

Clinical Pastoral Identity and the College of Registered Psychotherapists of Ontario

Bob Bond, June 2014

As Ontario MIND-, SOUL-, EMOTION-, RELATIONSHIP- AND/OR BEHAVIOR-CAREGIVERS do our respective ‘dances’ relative to the College of Registered Psychotherapists of Ontario (CRPO), some practitioners dancing in and others identifying themselves as out, there are identity issues and concerns cropping up all over. This paper addresses two areas of identity conflict, intending that better understanding will move participants towards ever-wiser decision making. The first identity issue is global ... *every* psychotherapy modality entering the CRPO is caught up in it. The second conflict zone is currently dividing the Ontario membership of the Canadian Association for Spiritual Care (CASC).

I. Psychotherapy and the Diagnostic and Statistical Manual of Mental Disorders (DSM)

Just about every *not quite yet regulated* MIND-, SOUL-, EMOTION-, RELATIONSHIP- AND/OR BEHAVIOR-CAREGIVER in the province looks at the controlled act of psychotherapy upon which the CRPO is built and questions – *deeply* questions – their belonging and identity.

There is a story behind this predicament, whose highlights read like this: In the autumn of 2005, the Ontario Coalition of Mental Health Professionals (OCMHP) submitted an extensive position paper to the Ministry of Health and Long Term Care (MOHLTC), arguing for the regulation of psychotherapists by Title Protection, and debating against regulation by way of a Controlled Act. In 2006, the Health Professions Regulatory Advisory Committee (HPRAC) wrote its official recommendation to the MOHLTC, also arguing against regulation via Controlled Act and, on their part, suggesting regulation via an Enforceable Scope of Practice (which suggestion the OCMHP vigorously opposed). In spite of every audible-to-the-public voice then directed towards the Minister’s ear clearly singing the same “No Controlled Act” song (and you may remember the summer and autumn of 2006 were full of OCMHP lobbying), lo and behold the 2007 legislation was built upon a Controlled Act!

Concluded by us at the OCMHP table was the realization (with multiple pieces of evidence provided by our lobbyist) that the fiercest voice heard by the Minister, somewhere in the back hallways, was actually that of the MOHLTC’s College of Psychologists, whose overarching interest was ‘turf protection’: If Psychologists could have kept everyone but Psychologists from doing (their version of) psychotherapy, they would have been very satisfied. What they did achieve were (a) regulation of psychotherapy via Controlled Act, and (b) a Controlled Act written using a DSM framework.

It is the Psychologists whose focus is treating Disorders which only they (alongside Psychiatrists) get to specify. Meanwhile, the vast majority of Psychotherapists, practicing

in any one of 30+ modalities in the province beyond Psychology, are focused on the *person* (or couple, family, group) rather than the “Disorder”, and – using the language of Cultural Anthropology – are intent on *healing* rather than “treatment” and curing.

Which is to say that the vast majority of Ontario’s Psychotherapists have found ourselves in the awkward situation of (a) being within the Scope of Practice of Psychotherapy (as described, from out of the medical model, in the legislation), (b) knowing we are dealing with seriously life-diminishing complexities in our clients’ lives, and (c) fully supporting the need to protect the public because our malpractice would harm them, yet (d) not feeling ‘at home’ inside the language and philosophy of the Controlled Act.

At the OCMHP [and thereafter the Ontario Alliance of Mental Health Practitioners (OAMHP)¹] and the Alliance of Psychotherapy Training Institutions (APTI), the determined, persistent, constructive response to such eventualities has been to “work with them!”.

So it was that, when the legislation (finally) was introduced by the Minister of Health, seeing that - despite the imperfections - *we certainly could live and work with it*, and recognizing worse possibilities if the legislative process got derailed by an election or hung up in some review that might move it further in a direction espoused by HPRAC or by the College of Psychologists (or by some other interest), we advocated strongly for the legislation quickly to be made law ... and many of you will remember taking part in that letter-writing campaign.

Similarly, now, in the spirit of “working with it”, what can and shall happen, we believe and intend, is that we (of the 30+ modalities) *will* populate the College (because we *are* the province’s psychotherapists and so we *belong* there) and then evolve it. An immediate “for instance” of our ownership might well be a helpful definition of “psychotherapy” (and other significant terms, like “counselling”) ... you will recognize that, to this point, the Transitional Council has deferred to definitions previously offered by HPRAC.

What must not happen, we at OAMHP and APTI tables agree, is for awkwardness / bumpiness to keep us out of our own institution!

II. Pastoral Care Specialists as Registered Psychotherapists

CASC is experiencing a more focused identity debate wherein some Chaplains (Specialists in Pastoral Care) are drawing broad distinction between a practice of Pastoral Presence on the one hand and Psychotherapy on the other. Offered here, in response, is reflection on Supervised Pastoral Education and the ‘product’ it certifies.

¹ Ontario Alliance of Mental Health Practitioners (OAMHP) is the new name, since 2012, of what previously was called the Ontario Coalition of Mental Health Professionals (OCMHP)

This discussion has a prerequisite: *Particularly* for CASC members who did not attend the “Hot Topics” session in Winnipeg, please first work your way through the presentation, “An Overview of the Legislation, And Consideration of the Question, ‘Am I In? Or Out?’”, which is the entry *two below the current one* on the CASC website page <http://www.spiritualcare.ca/page.asp?ID=37> [The “Overview” takes you through the defining factors (for us) of the legislation, plus relevant material from HPRAC, and simultaneously creates a scope of practice diagram.] Necessary from this review, in order to engage what follows, is familiarity with Figure 1 <see below> as it represents the provincial Acts Ontarians must obey.

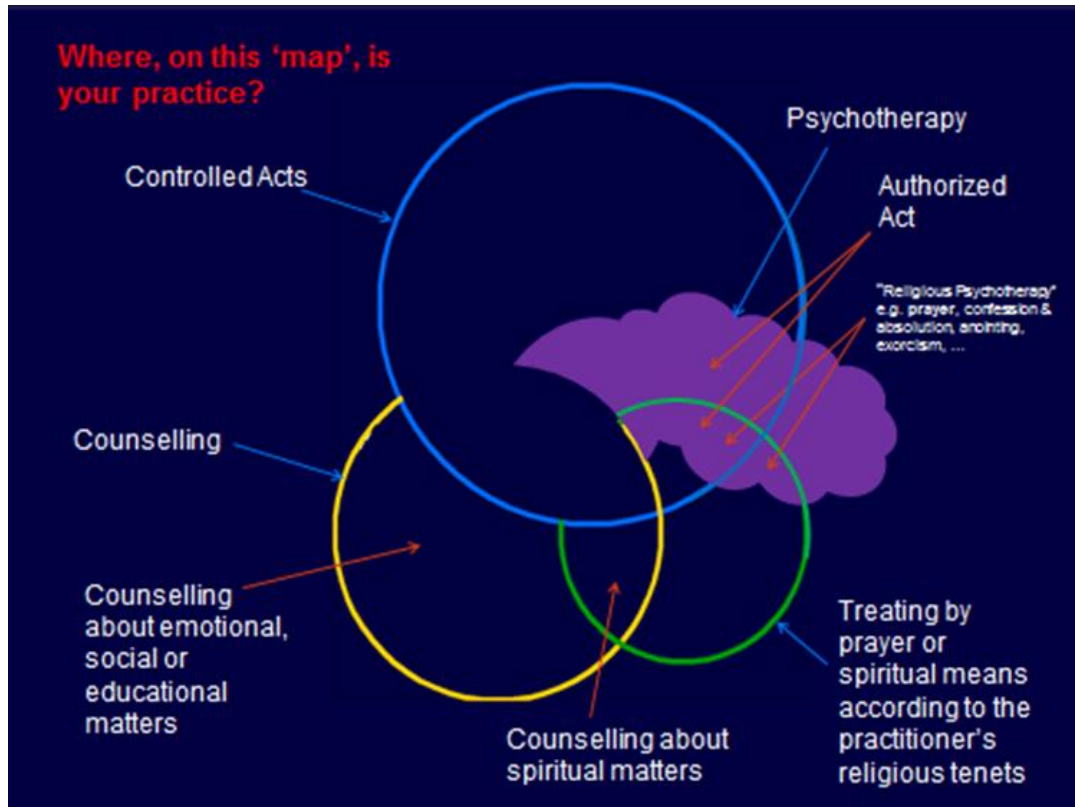


Figure 1

It is perhaps somewhat surprisingly the case that Figure 1 can be used to map the trajectory of Supervised Pastoral Education (SPE): the place where students start and the place where SPE brings them. Touching base with SPE’s origins in the man and the work of Anton Boison reveals this directly; consideration of the evolution of a student’s “safe and effective use of self” serves to confirm the matter.

a. Why SPE? – a historical reminder

Anton Boison writes of his first psychiatric hospitalization:

I was very happy to find that there were religious services on Sunday afternoons. But I soon discovered that the ministers from the neighboring village who conducted those services might know something about religion, but they certainly knew nothing about our

problems. They did no visiting on the wards – which may not have been entirely their fault, as they probably received little encouragement to do so. All they did was to conduct a formal service on Sunday afternoons, and for lack of anything better they usually gave us the same sermons they had given their own congregations in the morning. ... [One minister] preached on the text, “If thine eye offend thee, pluck it out.” I was afraid that one or two of my fellow patients might be inclined to take that injunction literally.²

Here Anton and his fellow patients were being cared for by what seminaries produced as ready-to-serve clergy, at that time (of course) void of clinical training. What we look back and witness, correspondingly, is “ministry” based, in entirety, within the ‘green circle’ zone of Figure 1.

In a 1948 paper, “The Minister As Counselor”, Boison continues to lament the behaviours of non-clinically trained practitioners. The case of Bernard C., a bright college student, is described and analyzed. Concerning the religious caregivers who had been involved with Bernard before his hospitalization, Boison writes:

They might have done him a real service by helping him to recognize and grapple with a serious accumulation of unassimilated experience, and by doing so before catastrophe had become an accomplished fact. Where [they] were at fault was in the lack of adequate individual attention. When Bernard was aroused and eager to do something about his situation, he was left to shift for himself, and the minister whose guidance he sought seems to have had nothing better to offer than occupational therapy. He set him to work singing in his choir, when what he actually needed was intensive psychotherapy.³

Seward Hiltner writes about Boison’s ever-sharpening ‘life mission’, based in his theological formation and responding to his experiences of and observations about mental illness:

... there was the conviction, growing out of his personal experience and his studies of psychiatry and the social sciences, that theology was method as well as content, and that the study of “living human documents” was an indispensable aspect of that method.⁴

Boison himself writes, in 1936, about his programmatic work:

While this project began with the service of the mentally ill, and while the great majority of our students go first to a mental hospital, the scope of the undertaking has been broadened to include other of the infirmities of mankind, such as are concentrated in our prisons, reform schools, child guidance clinics, general hospitals and almshouses. It is our plan to provide adequate supervision of these students not just by placing them in the care of the present type of specialist; we insist upon the guidance of someone who is engaged in exploring these fields of human experience from the specific angle of the student of religion. We are concerned to get light upon the causation, upon the treatment, and upon the implications of

² Anton T. Boison, *The Exploration of the Inner World*, (Harper Torchbook 1962) pp 5f

³ Anton T. Boison, “The Minister As Counsellor”, in *Vision From A Little Known Country – A Boison Reader*, (Journal of Pastoral Care Publications, Inc., 1992), p 101

⁴ Seward Hiltner, “The Heritage of Anton T. Boisen”, in *Vision From A Little Known Country – A Boison Reader*, (Journal of Pastoral Care Publications, Inc., 1992), p 139

such experiences for the problems and laws with which theology is concerned. Without such supervision it is our policy not to open any new center.⁵

David A. Steere summarizes:

Boison was convinced that the church must give attention to a ministry in the personal crises of life. Here we encounter the two central thrusts of his thought. First, there was a conviction that empirical study of certain types of mental illness would yield new understandings of the nature of religious experience and open avenues to an informed ministry of pastoral care. Second there was a belief that such studies would inevitably reinforce the fundamental structures of traditional theology as bearing an authoritative message for the sin-sick soul.⁶

Boison's own writing, on the impact of Clinical Pastoral Education (at a basic level, for every student intending to do ministry):

We are seeking to help the students, through the study of pathological manifestations, to understand the problems of so-called normal people, and the nature and function of religion in their lives. ... It is our conviction that effective psychotherapeutic work can be done without any advertising of the fact by anyone who has the necessary understanding and that no one has greater need for such understanding and no one has it in his power to do more effective work in the prevention of mental difficulties than the adequately trained representative of that profession which for centuries has been chiefly concerned with the inner adjustments of men.⁷

As to specialized care-giving fully formed through CPE, at the Twenty-Fifth Anniversary Conference of the Council for Clinical Pastoral Training (October 1950, University of Chicago), Boison offered a credo “[summarizing his] central convictions”, which rises to this climax:

The aim of psychotherapy is ... to remove the sense of alienation by restoring the sufferer to the internalized fellowship of the best and thus setting him free to strive for his true objectives in life.⁸

Let us recognize, then, from CPE's very origins, that (using Figure 1) the place where CPE (and PCE) takes the learner – who began in the ‘green circle’ zone – is out into the ‘purple cloud’ of psychotherapy. Getting out of the ‘green circle’ zone is the whole object, in fact, because the operation of religion's instruction, advise, direction and encouragement does not connect with, let alone address, case-specific human need.

⁵ Anton T. Boison, The Exploration of the Inner World, p 251

⁶ David A. Steere, “Anton Boisen: Figure of the Future?”, in *Vision From A Little Known Country – A Boison Reader*, (Journal of Pastoral Care Publications, Inc., 1992), p 188

⁷ Anton T. Boison, The Exploration of the Inner World, pp 262f

⁸ Anton T. Boison, Out of the Depths, (Harper & Brothers, 1960) p 197

b. The evolution of “the safe and effective use of self”

Across the past year, I’ve twice written and posted about CPE’s/PCE’s formation ‘trajectory’, though primarily in terms of the student’s evolution of “safe and effective use of self”. Lifting from documents posted on the CASC website:

Charged, as the pastor of St. John By The Gas Bar church is, with ‘keeping the faith’ so that the “flock’s” beliefs and practices, values and conduct are all “orthodox”, that pastor can be expected to do HPRAC’s Spiritual Counselling ... a whole lot! The pastor’s “effective use of self” will be to be as persuasive, charismatic and inviting as can be mustered. “Safe use of self” means adamantly sticking to orthodoxy [i.e. “to the faith”].

To take a clergyperson and evolve him/her into a spiritual care provider / chaplain / CASC “pastoral counsellor”, his/her knowledge and skillset must evolve, but most particularly his/her whole equipment around “the safe and effective use of self” must be done completely over.

*CASC is clear that until a practitioner has developed and integrated the equipment to accompany a person who wrestles **with everything including their deepest faith based beliefs, shattering all of it if necessary in order to build something current, grounded, whole and true to self**, (until this is possible) the practitioner is un-certifiable and can only practice under clinical supervision leading to certification. <emphasis added>*

c. Clinical Pastoral Identity

Upholding the historical framing of our movement, and the trajectory intended by our training, are important factors when deliberating professional identity. To take a lesser stand on “pastoral identity” within the ‘green circle’ zone is to miss the whole intent and genius of CPE (and PCE), which is to take practitioners (a) expert in the exegesis of sacred text and have them (b) obtain the clinical expertise to offer this exegetical skillset to “living documents” who seek self-understanding and self-actualization, knowing these two exercises (‘a’ and ‘b’) *together* comprise uniquely qualified “soul care” / psychotherapy ... this is our “clinical pastoral” identity, and – as a full package – it ought not be lost or reduced by any of us.

d. Interpretations and Statements from the CRPO

Having achieved this clarity, next we have to remain “as wise as serpents and as gentle as doves” in attending to what is ‘coming at us’ from the Transitional Council of the CRPO. Early in the College development process, the Toronto Anglican Diocese and Roman Catholic Diocese gained assurances that their clergy working as “chaplains” and “pastoral counsellors” would not be affected by the College. Aligned with this agreement, in October 2013, the CRPO Registrar wrote CASC-Ontario, citing a section of the Registered Health Professions Act (RHPA) -

29. (1) An act by a person is not a contravention of subsection 27 (1) [i.e. subsection on controlled acts] if it is done in the course of, (c) treating a person by prayer or spiritual means in accordance with the tenets of the religion of the person giving the treatment;

and giving the following interpretation:

The purpose of this provision, as we understand it, is to accommodate faith groups that employ prayer and spiritual means to “treat” or “heal” bodily ills, based on language used by their belief systems. This accommodation honours a longstanding tradition separating church and state, and was included so the RHPA would not impede such groups in their religious beliefs and practices. *It was not intended, however, to restrict the provision of pastoral counselling or spiritual care services in health care settings only to members of the particular faith group to which the spiritual care provider belongs*, as some would suggest. <emphasis added>

This interpretation leaves the door wide open for religious practitioners in the ‘green circle’ zone to ply their trade on anyone and everyone else in the Province (i.e. there can be non-clinically trained Anglicans, Baptists, Christian Scientists, Doukhobors, Hare Krishnas, Jehovah’s Witnesses, Roman Catholics and all the rest set out as chaplains and pastoral counsellors to the whole population in our public institutions).

How CASC responds to this is of singular importance to our profession as a whole, and to our professional identity in particular.

Surely we clinically trained individuals ought not respond by joining the ‘green circle’ zone religious practitioners. An earlier statement in that same letter from the CRPO Registrar reads:

Late last year the Ministry of Health and Long-Term Care (MOHLTC) advised the Transitional Council (TC) that the new College should focus on regulating “the profession of psychotherapy”, and that those with primary training in related fields such as addiction counselling, child & youth services and pastoral counselling, among others, would not become members of the new College unless they have acquired additional education and training which would qualify them as psychotherapists.

Rather than interpreting this as excusing CASC Specialists for joining the College, this is instead the very reason we ought to join the CRPO, having fully “acquired additional education and training” and then taking our stand on that professional formation and identity.

(Needful professional advocacy within the Province of Ontario next looks like clear and broad communication on the fact that ‘green circle’ zone work falls below the standards we, as a professional body, uphold for chaplaincy and pastoral counselling.)

e. Immediate Opportunities

The opportunities that present during the current ‘grandparenting’ period are immense, both for CASC and for spiritual care providers not certified by CASC. Practitioners with less-than-certifiable clinical and/or academic training can nonetheless join the CRPO and not be left behind ... a gracious and needful ‘in-gathering’. The larger point needing to be emphasized here is that, for CASC, the time is now to ‘stand up’ with our true-and-full Clinical Pastoral Identity and with a longer-than-two-year-view so as to seize upon the potential (via effective advocacy on our part!) for an end to the historic

state of ‘fuzziness’ about spiritual care standards in our province: After two years of grandparenting, only people academically and clinically trained to face “head on” the CRPO’s regular registration process will get in. This means, from a CASC perspective, that only Specialists in Pastoral Care and Pastoral Counselling (or their equivalent) will be up-to-provincial-standards (as regulated by the CRPO). Which is the situation our own Standards have intended all along: one where certified specialists, held to account by regular peer review, or else students under supervision, are the practitioners of pastoral care and pastoral counselling in our land.

III. Summary

This paper is essentially a “call” to pay close attention to the anxiety, debates and divisions currently ‘energizing’ Ontario’s Associations of MIND-, SOUL-, EMOTION-, RELATIONSHIP- AND/OR BEHAVIOR-CAREGIVERS, and those within our own Association in particular, and to do two things with them: (1) Hear the wisdom, and (2) With a long-term view, proceed in the most constructive direction.

The fact of CASC training and certification is that, from the father of our movement onward, it is training and certification in psychotherapy, and it prepares us to enter the CRPO. Our identity quite appropriately will be declared when we sign our name, “Jane Doe, D.Min., RP – Pastoral Care” or “Bob Bond, M.Div., RP – Pastoral Counselling”.

What CASC gets to do, alongside all the other modalities entering the CRPO with us, is not to be put off by the medical model language framing the legislation, because our entrance is done all-the-while holding the constructive goal of ‘together, making it our own’.