often the patient will not be far enough along in spiritual development to utilize many of the sacramental resources, and at the beginning of the relationship listening is probably the most important instrument of the religious worker. To make an accurate spiritual diagnosis one must know enough facts of the spiritual condition, its development, characteristics, expressions, and where possible, something of its origins. In some instances, simply the opportunity to talk freely will be of sufficient help to the patient so that he can go on to work out his spiritual concern largely by himself. Great help to the patient may come through the process of thinking through his relationship with various members of his household or community. By this means the admonition "If..thy brother hath aught

against thee, leave there thy gift before the altar, and go thy way, first be reconciled to thy brother, and then come and offer thy gift,"¹ will be more meaningful.

Another common concern of the sick person which is of interest to the chaplain is that of grudge-holding and of unresolved grievances. The question "What have I done to deserve this?" is often found in the person who either in act or feeling has wished some harm on someone else and has instead become ill himself. This problem is as old as the Book of Job and is no less a concern of psycho-analysts and medical social workers today.²

One of the early church fathers called the Holy Communion "medicine for the soul." Patients often mark the reception of the Communion as the turning-point of their illness. It is certainly the Church's chief "medicine," and it helps to sum up all that is good in the patient's relation to God and to other people.

One of the values of the sacramental action is that it helps to bring the patient's attention and interest outside himself, overcoming the withdrawal that is characteristic of many patients following operation. The Sacrament of Holy Communion or private prayer is one of the greatest forces of support to the patient who must face an operation. It is

1 St. Matthew 5:24.

2 See: Stephen, Karin, The Wish to Fall Ill, Cambridge University Press: London and New York, 1960 (Paper Back edition).

important to the patient whose body image is in jeopardy that he have continuing support from the community and from his church.

It is important too, that the patient realize the real meaning of the Sacrament, that it is not invested with magical significance or made a substitute for necessary medical care. The chaplain must be alert to the possibility that the patient who has not expressed guilt, fear, or resentment is likely to interpret the administration of Holy Communion without any discussion of his spiritual condition as a sign that "everything is all right." One of the factors found in illness is the evasiveness of the patient in facing his life situation. Religion and its sacraments may be a powerful force in helping the patient meet a difficult situation with courage and reassurance. Therefore, careful preparation, which takes into account both the objective meaning of the Sacrament and the subjective needs of the patient, is necessary. As the Book of Common Prayer says: "For as the benefit is great if with a true penitent heart and living faith we receive that Holy Sacrament,... so is the danger great if we receive the same unworthily."¹

In summary it may be said that the hospital chaplain finds many opportunities to help patients with spiritual problems. Such problems as loneliness, fear, bitterness and grudge, the sense of guilt, boredom, physical pain and mental suffering are all encountered by the chaplain. He must be

¹ "The Exhortations," Book of Common Prayer, Canada, 1959, p. 89.

sensitive to the need of patients to come to some satisfactory answer to the problems of evil, of ignorance, and of futurity. All of this the chaplain must combine with his unique resources of prayer, sacraments and Bible reading and pastoral counselling. As a member of a helping profession in the hospital setting he works with a vast team devoted to serving the patient and assisting him on the road to recovery. The relevance of these areas of concern to the chaplain is perhaps best summarized in The Modern Hospital, July, 1946:

As the knowledge of psychosomatic medicine emerges, the role of hospital attendants in the treatment of illness will grow in importance. It has long been recognized that the emotional tone of medical and nursing staffs and of nonprofessional hospital workers is in some way related to the quality of hospital care. This relationship, as it turns out, is direct and significant; good emotional tone is an essential of good psychic environment, the patient's recovery is aided; if the environment is unfavorable, it is retarded.¹

Scope of the Study

Some attempt will now be made to look at existing conditions of the chaplaincy at the Vancouver General Hospital. Personal interviews were conducted with each full-time chaplain and each full-time "official hospital visitor." By means of

¹ See also: Barry, Kevin, "The Catholic Chaplain," The Canadian Nurse, The Canadian Nurses' Association; Montreal, Vol. 57, No. 12, December, 1961, pp. 1142-3. See also: McKnight, Earle T., "A Chaplain Interprets His Work," The Canadian Nurse, The Canadian Nurses' Association: Montreal, Vol. 57, No. 12, December 1961, pp. 1339-1341.

a questionnaire and an interview, data regarding the chaplain's work were gathered.¹ Each chaplain also kept some statistics regarding his work for a two-week period, March 11-24th, 1962.² Although these statistics are not exhaustive, it is believed they show current trends and conditions.

Volunteers from the Bachelor of Social Work class and from members of the graduating classes of Anglican Theological College and Union College completed a short questionnaire³ and outlined their responses to the situations outlined in three brief case histories.⁴ These responses were in answer to three questions concerning the case history: (1) What is your initial reaction to the presenting situation? (2) Do you feel competent to handle the situation? and (3) To whom might you refer the people in question for further help if needed? The student each gave written answers and completed the questionnaires during the period of one hour. The three "case histories" were also given to the five hospital chaplains and two official visitors at the Vancouver General Hospital. Verbal answers to the same three questions were given by each chaplain and recorded by the interviewer.

There will be an attempt to find who sponsors the chaplains and what is the background training or education of each. The study will try to find answers to these questions: What sorts of problems does the chaplain face in the hospital

1 See Appendix A.

2 See Appendix C.

3 See Appendix D.

4 See Appendix B.

setting? What are his referral patterns? and What are his counselling practices?

In Chapter Three there will be an attempt to describe the development of the Clinical Pastoral Training Movement. Finally, the implications of the findings will be examined and suggested areas for further exploration outlined.

CHAPTER II

A CASE STUDY OF THE CHAPLAINCY AT THE VANCOUVER GENERAL HOSPITAL

The pastor is deeply and inevitably involved in problems of human welfare. Not only does his work take him intimately into the life situation of many families, but it is deep in the tradition of religious institutions that people should bring their problems to the pastor, and he is expected to help resolve them.¹

The fact that a person is hospitalized and separated from his community does not mean that his life's problems and anxieties are left behind in the community. He brings them with him--his social and psychological problems, and his religious and spiritual problems. Indeed, often the anxieties are intensified because of his hospitalization. In many instances these unresolved problems hinder his return to health of body and mind. But because the patient is institutionalized he cannot seek help beyond the hospital, and the resources of the professions must be brought to him.

Today the modern hospital brings many disciplines together to form a "treatment team" to serve the patient. The

¹ Cayton, H. R., and Nishi, S. M. Churches and Social Welfare, Vol. II, The National Council of the Churches of Christ in the U.S.A.: New York, 1955, p. 164.

Vancouver General Hospital is no exception. Medical doctors, nurses, social workers, psychiatrists, psychologists, therapists and teachers pool their learning and experience in ministering to the sick.

The one exception outside this team at the Vancouver General Hospital is the minister of religion. It is true that he is to be found visiting the sick in wards of the hospital but he does not come as a representative of the hospital nor as a member of the "team." He is sent by the community outside the hospital. This has not always been so at the Vancouver General Hospital.

In 1919 a group of Vancouver citizens, recognizing the need for a religious ministry, asked the Reverend Cecil C. Owen to become "Host" at the Hospital.¹ "Padre" Owen, as he was affectionately known, had been Dean of Christ Church Cathedral, Vancouver, for some 15 years and his religious counsel was sought by hundreds of people. The citizen's committee raised funds for his stipend and in 1920 he began what was to be a 30 year ministry to the sick at Vancouver General Hospital.

During the early years of the depression following 1929 the committee sought assistance from the Board of Trustees of the hospital to help pay for Padre Owen's services. The Board recognized his invaluable service to the patient and took

¹ The citizens committee was headed by Dr. Malcolm MacEachern, Medical Director, Vancouver General Hospital, 1912-1922. It was under Dr. MacEachern that the Social Service Department was begun at V.G.H.

complete responsibility for his salary. This arrangement continued until his retirement in 1950 at the age of 85 years.

The position of "Host to the Vancouver General Hospital" has never been filled since Padre Owen's retirement. Ministers of religion, however, continue ministering to the sick. The answer to the question "Who are the chaplains at the Vancouver General Hospital?" would seem initially to be a relatively easy task. Upon examination, however, this is not the case. Any answer to this question must consider three things: varying definitions of the word "chaplain," the hospital procedures respecting the chaplain, and denominational practices.

Definition of the Word 'Chaplain'

The Vancouver General Hospital makes no distinction between "Official Hospital Visitor" and "Chaplain." Indeed, the hospital's official registry of "Visiting Clergymen" may include ordained Pastors, Priests, Ministers, Commissioned Salvation Army Officers, Rabbis, Deaconesses, and both male and female Lay Workers. The expressions "Chaplain," "Official Hospital Visitor" and "Visiting Clergyman" are used inter-changeably. From the Churches' standpoint "Chaplain" generally refers to an ordained clergyman especially appointed to work in a hospital setting or institution or with a special group of people. "Hospital Visitor" refers to a full-time lay representative. In this paper "Chaplain" refers to both the ordained minister and the full-time lay worker unless the context indicates otherwise.

Hospital Procedures

The Vancouver General Hospital Administration has made an attempt to keep a registry of the "Visiting Clergymen." This was compiled by asking the various denominations to have their official representative(s) leave their name and address with the central administration offices of the hospital. This practice began in 1959 as a result of a decision of the Board of Trustees upon the recommendation of the Medical Board of the Hospital. Upon the completion of an application form¹ the visiting clergyman is issued with a card signed by the Hospital Director which indicates that the clergyman may "conduct appropriate religious rites and rituals within the Hospital." There are 33 "Visiting Clergy" listed as at March, 1962.

No set of standards of education or training are necessary to qualify as a "Visiting Clergyman." It is left to the denomination to select the person(s) to represent the church or sect.

It has been found difficult, however, to keep the list up to date. The hospital has not formulated procedures to assure this is done as occasion necessitates. Thus some who are listed have left Vancouver but their successors have not been registered. Each denomination must take the initiative of registration. At the present time one of the major denominations (Presbyterian) which hires a full-time hospital visitor is not registered with the hospital administration. In sharp contrast to this, the Salvation Army is officially registered with 18

¹ See Appendix E.

representatives although none is exclusively engaged in hospital chaplaincy or visiting. This seems to indicate that for this denomination each parish or congregation of the Salvation Army is "officially" represented and registered.

Not only clergy listed with the administration office visit the Hospital. Almost without exception the parish minister's duties include the "Visitation of the Sick." Within the boundaries of Vancouver city there are an estimated 200 clergy. In the course of any one week these clergy may visit their parishioners who are patients at the Vancouver General Hospital. For example, an estimated twenty parochial clergy visit patients in the Centennial Pavilion each day of the week.¹ In some instances these clergy perform "rites and rituals" but have no official sanction to do so from the hospital administration. There is no procedure for registering these clergy as "Visiting Clergymen."

Denominational Practices

Five denominations hire seven full-time hospital chaplains or visitors to visit patients in medical hospitals in Vancouver including the Vancouver General Hospital.² The Anglican Church and Roman Catholic Church each have one Chaplain working exclusively at the Vancouver General Hospital. The United Church supports two full-time religious workers. One of

¹ Tally taken by secretaries at the Information Desk, Centennial Pavilion, Vancouver General Hospital.

² It should be noted that three full-time Chaplains are on staff of Shaughnessy Military Hospital; one at St. Paul's Hospital; one at St. Vincent's Hospital.

these is a woman "Hospital Visitor;" the other is a retired minister. In both cases their time is divided between various hospitals. The Presbyterian Church hires a Deaconess who visits all hospitals in Vancouver. The Lutheran Church has two Pastors who visit all general hospitals in Vancouver, Burnaby and New Westminster and also other institutions such as Oakalla Prison and the B.C. Penitentiary.

The salary or stipend of four chaplains and visitors comes from sources outside Vancouver. To a limited extent, however, these four salaries are derived from Vancouver and British Columbia congregations through contributions to "Missionary Apportionment" or "Home Missions" which are collected by the central headquarters of the respective denominations. Salaries for Chaplains at the Vancouver General Hospital are sent from the following sources:

- (1) The Women's Missionary Society, Toronto, Presbyterian Church of Canada.
- (2) The Home Mission Board of the United Church of Canada, Toronto.
- (3) The Joint Committee of the two Vancouver Presbyteries, The United Church of Canada, Vancouver.
- (4) The Department of Charities, American Lutheran Church, Minneapolis, Minnesota, U.S.A.
- (5) The Anglican Synod of the Diocese of New Westminster, Vancouver.
- (6) The Alberta-British Columbia District of the Missouri Synod of the Lutheran Church, Edmonton, Alberta.
- (7) The Society of the Sacred Sacrament, Vancouver.

Preparation of the Chaplains

The training and educational background of the chaplains vary widely. Both women visitors have completed high school and one has taken a two year course in psychiatric nursing and one year of Normal School. Neither has received any instruction in hospital visiting or any formal courses in counselling, case work or the social sciences.

One of the chaplains spent two years in a seminary completing the "Pre-Seminary" course. He has taken two short courses (each two weeks in length) on "Family and Marital Relations" and "Mental Health." Another Chaplain holds the degrees of B.A., B.D., and D.D. His major study was philosophy and history. He has taken one class in psychology but no other courses in the social sciences. His theological courses did not include "Pastoral Counselling" and he found the training given for this work to be "inadequate."

One of the chaplains holds the following degrees and titles: A.Mus. T.C.L., A.T.C.L., and LTh. His theological course included courses in "Pastoral Counselling" which he found "helpful." The Roman Catholic chaplain received seven years of Seminary training with emphasis on philosophy and history. His courses included "Pastoral Theology" but he did not think this included what is known today as "Pastoral Counselling." He said he found Pastoral Theology "helpful" in meeting the problems he encountered in his ministry.

Another chaplain has the degree of B.Sc. (Chemistry), and a Diploma in Theology. He has taken "one quarter" (3 months) of Clinical Pastoral Training at Chicago.

The position of chaplain at the Vancouver General Hospital was a new experience for six of the seven chaplains. One chaplain served as a voluntary chaplain on a part-time basis to a home for the aged. This was for a period of two years while he was in charge of a parish. None of the other chaplains had previous experience as a hospital chaplain except that gained in a parish by regular visits to hospitalized parishioners. Two chaplains received a limited orientation to the Vancouver General Hospital from their predecessors. When he began work at Vancouver General Hospital one chaplain was taken on a 'tour' of the hospital by the Assistant Medical Director.

All of the chaplains and visitors thought that a course in "hospital chaplaincy" should be given in the Vancouver area. None, however, has clearly defined ideas about this. Their ideas respecting the scope of such a course ranged from a "few days orientation course on hospital work," through a course jointly sponsored by theological colleges in Vancouver, to a two year course in Clinical Pastoral Training integrated into the hospital services and administration. The Roman Catholic chaplain thought it would be difficult to combine all Churches in such a course but he felt his own denomination should make more provision for training of its clergy who are hospital chaplains. None of the Protestant chaplains contemplated any denominational boundaries but rather stressed that such a course should be inter-denominational.

The Chaplain at Work

At the time of admission to hospital each patient is asked to state his religious preference. A card which gives details of the patient is placed at the disposal of the chaplain the day following the patient's admission. These cards are sorted according to denomination by the "Information Desk Secretary" in Heather Pavilion. The cards of the following denominations are sorted: Anglican, Baptist, Lutheran, Presbyterian, Roman Catholic, United and Jewish. The remainder of the cards are destroyed.

The cards are placed in file cases in a small room behind the Heather Pavilion Information Desk and the chaplains are free to make what use they wish of them. This room, in which the chaplains sort their cards and plan their day's work, is shared by the Woman's Hospital Auxiliary which uses the room to cut and arrange flower bouquets. There are no facilities for hanging coats, no telephone, no chairs, no cupboard for storage or safekeeping of supplies. A desk may be used by the chaplains if they obtain a chair from the Information Desk or elsewhere. This, of course, is dependent on whether the desk is being used by the Woman's Auxiliary ladies.

One of the chaplains prefers to sort his cards in the main foyer of the Centennial Pavilion where desk and chair are available. Another chaplain prefers to return to his study at home to sort his cards. All the chaplains are loath to use the "Prayer Room" in the Centennial Pavilion for the purpose of

sorting cards. This has been done on occasion by some chaplains but they found that patients or visitors were prevented from using the Prayer Room when they found the chaplains were using the room.

Each card indicates the following information about the patient: name, age, address, when admitted, location in the hospital, employer, next of kin, denomination. The medical diagnosis is omitted. Four of the chaplains said emphatically that it would assist their work if they knew something of the medical diagnosis and prognosis. One of them said, "This would prevent the temptation to give false assurances when you can't be sure of the medical situation." Another remarked that the diagnosis "would help especially in making initial approach to the patient and especially when there had been attempted suicide or when the case was terminal." Two chaplains felt that the diagnosis could be helpful but not always. One of these remarked that he generally knew the diagnosis through his own experience in hospital work, the location of the patient in the hospital and often because the patient told him, although he never asked. One chaplain said that he did not wish to know anything of the diagnosis. Generally speaking, the chaplains were very pleased with the card system in use at the Vancouver General Hospital. The cards are similar to that kept by the Social Service Department in their file of official active cases.

Statistics of the religious denominations of each patient were taken for a two week period from the Social Service record

of daily admissions. Approximately 1,800 patients were admitted in this period.

Table 1. Number of Patients by Religious Denomination
Admitted to the Vancouver General Hospital
For the two-week Period, March 11-24, 1962

Denomination	No. Admitted	Denomination	No. Admitted
Anglican	333	Roman Catholic	263
Baptist	73	Salvation Army	12
Lutheran	104	United Church	460
Pentecostal	30	Jewish	47
Presbyterian	117	Other Groups	119
Protestant	131	No denomination	120
Total		1809	

Patients listed under "Pentecostal" include all those who indicated their religious preference as "Pentecostal," "Evangelical" or "Gospel." Those included under the heading "Other Groups" are patients who indicated their religious preference as one of the following: Greek Orthodox, Methodist, 7th Day Adventist, Jehovah Witness, Apostolic, Unitarian, Brethren Russian Orthodox, Plymouth, Wesleyan, Mohammedan, Mormon, Doukhobor, Sikh, Ukrainian Orthodox, Liberal Catholic, Christian Science, and Mennonite. Of the 120 who are listed under "No denomination," half indicated their religious preference as "Protestant-Non Practising."

Not all patients are visited by the chaplains. Indeed, each chaplain remarked on the difficulty of finding enough time to visit the members of his own denomination.

Table 2. Number of Patient-Visits by Chaplains
March 11-24, 1962

Anglican	200	Roman Catholic	207
Lutheran ¹	32	United ¹	377
Presbyterian	25		
Total of sample			841

The above statistics represent only the members of the chaplain's denomination who were visited by him. However, each chaplain remarked that he would not leave a ward without speaking a moment with each patient. Four chaplains visited the out-of-town patients more frequently than those from Vancouver. These latter they referred to parish clergy.

The referral to parish clergy is done in a variety of ways. One chaplain prefers to phone each parish minister and give each a list of patients from his parish. Another chaplain sorts the admission cards according to parishes and leaves them in a file cabinet for the parish minister. Still another chaplain writes duplicate cards and sorts the cards according to postal zone. These cards are then placed in an index cabinet and the parish clergy from each particular postal zone sort out their own parishioners.

¹ This includes both chaplains for this denomination.

Table 3. Number of Referrals of Vancouver General
Hospital Patients to Parish Clergy by
Chaplains or Visitors, March 11-24, 1962

Denomination	No. of Referrals	Denomination	No. of Referrals
Anglican	272	Roman Catholic	2
Lutheran	22	United Church	307
Presbyterian	1		
Total Number of referrals			604

One of the ministers of a large Baptist Church obtains the list of the members of his congregation who are patients by telephoning the Information Desk at Heather Pavilion. Many of the smaller sects depend on referrals from the patients themselves or from their relatives, friends and members of the congregation.

The number of visits which a chaplain makes is dependent on the time he may spend in any one week at the Vancouver General Hospital. Five chaplains have duties elsewhere and two work exclusively at the Vancouver General Hospital.

Table 4. Number of Working Hours of Chaplains
at the Vancouver General Hospital
March 11-24, 1962

Denomination	Days per Week	Hours per Week
Anglican Chaplain ¹	6	32
Lutheran 1. Chaplain	2	6
2. Chaplain	2	10
Presbyterian Visitor	2 $\frac{1}{2}$	5 $\frac{1}{2}$
Roman Catholic Chaplain ¹	7	25
United 1. Chaplain	6	14
2. Visitor	5	23

Except in the cases where counselling is requested (either directly by the patient or indirectly by referral) and where special church "rites and rituals" are performed (e.g. circumcision, baptism or Holy Communion), the usual length of time for a chaplain's visit is 5 to 15 minutes. Rarely do visits exceed this time although no arbitrary time limit is set. When occasion demands a chaplain may spend as much as an hour with a patient. In the case of long-term patients, hospital chaplains often make weekly visits. Most patients, however, are not in hospital long enough to allow for more than one visit. In the case of grave illness and when requested by the patient, his relatives or members of the professional staff of the hospital, chaplains will often make daily visits to patients.

¹ These chaplains work exclusively at the Vancouver General Hospital.

One chaplain wrote at length:

Regarding hours: no priest is ever "off duty" and his hours are as elastic as a doctor's. My note on Saturday,¹ March 17th reminds me that I spent the afternoon and part of the evening visiting and counselling the widow of a man who was a patient in the Vancouver General Hospital in February, but who died in White Rock Hospital early in March. I was asked to conduct the funeral and did so. This raises a point that may be worthy of consideration. The responsibility of the hospital ends with the death of a patient; but there is still the family to consider. They may be transient as this widow and her late husband were. They may have the most casual of church connections; in which case, the man who ministered to a deceased member of the family in his last illness may have the responsibility of doing something about the spiritual life of his survivors. In time the parish priest takes over--and the sooner the better; but meanwhile the chaplain must carry on. I have not been able to show on your form the time thus spent with bereaved families--some of it in hospital corridors and in the Prayer Room, some in their homes. In addition I have spent about four hours in these two weeks with relatives of seriously ill patients. One also does what one can by providing hospitality in one's home for relatives from out of town who have no friends in the city--we have had one such this past week. I have also driven two elderly relatives (old age pensioners) to their homes in Burnaby after they had visited near relatives in the Vancouver General Hospital. These are things which to my knowledge all the chaplains do from time to time.

This gives some indication of the variety of tasks performed by chaplains, and illustrates the difficulty inherent in the attempt to ask for precise time statistics from any professional group.

Counselling Practices

It is equally difficult to get a precise description or reasoning as to the purpose of the Chaplain's visit and what it is he feels he brings to the patient. If more time could have

¹ This refers to the statistical forms for March 11-24, 1962 which the chaplains completed. See Appendix C.

been used in the interview it likely would have produced more considered answers. Dr. Richard Cabot expressed the same difficulty:

The doctor seldom makes a swift and final diagnosis, seldom produces a triumphant remedy and departs in a blaze of glory. He does what he can professionally; but the larger part of his call is often social, he aims to encourage, to console, to amuse and distract, occasionally to instruct or to warn.¹

The chaplains were each asked, "What do you consider to be the most valuable aid(s) you bring to help the hospital patient on the road to recovery?" The answers varied from "cheerful presence;" to "Prayer and moral support;" to a more theological definition as "the vehicle of the Grace of God, that is, the ministry of reconciliation." One chaplain who had received Clinical Pastoral Training thought that the "listening ear" was the most valuable aid he brought to the patient. He described this 'aid' as also part of what every social worker brings in the casework relationship.

One chaplain found it necessary to be assured that he was understood about the 'aid' he brought to the patient. He had said in the interview that his ministry was one of reconciliation." Later he wrote a letter in which he said,

I could have said, "the ministry of healing" which is also correct but susceptible of being misunderstood as the application in some form of faith healing--which, by the way, should not be ruled out altogether. I prefer to think of the word "heal" in its older meaning of "to make whole," since our Lord...is concerned for the whole man, his soul, his mind, his body--and the bringing of the whole man into a proper relationship

¹ Cabot, Richard C., "Adventures on the Borderland of Ethics," The Survey, Vol. IV, No. 5, December 1, 1925, p. 275.

with God. Since in this endeavor the whole hospital--medical, nursing and social service personnel may be concerned--the hospital chaplain must work with them to the best of his ability as circumstances permit, and must have them daily in his prayers. And by the way, the past two weeks have left far too little time for personal prayer and devotional study!

Some chaplains were unable to be precise about a similar question, "Do you think the chaplaincy has any special skill or knowledge to help the treatment team of the Hospital?" All chaplains answered in the affirmative. When asked to describe this skill or knowledge, however, their answers were quite varied: "spiritual reassurance;" "prayer;" "the parish church is a great resource;" "physical well-being is closely related to spiritual well-being--anxieties and tensions cause some physical conditions." One chaplain suggested that the "parish experience gave an outlook which had breadth." This outlook, he thought, was akin to that of the social worker. He suggested that, "specialists have blind spots in the total picture whereas the chaplain and the social worker are often perceptive." Another chaplain said, "the chaplain is neither a social worker nor a doctor but he is uniquely qualified to diagnose, understand and help with spiritual problems. Spiritual health often affects physical recovery."

What constitutes "counselling" means many things to different people. This study cannot deal with all the possible meanings. Carroll A. Wise, in Pastoral Counselling, Its Theory and Practice, suggests that "counselling seeks to utilize the resources of personality, to work through tension-producing

experiences and to help the person grow to a new level of strength and maturity."¹ To what extent the chaplains have helped the patients through counselling there is no way of knowing. However, there is evidence that counselling is requested by the patients from the chaplains.

Table 5. Number of Patients seen for Counselling
 by the Chaplains
 During two week period March 11-24, 1962²

Denomination	Number of Patients
Anglican Chaplain	20
Lutheran Chaplain	2
Chaplain	12
Presbyterian Visitor	0
Roman Catholic Chaplain	10
United Chaplain	4
Visitor	4
Total	52

One of the chaplains in commenting on his completed statistical form said that under the column "Patients seen for Counselling" he, "included only those patients with problems such as the domestic inconvenience and upset occasioned by hospitalization and spiritual problems such as several terminal

¹ Wise, Carroll A., Pastoral Counselling, Its Theory and Practice, Harpers: New York, 1951, p. 38.

² During the same period 18 of the 1,800 admissions were referred to the Social Service Departments for casework services.

cases, and a man who fears he may become a paraplegic. I have not included, he said, "the fairly numerous cases of people who ask for straightforward answers to questions regarding the Church and the Bible, even where these cases involved a fairly long conversation." The difficulties in defining the boundaries of counselling are abundant.

All of the problems listed on the questionnaire have been dealt with by one or other of the chaplains at the Vancouver General Hospital. Some of the 'problems', of course, are more often brought to the chaplain than others. "Bereavement" was a problem which each chaplain had to face. Cases of bereavement were usually seen in the "family context" whereas all other problems were seen in the individual context. One chaplain attempts to refer to the parish clergy all cases where a death has taken place. He did not encourage the practice of a chaplain taking funerals and counselling the bereaved. He felt this to be beyond the hospital chaplain's bounds of duty. Because of the continuing work with the family he concludes this to be the parish pastor's responsibility.

The most commonly dealt with problem was that of "Grave Illness." Six of the seven chaplains have had to deal with this problem and three of these indicated its high incidence among the problems with which they had to deal. The only one who had not dealt with this problem was one of the women visitors.

"Religious Support" of various kinds received the most attention of the chaplains but was generally not regarded as a

'problem'. All chaplains at one time or another, make use of prayer. The more Catholic traditions make the greatest use of the Sacrament of Holy Communion whilst the more Protestant traditions lay emphasis on the Scriptural Reading, and extemporaneous prayer.

An interesting change over the years in the problems confronting the chaplain was given by one of the older chaplains. He remarked that the financial need of patients was the prominent problem a number of years ago and especially the worry caused through large hospital and medical bills. He noted that hospital and medical payment schemes have virtually erased this problem from those facing the chaplain.

Referral Patterns with Other Professions

The staff of a modern hospital is often greater in number than the patients it serves. This large staff consists, not only of nurses and doctors, but also of administrators and social workers, physiotherapists and radiologists, engineers and laboratory technicians, a vast array of domestic workers and a multitude of students of medical-oriented disciplines. With many of these the chaplain rarely, if ever, comes into contact. They work in the same building, serve the same people, but seldom cooperate in plans for the benefit of the patient.

The Vancouver General Hospital is a complex organization employing some 2,500 people for its capacity of 2,700 patients. Many professional disciplines cooperate as members of a "team" to serve the patient. Although none of the chaplains is

considered a member of this team, they are called upon from time to time to give service to a patient. In turn they refer patients to various disciplines.

Six of the seven chaplains have discussed with his medical doctor at one time or other the patient's condition. The one who has not so done is one of the women visitors. The chaplains reported that, although these discussions with the doctor were not frequent, they did involve some joint planning. One chaplain reported that he is called in occasionally when "medicine has given up."

The attempt to find the number of referrals to and from chaplains and other professions has not produced accurate statistics. Some chaplains recorded on the statistical form that they had received a referral from another profession but failed to say which profession or how often. Thus only a general trend can be indicated. By far the greatest number of referrals were to the city clergy.¹

On an interprofessional basis, the nurses cooperate most often with the chaplains. Before proceeding to a ward the chaplains usually speak with the head nurse at the nursing station regarding the patients on his list. The head nurse will tell them something of the patient's general condition and will often suggest when the patient has been particularly depressed and what seems to be the cause. They also advise the chaplain when the patient should not be disturbed. When a patient is

¹ See Table 3, p. 40.

critically ill the head nurse may also telephone the operators at the Information Desk in either the Centennial or Heather Pavilion. These clerks, in turn, will telephone the chaplain. Referrals of this type are usually only made to the Anglican and Roman Catholic chaplains who have requested that this be done. It is seldom that chaplains of other denominations are called in this manner and usually only at the request of the patient or a member of his family.

The next most frequent contact between the chaplains and another profession is that with the social worker. All chaplains expressed their pleasure of the interprofessional relations which exist between themselves and the social workers in the Social Service Department. From November 1961 to April 1962 bi-monthly meetings between the Social Service Department and the chaplains has meant greater mutual understanding and cooperation between the two professions. They have discussed mutual problems and concerns such as interprofessional referrals, welfare resources in Vancouver and joint planning for boarding home care for elderly patients.

All chaplains agreed that they would be willing to share "personal and social information" about a patient with another profession. The chaplains said they would have to withhold information if it was "given in secret" or if they were bound by the "seal of the confessional." Generally speaking, the chaplains' thinking about this subject reflected the professional code of ethics for social workers:

Respect and safeguard the right of persons served to privacy in their contacts with the agency, and to confidential and responsible use of the information they give.¹

One chaplain spelled out this responsibility in these words: "The social and personal information which is given to a chaplain by a patient is intended not to be told to nobody, but not just anybody." The chaplains usually preface their statements in this regard by saying that they would not mind sharing information with other professions so long as it would be helpful in leading to the patient's recovery. The chaplains did not say who would decide whether the information would be helpful but the implication seemed to be that they themselves would have to see the relevance of information possessed before sharing would be possible.

Referral Patterns Indicated in Three Case Examples

The answers given in the three case examples to the question "To whom might you refer this case?" have shown that the chaplains are primarily Church-oriented with respect to referrals. They suggested the use of a variety of Church agencies (including parish minister, home for unmarried mothers, men's clubs, Church Matrimonial Bureaus and Marriage Counsellors, the Chancery Office and "down town Churches"). Among the community social service agencies which the chaplains suggested for referral were the Departments of Social Welfare at both provincial and municipal levels, Children's Aid Society, Family

¹ "Code of Ethics," in Standards for the Professional Practice of Social Work, New York: American Association of Social Workers, 1951, p. 5.

Service Association, Vancouver General Hospital Social Service Department, Department of Immigration, R.C.M.P., and Catholic Charities.

An examination of the first referral in each case example suggested by each chaplain indicates that 14 referrals were made to Church-sponsored agencies (including parish clergy) and 7 referrals were made to secular social agencies. This same referral pattern is indicated in the suggested referrals made by the theological students. Twice as many first referrals were made to church agencies than to secular welfare agencies.

The Bachelor of Social work students on the other hand, made 21 of their "first choice" referrals to secular agencies and 9 to church organizations.

The chaplains suggested a total of 50 different agencies or professional people to whom they would refer the three cases. Of these, 29 were church-sponsored and 21 were secular agencies. The theological students mentioned 40 possible referrals to church agencies and 34 to welfare agencies. The Bachelor of Social Work students gave a total of 60 possible agencies to which they would consider referral of the three cases. Of these, 40 were to secular welfare agencies.

This indicates that for chaplains and theological students the frame of reference for interprofessional or inter-agency referral is decidedly church-oriented. The secular agency is used only half as much as the church agency. The social work students, on the other hand, are oriented to secular agencies.

Both disciplines feel that their own specialties can handle adequately and effectively the problems illustrated in the case histories.

There is evidence on the other hand, that no small amount of consideration is given to inter-professional referral. Each profession has a regard for the contributions which the other can make.

CHAPTER III

THE CLINICAL PASTORAL TRAINING MOVEMENT

Only the Sham knows everything; the trained man understands how little the mind of any individual may grasp and how many must cooperate in order to explain the very simplest things. ¹

It was Mary Richmond who observed this in her classic description of the casework process at the beginning of the twentieth century. What the emerging profession of social work had to show was that social problems could not be handled in just any haphazard fashion. In order to meet effectively the increasing amount of social problems it was necessary that social workers have the facts of the social situation so that they might make an objective assessment and diagnosis. It was necessary to have a method in their work which incorporated a body of scientific knowledge of human and societal dynamics with a set of values and goals. Social workers were not "born;" they had to be trained in this method of dealing with social problems. Even today, fifty years later, the urgency and necessity of

¹ Richmond, Mary E., Social Diagnosis, Russell Sage Foundation, 1917, from the flyleaf. (Quoting from Hans Gross, Criminal Investigation, translated by Adam and Adam, A. Krishnamachari: Madras, India, 1906.)

training for social work is repeated.¹

Thirty years ago a minister received a training which had changed little in the previous hundred years. The traditions and teachings of the Church were handed on to ministers through an educational process which departed but slightly from such subjects as History, Theology, Liturgics, Greek, Hebrew and Biblical studies. The graduate from these courses was considered prepared to meet the problems that lay ahead for him in the parish. From the turn of the 20th Century, however, the increasing complexities of life and the revolution in the pace of living precipitated many new situations which had to be faced by the minister. Now he found himself faced with stresses in human life caused by a world war, a vast depression, and a widespread bureaucracy in almost every walk of life all of which had led to a depersonalization of much of individual life. Many people had broken under the strain. There was a need for ministers specially trained in understanding the social and psychological factors that wreck mind and nerves and character.

Origins and Development

In 1925 Dr. Richard C. Cabot had seen the unique opportunity which the clergyman had in coming into fact-to-face contact with many of these problems. Further he saw the dire

¹ Morgan, John S., "Social Welfare Services in Canada," in Social Purpose for Canada, edited by Michael Oliver, University of Toronto Press: Toronto, 1961, p. 165.

need for "clinical training" to augment the theological students' education. "When we urge a theological student to get 'clinical experience' outside his lecture rooms and his chapel, to visit the sick, the insane, the prisons and the almshouses," he said, "it is not because we want him to get away from his theology but because we want him to practise his theology where it is most needed, i.e., in personal contact with individuals in trouble."¹ Dr. Cabot was suggesting that every student for the ministry be given a clinical training for his pastoral work similar to the clinical training a medical or social work student receives during his professional education.

Although this essay of the renowned Dr. Cabot in Survey Graphic was one of the most influential writings of the time in promoting clinical pastoral training, it is not to be supposed that he was alone, nor even the first, in thinking of the new idea. Few people realize that the idea of providing seminarians with a clinical experience was first set forth in 1913 at the General Convention of the Protestant Episcopal Church by the Reverend William Palmer Ladd. It was not until 1922 that anything was initiated, however, and it is perhaps significant that the proponent this time was another physician, Dr. William S. Keller, of Cincinnati. He offered to accept a few seminarians and to provide them with first hand experiences with people, under professional supervision, and primarily

¹ Cabot, Richard C., "Adventure on the Borderline of Ethics," The Survey Graphic, December 1, 1925, Vol. 25, No. 5, p. 276.

within the framework of existing community services. Thus in 1923 the Cincinnati Summer School was launched. By 1936 this program was expanded into one year of training.

In yet another person, a contemporary of Dr. Cabot, the Reverend Dr. Anton T. Boisen, there was also the attempt to think through this new concept in theological student training. Boisen, a middle-aged minister, had come through a serious nervous breakdown that had confined him for several months in a mental hospital. He had studied his own case and those of his fellow patients and upon his release he enrolled at Harvard University to pursue the subject of mental illness. At Harvard he found a group headed by Dr. Cabot--eminent men such as Macfie Campbell, William McDougall and Elwood Worcester--all deeply interested in the mentally ill. With their help he prepared himself for a ministry to the mentally ill and, at the same time, for further research which would be used to train future ministers. It is thus that Anton T. Boisen has been called the "Father of the Clinical Pastoral Training Movement."¹

The first opportunity to test the new thinking came when the Worcester State Hospital (2,200 Mental patients) offered the Protestant chaplaincy to Boisen. He soon demonstrated that a chaplain giving full time to an intelligent, daily ministry

¹ Eastman, Fred, "Father of the Clinical Pastoral Movement," The Journal of Pastoral Care, Spring 1951, Vol. 5, No. 1, p. 3.

to mental patients individually and in groups was far more effective than the plan in most hospitals which simply consisted of having pastors of local churches come in on Sundays to conduct a worship service.

That this opportunity for Dr. Boisen was not only possible but amazingly successful is due in large part to Dr. William A. Bryan who was (as Miss Ida Cannon has so aptly described¹ him in her account of pioneering in medical social work) the "extraordinarily uninstitutionalized Superintendent" of the Worcester State Hospital.

In June of 1925 four Theological students came for the summer course given under Boisen's direction in cooperation with the medical staff. The number of students who came for the clinical training increased rapidly. By 1929 a total of 41 students had taken the summer course.

The Council for Clinical Pastoral Training

The growing demand for "clinical training" needed firmer foundation and on January 21, 1930, "The Council for Clinical Training of Theological Students" was incorporated with the adoption of a constitution. The founders² made it clear to every student that he must not think that he was being trained as a junior psycho-analyst or psychiatrist. The Council aimed to accomplish three things:

¹ Cannon, Ida M., On the Social Frontier of Medicine, Harvard University Press, 1952.

² The founders included: Richard Cabot, Henry Wise Hobson, Samuel Eliot, William A. Healy, and Ashely Day Leavitt.

1. To open his (the student's) eyes to the real problems of men and women and to develop in him methods of observation which will make him competent as an investigator of the forces with which religion has to do and of the laws which govern these forces;
2. To train him in the art of helping people out of trouble and enabling them to find spiritual health;
3. To bring about a greater degree of mutual understanding among the professional groups which are concerned with the personal problems of men.¹

Very soon after its incorporation, the Council began experimenting with training programs in institutions other than the three mental hospitals in use. There was a tentative movement into the area of delinquency, with centers first at the Judge Baker Guidance Center in Boston, and later at both the Norfolk, Massachusetts, Prison Colony, and at the Illinois State Training School for Boys at St. Charles. In the summer of 1932 two students were placed at the Massachusetts General Hospital in Boston under the joint supervision of Dr. Austin Philip Guiles and Miss Ida M. Cannon, Supervisor of the Social Service Department. The Reverend Russell L. Dicks, Chaplain at Massachusetts General Hospital worked closely with Dr. Cabot and piloted the general hospital training through its formative stages. Later (1936) the two men (Dicks and Cabot) collaborated on writing The Art of Ministering to the Sick.²

¹ Eastman, Fred, "Father of the Clinical Pastoral Movement," The Journal of Pastoral Care, Spring 1951, Vol. 5, p. 5.

² Richard C. Cabot and Russell L. Dicks, The Art of Ministering to the Sick, MacMillan: New York, 1936.

In 1934 the Federal Bureau of Prisons approached the then Federal Council of Churches with the request that it train and nominate for appointment candidates for a revitalized chaplaincy service for its system. Both organizations turned to the Council for Clinical Training for assistance and in January 1936 the first trained chaplain was appointed to the staff of a correctional institution.¹ Two students were assigned to the Federal Reformatory at Chillicothe, Ohio, that summer. The Bureau soon became the first correctional system to require a period of in-service training for all Protestant Chaplains before permanent appointment, in addition to previous academic and clinical preparation.

Although the founders agreed upon the major objectives of Clinical Pastoral Training, they differed on others. Cabot thought that the main emphasis of the training of students should be placed upon developing ability and skill in dealing with persons afflicted with bodily disorders--the ill or dying, the deaf or blind, the other disabled. He, therefore, advocated that most students be trained in general hospitals.

Boisen, on the other hand, was chiefly interested in mental hospitals where the minister-to-be would come into contact with patients suffering from mental illness. His thinking was that a minister in the parish is dealing all the time with mental health problems and that he meets a large number of persons in the incipient stages of mental trouble.

¹ The Training School at St. Charles, Illinois.

Therefore, he argued, the student should be trained to recognize the illness and help the person in his struggle for mental health.

Meanwhile the movement for the clinical training of theological students grew rapidly. Boisen went as Chaplain at the State Hospital at Elgin, Illinois. From there he was able to continue offering courses in religion and mental health at the Chicago Theological Seminary and also make Elgin Hospital, not only a training centre for the Council, but a base for fundamental research.

Varying Emphasis

In its brief history there have been at least four emphases in clinical pastoral training. The Council attempted to answer the question as to how it might best train the minister to be of help to individuals in trouble. The different phrasings of the question itself symbolize these changes.

In the initial phrase the wording was "What must I do to be of help to the patient or inmate?" Thus students participated in the usual activities of the Chaplain's department, but also in a number of other things considered as integral part of clinical training. They worked on wards, and they organized talent shows in the institution. They supplemented the inadequately staffed social service departments by making home visits. They worked at patient recreation. However, it was not long before the limitations of this were recognized. The patients were confused by the student's quick changes in role, as were the students themselves.

Many left the training center with the concept of the good pastor as a loosely organized combination of social worker, recreation leader, choir director and preacher. ¹

The question then became "What must I know to be of help to the patient?" At this time the emphasis was on collecting information about the patient and writing case histories. The 'case history' approach showed short-comings too. Knowledge alone did not help.

Then the interests switched to pastoral counselling and the question was phrased "What must I say to be of help to the patient?" So the students learned the techniques of recording--"verbatim" and "process"--which were subsequently used in intensive supervision with the Chaplain Supervisor. They studied many techniques--the psycho-analytic, the non-directive, and their variations. Again it was discovered that this was not enough. The patients often responded differently to the same words.

The final phase came in answer to the question "What must I be to be of help to the patient?" This era concentrated on the relationship between the patient and the student. They had realized that, although patients come and go, the one constant was the chaplain or student.

Thus, the clinical pastoral training programs of the Council today center upon the interpersonal relationships between the student and his patients.

¹ Kuether, Frederick C., "The Council for Clinical Training," Pastoral Psychology, October 1953, Vol. 4, No. 37, p. 19.

Because the student, rather than the patient, is the one who wishes to learn how to be of help, the major concern of the training program is with the student. He is asked, and given help, to bring under the closest scrutiny all of his relationships: to the patients who are in his care; to his fellow students and the associates with whom he must cooperate; and to his staff and the Chaplain Supervisor to whom he is responsible. To this end all the resources of the training center are put at his disposal: the intense personal needs of the patient, the insights and techniques of all of the healing arts, and the maturity, experience and skill of the Chaplain Supervisor.¹

The varying emphases or stresses on objectives and goals by the eminent leaders of the clinical pastoral movement lead ultimately to two fundamental differences. Some saw the greatest contribution of clinical training to be the insight the student gained into his own personality and his role as a religious worker. In this sense the training was not only a preparation for an institutional chaplaincy to serve people in severe crisis situations but also "therapeutic" for the student himself. Other leaders emphasized training in terms of the usual parish ministry. The Council favored the former emphasis.

The Institute of Pastoral Care

The latter emphasis found expression in the incorporation of the "Institute of Pastoral Care" in 1944. The "Institute" is a non-sectarian educational foundation which, under the direction of a Board of Governors, sponsors "Summer Schools of Pastoral Care."

As its primary goal, the Institute seeks through its training programs to strengthen contemporary religious

1 Kuether, Frederick C., op. cit., p. 20.

leadership so that the spiritual needs of people can be served more adequately. It strives to help clergymen gain insights and skills which will make their ministry more meaningful.

Secondarily, it provides a coordinated program which helps individuals meet the clinical pastoral training requirements, (1) prescribed for some seminary students, (2) specified for certification as a Professional Hospital Chaplain, and (3) needed for accreditation as a Chaplain Supervisor.¹

The Institute's first Summer School of Pastoral Care was offered at the Massachusetts General Hospital in Boston. The Institute's curriculum follows the traditional clinical pastoral training course with a slight shift in emphasis. In distinction to the Council's orientation to preparation of the institutional chaplain, the Institute emphasizes the parochial ministry and the need of ordained clergymen to benefit from such training. The Institute sees in clinical pastoral training a means of preparing clergymen to serve their parishioners more effectively in this modern day. At the same time they express a concern and recognize their responsibility for training for the institutional ministry and the student-minister wherever it is possible.

The work of the Institute has now expanded to forty-nine² institutions across the United States--general medical hospitals, mental hospitals, correctional institutions and state schools.

1 See Appendices F and G.

2 "Council for Clinical Training, Inc., Clinical Pastoral Training Programs and Member Seminaries by-Region," Journal of Pastoral Care, Vol. XV, No. 4, Winter 1961, pp. 225-230.

Each school is, to all practical purposes, an autonomous self-sustaining unit under the direction of a Chaplain Supervisor accredited by the Institute of Pastoral Care. Most of the courses offered are six weeks in length but many are twelve weeks.

The Council, on the other hand, has expanded to include fifty-three institutions at which clinical pastoral training is offered. Training is available in quarterly periods, three months in length. The first quarter is seen as an "Introductory" period of training. Increasing numbers of qualified applicants are being accepted for one year "General Practice" Internships. A few students qualify each year to continue a second year of "Supervisory Training" residencies. Thus Council centers are open throughout the year to accommodate the growing number of pastors and students who are seeking supervised clinical experience. More than 3,000 persons have been trained by the Council since its inception.

Cooperation between the Council and the Institute

There is a good deal of cooperation and reciprocity between the Institute of Pastoral Care, Inc., and the Council for Clinical Training, Inc., as well as the member theological seminaries and the training centers. There have been attempts¹ to merge the Council and the Institute and organic union is

¹ Burnes, James H., "The Institute for Pastoral Care," Pastoral Psychology, October 1953, Vol. 4, No. 37, p. 23.

desired by some. However, the main obstacle is financial as the training programs are subsidized by the secular institutions where training takes place.

There is, none-the-less, cooperation and agreement between the Council and the Institute respecting the goals of Clinical Pastoral Training.

The following four goals for this training are agreed upon by the two organizations:

1. To enable the student to gain a fuller understanding of people, their deeper motivations and difficulties, their emotional and spiritual strengths and weaknesses.
2. To help the student discover more effective methods of ministering to individuals and groups, and to intensify his awareness of the unique resources, responsibilities, and limitations of the clergy.
3. To help the student learn to work more cooperatively with representatives of other professions and to utilize community resources which may lead toward more effective living.
4. To further the knowledge of problems met in pastoral care by providing opportunities for relevant and promising research.¹

If Clinical Pastoral Training achieves these goals it helps the students see how to make available the resources of religion, its faith and practice, to people in crisis-situations. The student gains a wealth of information as to what people are like in their interpersonal relations, and how his contribution as a religious worker can be meaningful and helpful to them in just such experiences. The training provides the student with

¹ "Opportunities for Study, Training, and Experience in Pastoral Psychology - 1955," Pastoral Psychology, Vol. 5, No. 50, January 1955, pp. 22-40.

an opportunity to become aware of how he approaches people, what his real attitude toward people is and what role he performs for them. It enables the student, as can nothing else, to see people as people, and to see how they handle their difficulties in living. It is a concentrated experience in the laboratory of interpersonal problems.

The Literature of Pastoral Care

Cooperation between the "Institute" and the "Council" is also manifested in the joint publication of The Journal of Pastoral Care. On the twenty-fifth anniversary of the Clinical Pastoral Training Movement in 1950 The Journal of Clinical Pastoral Work and The Journal of Pastoral Care merged in one publication.¹ It is "published" monthly in the interests of sharing experiences and interpretations of pastoral work, interprofessional relationships, the theology of pastoral care, and clinical pastoral training.²

Another journal related to the clinical pastoral movement is Pastoral Psychology which first appeared in February 1950. This monthly journal "grew out of an awareness of a deeply felt need on the part of the minister for insights and skills of dynamic psychology and psychiatry."³ It was thought

1 Both of these journals first appeared in 1947.

2 From the inside cover of the Journal of Pastoral Care, published at Andover Hall, Cambridge 38, Massachusetts.

3 Pastoral Psychology, Editorial, Vol. I, No. 1, February 1950, p. 1.

that these insights and skills could be presented in a way that had immediate and practical application to the minister's work, and within the religious frame work of the pastor's point of view. The first editorial advisory committee included Otis Rice, Charles Holman, Carroll Wise, Paul Maves, Karen Horney, Karl Menninger and Margaret Mead.

Other journals which are related to the subject of pastoral care include: Marriage and Family Living, a quarterly journal published by the National Council on Family Relations, Chicago, Illinois; the Journal of Psychotherapy as a Religious Process, published annually by the Institute for Rankian Psycho-analysis, Inc., Dayton, Ohio; and The Journal of Religion and Health, a quarterly journal of the Academy of Religion and Mental Health, New York 16, N.Y.¹

The Journal of Pastoral Care and Pastoral Psychology are the two most significant journals to the chaplain and the pastoral minister. The former journal is closely integrated with the training centers of the Council and the Institute. For this reason the emphasis of the literature is on the role of the chaplain in various institutions. There are also some articles interpreting the dynamic needs of the patient or parishioner. The "setting" for many of the articles is the hospital and their subject matter bears on special problems

¹ For a more complete listing to periodical literature see: Index to Religious Periodical Literature, distributed by the American Theological Library Association, Princeton Theological Seminary, Princeton, New Jersey.

of physical and mental illness. The Journal of Pastoral Care also contains articles on basic research.

Pastoral Psychology is not specifically designed to meet the needs of clergy who specialize in clinical pastoral work, but rather for all who study the psychology of religion. Thus the journal is not only of value to the minister, whatever his role or position, but to psychiatrists, social workers, and counsellors. The subject matter of the articles in Pastoral Psychology indicates a broad range of topics written by eminent men in the fields of religion, psychiatry, medicine and, to a limited extent, social work. Articles appearing in Pastoral Psychology are repeatedly welcomed for republication in such journals as The Modern Hospital and Mental Hygiene.

The literature of any profession, and especially that of its official journals, is the best guide available to those outside the profession to grasp a working knowledge of a particular profession. The literature records the history of the profession and its struggle for identification, for relevance, for expertise in its subject matter and something of its standard of research. The professional writing describes the developing methods, techniques and skills of the profession and its particular contribution to human life and knowledge.

Something of the contribution of the literature of the Clinical Pastoral Training Movement in developing the new 'profession' role of the chaplain has already been alluded to in the previous chapter. However, so that the implications

of this Movement might be made more articulate, it is expedient to examine closely some of this literature. A particularly relevant publication for this purpose is The Journal of Pastoral Care, Volume X, Number 4, (Winter) 1956.

An article by Archibald F. Ward, Jr., Ph.D., Chaplain, Eastern State Hospital, Williamsburg, Virginia, articulates the "therapeutic role" of the chaplain.¹ In the article entitled "Therapeutic Procedures for the Chaplain" Dr. Ward qualifies the term "therapeutic procedures" as referring to the

non-medical practices and processes which aim at the "treatment" of the person who is (mentally) ill or emotionally disturbed--hopefully to cure, but also to make endurable what is not yet curable; and whenever possible, to receive the grace that redeems the weakness in illness and transforms the person in such a way that he can transcend his difficulty even if he cannot escape it.²

He prefers to think of procedures rather than "techniques" for fear of implying some kind of manipulation. Similarly, the adjective therapeutic is used in his article rather than such nouns as therapy and therapist because the latter two enjoy, and even promote, an extremely ambiguous status. "The adjective therapeutic properly focuses attention upon the nature and quality of the principles in any activity which aims at participation in the healing process."³

1 Ward, Archibald F., "Therapeutic Procedures for the Chaplain," The Journal of Pastoral Care, Vol. X, No. 4 (Winter) 1956, p. 208.

2 Ibid.

3 Ibid.

Dr. Ward suggests that the chaplain, like the psycho-therapist, can succumb to the culturally-conditioned trap of the doctor-patient relationship wherein the doctor is the active participant and the patient the passive recipient of treatment.¹ A great many attitudes must be unlearned before either the chaplain or the psychiatrist (or the social worker for that matter) can do adequate therapy.

The pastor-parishioner relationship, like the doctor-patient relationship, may be summarized in the pastor (or doctor) saying, "What you need to do is thus and so...." The chaplain or psychiatrist, on the other hand, is aware that most sick people have not suffered from any lack of being told what they ought to do or even need to do. The question is pre-eminently one of being able to do what is needful. The role of the chaplain then, becomes one of helping the patient to become able as well as to assist in the definition and clarification of goals. To enter into this kind of therapeutic relationship with the patient involves the active participation of the patient himself and an absence of the "I am the doctor" attitude on the part of the chaplain.

But what is it that the chaplain does with his patient?-- and what is the nature of the process that hopefully results in healing?

Dr. Ward begins by stating the general proposition that the efficacy of the procedure consists in the relationship and

¹ Ward, Journal of Pastoral Care, p. 209.

the consequent process of interaction between two or more persons. But, he notes, some interactions and reactions can be harmful and some helpful. "So we must ask ourselves now, what is the goal of this relationship? What kind of action and inter-action do we want to make possible?"¹

What can hopefully take place in this relationship is communication. Communication is at the very heart of the therapeutic process, he claims. In some senses a person becomes ill because communication has broken down--communication that is, about the significant events and meaning in life. What usually needs to be communicated involves a painful experience. Not simply the experience itself, but the individual's response to that experience and the meaning which it has for him.

The author makes clear that not all of the patient's painful details need to be rehearsed. What the chaplain is after is understanding the pattern of response to life rather than the infinite examples from the past. What is in very special need of communication is feeling. Very often the chaplain can handle the "facts" or content of past painful events more adequately than the feelings which are associated with them. Some of the feelings may be of guilt or shame. What may be much more difficult for the chaplain to handle are feelings almost universally present of hostility, resentment and bitterness.

1 Ibid., p. 209.

But what does the chaplain communicate? First of all, the chaplain communicates understanding, or more properly, the attempt to understand. What the chaplain needs is not simply knowledge (though he indeed needs all the knowledge he can acquire) but rather an attitude and perceptive skill. The chaplain also communicates a degree of permissiveness. Another quality he communicates is acceptance. Permissiveness concerns a particular act, whereas acceptance concerns primarily a person. The concept of acceptance, claims Dr. Ward, is so vast that, "like the love of God, the more we experience it or participate in it, the infinite we discover it to be."¹ To accept the person means also to accept what he is attempting to communicate, and to explore this communication with him at the right time.

Perhaps the most difficult part of acceptance is that we can scarcely accept in others what we cannot accept in ourselves. "The beam in our own eyes hinders the removal of the splinter in the eye of our brother."²

If the chaplain can communicate an attempt at understanding, an appropriate amount of permissiveness, and that acceptance which is love, then it becomes possible for the patient to communicate those feelings and experiences which need to be communicated if healing is to take place.³

Dr. Ward then discusses the question of goals and values and what it is the client wishes to be.

1 Ibid., p. 213.

2 Ibid., p. 214.

3 Ibid.

At this time both the patient and the chaplain will be asking what values are adequate and on what basis do we determine what values are adequate. And what resources are available to help one achieve these values?....

Once again, when we reach this stage of the relationship, the question of freedom and responsibility assumes a new importance. A person who is blind has neither the freedom to see nor the responsibility of seeing; but once we see what we are actually doing, we become free to ask ourselves whether this is what we want to continue--a question which would be quite meaningless so long as we were blind. In other words, we become at last free to accept responsibility for ourselves.

I suppose that the question we naturally ask now is something like this: How does this process differ from other therapeutic relationships? Not that so much, perhaps, as: What is the unique factor about the chaplain's entering into this sort of relationship with his people?

When I say chaplain, I also refer to what the chaplain represents. And here we must talk primarily about what he represents to the sick. Every person who enters into a therapeutic relationship responds at least in part to what the therapist...represents or symbolizes for him. And at various phases in the therapeutic process, the therapist may come to represent various significant persons in the patient's past.

By virtue of his profession, the chaplain has a two-fold symbolic meaning: he represents the divine, and he represents the church or synagogue; both God and man. Not merely man in general, but the culture in which man lives; more particularly, the judgmental and condemnatory part of man's culture as well as, or even more than, the means of grace.

Many sick people have been seriously hurt by their experiences in churches. Some have been seriously hurt by their distorted views about God, or, more properly, by the views about God which have been imposed upon them by others. ¹

When such persons are able to communicate their deepest feelings to the chaplain (which means also that the chaplain's attitude is of such a quality as to make possible such communication), something happens which is different from what happens if the same feelings were communicated to some other person. In fact, the what

1 Ibid., p. 216.

2 Ibid.

varies with the to whom: though the same external facts may be communicated, I think we have to say that the feelings which are communicated about the facts or events depend greatly upon the person to whom they are communicated; and we have to say also that the meaning of the communication is different. So far as the therapeutic efficacy is concerned, it is reasonable to expect, as our own experience has demonstrated, that acceptance by "a man of God" can open the way to the acceptance of God's acceptance of us, and that acceptance by a representative of the church can lead to the hopeful possibility that our fellow men can likewise come to accept us and that indeed we can accept our fellow men.¹

The above account of one article in the literature of clinical pastoral training clearly indicates that the emerging role of the chaplain is receiving considerable scholarly attention. In many similar articles the chaplain's relationship with the patient has undergone close scrutiny. A sincere attempt is being made to assess the dynamics of the relationship and where this relationship may be improved to assist the patient.

But lest the new roles of the "Institutional Chaplain" and the "Pastoral Counsellor" form an "isolationism" apart from the Church, the Editorial in this issue of The Journal of Pastoral Care sounds a timely warning. The editor takes this cautionary measure in view of the suggestions of H. Richard Niebuhr and his associates who had just made a survey of American theological education. The editor notes the necessity to hammer out a theology for pastoral care,

that is rooted in historical revelation. At the same time the classical theologian can well use the help of those whose interests lie in the field of pastoral care in facing up to the relevant questions being asked

¹ Ibid., p. 217.

by our fellow members of the healing team, i.e., social workers, physicians, psychoanalysts, etc. The time is ripe for us to accept the warning of Niebuhr and return it in the form of a challenging invitation to a creative fellowship of correlation.¹

Paul Tillich in his article, "Theology and Counselling," does just such "hammering."² He describes theology and counselling as functions of the Church. "Theology, in its doctrine of the Church, tries to give the theoretical foundations of theology itself and of counselling."³

In the same issue of The Journal of Pastoral Care there is an interesting article by Cordelia Cox, "The Church's Relation to Social Service Students."⁴ The purpose of the article is to discuss some of the elements entering into the relationship of the established Church to students receiving professional training in schools of social work. Miss Cox discusses some motivations students have when choosing social work. She claims that motivations for the choice of any profession are exceedingly complex, with component parts sometimes at variance with one another.

1 "Editorial," The Journal of Pastoral Care, Vol. X, No. 4 (Winter) 1956, p. 238.

2 Tillich, Paul, "Theology and Counselling," The Journal of Pastoral Care, Vol. X, No. 4 (Winter) 1956, pp. 193-200.

3 Ibid.

4 Cox, Cordelia, "The Church's Relation to Social Service Students," The Journal of Pastoral Care, Vol. X, No. 4, (Winter) 1956, pp. 201-207.

It may even be that, lost behind an outworn concept, a ready phrase, or a platitude, the true reason for his (the student's) professional choice is not fully understood by the individual himself.¹

The author suggests that many students in schools of social work are searching eagerly for a "personal and professional philosophy of life which is great enough to encompass the world unfolding before them."²

In the same issue of The Journal of Pastoral Care there is a reprint of an article from Marriage and Family Living.³ The author is Maurice J. Karpf, Consultant on Family and Psychological Problems, Beverly Hills, California. In his article, "Some Guiding Principles in Marriage Counselling," Dr. Karpf lists some sixteen aims and principles in the counselling process. Dr. Karpf elaborates each principle and spells out relevant details respecting the handling of special circumstances in marriage counselling.

Another article describing an original research project is written by Samuel Southard, Th.D., Professor of Pastoral Care, Institute of Religion, Texas Medical Center.⁴ The purpose of his paper, "Religious Concern in Psychoses," is to indicate something of the significance of religion in 170

1 Cox, The Journal of Pastoral Care, p. 202.

2 Ibid., p. 207.

3 Karpf, Maurice J., "Some Guiding Principles in Marriage Counselling," The Journal of Pastoral Care, Vol. X, No. 4 (Winter), 1956, pp. 219-225.

4 Southard, Samuel, "Religious Concern in Psychoses," The Journal of Pastoral Care, Vol. X, No. 4 (Winter), 1956, pp. 226-233.

patients at Central State Hospital, Kentucky. These were patients seen on their first admission by one of the Protestant chaplains in the period 1951-1953. Dr. Southard concludes that neither the particular Protestant denomination of a patient nor the fact of church membership as such was significant in the psychiatric diagnosis of the 170 first admission patients interviews by the Protestant chaplain. Among other conclusions he draws from his study is that,

Certain persons who have been exposed to religious teachings or to church fellowship over a period of time may use religious teachings in the expression of their psychoses or may come into open conflict with a church group as the first break with society. Religion may be the language through which the patient seeks to communicate his emotional disturbances. ¹

This brief review of the literature illustrates that The Journal of Pastoral Care attempts to give an objective and scholarly treatment to the subject matter of pastoral care both for the Institutional Chaplain and the parochial minister. Any of the articles might well be found in journals of social work.

Standards and Accreditation

Clinical Pastoral Training may be termed a supervised experience which provides theological students and clergy with opportunities for intensive clinical study of problems in interpersonal relationships. Or, as Professor Rollin Fairbanks defines it, "Clinical training is the performance of pastoral

¹ Southard, The Journal of Pastoral Care, p. 233.

work under competent supervision, such work being recorded and submitted for evaluation and criticism."¹ It seeks to make clear, in understanding and practice, the resources, methods, and meanings of religion as these are expressed through pastoral care.

There are three levels of training available:

1. "The Student Chaplain" or "Introductory Period of Training."

This consists of the twelve week full-time period of training and is generally considered the norm by both the Council for Clinical Training and the Institute of Pastoral Care. The theological student or clergyman who takes part in this course is required to participate in all the activities of the Chaplain's Department of the Hospital. If at all possible the student is encouraged to live in residence. The courses are designed to be part of the student's preparation for a parish ministry or an institutional chaplaincy depending on the particular emphasis of the training establishment. The course is structured so that the student will gain some understanding of the mentally or physically ill person, the administrative procedures and problems in dealing with such people, and above all, both the pastoral and religious concerns in any ministry to them. In the process of the training experience there is a major focus on the dynamics of interpersonal processes especially as these involve the student.

¹ Hiltner, Seward, Ed., Clinical Pastoral Training, The National Council of Churches, New York, 1945, p. 38.

In order to be accepted for any such program of training, a student must have his Bachelor's degree, have completed at least one full year in a recognized theological seminary,¹ and have been interviewed and recommended by such an accrediting and certifying body as the "Council" or the "Institute."

2. "The Chaplain Intern" or "General Practice Internships"

The second level of training is concerned with men interested in specialized training for a ministry to the physically or mentally ill. It is recognized and stressed by standard-making bodies such as the Council for Clinical Training Inc., The Association of Mental Hospital Chaplains, and the Hospital Chaplains' Association of the American Protestant Hospital Association, that this ministry requires intensive preparation. Hence a period of at least one year in the hospital is demanded for accreditation.

It is required that candidates for training shall have been ordained to the ministry with full college and seminary preparation. No candidate is accepted for training who has not been personally interviewed and recommended.

3. "The Chaplain Resident" or Supervisory Training Residencies"

The third level represents an additional full year of training in the hospital following the initial year as Chaplain

¹ Preference is given to students enrolled in theological colleges or seminaries which are "accredited," "associated," or "affiliated" members of the "American Association of Theological Schools in the United States and Canada." There are 14 such colleges in Canada including Union Theological College, Vancouver, B. C., and the Anglican Theological College, Vancouver, is presently negotiating for affiliation with the A.A.T.S. See: The Twenty-Second Biennial Meeting of the American Association of Theological Schools in the United States and Canada, Bulletin 24, June 1960, for complete listing of accredited Colleges and Seminaries.

Intern. Candidates for training are usually men intending to specialize not only in an institutional ministry, but also to obtain accreditation as "Chaplain Supervisors" of clinical pastoral training programs. In some instances men seek training in order to prepare themselves to teach in the pastoral theology department of a theological seminary. Such training requires additional experience in working with physically and mentally ill patients and an understanding of teaching skills in order to interpret the basic implications of the ministry to the hospital patient.

It must be remembered that this modern emphasis on the approach to pastoral work developed in the secular institutions outside the seminaries before it was brought within them. It is only recently that clinical pastoral training has had close ties with the curriculum of theological colleges or seminaries. A very few schools, Virginia Theological Seminary for example, require the clinical training course for all seminary students. Many schools make it optional for students as one unit of the field work requirement. Any course credit is given by the schools, not by the Council or the Institute.

Some clinical training programs in the seminaries are directly connected with courses offered by the seminary and the direction is shared by a member of the faculty. The course in group therapy at the University of Southern California, for example, includes formal course work, the organization of the students in a group therapy program and work in group therapy .

in a hospital under the direction of a psychiatrist.¹

One of the most outstanding examples of the cooperation between the seminaries and the training centers is that at Houston, Texas. In 1954 the Institute of Religion was established at the Texas Medical Centre which united the resources of the Baylor University School of Medicine and five Texas seminaries. These are: Austin Presbyterian, Brite College of the Bible, Episcopal Theological Seminary of the Southwest, Perkins School of Theology, and Southwestern Baptist. The work of the Institute of Religion is an integral part of the pastoral care department of each of these five seminaries. Students from each seminary receive their "clinical pastoral education" in Houston, but receive credit in their own seminaries for courses taken in the Institute. Provision is made for obtaining B.D., Th.M., S.T.M., and Th.D. degrees. Members of the Institute faculty are chosen by mutual selection and become members of the faculties of each of the five seminaries. The training programs are not only for ministers but also for medical students, nurses and doctors. They offer an opportunity for developing working understanding among all the professions concerned with persons in need of healing.

¹ See Niebuhr, H. Richard, Williams, Daniel D., and Gustafson, James M., The Advancement of Theological Education, Harpers and Brothers: New York, 1957, pp. 123-127. See also: Hiltner, Seward and Ziegler, Jesse H., "Clinical Pastoral Education and the Theological Schools," The Journal of Pastoral Care, Vol. 15, No. 3, Fall 1961.

Curriculum

The content of these courses given in Clinical Training Centres can be described briefly.¹ There are lectures by staff personnel. These present the necessary material to help the student gain some understanding of the patient, and what the hospital does to help him get well. Along with these lectures the student attends staff conferences and in this way has an opportunity to see and hear the therapeutic team at work. The focus of the program is personal contact with patients, primarily through actual interviewing as a chaplain. It comes also in supervised social and recreational contacts inside the hospital and at the community level. There are regular seminars conducted by the chaplain supervisor and medical personnel in which the pastoral and religious concerns of a hospital ministry, the characteristics of physical and mental illness, and the dynamics of personality development are discussed. The

¹ The curriculum of The Institute of Pastoral Care, at Emmanuel Hospital, Portland, Oregon (June 5 - August 25, 1961) requires six book reviews of such books as: Rollo May, The Meaning of Anxiety; Seward Hiltner, The Counsellor in Counselling; H. Flanders Dunbar, Mind and Body--Psychosomatic Medicine. Lectures include such subjects as: "Goals in Planning Calls," "Procedures to be Avoided in Calling upon the Sick," "Emotional and Spiritual factors in Hospitalization," "Ministering to the Critically Ill, the Chronically Ill, the Bereaved," "Pre-operative Calling," "Ethical Problems in Pastoral Calling," and "Alcohol Problems." A minimum of 21 interviews is required of each student followed by verbatim recording for use in supervision periods. Each student must submit a written self-evaluation (following a suggested outline) and an evaluation of the course at the end of his period of training.

course usually includes a required amount of reading to supplement the hospital experience, but such reading is recognized as secondary in importance to the clinical experience itself. Finally, regular personal conferences or supervisory periods are held with each student. These give him the necessary opportunities for further exploration of concerns that could not be dealt with in the more formalized parts of the program.

Expansion of the Movement

The growth and expansion of the Clinical Pastoral Movement in the United States has already been described. This growth has only recently begun to expand to other countries.

In 1958, clinical training achieved mention for the first time in a report of a committee of the Lambeth Conference, not as something familiar, or to be commended, but merely in these terms:

The Committee has taken note of the experiments which have been undertaken...in the United States in providing courses of clinical pastoral training, in which doctors and psychiatrists have been found ready to cooperate.¹

In England the first clinical pastoral training course was undertaken at the Deva Hospital in Chester, a psychiatric hospital of approximately two thousand patients. In previous years short orientation courses of seven or ten days' duration had introduced hundreds of theological students to hospital life, but the name "clinical pastoral training" should not be used for such brief orientation courses.

¹The Lambeth Conference, 1958, S.P.C.K.: London, 1958, Part 2, p. 104.

In New Zealand the first six weeks' course was held in 1959. It has been impossible to determine when clinical training began in India but it is known to have started before 1958. It was pioneered at the Clara Swain Hospital in Bareilly, India. In Australia the first course in clinical training was introduced in February 1961, at Melbourne.

In 1958 the Institute of Pastoral Training was begun in Nova Scotia. The cooperating colleges included Acadia University, Pine Hill Divinity Hall, University of King's College, The Faculty of Medicine at Dalhousie University, the Presbyterian College, and Andover Newton Theological School, Newton Centre, Massachusetts. The annual six week course is interdenominational in scope, and open to all pastors and theological students. The course is given at the Nova Scotia Sanatorium, Kentville, Nova Scotia.

CHAPTER IV

IMPLICATIONS OF RECENT DEVELOPMENTS

The Greek physicians are quite right as far as they go; but Zamolxis...says further, 'That as you ought not to attempt to cure the eyes without the head, or the head without the body, so neither ought you to attempt to cure the body without the soul; and this is the reason why the cure of many diseases is unknown to the physicians of Hellas, because they are ignorant of the whole, which ought to be studied also; for the part can never be well unless the whole is well'.¹

The complexity of the psychological, physical, social and spiritual ills to which human beings are exposed today demands the skills and resources of all those engaged in the helping professions. No longer can the community's needs be served without due regard to the contribution of each profession and its inter-relatedness with each other profession. Perhaps no profession more than social work is aware of this and it behoves the student of social work or the ministry to be keenly aware of this inter-dependence.

¹ The Dialogues of Plato (Jowett Translation), Random House: New York, 1937, Vol. I, pp. 6-7.

Implications for the Churches

It is in the context of the Churches that the implications of this study have special relevance. Too long has the Church attempted to answer the needs of men without the help of the younger professions and their knowledge and experience. These younger professions have arisen partly because needs of mankind were not being met by traditional institutions such as the family and the Church. The Churches, thus, must examine the relevance of social and psychological sciences to their ministry. The theological student needs the understanding of the dynamics of personality no less than the student of social work. This was reiterated by Frank Weil when he said that:

Social workers often feel that pastoral counselling is not sufficiently grounded in knowledge of the social sciences and methods of social work; that there is not sufficient understanding to identify a personality problem of the individual or the nature of a family problem. Hence there is lack of referral from church to social agency and vice versa.¹

The Church ought to make opportunity available to the theological student for a study of the dynamics of personality. In order to do this the Churches have much to gain from the teaching practices used in social work education. The practical training "in the field" should have its corollary in theological education. There is a dissatisfaction

¹ Weil, Frank L., "Co-operation of Church and Social Work," Proceedings of the 76th National Conference of Social Work, 1949, Columbia University Press: New York, 1949, p. 125.

generally on the part of clergymen and theological students regarding their training in counselling and pastoral care. Social work education offers a vast literature and practical experience in such techniques as interviewing, casework, recording, supervision and evaluation. Although social work is a much younger profession it has systematically examined these techniques and its experience and knowledge are not to be lightly regarded by the Churches.

Although this knowledge and experience can be gained by embracing many of the contributions which the social work profession can make to the ministry, it must be remembered that schools of social work do not find their raison d'etre in the training of ministers or chaplains. They are concerned with training social workers. The Church, then, must look at more appropriate resources for training.

It is in the Clinical Pastoral Training movement where such resource is to be found. Church authorities may lightly regard this "up-start" movement in the Church because it has departed from traditional forms and patterns of training for the ministry. But what has changed is the social and economic pace of all people and the Church must provide appropriate training to her ministers so that this ministry may be made relevant. The high standards and professional competence of the Clinical Pastoral Movement commends itself to the considered scrutiny by the authorities of the Churches.

It is of particular significance to the Church that students who have taken Clinical Pastoral Training have almost universally applauded the advantages of this training.¹ For many ministers who have had years of parish experience, the clinical training has revitalized their ministry. They have found the training has answered many of their problems respecting counselling and assisting parishioners. For younger clergymen, the clinical training has equipped them to function as Chaplains in the complex organization of the modern institution with competence and effectiveness. The training has helped them to define their role and to determine their particular objectives in the context of the goals of the total institution.

The heart of the clinical pastoral training program lies in the supervised minister-patient relationship which takes place within the interdisciplinary professional setting of a modern treatment institution. The clinical student (seminarian or minister) is confronted by the patient and his needs and also by his own feelings about the patient. In this process he is confronted, often to his own amazement or pain, by feelings and questions about himself, the relevance of his Christian faith, and the meaning and validity of his role as a Christian pastor. Those responsible in the Church for

¹ Thomas, John Rea, "Evaluations of Clinical Pastoral Training and 'Part-time' Training in a General Hospital," Journal of Pastoral Care, Vol. XII, No. 1 Spring, 1958; and Bruder, Ernest E., and Barb, Marian, "A Survey of Ten Years of Clinical Pastoral Training at Saint Elizabeth's Hospital," Journal of Pastoral Care, Vol. X, No. 2, Summer 1956.

teaching "Pastoral Theology" may well examine this experience in relation to what is presently taught and experienced through traditional education courses.

There is, it seems, only a limited field work experience in the traditional pattern of education of the ministry. There is, too, almost no emphasis on student experience in face-to-face counselling and interpersonal relations. The sterile academic pursuits of the class room must be made relevant by a process of vital personal encounters in the parish or institutional setting. Pastoral theology or "practical theology" (as it is sometimes known) cannot do justice to the seminarian's total preparation except in the context of the supervised minister-patient (or minister-parishioner) relationship.

Experience in all professions has shown that special skills and training in personal relations is required of those charged with responsibility to supervise students. "Age" or "Experience" does not necessarily result in the acquisition of this ability. It requires training in human relations, casework, and dynamics of personality. Just as the "leader" must first have been a "follower," so the "Supervisor" must have been "supervised" before he can effectively fulfill this role.

The prerequisite, then, for the Church is to equip herself with clergy who have been trained in the established schools of Clinical Pastoral Training. These clergy must then

be placed in the strategic teaching posts of the Church including the seminary and the institutional chaplaincy. In Vancouver, for example, there is need for clinically trained chaplains at all general hospitals, prisons, and mental hospitals. These institutions could then be used as training centers for field work placements for training theological students. The pattern of field work placement might well follow that established by the School of Social Work at the University of British Columbia. That is, two days per week "in the field" during the academic term.

A further implication of this study is the need for a Clinical Pastoral Training Centre in British Columbia. The only training centre in Canada at the present time is in the Maritimes, and there is a dire need for a similar centre in western Canada. There is much to be said for establishing such a centre in Vancouver. Not only are there two large seminaries located in Vancouver which train clergymen for British Columbia and western Canada, but there are an unusually large number of treatment centres located near by. Some of the treatment centres that could be used for clinical training are: The Vancouver General Hospital, Oakalla Prison, Haney Correctional Institution, Essondale Mental Hospital, Crease Clinic, St. Paul's Hospital and Shaughnessy Military Hospital. There is also proximity to the University of British Columbia (to which the Theological Colleges are already affiliated) which can offer the facilities of an extensive library and the Department of Religion.

There is the possibility of using the resources of the School of Social Work and especially for the teaching of Human Growth and Development.

It is recognized that these implications require lengthy consideration by the Churches and the respective institutions mentioned above. However, it behoves the Churches of British Columbia to "come to grips" with the potential resources of Clinical Pastoral Training, in the training of their ministers.

Implications for the Vancouver General Hospital

The historic influence which the Church has had in the nurture and development of hospital facilities throughout the world does not require further elaboration. It is sufficient to say that, although the administration of hospitals has largely changed from church direction to secular, the church continues to minister to the spiritual needs of the patient.

In most hospitals this ministration is at best "surface," lacking coordination and having virtually no accountability to hospital administration. At the Vancouver General Hospital under the present regulations anyone may fulfill the chaplain's role so long as they are recommended by a church authority. There needs to be a close examination of administrative policy and procedure to enable that the hospital personnel make appropriate and effective use of the chaplain.

The Vancouver General Hospital may also examine the facilities it offers to the chaplain to "perform religious

rites and rituals." Much of the chaplain's time is spent in counselling but no office space is provided. There is no central office to facilitate referral from the doctors, social workers and nurses. None of the chaplains suggested that a chapel be provided in the hospital but all of them mentioned the extreme difficulty occasioned by the lack of office facilities.

The chaplains expressed pleasure at the recently instituted bi-weekly meetings between themselves and some members of the Department of Social Service at the Vancouver General Hospital. They felt there was much to gain from the social workers and expressed the hope that this inter-professional contact would continue. Similar meetings between chaplains and medical doctors, psychiatrists and nurses could be patterned in like manner. This would increase understanding of each other's contributions and of one another's inter-professional role.

The main implication of the study for Vancouver General Hospital, however, is the focus it draws to the advantages to the hospital and patient which might result from having a fully trained clinical chaplain on the staff. Such a chaplain at Vancouver General Hospital would have to be fully integrated into the administrative structure and with the professional services given at the hospital (See Appendix F). Not only would a trained chaplain be valued as a competent resource for referral from various professions but he would be an agent for

coordination of all chaplaincy services at the hospital. He could give orientation to new chaplains and conduct "in-service training" to present chaplains. This latter training may well follow that used in many social work agencies in training the non-professional social worker. He might also be used as a chaplain-supervisor for theological students doing "field work" at Vancouver General Hospital, and as a resource for social work students studying social agencies and community services in Vancouver. This would necessitate integration of a Chaplain's Department with courses and training offered at the School of Social Work and the Theological Colleges affiliated with the University of British Columbia. A greater expansion of such a program would be the institution of a Clinical Pastoral Training Centre at Vancouver General Hospital. This might be designed to meet the clinical training needs of British Columbia clergy and possibly as a training centre for western Canada.

Although implementation of the foregoing implications for the Vancouver General Hospital would no doubt encounter difficulties they are not insurmountable. The "ground work" has been done in various general hospitals in the United States and in some state-operated hospitals in Canada.

Implications for Social Work

It may well be asked what relevance the preceding chapters have to the profession of social work. Is not the role of the chaplain of peculiar interest to religious bodies? The answer to this lies in the basic "holistic" concept of man

to which the social worker attaches much significance. Man cannot be seen from the point of view that he is a "segmented being." He is not just 'parts'. He is the sum of the parts. Man is a totality and the "part can never be well unless the whole is well."

Such considerations as these lead the enquirer into the realm of goals or objectives of social work. It is said that social work seeks to assist individuals, groups, and communities to reach the highest possible degree of social, mental, and physical well being.¹ The methods that social work applies to achieve this goal differ from those of other professions, such as medicine, law, the ministry, nursing, and teaching, because social work operates in consideration of all social, economic and psychological factors that influence the life of the individual..² Such an attempt to consider all factors influencing the lives of people cannot ignore some of the factors in life or the definition becomes invalid. Moral, religious and ethical values are inevitably part of social, economic and psychological factors. Nor can social work ignore the problem which is posed in the question, "What is the highest possible degree of well-being to which social work aims?" Or, "What is life's purpose?"

1 United Nations Economic and Social Council, Training for Social Work: An International Survey, 1950, p. 10.

2 Friedlander, Walter A., Concepts and Methods of Social Work, Prentice-Hall: Englewood Cliffs, New Jersey, 1958, p. 7.

"For clients, for workers, for young people just emerging to manhood and womanhood, for adults in the prime of life, the old in their declining years, this searching question of life's purpose persists. To it social work must somehow find some answer, else the saving of life and of material goods, and the release of personality from inhibition and from conflict will still leave empty, restless, unsatisfied individuals."¹

Does social work, then, consider man in his totality?² Man has a mind and a body; has he a spirit and a soul? And if he has, how often is it taken into account in social work practice?

There has been, for the most part, cooperation between psychiatry and social work. Social work has an indisputable place among mental health professions. Likewise, social work, since the beginning work done by Dr. Richard Cabot, has been an important member of the medical hospital team. There is more and more realization of the contribution that social work can bring to human problems.

There is, however, an inconsistency, an alienation between the church and social work. Because of the scientific emphases of medicine, psychiatry and social work, these disciplines have tended to discount the spiritual aspects of man's

¹ Lenroot, Katharine F., "Fundamental Human Needs Facing the Social Worker Today," The Family, Vol. XVI, No. 4 (1935), p. 102.

² Sladen, Kathleen, The Question Arises, Master of Social Work Thesis, The University of Toronto: Toronto, 1957, p. 5.

being. As one man has put it,

The alienation of the church and social work may be attributed in large measure to the fact that training for social work in the established schools...is tied to those social sciences that claim little connection with religious philosophy.¹

This is not imply, however, that there is a gulf between the professions of the ministry and social work that cannot be crossed. The roots of social work go too deeply into the Judeo-Christian heritage to suggest that. But recently much more has been said about the relevance of religion to social work. Charlotte Towle believes that,

...spiritual needs of the individual must also be recognized, understood, and respected. They must be seen as distinct needs and they must also be seen in relation to other human need.²

And herein lies the crux of the matter. The spiritual needs of the person must be recognized. The social worker must be able to perceive the spiritual need of the client even as he is trained to perceive the bio-psycho-social needs of the client. For "society owes him, through the social worker, the help he truly needs, rather than the help he specifically asks."³ The social worker does not fulfill his professional

1 Weil, Frank L., "Co-operation of Churches and Social Work," The Social Welfare Forum, National Conference of Social Work, 1949, Columbia University Press: New York, 1950, p. 126.

2 Towle, Charlotte, Common Human Needs, National Association of Social Workers: New York, 1957 (Original publication 1945), p. 8.

3 Pray, K., "Restatement of General Principles of Social Casework Practice," Journal of Social Casework, Vol. XXVIII, No. 8, p. 286.

competence if he does not recognize the spiritual needs of his client, and does not offer interpretation and the opportunity for appropriate spiritual help. The fact that a client may not "see" his need initially is hardly a valid reason for its virtual negation by the social worker. Sometimes it would appear that so great has been our concern for client self-determination that the fear of imposing something upon the client has prevented us from fulfilling as well as we might the educational role inherent in social work goals. ¹

Gordon Hamilton says, "We believe in the wholeness of individuals and the interdependence of society, national and international, cultural, economic and spiritual."² Most social work literature, however, denies the latter, although some social workers view the religious need as the most vital of all.

Social workers may agree that the immediate extrinsic end of their work is a better adjustment of the individual to all parts of the environment, but the statement is meaningless outside the context of what is 'better'. That is a question which in the final analysis must perforce be answered in terms of some meaning, some purpose to human life. There can be no standards of adjustment or adaptation to an environment, there can be no bad, better or best, there can be no measure or evaluation without an answer to the fundamental question: To what end does man live in this or any environment? What is the purpose of human life? Essentially this is a religious question and ultimately social work must find the answer in

¹ Bowers, Swithun, "Social Work as a Helping and Healing Profession," Social Work, Vol. II, No. 1 (January 1957), p. 58.

² Hamilton, Gordon, Theory and Practice of Social Case Work, Columbia University Press: New York, 1951, p. 4.

the sphere of religion. For try as we will, we cannot divorce the ultimate objectives of society from the question which is basic to all religion--What is man? Where lies his destiny?¹

Social work, by its very nature as a helping profession, must necessarily consider the total nature of man. This is basic to its practice. For social work's specific goals will vary directly with its view of the "wholeness of man."²

What, then, are social work's ultimate objectives? Canadian social workers have apparently done too little in examining their philosophy³ and "...perhaps more time and attention should be given to religion as a factor in human life,...in social organization and in social work practice...."⁴

The training for this practice begins at a School of Social Work. It is here that first consideration can be made to make available to the student the training necessary for the social worker to perceive the spiritual needs of a client. Just as the social worker is trained to recognize social, physical and psychological needs, so he must be able to recognize spiritual needs. This latter recognition cannot be assumed nor taken for granted any more than the former.

1 Bowers, Swithun, "The Nature and Definition of Social Casework," Part II, Journal of Social Casework, Vol. XXX, No. 9, p. 375.

2 Sladen, Kathleen, op. cit., p. 10.

3 Touzel, Bessie, The Moral Foundations of Social Work, - a series of two lectures delivered at the Fourth Western Regional Conference of Social Work, Regina Saskatchewan, July, 1953, p. 3.

4 Spencer, Sue, "Religion and Social Work," Social Work, Vol. I, No. 3, July 1956, p. 26.

Training is needed. This is a first implication of the clinical pastoral training movement. That is, these ministers of religion, physicians, and psychiatrists (in the Clinical Pastoral Training Movement) have shown that spiritual problems can be dealt with more effectively with a method of diagnosis but only when there is a clear perception of the needs expressed. These methods may well be examined with a view to being incorporated into the training of the social workers.

Clinical Pastoral Training has given a new dimension to inter-professional relations in terms of the confidence the health professions have in the clinically trained chaplain. His training in human growth and development, the practical experience and intensive supervision, the methods of recording, the conscious use of his relationship as chaplain in an institution, and his awareness of inter-professional team work, gives the chaplain a competence which is recognized by the health professions. He is regarded as a member of the treatment team.

In British Columbia, it is of particular importance that social workers give lively consideration to what they may gain for their client through the availability of the clinically trained chaplain. The social worker would be assured of a competent handling of the client he referred to the latter. Much pioneering work needs to be done.

Not only has social work something to gain, it has something to give. Social workers and the School of Social

Work are the main agents in this province through which the social sciences find practical and tested application. The social worker's education and his profession is one of society's main institutions answering human need. The resources of social work education might be made available to the theological student. Without training the latter cannot adequately assess the needs of people any more than social workers can assess spiritual needs without training. Those engaged in the training of ministers must take due regard of the techniques of social work training. The training of the minister would be effectively enhanced by training techniques such as the practical interview, supervision, recording and self-evaluation. Because social services are so diverse and complex, the minister of religion needs some introduction to this wide topic. The chaplain's referral patterns indicate scanty appreciation of the agencies available to serve his "parishioners."

The Church and its ministry has begun through Clinical Pastoral Training to search out the contributions which social and medical science can make to understanding of individuals and their society. The Church to a limited extent in clinical training has applied some techniques of training including the clinical conference. Herein the contributions of each discipline are given. Not only does the "holistic" view of man find expression in this technique, but there are decided advantages for the patient in terms of understanding of his case. In view of this it is not surprising to learn that there is a very real

rapport being established between some medical doctors, psychiatrists and ministers. So much so that the editor of the British Medical Journal of January 24, 1959, was moved to remark that medical practice in Britain must consider "Catching up with Cabot."

The survey of literature respecting the two professions of social work and the ministry indicates that the church is exploring social work to a considerable degree. This is also suggested by Miss Skenfield in her recent study.¹ She had discovered more literature from Church sources than from social work. Although this trend cannot be completely accounted for in the Clinical Pastoral Training Movement, its influence must be recognized. The articles published in Pastoral Psychology and the Journal of Pastoral Care are of high standard. Social workers may use these journals as resource material in coming to a better inter-professional understanding between the ministry and social work.

To take advantage of the implications of this study one must not lose sight of the fact that all professions exist to serve the "client," the "patient," and the "parishioner." The obstacles which limit inter-professional cooperation must not be allowed to deter efforts to seek ways and means of cooperation. The perfection of the service offered to the patient should be the constant goal of all professions.

¹ Skenfield, Alfreda, Social Worker and Minister in Welfare Services, Master of Social Work Thesis, University of British Columbia, 1960.

APPENDIX A

HOSPITAL CHAPLAINS AND OFFICIAL VISITORS QUESTIONNAIRE

IDENTIFICATION

Name and Title _____
Name of denomination represented _____
Are you a Hospital Chaplain: Part-time _____; Half-time _____; Full-time _____
Are you paid for this work? _____
If 'yes', by whom? _____
When did you begin work at this hospital? _____
Do you visit other hospitals? _____; Which? _____
Were you a (full/half/part-time) Chaplain in another institution before coming to this hospital? _____; If 'yes', where? _____
Did you receive any orientation to this hospital when you began work here? _____. If 'yes', from whom? _____
Name of this hospital _____

EDUCATION AND TRAINING

- A. Academic (circle highest year completed)
High School 1 2 3 4 Undergraduate major _____
Undergrad. College 1 2 3 4 Undergraduate degree _____
Graduate Education in Theology From To (dates) Degree/Dip.
Seminary years 1 2 3 4 _____
Year Ordained _____
Other Graduate Professional School _____
- B. Did your undergraduate or theological education include courses in Pastoral Counselling? _____
If 'yes', do you consider this training: _____ adequate
_____ helpful
_____ inadequate
- C. Have you taken Clinical Pastoral Training? _____
If 'yes', how long was the course? _____; Where held? _____
- D. Have you received special training in another discipline? (check)
Psychology _____; Casework _____; Sociology _____; other _____
- E. Do you think a course in Hospital Chaplaincy should be given in the Vancouver area? _____. Please comment: _____

APPENDIX A (Continued)

COUNSELLING

- A. How many people did you visit in hospital in one recent month? _____
- B. How many people did you see in hospital for counselling? _____
- C. What was the focus of counselling during this period?:

	I	F
Alcoholism _____		
Bereavement _____		
Drug Addiction _____		
Grave Illness _____		
Religious Instruction _____		
Religious explanation _____		
Religious support: _____		
before operation _____		
prayer _____		
sacraments:baptism _____		
Mass or Holy Comm'n _____		

	I	F
Housing _____		
Vocational Training _____		
Occupational Prospects _____		
Financial Need _____		
Marital Relations _____		
Parent-child Relations _____		
Schooling/educational _____		
Mental Health _____		
Recreational activities _____		
Other(please describe) _____		

"I" Considered Individually;

"F" Considered in a Family Context

- D. From the above list, please select the three most common problems you have had contact with; list in order of predominance:

- E. What do you consider to be the most valuable aid(s) you bring to help the hospital patient on the road to recovery? _____

- F. Do you think you could help the patient more if you knew his medical diagnosis _____

- F. Would you be willing to share personal and social information about a patient with another profession? _____
- If 'yes', would you hold any limits(comment)? _____

- G. Do you think the Chaplaincy has any special skill or knowledge to help the Treatment Team of the Hospital? _____.If 'yes', describe briefly: _____

APPENDIX A (Continued)

REFERRAL

- A. Did you refer any patients to other professions last month? _____
If 'yes', TO WHOM? HOW MANY? (Month _____)
- | | | |
|---------------|-------|---------------------|
| Psychiatrist | _____ | _____ |
| Medical Dr. | _____ | _____ |
| Nurse | _____ | _____ |
| Teacher | _____ | _____ |
| Social Worker | _____ | _____ |
| Lawyer | _____ | _____ |
| Other | _____ | _____ Specify _____ |
- B. Did you receive any referrals in the above month from other professions? _____. If 'yes', HOW MANY? FROM WHOM?

- C. Have you ever discussed the patient's illness or problem with his doctor? _____
- D. Do you refer patients to their parish minister? _____
If 'yes',
(a) Who does this?: self ____; wife ____; volunteer ____; secretary ____
(b) How is this done?: letter ____; telephone ____; personal visit ____
(c) About how many referrals are made in one month? ____
(d) How much of your time does this take? _____ hours per week.

JOB DESCRIPTION

- A. How many hours do you spend at your work in one week? _____
- B. How many hours do you spend at this hospital in one week? _____
- C. Do you have professional duties elsewhere? _____
What are they? _____
- D. Where is your study or office located? _____
- E. Do you conduct Public Worship Services? _____
If 'yes', Where? _____. When? _____
- F. Do you visit patients outside your own denomination? _____

CASE ONE

APPENDIX B

SAMPLE CASE HISTORIES

Mrs. A., a 28yrs. old mother, has just given birth to her third child, but expects to be in the hospital for some time because of a Caesarian Section and further medical complications. Her mother has been looking after the other children while she is hospitalized. Mrs. A. has asked you to come to see her as she wanted to speak to you about her husband who has been drinking excessively. Her husband is coming to see her tomorrow afternoon and she wonders whether you will speak to him. She says that her husband's well-paying job will be lost if he doesn't 'straighten up' as his Company has given the last warning. This is more serious as the marriage is also likely to break up because Mrs. A. says she doesn't know how she can carry on under the strain and especially now with the new baby. Mrs. A. states, "You see it really goes back to before we were married. I was brought up in _____ Church and my parents were very much against me marrying someone who was nominally of another faith. But I went ahead anyway." The Church had been very meaningful for her but she left it behind on the assumption that marriage came first. They have never attended church since marriage and now the oldest children are of school age they are of age to be attending Sunday School and Church instruction. This issue about the children attending Church activities has been raised mostly by Mrs. A.'s parents who are now in town looking after the children. Mr. A. resents their interference. It has been during this recent period that Mr. A. has resorted to more drinking than ever.

CASE TWO

Gordon, age 25yrs., has been a patient in the hospital for almost five months but has in no way identified his religion. However, he has just requested you to come to see him and he tells you that he has been receiving physio-therapy on his foot and is now almost ready to leave the hospital. He mentions that he has had a lot of time to think about life but now wants some advice. When you ask him what it is he tells you that when he returned from Germany (where he served with the Canadian Army and where he hurt his foot) he brought back a German girl friend whom he was going to marry when he got out of hospital. However, since then he says he has found he does not love her and she has been suggesting the same thing on her part. However, she is almost six months pregnant by him and he doesn't know what to do. The girl friend has been working in a small cafe in the kitchen department and has not learned English. Although Gordon has a fairly good paying job to go to when discharged, he has not any money saved up at the moment. He especially wants to know how he can help his former fiancée. He appears genuinely distressed about this whole situation and asks you if you think God will ever forgive him for this mistake.

CASE THREE

Whilst returning one morning to a men's ward in which you had left your brief case the day before, you are requested to come to the bedside of an old man, Mr. B., age 71, who has been admitted since you were last there. He tells you that he was knocked down by a car late last night just before he was to board the bus for his home at Aldergrove. (about 50 miles from Vanc.) He is now very worried about his wife as she does not know how to fill the oil burner, which is a daily task, and they have no telephone so he cannot contact her. This is even more complicated because his leg is broken and he won't be able to leave the hospital for at least two months. Although he has been getting the Old Age Security pension his wife is only 64 yrs. old and is not eligible. Mr. B. tells you that he has been supplementing his income by part-time janitor work at his Church in Aldergrove but he says he can't expect to get this while he is in hospital. When you ask him what Church it is, he indicated a denomination other than yours. He is quite distressed by this whole situation and wonders whether you can help in any way.

APPENDIX C

NAME _____
DENOMINATION _____

HOSPITAL
CHAPLAIN'S
STATISTICS

N.B. THESE STATISTICS APPLY ONLY TO THE VANCOUVER GENERAL HOSPITAL
(Give the total numbers for each day in the appropriate spaces provided)

DATE MARCH	No. of visits V.G.H.	Patients seen for Counselling	Referrals to Parish Clergy	Ref. to other * Professions	Ref. from other * Professions	Hours spent at VGH	Religious Services, Inter-Prof., Denom., meetings attended. (Describe)
SUNDAY 11th							
MONDAY 12th							
TUESDAY 13th							
WEDNESDAY 14th							
THURSDAY 15th							
FRIDAY 16th							
SATURDAY 17th							
SUNDAY 18th							
MONDAY 19th							
TUESDAY 20th							
WEDNESDAY 21st							
THURSDAY 22nd							
FRIDAY 23rd							
SATURDAY 24th							
TOTALS							

*List which professions referred to: _____
referred from: _____

Return to: R.D. MacRae
6050 Chancellor Blvd.
Vancouver 8, B.C.
Phone: CAstle 4-9020

APPENDIX D

COMPARISON OF STUDENT BACKGROUNDS (Social Work, Theology)1. IDENTIFICATION:

Faculty _____ Age last birthday _____
 M ____ F ____ Are you married ____; If 'yes', How long ____; How many children do
 you have ____.

2. EDUCATION:

A. Academic (circle highest year completed)

High School	1 2 3 4	Undergraduate University Major	_____
Undergraduate College	1 2 3 4	Undergraduate Degree	_____
Post Grad. years	1 2 3 4	From	To (date) Degree
Theology		_____	_____
Social Work		_____	_____
Other Graduate or Professional Training		_____	_____

B. Content

(1) Did your theological education include courses in Pastoral Counselling?

Yes _____ No _____

If 'yes' do you consider this training: adequate _____ Helpful _____
 inadequate _____.

(2) Have you taken Clinical Pastoral Training? Yes _____ No _____

If 'yes', how long was the course? _____ Where held? _____

(3) Have you received special training in another discipline? Yes _____ No _____
 psychology _____; casework _____; sociology _____; other? _____

3. CASE EXAMPLES:

A. Theology Students answer cases in the order: 1, 2, 3.

Social Work Students answer cases in the order: 3, 2, 1.

B. Mark each case clearly: e.g. "case #1."

C. Read only one case at a time, and complete your remarks before proceeding to the next case.

D. Treat each case as a separate entity, and write down all remarks applicable to each case.

E. Assuming that you are a Social Worker or Chaplain at the Vancouver General Hospital comment how you would handle each situation, with specific reference to:

(1) Your initial reaction to the presenting problem.

(2) How confident or qualified you feel in discussing this problem with the individuals involved.

(3) The agencies or persons that may be consulted, including consideration of possible referrals and other people or agencies.

APPENDIX E
THE VANCOUVER GENERAL HOSPITAL
APPLICATION AS VISITING CLERGYMAN

I hereby apply to be named a Visiting Clergyman at
The Vancouver General Hospital:

Name: _____

Address: _____

Phone: _____

Denomination: _____

Service you plan to render patients in this Hospital?

If accepted as a Visiting Clergyman at The Vancouver General Hospital, I agree to abide by the rules and regulations of the Hospital at present in force and those which may be subsequently promulgated by the Board of Trustees.

Signature: _____

Date: _____

Endorsed by Superior: _____

(For Departmental Use Only)

STANDARDS FOR THE WORK OF THE CHAPLAIN IN THE GENERAL HOSPITAL
Officially Approved 1950 by the
AMERICAN PROTESTANT HOSPITAL ASSOCIATION ¹

INTRODUCTION

It is the intention of the Committee on Accreditation to state the minimum training and experience required of a clergyman seeking appointment as a full time chaplain, and to describe goals and practices normally expected of him. This statement is prepared for hospital administrators, boards of directors, medical staffs, and church authorities who desire a high quality of religious work within their institutions and wish to strengthen and improve their chaplaincy service.

A. THE ACCREDITED CHAPLAIN

It is essential that anyone who is to serve as a chaplain should be properly qualified. In order to assist hospital administrators and others charged with the responsibility for selection hospital chaplains the AMERICAN PROTESTANT HOSPITAL ASSOCIATION has established the following minimum standards for accreditation of chaplains:

1. College and seminary degrees or their accepted denominational equivalent.
2. Ordination or appropriate ecclesiastical endorsement and evidence of current good standing within a denomination.
3. A significant period of clinical pastoral training such as a minimum of twenty-four weeks (960) hours or its equivalent and written recommendation by the instructor of the center attended.

This training to have been obtained in a general hospital with a psychiatric service or in a general hospital, mental and/or correctional institution. "Equivalent" may be interpreted by the Committee on Accreditation to mean (a) graduate academic degrees in Pastoral Psychology, Pastoral Counseling, Clinical Psychology, Social Relations and other related fields, (b) publication of significant books in the field of ministering to the sick and (c) other outstanding contributions. Until January, 1955, some latitude in interpretation rests with the Committee on Accreditation. Training centers which subscribe to the general objectives listed below and provide acceptable courses of training may seek recognition by a committee to be created for that purpose.

4. Three years of parish experience or its equivalent. "Equivalent" may be interpreted by the Committee on Accreditation to mean a total of five years' experience in such position as the following: Chaplain in the Armed Services; student pastor, or student religious worker; teacher, lawyer, doctor, social worker, or counselor.

¹ Johnson, Paul E., Psychology of Pastoral Care,
Abington Press: New York and Nashville, 1953, Appendix A, p. 337.

Members of the APHA may apply for accreditation by supplying evidence to the Executive Director of the APHA (or whomever he may designate) that they have complied with the Minimum Standards for Accreditation listed above, or by January 1, 1950 have served not less than five years as a hospital chaplain and have fulfilled all but one of the "Standards".

Non-members of the APHA shall pay an Accreditation Fee of ten dollars. An individual who fulfills part of the requirements for accreditation and has made arrangements to complete them may apply for a temporary endorsement entitled, "In Process of Accreditation".

The general objectives of clinical pastor training centers are as follows:

1. To enable the student to gain an understanding of people - their deeper motivations and difficulties, their emotional and spiritual strengths and weaknesses.
2. To help the student develop effective pastoral methods for ministering to people, and recognize his unique resources, responsibilities, and limitations as a religious worker.
3. To help the student learn how to cooperate with representatives of other professions and utilize community resources for achieving more effective living.
4. To encourage in the student a desire for that further understanding which is to be obtained by appropriate and pertinent research.

B. THE APPOINTMENT OF THE CHAPLAIN

The chaplain should be appointed by the hospital Board of Directors on the recommendation of the hospital administrator. The three most common ways of selecting a chaplain for appointment are:

1. A church authority nominates an accredited candidate.

In a denominational hospital, the denominational authorities make the nomination. In a non-sectarian or state-supported hospital, the local or state church federation or council of churches or other authorizing agency make the nomination. The hospital administrator and Board of Directors then appoint or reject the nominee.

2. A special chaplaincy committee is appointed to nominate an accredited candidate.

The hospital administrator then accepts or rejects the nominee.

3. The hospital administrator presents a candidate to his Board of Directors.

Final appointment is made by the hospital Board of Directors only after accreditation and church endorsement have been obtained.

Whether the chaplain is paid entirely or only in part by the hospital or his salary is furnished by an outside organization, the hospital should have the final authority to accept or reject a candidate for hospital chaplaincy; the appropriate ecclesiastical authority should bear the responsibility for nominating the candidate.

C. THE CHAPLAIN'S RESPONSIBILITY TO THE ADMINISTRATOR

Because of the complex religious situation in any community the hospital chaplaincy should be carried on by the chaplain in close relationship with the administrator and a special committee on religious activities composed of two or more members of the hospital Board of Directors.

Regardless of the source of the chaplain's salary he should be answerable to the hospital administrator and the Religious Activities Committee for the quality of his work and the expenditure of his schedule. The chaplain as the head of a recognized service in the hospital organization should have that personal access to the hospital Board of Directors possible for the head of any other service.

The chaplain should present written descriptive reports of his activities to the administrator and the Religious Activities Committee at stated intervals.

D. COOPERATION WITH OTHER HOSPITAL PERSONNEL

The chaplain works best as an integrated member of a team headed by the attending physician. As such he is better able to direct his skills and resources toward the spiritual needs of a patient than when working alone. Although the chaplain should acquaint the physician with any pertinent information which may have come to his attention, nevertheless the chaplain reserves the right to respect the confidential nature of information given by a patient in the spirit of confession. While not every patient seen by the chaplain needs to be discussed with the physician, such consultation between physician and chaplain will often occur.

As a rule, the chaplain will spend most of his time with those patients who are under severe physical or mental stress, or have especially difficult personal, social, or spiritual problems; therefore the major portion of his energy and effort will normally be devoted to a selected number of patients.

E. SOURCES OF REFERRAL

In a general hospital the chaplain can minister intensively to about forty patients; some of whom he will see daily, others on alternative days, the rest perhaps once a week. This means he makes an average of fifteen pastoral calls every day, in addition to speaking with scores of individuals. Experience has shown the following sources of referral to be most common:

1. The physician asks the chaplain to call on his patient.

These should be selective referrals: that is, persons with definite and, usually, acute need. Some hospitals have found that when the chaplain makes rounds periodically with the attending physician, he is not only introduced in his professional role, but is shown persons in need of his care who might otherwise have been missed.

2. A nurse, social worker, or other hospital employees asks the chaplain to call on a patient.

While it would be best to have the physician request the chaplain to call upon his patient, it has been found that other personnel also have opportunity to observe a patient's spiritual condition and refer the patient to the chaplain, who, if the need arises, discusses the patient with the attending physician.

3. A relative or friend asks the chaplain to call on a patient.

On such occasions the relative becomes a part of the chaplain's professional responsibility.

4. The patient's parish minister asks the chaplain to call.

Courtesy requires the chaplain to report to the referring minister that the call has been made. Cooperation between the hospital chaplain and the local clergy is helpful not only to the patient, but also to the hospital as a means of fostering the confidence of the patient and family.

5. The patient asks to have the chaplain call.

A letter or folder distributed to patients after they are admitted stating that the hospital has a chaplain who will call on anyone who asks for him, and announcing the place and time of scheduled religious services within the hospital may lead to this request.

6. The chaplain is notified in cases of critical illness (DL) and death.

In addition to calling on and ministering to the patients referred to him, chaplain can take the initiative and discover many patients who need his care. The admitting officer is usually the first person to see the patient officially. If the chaplain has a good working relationship with this officer, information on the admission slips can often be most helpfully interpreted to the chaplain. For example, a patient from a distance may not be visited frequently by the family and friends, a patient facing surgery, especially when it may mean severe illness, prolonged convalescence, or a difficult post-operative adjustment needs special care; and an aged, isolated or indigent patient may face peculiarly complicated problems. Some patients will have courage to reveal their spiritual needs only if they have had opportunity to observe and get acquainted with the chaplain while he is doing general visiting.

F. THE CHAPLAIN'S RECORDS

Detailed records enable the chaplain to minister more effectively, facilitate research aimed at improving and enhancing the value of his work, form the basis of confident and effective teaching, and become the indispensable source of his periodic reports to the hospital administrator and Religious Activities Committee. They may take the following forms:

1. The entry may be made on a sheet filed in the medical record folder. This may consist of a notation of the day, hour, and length of the call, or it may be a brief note of the principle topics of conversation.
2. The chaplain may keep a notebook or card index record. This may contain information which helps him identify patients and recall significant data about them.
3. More elaborate records are filed in the chaplain's office. Such records are detailed, and usually follow a standard outline. They are designed to help objectify the patient's needs to the chaplain's mind, to show him what gains have been made, or what strengths and resources have been tapped, and to point up his mistakes and failures.

G. WORSHIP IN THE HOSPITAL

Patients in a hospital need the best ministry the community can provide. All scheduled religious services should be either led by the chaplain or arranged through him. Young people's societies and missionary groups should only be brought into the hospital under careful supervision and for the purpose of making a recognized contribution to the patient's welfare. Ordained persons, commissioned workers, and recognized qualified and responsible visitors should be permitted to call upon the patients of their acquaintance. All other "religious" workers should be directed to the chaplain's office for screening. Some of them should be encouraged, instructed, and supervised so their efforts will be constructive; others should be tactfully discouraged.

In all general or open services denominational emphasis should be avoided since highly ritualistic programs, proselyting, and fervid revivalism (especially in a hospital setting) fail to serve the larger Christian goals. In order to make general services available to a large number of patients, some means of broadcasting the services to the bedside is needed. Then, if the patients wish to listen, they may do so by turning on the broadcasting system or earphones. The preaching should be simple, comforting, dignified, and practical. In any case, worship conducted at the bedside is usually more important and meaningful than a service a patient attends. The chaplain's office should be equipped with a Communion Set, Bibles, prayer and other devotional books and pamphlets, so that the chaplain can give the patient whatever ministry is needed.

H. CONCLUSION

Where sickness and suffering are concentrated, spiritual needs are felt more acutely. In ministering to patients and their families the chaplain is concerned with aiding recovery if he can; nevertheless, restoration of physical health is not his major field. Rather, his mission is to personalize the vitality of the Christian religion.

Although the chaplain's main function is ministering to patients and their families, this is not all he contributes to the hospital. While the administrator forms the attitudes of the workers and the general atmosphere of the hospital, the chaplain can have a definite influence on the morale and well-being for many members of the staff and employees and in special circumstances may serve as the official personnel counselor. In addition he can be useful as counselor for student nurses, advisor on religious activities for the School of Nursing and classroom lecturer. As an unofficial good-will ambassador, the chaplain can be valuable to the hospital as a builder of vital public relations. He will endeavor to minister to the spiritual needs of all who enter the hospital. If because of differences in Faith or for other reasons his ministry is not acceptable to a person, he will be prepared to call in who-ever is needed.

Through his understanding and poise, word and deed, he seeks to encourage one, relieve another of worry, aid a third to bear suffering, break the grip of despair for a fourth, gain serenity for one facing death, and to comfort the bereaved; so that individuals may be led to personal growth, deeper understanding of their fellows, and increasing consciousness of God.

COMMITTEE ON ACCREDITATION

James H. Burns, Chairman
Carl J. Scherzer, Secretary
L. B. Benson, exofficio
John M. Billinsky
Albert G. Hahn
Everett R. Plack
Bryce L. Twitty

Standards for Clinical Pastoral Education Adopted by the National
Conference on Clinical Pastoral Training, October 1, 1952 ¹

I. DEFINITION OF CLINICAL PASTORAL EDUCATION

Clinical pastoral education is an opportunity for a theological student or pastor to learn pastoral care through interpersonal relations in an appropriate center, such as a hospital, correctional institution or other clinical situation, where an integrated program of theory and practice is individually supervised by a qualified chaplain-supervisor, with the collaboration of an interprofessional staff.

II. QUALIFICATIONS OF THE CHAPLAIN-SUPERVISOR

1. Graduation from an accredited theological school upon the completion of a three-year graduate course beyond the bachelor's degree or its equivalent.
2. An adequate period of pastoral experience, with ordination and denominational approval.
3. At least one year full time of clinical pastoral education, and in addition three months of supervised clinical teaching.
4. Professional competence including graduate studies, past experience, and demonstrated performance.
Graduate degrees in appropriate fields with clinical orientation are recommended and may be evaluated as follows:
Six months' credit toward clinical education may be given for an appropriate doctor's degree. Three months' credit may be given for an appropriate master's degree.
5. Personal qualifications to be appraised by an accrediting committee in a face-to-face interview.

III. REQUIREMENTS FOR THE CLINICAL TRAINING CENTER

1. A chaplaincy service which is well established and recognized as a functioning part of the center, with a chaplain accredited as a supervisor (see II).
2. A progressive institution, oriented toward therapy or rehabilitation, serving an adequate number of patients or inmates accessible to the chaplain's program, maintaining an interprofessional staff available for continuous teaching of theological students.

- a. General appreciation within the institution of the role of a chaplain, recognition of theological students as functioning members of the chaplain's department, and adequate opportunity for them to work in significant and appropriate clinical tasks.

¹ Johnson, Paul E., op. cit., Appendix B., p. 337.

- b. An alert and cooperative administration and staff, who will be ready to assume responsibility for implementing the clinical program.
3. Maintenance should be provided for students in training, or such provisions as may be comparable to the internship programs of other professional groups in the institution.

IV. MINIMUM ESSENTIALS OF CLINICAL PASTORAL EDUCATION

1. A supervised practicum in interpersonal relations.
2. Writing of clinical notes for consultation with the chaplain-supervisor.
3. A continuing evaluation of the student's experience and growth to be offered during the training period.
4. Frequent association with an interprofessional staff who are genuinely interested and qualified to teach students.
5. Adequate provision for group discussions, seminars, and other group experience for all students.
6. A continuing concern for an integration of psychological, ethical, and theological theory with practical understanding of the dynamics of personality and facility in interpersonal relations.
7. A written evaluation of his experience to be made by the student to his chaplain-supervisor at the end of the training period.
8. A final summary evaluation of the student's work and capacities to be written at the end of the training period by the chaplain-supervisor, discussed with the student, and with his knowledge made available to the appropriate responsible parties.

V. MINIMUM PROGRAM RECOMMENDED FOR CLINICAL PASTORAL EDUCATION

1. For the theological student who is preparing for the parish ministry :
 - a. An introductory course to clinical pastoral care during the entire academic year, with one day per week at an accredited center and under the direction of an accredited chaplain-supervisor who is a functioning member of the staff of the center; and
 - b. Clinical pastoral education for twelve weeks, full time.
2. For the student who is seeking a master's degree in pastoral care, at least six months' clinical pastoral education, full time.
3. For the advanced student preparing for the teaching of pastoral theology and pastoral care, an appropriate doctor's degree with at least nine months, full time, of clinical pastoral education, and in addition three months of supervised teaching of pastoral care.

VI. SPECIAL CONSIDERATIONS

1. For pastors and other religious workers seeking additional training:

- a. Full-time participation in clinical pastoral education for six to twelve weeks is recommended.
- b. Where this is not possible, participation in orientation programs at an accredited center is recommended.

2. For chaplains serving full time, at least twelve months' full-time clinical pastoral education is recommended, six months of which are to be in the type of institution which he serves. Where this standard has not yet been attained, hospital administrators are encouraged to release their chaplains periodically for the necessary training.

APPENDIX H
BIBLIOGRAPHY

Books

The Air Force Chaplain. Department of the Air Force, Washington, D. C., Air Force Manual No. 165-3.

Belgum, David, Clinical Training for Pastoral Care. Westminster Press: Philadelphia, 1956.

Book of Common Prayer Canada 1959. Cambridge University Press: Cambridge, 1959.

Cabot, Richard C., What Men Live By. Houghton Mifflin: Boston and New York, 1914.

Cabot, Richard C., and Dicks, Russell L., The Art of Ministering to the Sick. McMillan: New York, 1936 (Re-issued 1947).

Cayton, H. R., and Nishi, S. M., The Churches and Social Welfare. Vol. 2, National Council of the Churches of Christ in the U.S.A.; New York, 1955.

Cannon, Ida M., On the Social Frontier of Medicine. Harvard University Press: Harvard, 1952.

Cross, F. L., The Oxford Dictionary of the Christian Church. Oxford University Press: New York, Toronto, London, 1958.

The Dialogues of Plato (Howett Translation). Random House: New York, 1937.

Elliott, Mabel A., Crime in Modern Society. Harpers and Brothers: New York, 1952.

Friedlander, Walter A., Concepts and Methods of Social Work. Prentice-Hall: Englewood Cliffs, New Jersey, 1958.

Fox, A. H. Purcell, The Church's Ministry of Healing. Longmans, Green and Company: New York, 1959.

Hamilton, Gordon, Theory and Practice of Social Case Work. Columbia University Press: New York, 1951.

Hiltner, Seward, (Editor) Clinical Pastoral Training. The National Council of Churches: New York, 1945.

Hofmann, Hans, The Ministry and Mental Health. Association Press: New York, 1960.

Index to Religious Periodical Literature. Princeton Theological Seminary, Princeton. (Biennial publication.)

The Lambeth Conference 1958. S.P.C.K., London, 1958.

Niebuhr, H. Richard; Williams, Daniel D., and Gustafson, James M., The Advancement of Theological Education. Harper and Brothers: New York, 1957.

Maves, Paul B., (Editor), The Church and Mental Health. Charles Scribner's Sons: New York, London, 1953.

Oliver, Michael, Social Purpose for Canada. University of Toronto Press: Toronto, 1961.

Richmond, Mary E., Social Diagnosis. Russell Sage Foundation: New York, 1917.

Social Welfare Forum. National Conference of Social Work, Columbia University Press: New York, 1951.

Standards for the Professional Practice of Social Work. American Association of Social Workers: New York, 1951.

Stephen, Karin, The Wish to Fall Ill. Cambridge University Press: Cambridge, 1933 (Paper back edition 1960).

Stroup, Herbert Hewitt, Social Work, An Introduction to the Field. American Book Company: New York, 1948.

Taft, Donald R., Criminology, A Cultural Interpretation. MacMillan: New York (Revised edition) 1950.

Towle, Charlotte, Common Human Needs. National Association of Social Workers: New York, 1957 (Original publication 1945).

United Nations Economic and Social Council, Training for Social Work: An International Survey. United Nations: New York, 1950.

Wise, Carroll A., Pastoral Counselling, Its Theory and Practice. Harpers and Brothers: New York, 1951.

Witmer, Helen L., Social Work: An Analysis of a Social Institution, Farrar and Rinehart: New York, 1942.

Articles

Annual Report of the Director of Corrections for the Year Ended March 31, 1961. (British Columbia), Queen's Printer: Victoria, 1961.

Barry K., "The Catholic Chaplain." The Canadian Nurse, The Canadian Nurses' Association: Montreal, Vol. LVII, No. 12 (December), 1961.

Benda, Clems E., "Bereavement and Grief Work." The Journal of Pastoral Care, Vol. XVI, No. 1 (Spring), 1962.

Bonet-Maury, G., "Hospitality (Christian)." Encyclopaedia of Religion and Ethics, James Hastings, Editor.

Bowers, Swithun, "Social Work as a Helping and Healing Profession." Social Work, Vol. II, No. 1 (January), 1957.

Bowers, Swithun, "The Nature and Definition of Social Casework Part II." Journal of Social Case Work, Vol. XXX, No. 9 (September), 1949.

Burns, James H., "The Institute of Pastoral Care." Pastoral Psychology, Vol. IV, No. 37 (October), 1953.

Cabot, Richard C., "Adventure on the Borderline of Ethics." The Survey, Vol. IV, No. 5 (December), 1925.

"Council for Clinical Training, Inc., Clinical Pastoral Training Programs and Member Seminaries by Region." The Journal of Pastoral Care, Vol. XV, No. 4 (Winter), 1961.

Cox, Cordelia, "The Church's Relation to Social Service Students." The Journal of Pastoral Care, Vol. X, No. 4 (Winter), 1956.

Eastman, Fred, "Father of the Clinical Pastoral Movement." The Journal of Pastoral Care, Vol. V, No. 1 (Spring), 1951.

Finnegan, Hugh, "The Chaplain and His Work." The American Prison Association Proceedings, 1934.

Gluckman, R., "The Chaplain as a Member of the Diagnostic Clinical Team." Mental Hygiene, Vol. II, No. 37 (April), 1953.

"Helping the Dying Patient." National Association of Social Workers, New York, 1960.

Heron, James W., "The Ideal Chaplain from the Superintendent's Point of View." American Prison Association Proceedings, 1928.

Hiltner, Seward, and Ziegler, Jessie H., "Clinical Pastoral Education and the Theological Schools." The Journal of Pastoral Care, Vol. XV, No. 3 (Fall), 1961.

"The Institute of Pastoral Care, Inc., Clinical Pastoral Training Centers." The Journal of Pastoral Care, Vol. XV, No. 4 (Winter), 1961.

Karpf, Maurice J., "Some Guiding Principles in Marriage Counselling." The Journal of Pastoral Care, Vol. X, No. 4 (Winter), 1956.

Kennedy, Natalie, "Helping the Dying Patient and His Family, Part 3." National Association of Social Workers: New York, 1960.

Kirk, T. E., "The Role of the Chaplain in a Hospital." Medical Services Journal, Vol. XVII, No. 10 (December), 1961.

Kuether, Frederick C., "The Council for Clinical Training." Pastoral Psychology, Vol. IV, No. 37 (October), 1953.

Lindemann, Erich, "Symptomatology and Management of Acute Grief," American Journal of Psychiatry, Vol. XI, 1944.

Lenroot, Katharine F., "Fundamental Human Needs Facing the Social Worker Today." The Family, Vol. XVI, No. 4, 1935.

McKnight, E.T.A., "A Chaplain Interprets his Work." The Canadian Nurse, The Canadian Nurses' Association: Montreal, Vol. LVII, No. 12 (December), 1961.

"Medicine and the Church." A Statement Approved by the Council of the British Medical Association, British Medical Journal, November 8, 1947.

Mental Health Services Annual Report 1961, Department of Health Services and Hospital Insurance, Queen's Printer: Victoria, 1962.

Morgan, John S., "Social Welfare Service in Canada." Social Purpose for Canada, Edited by Michael Oliver, University of Toronto Press: Toronto, 1961.

Morris, Albert, (Editor), "What's New in the Work of the Church and the Chaplain in Correctional Institutions?" Correctional Research, A Publication of the United Prison Association of Massachusetts, Boston, Bulletin No. XI (November), 1961.

"Opportunities for Study, Training and Experience in Pastoral Psychology." Pastoral Psychology, Vol. V, No. 50 (January), 1955.

- Parsons, Talcott, "Mental Illness and 'Spiritual Malaise': The Role of the Psychiatrist and the Minister of Religion." in The Ministry and Mental Health, Edited by Hans Hofmann, Associated Press: New York, 1960.
- Pray, K., "Restatement of General Principles of Social Casework Practice." Journal of Social Casework, Vol. XXVIII, No. 8, 1947.
- Ross, Matthew, (Editor) Survey of Mental Health Needs and Resources of British Columbia, Queen's Printer: Victoria, 1961.
- Southard, Samuel, "Religious Counselling in Psychoses." The Journal of Pastoral Care, Vol. X, No. 4 (Winter), 1956.
- Spence, Sue, "Religion and Social Work." Social Work, Vol. I, No. 3 (July), 1956.
- Strunk, Orlo, and Reed, Kenneth E., "The Learning of Empathy: A Pilot Study." The Journal of Pastoral Care, Vol. XI, No. 4 (Winter), 1957.
- Tillich, Paul, "Theology and Counselling." The Journal of Pastoral Care, Vol. X, No. 4 (Winter), 1956.
- Touzel, Bessie, The Moral Foundations of Social Work. Fourth Western Regional Conference of Social Work, Regina, Saskatchewan, July, 1953.
- The Twenty-Second Biennial Meeting of the American Association of Theological Schools in the United States and Canada. Bulletin 24, June 1960, Union Theological Seminary: Richmond, Virginia, 1960.
- Walsh, James J., "Religion and Health." The Catholic Encyclopaedia, Vol. VII, 1910.
- Ward, Archibald, F., "Therapeutic Procedures for the Chaplain." The Journal of Pastoral Care, Vol. X, No. 4 (Winter), 1956.
- Weil, Frank L., "Co-operation of Churches and Social Work." The Social Welfare Forum, National Conferences of Social Work 1949, Columbia University Press: New York, 1950.
- Whiting, Henry J., "Current Emphasis in Casework Under Religious Auspices: Integration of Casework and other Programs." Social Welfare Forum, National Conference of Social Work 1951, Columbia University Press: New York, 1951.
- Weiss, David, "The Ontological Dimensions in Social Casework." The Social Worker, Vol. XXX, No. 1 (January), 1962.

Wise, Carroll, S., "The Place of Clinical Training in the Department of Pastoral Theology." The Journal of Pastoral Care, Vol. V, No. 1 (Spring), 1951.

Unpublished Works

Collier, Elizabeth A., The Social Service Department of the Vancouver General Hospital: Its History and Development 1902-1949. Master of Social Work thesis, University of British Columbia, 1950.

Sladen, Kathleen, The Question Arises: A study on Social Work and Religion. Master of Social Work thesis, University of Toronto, 1957.

Skenfield, Alfreda, Social Worker and Minister in Welfare Services. Master of Social Work thesis, University of British Columbia, 1960.

Standards for Mental Hospital Chaplaincy, Association of Mental Hospital Chaplains, 1953 (Mimeographed Brochure).