

## **THE PROSPECTS & CHALLENGES OF CLINICAL PASTORAL EDUCATION IN PASTORAL CARE TRAINING IN INDIA**

It is my privilege and honour to greet you all at this epoch making gathering of pastoral care providers of the Camillian family all from all over the world. I am excited by the variety and richness of the experiences all of you bring into this gathering. I feel privileged because as a youngster in this field of ministry I am invited to share with you who are the veterans of pastoral care with tremendous amount of experiences and stories to narrate. It is also exciting because I feel that all of us who are called to minister to the sick are not only living out our special call in the Camillian family, but also continuing the evangelizing mission of Christ in the modern world in a most relevant manner.

My task here is to share with you some thoughts and reflections on how to use Clinical Pastoral Education in the pastoral care training of future ministers of care, especially in the Indian context. I will focus my paper on this theme first by sharing my personal journey to the CPE experience, then sharing the unique context of the Indian health care milieu and then discussing some of the possibilities and challenges of using CPE for the training of pastoral care providers in the Indian context.

### **My Personal Journey to the CPE Experience**

I first heard of CPE from a special person who is present in this gathering in 1986. Fr. Arnaldo Pangrazzi was visiting India and was giving a talk to some religious about CPE. I was just beginning my philosophy studies in the seminary and was just 19. Something about his talk must have struck me because even though I did not understand anything about CPE then, I started musing the idea that this might be my Camillian ministry in the future. After my novitiate I was still searching my “personal vocation” and asked my superiors to give me an year to work in the pastoral care field to test the waters and verify my calling in this field. I enrolled in a one year diploma course in pastoral counselling and led by Rev. Carlos Welch, a Presbyterian minister, who was a pioneer in the Pastoral care work in India, I started to savour richness of this ministry (as well as its challenges). During this year I had the privilege of working in three major fields of pastoral care ministry- Pastoral care in a general hospital (St. John’s Medical College hospital with my mentor Fr. Albino Turcato), an oncology hospital ( Kidwai) and a mental health institution (Atmashakti). Experiences and learning from these places and

36 verbatim I processed with my supervisors that year gave me a rich immersion into pastoral care and the basics of CPE.

After my ordination one year I worked in a parish and another year in formation. Then I was given the opportunity to prepare specifically in the field of pastoral care by studying CPE in the USA, it was the starting of a challenging and fruitful journey. I was sent into a land of many new experiences and opportunities. In May 1997 I started my CPE expedition at St. Luke's Medical Centre, Milwaukee. The experience was intense and the environment tough, yet the grace of God through the interventions of some wonderful people helped me sail through the storms of CPE that year, four units of intensive CPE training.

After completing the four units of CPE and after being certified as a chaplain, I was accepted into the supervisory CPE programme at St. Elizabeth's Medical Centre, Boston. If I thought the four units of CPE in Milwaukee was tough, the coming years were much tougher and challenging. The unpredictability of the process and the high demands and expectations from the programme seasoned me well. After passing through the many stages of CPE supervisory steps I was certified as a full supervisor in 2002 May.

Returning to India I was hoping to establish a full CPE training programme in Bangalore, but due to the need of the Delegation, I was given the primary responsibility of guiding our HIV/AIDS ministry in Bangalore. Along with this responsibility, I have been conducting at least one unit of CPE per year in St. Johns' Medical College Hospital and many short programmes in the field of pastoral care and ministry for various groups.

The reason I shared this journey in a detailed manner is because it is my personal experience of CPE journey that gives me the conviction and hope that it is a great model of training in pastoral care and its adaptability for the Indian context – for that matter any other cultural milieu- I am a living testimony for its adaptability.

#### A Historical Survey of the Beginning of CPE in India

CPE movement came to India, just like its mother country USA through the protestant church. It was the vision of Rev. George Isaac, presently a bishop of the Church of South India, that brought CPE to India. After his exposure and training in CPE in the USA he came to India drafted a curriculum of Diploma in Pastoral Health Ministry in association with Serampur University, which was launched in Christian Medical College,

Vellore on July 4<sup>th</sup>, 1994. Supervisors from Chicago Lutheran General Hospital and the Evangelical Health System offered CPE units to students of this diploma programme. They also sent Rev. J. Prasantham for CPE training in Chicago and he came back after being certified as an Associate Supervisor to offer CPE for the DPHM students in Vellore from 1997. He continued giving CPE in the same hospital also independent units to students who are not DPHM students till 2002, when he returned to USA to settle there. One student who was trained there, a Baptist, is offering a “CPE-like” programme in Bangalore at present. Other than this the movement got stuck and is almost at a dead end in the protestant community.

In the Catholic tradition a similar programme was started in 1994 at St. John’s Medical College Hospital, Bangalore by Fr. Thomas Kalam C.M.I., the present Director of the hospital. This was a two and half month programme on pastoral care training with special emphasis on pastoral counselling in the hospital context. This was where Camillians started getting the feel of pastoral care training in India as some of them attended this training.

Next were the interventions of Fr. Anselmo Zambotti who came to India to give a one month CPE crash course to our seminarians. Later Fr. Richard O’Donnell also came to India and offered a short one month programme to our seminarians.

I have indicated earlier my journey of CPE and after my returning to India, I am offering every year one unit of CPE in the same hospital Fr. Kalam started the pastoral care training and so far I have conducted three such programmes.

#### Context of Health Care and Pastoral Care in India

India as you know is a country with more than one billion people. Majority of the population are following the Hindu tradition, which is more than a religion, is a way of life. Although there is a greater velocity in the economic development of the nation, we are also witnessing greater disparity in all development sectors between the poor and rich populations. This is evident in our health care system as well. Most people have to depend on the public sector (civil) for any of their health care need. Those who can afford they can access any levels of health care in the private sector. In fact India is fast developing its health tourism sector.

Catholics form 2.1 % of 1 Billion of the total population. Yet Contributes 22% of health facilities in India (5000 health facilities in total) and 33% of total health personnel

in the country are Catholics. Interestingly 85% Catholic health facilities are in rural areas serving the poorer section Spread out in 149 dioceses. Some details of these institutions are the following:

<b>Medical colleges (Universities)</b>	<b>6</b>
<b>Nursing Schools</b>	<b>114</b>
<b>Hospitals</b>	<b>764</b>
<b>Dispensaries &amp; HCs</b>	<b>2587</b>
<b>Rehab centers</b>	<b>70</b>
<b>Leprosaria</b>	<b>165</b>
<b>For the aged</b>	<b>418</b>
<b>Centres for alternate Systems of medicine</b>	<b>61</b>
<b>Care Homes for PLWHA(HIV/AIDS)</b>	<b>58</b>

With the advent of modern private and highly specialized hospitals in the country, Catholic health care institutions are searching for new identity to exist and meaningfully witness the healing mission of Christ as an effective mode of evangelization. The Bishop’s Conference of India is recognizing and even encouraging the Catholic hospitals to rediscover their uniqueness as “Catholic” by integrating pastoral care to provide holistic and humanized care to people who access our services.

Interestingly still today Pastoral Care is at the bottom of the priorities of the Catholic institutions. At best they are offering sacramental care to Catholic patients, who are a very small minority of the total patients accessing our care. The question becomes all the more critical in this context “what is unique about Catholic health care in India”? Perhaps Camillians can play a significant role in defining and animating catholic health care in India to new and vitalized territories.

#### Pastoral Care Training through CPE

I don’t have to argue much about the adaptability of the CPE model in training people in pastoral care. There are many testimonies of the same various parts of the world. As we all know, CPE developed in the Protestant tradition in the United States. It was initiated by Anton Boison in 1924 and took another 42 years to develop into a

uniform model of educating pastoral care people in the USA (Formation of ACPE). IN 1968 the National Association of Catholic Chaplains was formed in the USA which eventually became the Catholic version of CPE movement. CPE soon spread to other countries, primarily transported by Americans and those who studies in the USA. It took roots in Europe, Australia and Philippines with local adaptations and changes.

In India as I have already indicated we have tested and tasted CPE training. CMC Vellore and St. Johns, Bangalore offers good learnings about what goes well and what doesn't in adapting CPE model of training for pastoral care providers. My first indigenous CPE unit in India confirmed my faith that CPE model is an effective way of raining people in pastoral care.

My first attempt to explore the possibilities of how this programme can be introduced and adapted in the Indian context was at John's Medical College Hospital. The programme was named as "Clinical Pastoral Course" and it was from January 14<sup>th</sup> to march 15<sup>th</sup>, 2003. The participants were from different parts of the country, all of them Catholic, 10 religious sisters and 4 priests. It was a residential programme with theoretical inputs and practical exposure to actual ministry in the hospital. The programme was designed in the model of a unit of Clinical Pastoral Education, but adapted to meet the specific needs of trainees and that of ministry recipients. The goal of the programme was to train personnel to develop a better understanding of the pastoral ministry in healthcare, and to acquire the necessary spiritual, psychological and behavioural skills for the ministry. The curriculum and methodology included the following: Lectures on various topics of pastoral care ministry; personal goal setting; Supervised clinical experience; Individual supervision verbatim lab; Interpersonal Relations Seminar; Pastoral Rounds; Reflection Group; Theological Reflection Seminar; Worship and Evaluations. The total programme had 400 hours and out of which 200 hours were ministry in the hospital.

Some of the significant learnings of the experience are the following:

- *Unlike our general perception, most patients and families wanted spiritual support and guidance while they were hospitalized due to an illness and really appreciated the ministry of pastoral care interns.*

- *Irrespective of their faith/religion, (more than 90% non Catholics) most patients welcomed the pastoral care intern, even though they were all Catholic priests and sisters.*
- *Praying with patients and families was always appreciated and demanded most. They felt that the pastoral care intern is an agent of God's healing comfort to them.*
- *The visit of the intern was comforting to most patients and gave them a feeling that the hospital cares for them in all their needs.*
- *Medical staff, particularly the nurses appreciated the presence of pastoral care interns in their units.*
- *The interest of the Doctors and nurses to be involved in the training by sharing their knowledge and desire to promote holistic health care was encouraging.*
- *As a trainer, I found that the principles of Clinical Pastoral Education work very well with Indian students in training them to be competent pastoral care providers.*

These learnings confirm to me that pastoral care is an integral component of holistic health care and as such is a right of every individual who come to our health care facilities for healing. This is from the perspective of patients and other health care personnel. How about the students in pastoral care? How did they perceive the programme?

For most of them it was difficult to enter into a new process of learning. Having been used to the theoretical model of education where head was the centre of activity, they all felt confused and not sure how to utilize the heart level learning. Besides, as the language of the heart (emotions and feelings) is alien to most people in India, the challenge is heavier. In India we are not used to express our feelings and emotions easily and we do not even have sufficient vocabulary to describe what we feel. It was a familiar territory though as I went through these experiences in my training struggling to identify and name my feelings. Through practice, encouragement and lots of pushing from the supervisors I learned the language of feelings and now I can understand my students and guide them in a similar process and help them access this new language which I feel is central to the pastoral care ministry.

Another area of challenge I faced was that many students who did the programme also look forward to CPE as a way to deal with their personal problems. In other words, using CPE for personal therapy. In the USA I would refer them to professionals. In India as there are not sufficient professionals in the field, the supervisor also have to address some of these issues and empower the students to deal with their problems before they are equipped to journey with the issues of patients.

Adult learning method of CPE is also a challenge. Having been familiar with the “spoon-fed” methodology, students struggle to cope up with the task of developing and following their goals and objectives in learning. There is lots of resistance in the beginning to “just tell me what I should do” rather than “you design your plan of learning” method.

The expectation of the students to “learn counselling” through CPE is also a challenge. Historically in India all the CPE programmes were heavily filled with classes on counselling. In fact many students apply to CPE to become counsellors. I feel it is a great danger still if we divert CPE as a way to learn counselling. The best example is the CMC Vellore story. The original CPE movement has now become a highly academic course in Pastoral Counselling.

Another challenge is the diversity of the CPE group. In the three programmes I conducted so far, I am yet to receive a lay person or non Catholic. I feel there needs to be greater sensitisation to attract diverse groups to CPE formation.

Conclusion:

I think the greatest challenge of all would be defining pastoral care and the identity of the pastoral care providers in the Indian health care context. Once this is clarified and when Pastoral Care constitutes the core of Catholic health care identity, CPE formation would find its relevant place in the ministry of the Church in India. I feel that Camillians in India have a unique role to enter this area and fill a vacuum that is existing in the health care provision of our country. I hope we will respond to it creatively and promptly.

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*Talk given at the International convention of the Camillian Chaplains in Rome on November 15<sup>th</sup>, 2005.*