

To the Graduate Council:

I am submitting herewith a dissertation written by Wayne Edward Wylie entitled "Needed Health Counseling Competencies of Ministers." I recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Education, with a major in Health Education.

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NEEDED HEALTH COUNSELING COMPETENCIES OF MINISTERS

A Dissertation
Presented for the
Doctor of Education
Degree
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Wayne Edward Wylie

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He started to sing as he tackled the thing
That couldn't be done, and he did it.

--Edgar A. Guest

The relationship based on love, honesty, communication, and understanding that exists between Pamela, Matt, Mark, and Melissa and myself made it possible for me to sing as I worked on this study. It is to these four precious people in my life that this work is dedicated!

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ABSTRACT

The purpose of this study was to characterize current health counseling practices of the church of Christ minister and to identify areas of needed health counseling competencies which should be addressed during professional preparation of the minister. To accomplish this purpose this study was designed to answer 16 specific research questions.

The subjects which made up the sample for this study came from the population of active local ministers of the churches of Christ who resided in the states of Arkansas, California, Oklahoma, Tennessee, and Texas. The random, proportional stratified sampling technique was used to select 266 ministers to participate in the study.

A questionnaire was designed for use in this study. A jury made up of four health professionals, three full-time church of Christ ministers, and four academic or administrative personnel employed by church of Christ supported colleges or universities provided critical, constructive evaluation of this instrument. Three revisions were made. The final form of the questionnaire which consisted of 17 items was mailed to the sample.

A total of three mailings yielded a response rate of 52 percent. Of this percentage, 108 questionnaires were selected for use in the study. In addition to simple response percentages the statistical procedures of Kendall's coefficient of concordance, Spearman's rank

correlation coefficient, and chi-square were used in the analysis of the data. A conceptual health education curriculum was developed and suggested, based on the findings of this study, for use in the schools, colleges, and universities that train ministers.

Specifically it was found that the church of Christ minister is most frequently called upon to offer counsel in the health-related areas of marital problems, pre-marital problems, mental or emotional problems, patient counseling, death education, alcohol problems, drug use or abuse, and aging, respectively. There were no differences among the ministers concerning the types of actual counseling done or types of health education which they perceived to be needed in respect to the independent variables of state, community size, congregation size, age, preaching experience, and educational level. It was also found that the majority of the ministers surveyed felt that their training for the ministry had not adequately prepared them to offer health counsel. The majority of the sample indicated that all health topics listed on the questionnaire should be required during initial preparation for the ministry. Other findings were also noted.

On the basis of the findings, the following conclusions were drawn:

1. The minister is a health counselor.
2. The schools, colleges, and universities that train

ministers do an inadequate job in preparing the ministers to counsel in health-related areas.

3. Ministers offer health counsel whether they feel qualified to do so or not.

4. For the most part, if the minister does feel qualified to offer health counsel it is as a result of prior experience or extra-curricular training and not as a result of initial training for the ministry.

5. The types of health counseling cases which are brought to the minister are common to all ministers regardless of the independent variables of state, community size, congregation size, age, preaching experience, and educational level.

6. Health education is a desired program of study by the minister to be included in his initial preparation for the ministry.

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CHAPTER I

INTRODUCTION

The health professionals of 1980 had but to open a journal of their profession to be confronted with the challenge of developing more and better health education programs. This challenge has resulted from an increased awareness by the public that not only do health related problems exist within their communities but they are occurring in increasing numbers.

For example, in 1976 the Alan Guttmacher Institute reported that of the 10 million unmarried females in the 15-19 year age group within the United States, an estimated 3.2 million were sexually active. One million of these sexually active females become pregnant each year with 300,000 cases ending in abortion and 580,000 cases ending in the birth of illegitimate children. This study also found that an additional 30,000 females younger than 15 years of age become pregnant each year. Forty-five percent of these cases end in abortion. Another 36 percent of these cases result in the birth of illegitimate children.

The incidence of venereal diseases has risen steadily in recent years within the United States. All ages are being affected; however, incidence is particularly high among teenagers and young adults. In 1977, the Venereal Disease Action Council of Texas reported that an estimated

428 girls across the state of Texas are absent from school each day because of complications associated with gonorrhea. This organization also estimated that 2.5 million Americans suffer annually from gonorrhea making it the second most common communicable disease in our country. Only the common cold keeps venereal disease from being the most rampant communicable disease.

Mental and emotional problems are also on the increase. Johnson reported that signs of stress are continually mounting in our society (1973). He found that someone in the United States attempts suicide every minute of the day and that 70 times a day these attempts succeed. In addition to the increasing number of the adult population that will need help with mental and emotional problems, it has been estimated that 10 million children under the age of 18 will experience some form of mental illness necessitating intervention (Dale, 1978).

Also the number of alcoholics in our country is increasing every year as is the number of alcohol-related deaths. While there are no specific figures on the number of non-alcoholics who abuse alcohol, Kinney and Leaton (1978) reported that alcoholics make up 4 percent of the United States population aged 20 and over. This computes to be approximately nine million alcoholics in this age group in the United States.

All of the above statements indicate that the American

people need help with these health problems as well as others which were not mentioned. While health education cannot be viewed as a panacea for all health related problems, it can aid in the establishment of a strong foundation toward prevention.

The challenge of developing more and better health education programs is one which should be shared by the home, school, and community. In 1974, Fodor and Dalis developed a model, Individual Health as Influenced by Home-School-Community Interaction, which illustrated this concept. This model reflected a goal of fully developing the individual physically, mentally, socially, and morally. This goal was brought about by the interaction of forces within the home, community, and school. The forces of the home were illustrated as the primary and fundamental influences upon the development of the individual. The school and community were shown to supplement the home and depended upon various agencies and sub-groups within their structure which have the ability to favorably or adversely influence the individual's health. This model has done much to provide valuable insight in the development of better and more unified health education programs.

With this concept of sharing in mind, the health educator should strive to include every possible resource available to meet the health education needs of the people. One ally within the community that should be better utilized to

provide health education is the local church. It has been suggested that since the church is an influential part of many people's lives, it would seem appropriate to extend health education to the church setting (Byrne, 1979). It has been pointed out that those who work with young people in their religious training have many opportunities to serve as counselors (Todd, 1966). We can only assume that the same would be true for the adults. Therefore, within the church setting health education could be provided for whole families rather than the fragmented approach of reaching children in the schools and adults at their jobs.

The idea of involving the local church in providing health education to the people is not unrealistic. The church shares a common goal with the health education program: that of attending to the physical, social, and mental growth of mankind. In their desire to imitate the ministry of Christ, many religious groups are discovering that in order to offer spiritual guidance they must also offer guidance and help to those suffering from physical, mental and emotional, and social problems. In the first century, Christ utilized this approach in His own personal ministry. The Bible states:

And Jesus was going about all the cities and villages, teaching in their synagogues, and proclaiming the gospel of the kingdom, and healing every kind of disease and every kind of sickness. And seeing the multitudes, He felt compassion for them, because they were distressed and downcast like sheep without a shepherd (Matthew 9:35, 36, New American Standard Bible).

I. NEED FOR THE STUDY

Brister (1978) stated that the church should help prevent alcoholism, crime, sexual promiscuity, and "evil of every form" to the limit of its ability. While most would agree with Brister, it must be recognized that his suggestion carries a limitation. This limitation is that there are limits to the ability of the local church to minister to many of these needs. If this ability of the church could be improved upon, then prevention could become more of a reality.

Research indicated that the minister is being asked to counsel more and more in health-related areas (Routh, 1978). This would indicate that many people rely upon the minister of the church to solve their physical, mental, and social problems and do not hesitate to call upon him for help. These people accept the counsel received from the minister as being the best possible for them and seek no other. Although church supported schools and colleges are doing a good job in preparing the prospective minister to attend to the spiritual needs of the people, very little is being done to prepare him to attend to the non-spiritual needs of the people. This creates frustration for the minister and to those who faithfully come for counsel.

The time has come for the church supported schools and colleges to train the prospective minister in the area of health education. The minister is in a very strategic

position within the church to disseminate health information in the areas of human sexuality, drug abuse, alcoholism, mental and emotional health, death education, aging, and venereal disease. If exposed to a good health education program in conjunction with strong religious training while in seminary, the minister could be of invaluable assistance to the local church in establishing programs that would help prevent health-related problems of the people. He would also be better prepared to offer health counsel.

II. PURPOSE OF THE STUDY

The purpose of this study was to characterize current health counseling practices of the church of Christ minister and to identify areas of needed health counseling competencies which should be addressed during professional preparation of the minister.

III. STATEMENT OF THE PROBLEM

To effectively characterize current health counseling practices of the church of Christ minister and to identify those counseling competencies which should be addressed during professional preparation of the minister, this study was designed to answer the following questions:

1. What are the most frequent types of health counseling that the minister is expected to provide?
2. How often is the minister called on to offer health counsel?

3. In the opinion of the minister, did his ministerial training adequately prepare him to offer health counsel?

4. Does the minister feel adequate in offering health counsel?

5. As perceived by the minister, what health instruction should be included in ministerial training programs?

6. Is there agreement among the ministers concerning the types of actual health counseling done in respect to the independent variables of state, community size, congregation size, age, preaching experience, and educational level?

7. Does agreement exist among the ministers concerning the types of health counseling education which they perceive to be needed in respect to the independent variables of state, community size, congregation size, age, preaching experience, and educational level?

8. Is there agreement between types of health counseling actually done by the minister and the types of health education which they perceive to be needed by the prospective minister during ministerial training?

9. Is there a significant relationship between adequacy of training for the ministry and felt counseling adequacy of the minister?

10. Does a significant relationship exist between adequacy of training for the ministry and the minister's educational program recommendations for ministerial training?

11. Is there a significant relationship between felt counseling adequacy and educational program recommendations for ministerial training?

12. Does a significant relationship exist between felt counseling adequacy of the minister and participation in extra-curricular coursework or training by the minister?

13. Is there a significant relationship between educational program recommendations for ministerial training and participation in extra-curricular coursework or training by the minister?

14. Does a significant relationship exist between adequacy of training for the ministry and participation of extra-curricular coursework or training by the minister?

15. Is there a significant relationship between percentage of time spent in counseling situations and felt adequacy of training for the ministry, felt adequacy of counseling, or participation in extra-curricular coursework by the minister?

16. Does a significant relationship exist between felt counseling adequacy of the minister and the variables of preaching experience, age group, or educational level?

IV. BASIC ASSUMPTIONS

The following basic assumptions were made for this study:

1. The ministers included in this study were

representative of other ministers within the churches of Christ.

2. The ministers surveyed would render truthful information to the questions contained on the survey instrument.

3. The ministers were able to identify the most requested health counseling problems that people brought to them.

4. The ministers surveyed were able to recommend health areas that would be beneficial for the seminary to include within its curriculum.

V. DELIMITATIONS

The parameters of this study were as follows:

1. Only ministers who were members of the church of Christ and active in local congregational work were surveyed.

2. The sample was taken from ministers in the states of Arkansas, California, Oklahoma, Tennessee, and Texas.

VI. LIMITATIONS

The limitations of this study were:

1. The survey instrument selected for this study may have been a limiting factor to the amount and type of information received.

2. The directory used in selecting the sample may not have represented all active, local ministers in the study population.

3. Because there are no female ministers within the church of Christ, only the male point of view was obtained.

VII. DEFINITION OF TERMS

The following terms are defined as they relate to this study:

1. Active, local minister--a person who is employed by a local congregation to serve in the capacity of minister.

2. Church--the term "church" as used within this study refers to the universal group of people who have recognized the divinity of Christ and have obeyed His teachings.

(Note: as defined by the churches of Christ.)

3. Health Counseling--Everly (1980) has defined health counseling as a combination of education and counseling as it pertains to health-related issues and personal health concerns.

4. Health Education--health education has been defined by the following statement:

. . . a plan that provides for the sequential arrangement of learning opportunities designed to favorably influence health attitudes, practices, and cognitive skills that are conducive to the optimum development of the individual, the family, and the community (Fodor and Dalis, 1974, p. 6).

5. Local Church--the local church refers to a specific, local congregation of people who have recognized the divinity of Christ and have obeyed His teachings.

6. Prospective Minister--a student who is enrolled in a school, college, or university preparing to become a

minister.

7. Seminary--schools supported by the church which train men to become ministers.

CHAPTER II

REVIEW OF RELATED LITERATURE

I. INTRODUCTION

Much has been written during the last years of the seventies that would strongly suggest that health education should be a vital part of the overall education of the individual. Also the need for community health education programs specializing in adult education has been documented numerous times. Even though our schools of higher education are better training health educators to be placed in the public school systems and in the community health programs, much more needs to be done in order for more positive results to occur. Allies need to be identified that can assist the health educator in this challenge.

It has been suggested that since the church is an influential part of many people's lives, it would seem appropriate to extend health education to the church setting (Byrne, 1979). Mankin (1980) reported that recent Gallup polls indicated that more than 100 million adults claim to be members of a church or synagogue. It was estimated that 40 million of these adults attend church service weekly and that 17 million of these admitted attending church service more than once a week. No statistics were available for the non-adult population; however, it has been pointed out that those who work with young people in their religious

training have many opportunities to serve as counselors.

One way to better utilize the church in responding to health-related needs of the individual would be to more adequately prepare the minister to serve as a health counselor. Too many times the church issues the message of "thou shalt not" to those who have already "done" and need help. Indeed the "thou shalt not" message of the church must continue to be heard for they are "signposts set by God Himself to protect our happiness and to make our life's journey as tragedy free as possible" (Graham, 1970, p. 118). However, the church must learn to minister more effectively to those that find themselves in problem situations as a result of "sin." Jones (1978) reminded us that Jesus Christ sought to minister to the hurts and needs of persons before He pronounced the words of redemption. The minister of today must learn to do likewise. By doing so, he could greatly aid the health educator in combating the health problems of today. By not doing so, he is negligent in following the example of Jesus.

II. THE MINISTER AS A COUNSELOR

Rosen made the following statement concerning the minister and his role, "I believe the clergy have much to contribute and ought to be an integral, not peripheral, part of the health team" (1974, p. 290). He firmly believed that health is a fundamental pillar of religion and has been

an integral part of religion from the very beginning of time. However, it should be pointed out that the clergy as a whole are divided on this issue. Many believe that health is a byproduct of religious practice (Rosen, 1974). Because the minister does provide various kinds of education, it seems logical that he could function in a preventive role of health-related problems.

Routh (1979) cited a study done by Blizzard that revealed that more than 70 percent of the time of the full-time urban minister was required for administration and counseling. In a research report done by the Association of Theological Schools in the United States and Canada, 64 core clusters of qualities and skills for the clergy were distinguished (1975). Four of the top 15 clusters related to the area of counseling whereas preaching was listed as 25th in importance. Core cluster number six specifically described the minister as a perceptive counselor.

Hamilton (1972) has found that the contemporary minister is called upon for various types of counseling: religious, personal-social, vocational, educational, pre-marital, and marital. Todd (1966) acknowledged that every preacher who is doing the kind of job God would have him to do will have many opportunities to counsel those whom he teaches. Brister (1978) reported that whether or not the pastor sets out to be a counselor, the necessity of counseling soon settles upon him. He strengthened this finding by

stating, "Life propels God's servants into counseling situations whether they are ready or not" (1978, p. 39).

Wise (1951), who also viewed the minister as an important part of the health team, reported that the minister was indeed a counselor and that those to whom he ministered expected to be saved from something. Brister (1978) found that people turn to pastoral counselors much like the Lycaonians faced Paul and Barnabas in biblical times; they have the hope that the "gods have come down in the likeness of men." With this in mind, we can better understand what Leslie meant when he stated:

This minister is more of a general practitioner than he is a specialist. He is used to seeing a great variety of activities and struggling with a great variety of problems. When in a single day he shares the sorrow of a sudden death, the joy of a new birth, and the anguish over a drug-induced illness, and when within a few hours he ministers both to a senile grandmother and to a heartbroken adolescent, he knows the kind of variety that is common in family counseling (1974, p. 11).

III. THE MINISTER'S TRAINING

Having noted the many different areas of counseling that are demanded of the minister, it is fitting that attention be given to the type of training that the minister receives. Jones (1978) reported that a recently completed, unpublished study of the history of theological education revealed that the professional curriculum of schools and seminaries has changed very little since it was initially designed. This is very perplexing because many beginning

ministers are finding that the type of counseling for which they are best prepared, religious, is not the type of counseling they are called upon to do most frequently (Hamilton, 1972).

As early as 1953 it was recognized that a major complaint of ministers was that they were not really prepared to work with people; that the real training for the work that they had to do was on the job and had come by trial and error (Howe). In 1966, Todd wrote:

It is a tragic truth that most who have the occasion to counsel with students are in no way qualified to serve in this capacity. But perhaps an even greater tragedy is that we as teachers do not realize our own limitations in this area. Much harm can be caused by the person who assumes that he can help everyone who comes to him seeking counsel with regard to personal, family, social, psychological, and religious problems (p. 320).

The study done by Blizzard (as cited by Routh, 1979) revealed that many ministers felt that their training did not prepare them for the reality of counseling. Adams (1970) stated that having learned very little about counseling techniques in seminary, he began with virtually no knowledge of how to counsel.

Revelations of this nature have become common and led Routh to state that the biggest problem that the minister faces is that of phoniness (1979). It is this reason that he stated within the same article that it is so important to prepare persons who are competent to minister.

The above discussion leads us to perceive a need

which must be confronted. As Hulme (1974) has stated, this need is not normally to sell the clergy on the significance of their opportunity, but how to train them to do their job better. Van den Blink was of the opinion that the time is ripe to recast the training programs in pastoral care (1974). It has been suggested that seminaries should use their resources and opportunities to better prepare men to minister to the needs of people instead of merely schooling them in biblical, historical, and theological subject matter (Howe, 1953). Biblical scholars have reminded us that the Bible and the faith is highly contextual; therefore, training for the ministry should also be contextual (Jones, 1978).

Meyer (1972) was of the conviction that the answer to the need of training the preacher to better minister to the people is not to discard the classical curriculum, but rather to apply and integrate the cognitive fields with the practical. Surveys that he has taken among ministers, denominational leaders, alumni, and students have indicated that while more stress on the practical, personal, interpersonal, and social aspects of ministry is needed, it must not be at the expense of a strong core of biblical and theological studies. This represents a concept which should never be violated. Instead, while affirming the traditional and long established content of theological education, schools and seminaries should shape their curricula to

accommodate the particular realities of the constituencies which their graduates may be called to serve (Jones, 1978).

Jones (1978) also suggested that the objectives of the seminary curriculum should provide learning experiences which would make accessible to the students specific information concerning specific problems, knowledge of various methods for approaching and resolving problems, and information concerning resources within the community for coping with problems and for effecting substantive change. Two of the five goals of a Master of Divinity Program suggested by Meyer (1972) were the fostering of a concern in the students to meet the needs of a suffering and sinful world and helping the students to integrate the spiritual, personal, practical, and cognitive aspects of their preparation for Christian ministry. If these goals were implemented into all seminaries it would be easier to agree with the following statement: "A good seminary education, rather than medical school or a degree in clinical psychology, is the most fitting background for a counselor" (Adams, 1970, p. 61).

Presently, an awareness that there is a need for improved seminary training exists. In the future, it needs to be more in-depth, more practical, and more a part of the seminary curricula (Collins, 1979).

IV. THE MINISTER AND SELECTED TOPIC AREAS

Counseling is one of several skills, including preaching and teaching, that should be constantly updated in pastoral practice (Brister, 1978). For the skill of pastoral counseling to be constantly updated, knowledge in many different health areas is needed. It has already been suggested that the minister should be able to offer effective counsel for different types of problems. A study by Sandler (1966) revealed that the problems most commonly brought to ministers for counseling were marital problems, drinking problems, lack of faith, and sexual maladjustments. Collins (1979) reported that the Joint Commission on Mental Health conducted a national survey which revealed that almost one-half of all people in need of counseling as it related to mental and emotional problems had sought help from a clergyman. With these problem areas in mind, a brief look at the literature associating them with the church is in order.

Human Sexuality

Rosen (1974) stated that religion has fostered unhealthy taboos against the body and sex. Clayton (1969) suggested that a major error in the church's attempt to deal with sex is its insistence that total abstinence is the only moral possibility for the unmarried Christian. It has been the belief of some that to discuss ways in which

one might apply the gospel in his/her use of non-marital sex would be to give the church's approval to non-marital sex. Instead, Clayton (1969) felt that the church left young people without guidance while pretending that such guidance was unnecessary. These beliefs by Clayton led him to make the following statement:

. . . because the church has insisted that virginity is the only acceptable condition for an unmarried Christian, we have failed to provide any moral guidance at all for the Christian young people who become sexually involved before marriage. The church must acknowledge that unmarried, sexually experienced Christians really do exist, and must extend a constructive ministry to them (1969, p. 46).

Ira North, a well known church of Christ minister, in an article discussing the topic of homosexuality, has said that the best answer to sexual problems is that of prevention (1965). However, Emery (1979) has pointed out that it is evident that merely knowing the biblical passages concerning such things as divorce, remarriage, and sexual activity is insufficient preventive teaching. Graham (1970) stated that the "whys" within religion must be discussed in conjunction with the "don'ts."

Many times such discussions cannot be conducted because local congregations do not have in their number persons who are trained well enough to teach about human sexuality (Vertz, 1979). This strengthens the argument for ministers to be trained in this area during their seminary experience. However, we must also keep in mind that even when there are qualified people within the church to teach

in the area of human sexuality, they do not because as North put it, "We are so squeamish and prudish that we would prefer to put our heads in the sand and pretend there are no problems" (1965, p. 254).

Faulkenberry and Vincent (1979) reported that the data supported the premise that there is a need for comprehensive family planning programs and that these programs must meet the needs of all potential parents, not just the adult or married sectors of our society. Emery (1979) has found that pre-marital counseling and preparation for marriage needs attention long before the youth are ready for marriage. It is logical that this attention be given by the church because it has been reported that those who work with young people in their religious training have more opportunities to serve as counselors than any other group outside of the professional counseling field (Todd, 1966).

A related study conducted by Allen and Cole (1975) found that although more seminary students wanted to offer family planning counseling services than their predecessors of 10 years, very few thought they were qualified to do so. The study revealed that 76 percent of the Methodist students surveyed, 62 percent of the Conservative-Baptist students surveyed, and 77 percent of the Lutheran-Episcopalian students surveyed planned to offer family planning counseling within the church setting. However, they also found that there was a continuing lack of adequate training in

this area provided by the seminaries. Mezydlo, Wauck, and Foley found that with comparable training and office settings, the clergyman could perform as well, and in some cases better, than the layman counselor (1973).

The literature does reveal that those young people who do attend church services regularly are less prone to experience involvement in pre-marital sexual activities (Young, 1979; Bell, 1974). However, the figures representing those who do are substantial enough to reflect a real need for better sex education within the church. Young found that of students enrolled at a church-related college, 27 percent of the males and 10 percent of the females expressed favorable attitudes toward pre-marital sexual intercourse (1979). However, he found within the same study that 61 percent of the males and 36 percent of the females reported participation in pre-marital sexual intercourse. The actual behavior of these students was not in agreement with expressed attitudes of the same students.

King, Abernathy, Robinson, and Balswick (1976) measured religiosity by the Putney-Middleton Scale of Religious Fundamentalism rather than by church attendance and found that while religiosity is related to pre-marital sexual attitudes among men, it is not related to pre-marital sexual behavior among males or females. Once again, a significant difference between attitude and actual behavior existed.

It is interesting to also note that Young's study revealed that oral-genital sex was not viewed as negatively as pre-marital sexual intercourse by the females surveyed (1979). One can only speculate as to why this would be, but it may be a direct result of the church only addressing itself to pre-marital sexual intercourse with its "thou-shalt-nots" while never mentioning oral-genital sex.

Mental and Emotional Health

In 1962 Moser recognized that a well-trained clergy is among the strongest assets a community has for mental health. Pastors are frequently the ones to whom distressed persons first turn for help (Van den Blink, 1974). Van den Blink (1974) also stated that the minister is in a position to render aid to families who might otherwise never get any help at all because they are often aware of family conflicts before they reach the crisis stage. The clergy's assets include availability, experience, tradition, and the special significance of the religious leader (Clemens, Corradi, and Wasman, 1978).

For many, the properly trained minister can be the entry point to mental health services because he can be a very effective provider of these services. Rosen (1974) pointed out that there is a striking similarity in traditional parish work to modern community mental health activities and concepts. The minister's position within the community is often a strategic one since often times

people with mental and emotional problems go to him before they will even consider going to anyone else. Since he is in such a strategic position, we must ensure that he is trained to identify mental health problems, in ways to help the patient, and to refer the patient to those who can better help if the condition merits referral. Brister (1978) found that if referral is indicated, church members trust a minister to know whom to contact in related professions.

This trust presents some problems because Caplan found that most ministers are not trained by their seminaries to consult with colleagues from other professions (1972). Inadequate training in mental health skills and the complex demands of parish life are other problems which confront the clergy in the area of mental health (Clemens et al., 1978). Caplan's findings also revealed that by the early 1960s, the clergy's needs had crystallized around three areas: more education, help with handling the growing numbers of emotional problems that were brought before them, and some form of support that would raise their sense of accomplishment and self-esteem (1972). In response to this finding, Rosen (1974) has suggested that with cooperation among practicing professionals, it is possible that more interdisciplinary information in the overlapping fields of religion and health will find its way into the seminary curricula.

The Joint Commission of Mental Health, as reported by Collins in 1979, revealed that pastoral counseling is unquestionably the single most important activity of churches in the mental health field. Collins also stated that the most common reasons why the minister is sought out to counsel in the area of mental and emotional health are that he is readily accessible, that the cost factor is non-existent, and that society places less stigma on pastoral counseling than on psychiatric counseling. Because of similar reasons, Wimberly (1976) found that the black churches have been pressed into meeting the needs of their mentally ill since the days of segregation. Because of this finding, he has concluded that it is very important that the pastoral counselor, black or white, be able to enter into the experience of his client and to offer constructive counseling. A related study done by Pugh and Mudd (1971) concurs with Wimberly's conclusion.

Religion and Alcohol

As was stated in the introduction, alcohol is the third most serious public health problem in the United States. In 1971 Conley and Sorenson reported that over 50 percent of all highway fatalities are alcohol related and that over 74 percent of fatally injured pedestrians had excessive alcohol blood-level counts at the time of their death. They also reported that alcoholism accounts for over 25 percent of all first admissions to mental hospitals.

Kinney and Leaton (1978) have reported that 95 percent of the alcoholic population are employed or employable. This makes up 5 percent of the nation's work force. The remaining 5 percent of the alcoholic population is equated to the "skid row" individual.

In relation to this problem Lamkin has quoted Graham as saying, "It seems clear that denominations need to think more carefully about this problem and what they can do" (1978, p. 29). In Lamkin's article, Graham further revealed that denominations have not done the best that they could in educating people, especially young people, about the dangers of alcohol. He thinks that instead of being compassionate and helpful they have been judgmental.

There are many within and without the church setting who believe that the nation's clergy should play a larger role in the healing of the alcoholic (Buursma, 1978). A 1974 Harris poll conducted for the National Institute on Alcoholism found that 87 percent of those questioned felt that ministers should be more involved in counseling alcoholics. "More alcoholics continue to have initial contact concerning their problems with the clergy than with all other professional persons combined" (Conley and Sorenson, 1971, p. 127). Daugherty, executive director of the Kentucky Alcoholism Council and a key figure in a sweeping new program designed to aid churches in understanding and accepting parishioners with alcohol-related

problems, stated, "The minister is often the first person the alcoholic, or the alcoholic's family, goes to for help" (as cited by Buursma, 1978). It is easy to understand that if the minister does not know how to deal with this problem, the alcoholic may continue to grope for help, without really seeking it, for years.

It should be pointed out that while some see the church as the greatest hope in the primary prevention of alcoholism, there are some who view the church as one of the main causes of alcoholism (Conley and Sorenson, 1971). One reason for this viewpoint is that too many times religious denominations shun the alcoholic, dismissing him as a "weak-willed unregenerate" who is beyond redemption (Buursma, 1978). Another reason is that because of an unresponsive attitude by the church to the alcohol drinker he soon is on the road to becoming an alcoholic. Instead of reaching out with loving arms, the church too often turns its back in judgmental fashion; thus, isolating the person with alcohol problems.

This isolation is too often damning. It has been found that those church groups who take a very strong stand against using alcohol in any form have their share of alcoholics. Cahalan and Cisin (1968) conducted a study which revealed some very interesting findings. They reported that while 92 percent of the Jewish population drink alcohol, only 11 percent of these drinkers are heavy

drinkers. Of the 91 percent of the Episcopalians who drink, 13 percent were found to be heavy drinkers. Eighty-three percent of the Catholics were found to be consumers of alcohol with an alarming 25 percent of these being heavy drinkers. Eighty-one percent of the Lutherans were found to be drinkers with 19 percent of these drinkers qualifying as heavy drinkers.

Only 66 percent of the Methodist group which also included representatives from the United Church of Christ, Congregationalists, Disciples of Christ, Evangelical, and United Brethren were found to be drinkers. Heavy drinkers made up 15 percent of this group.

Baptists had the lowest percentage of drinkers, only 47 percent, but it was reported by Cahalan and Cisin that 17 percent of these alcohol users were heavy drinkers (1968). A more recent study by the St. Joseph Missouri Alcoholism Unit revealed that there are more Baptists in treatment for alcohol-related problems than members of any other church group (Buursma, 1978).

Kinney and Leaton have reported that one of the ways the clergy may be of potential assistance is to help the alcoholic deal with "sin" and feelings of guilt, worthlessness, and hopelessness (1978). These authors emphasize that the alcoholic needs real assistance in updating his concept of God. They state:

The alcoholic getting sober feels remorseful, guilt-ridden, worthless, endowed with a host of negative

qualities, and devoid of good. In his mind he does not fit the picture of someone God would like to befriend or hang around with (1978, p. 181).

Small and Wolf (1978) reminded us that for the alcoholic, abstinence from alcohol is only the beginning of recovery. A study of the abstinent alcoholic conducted by Gerard, Saenger, and Wile indicated that the majority of abstinent alcoholics are not functioning effectively in life (1962). It was found that 54 percent of the abstinent alcoholics surveyed were overtly disturbed while 24 percent were considered to be living life "inadequately." The more recent study of Small and Wolf found that many abstinent alcoholics show signs of stagnation, resentment, and general unhappiness (1978). They stated, "As he overcomes his dependence on alcohol and remembers again to live, he will need healthy companions to guide or accompany him on his journey toward health" (1978, p. 36). Because of these findings, ministers and other counselors must be trained to also help recovered alcoholics through the crucial time of realizing and rechanneling their own creative energies.

Conley and Sorenson report that historically, the church stands out as one of the first American institutions to respond to the problem of alcoholism in society and to express concern for the alcoholic as an individual (1971). They write, "Over the last 200 years the church has developed a closer association with the alcoholic than with almost any other ill or troubled person" (1971, p. 5). Various

religious groups and agencies have been created to help the alcoholic. These church-related services have ranged from local halfway houses to the internationally recognized Salvation Army. Several church groups have instituted specific projects to provide leadership and research. Two of these are the Department of Drug and Alcohol Concerns within the United Methodist Church and the National Clergy Council on Alcoholism and Related Drug Problems within the Roman Catholic Church. However, the vast majority of the services which churches are providing for alcoholics include only treating persons who are already addicted to alcohol (Conley and Sorenson, 1971). Some religious groups are making no attempt to actively and collectively serve the alcoholic.

Recognizing the important position that the church has in relation to the alcoholic, Conley and Sorenson (1971) suggest that more programs be developed which are directed toward developing community-wide attitudes which foster responsible use of alcohol. John (1977) cited Noble, the director of the National Institute on Alcohol Abuse and alcoholism, as calling on churches to provide greater training opportunities to prepare the clergy to handle problems of the alcoholic, and to provide them with an increased understanding of what alcohol does to its victims physically, spiritually, and psychologically. It has been reported that the United States Navy has recognized that

its chaplains fulfill a vital role in providing help to service personnel and their families suffering from the effects of alcohol abuse (John, 1977). Therefore, they have provided numerous workshops at United States and overseas naval facilities where their chaplains are taught to detect symptoms of alcoholism, to handle confrontations, to provide referrals to helping agencies, and to provide after-care counseling. The religious training of today's minister should provide the same.

John (1977) does report that there are presently at least two interdenominational programs to help future clergymen participate as care givers for alcoholic persons: the Pastoral Institute for Training in Alcohol Problems and one sponsored by the Black Churchmen's Ecumenical Institute. Both of these programs are funded by the National Institute on Alcohol Abuse and Alcoholism. The theological schools which make up the Boston Theological Institute benefit from the Pastoral Institute for Training in Alcohol Problems while the Black Churchmen's Ecumenical Institute is aimed at inner-city ministers in Washington, D.C. More programs of this nature are needed which would reach more of the clergy.

V. STUDIES RELATED IN METHODOLOGY AND CONTENT

Givens (1976) conducted a study that surveyed the extent and the nature of the counseling ministries of the

preachers of the churches of Christ. A two page, 11 item questionnaire was sent to a sample of 500 church of Christ ministers. This sample was selected based on the number of local congregations that existed within each state as compared to the total number of local congregations in the United States. According to this percentage, a corresponding percentage of the 500 desired for the sample were selected from each state; thus, a stratified random sampling technique was utilized. Only 135 of these ministers returned the questionnaire. This represented a return rate of 27 percent.

The results of this study revealed that 95.6 percent of the ministers returning the questionnaire considered counseling to be useful to essential in their overall ministry. While 76 percent of these ministers served congregations of 250 members or less, the majority, 50.4 percent, indicated that they spent 10 percent of their time counseling. An additional 46 percent indicated that they spent 20-50 percent of their time counseling. These ministers revealed that the most frequent types of counseling cases in order were: marriage counseling, pre-marital counseling, doctrinal cases, alcohol cases, drug cases, suicide cases, and severe emotional cases. The most frequently counseled age group was 19 and under, while individuals 61 and over were counseled the least. Sixty-nine percent of the ministers had taken three or less

counseling-related courses while the remaining 39 percent stated that they had taken four or more courses. When asked if they would take additional counseling-related courses, 73.8 percent indicated that they would if they had the opportunity.

Virkler (1979) conducted a study to provide a feedback loop from ministers now in parish work to seminary curriculum committees and others involved in the training of ministers regarding the kind of counseling ministers are expected to do, the counseling procedures they generally use, and the areas in which they felt their seminary counseling training was either adequate or deficient. The results of this study were derived by randomly administering a questionnaire, which focused on the above questions, to 105 active, Protestant ministers in a northern and southern community. The 54 ministers who completed this questionnaire represented a return rate of 51 percent. Approximately 140 items of data were collected from each minister.

No significant differences were found to exist between northern and southern sub-groups of ministers. The mean and median ages of the ministers who returned the questionnaire were 43 and 42 respectively. The mean and median years of experience in the ministry were 15. Although 74 percent of these ministers had a bachelor's degree, 55 percent of this group also had a Master of Divinity degree, 27 percent reported that they had no seminary

courses in counseling. However, of the ministers sampled, 74 percent said they saw parishioners for regularly scheduled counseling appointments.

There was a significant variation in the number of hours ministers reported spending weekly in counseling, with a range from an average of zero to an average of 25 hours. Specifically, the mode was three hours, the median was between three and four hours, and the mean was six hours weekly. The most common problems Virkler found that these ministers were expected to deal with were marital, pre-marital, spiritual, and emotional (depression, anger, guilt, loneliness, low self-esteem) issues.

Virkler expected that these ministers would extensively utilize referral resources because of the diversity of the problems they were expected to handle. However, he was surprised to discover that the majority of the ministers surveyed refer 10 percent and less of their parishioners to other resources.

This study further revealed that 38 percent of the ministers surveyed felt that their seminary counseling training was moderately to very adequate. The remaining 62 percent indicated that their training was somewhat to significantly deficient. These ministers specifically indicated that seminary counseling training in areas of depression, alcoholism, suicidal thoughts, drug abuse, abortion, masturbation, child abuse and spouse abuse, and

homosexuality was somewhat inadequate to very inadequate.

Stephan (1971) directed a research project that was designed to study the counseling practices of clergymen. The major purposes of this study were to find out if the clergyman was doing more counseling then than 10 years ago, whether there was any change in the types of counseling problems over the past 10 years, to find the relationship between the types of problems brought to him and those with which he felt most helpful, and to discover the relationship between problems least brought to him and those he found most difficult. A questionnaire was sent to 300 randomly selected clergymen: 150 in St. Louis and 150 in San Diego. Although 113 questionnaires were returned, only 91 were analyzed.

From the collected data it was concluded that the clergy are doing more counseling, particularly in those areas where they feel most adequate and helpful. For example, more counseling cases were reported in the area of marriage problems. This was also the area that the ministers felt most helpful. Areas of drug usage, alcoholic problems, and personality disorders were the most difficult areas for the clergy to counsel. They also reflected the fewest number of cases brought to the minister. This finding led Stephan (1971) to state that counseling done by clergymen may not reflect some of the more troubling social issues that the church members have because these areas were too

difficult to counsel. This finding strongly indicated that the clergyman needs additional training in order to counsel these particular social issues.

VI. SUMMARY

While the literature is very limited and elusive in this area, the message that it reveals is quite plain. The local minister is, and has been for years, in a very strategic position to provide health related information and counseling to those whom he serves. The time is upon us when the minister needs to become an active part of today's health team.

The idea of extending health education to the church setting is very attractive because within this setting whole families can be served. It is a logical idea as well. Literature indicates that the church member has come to expect help in health-related problems from the church leaders. The average minister is finding himself beset by various counseling situations daily. It is attractive also because the goals of religion and health education complement each other and in some instances are common to both domains.

Even though the idea of extending health education to the church setting is both attractive and logical, it is not free of limitations. The largest limitation, and the most obvious, is that the church is unprepared to respond

to many of the health needs of today. While the minister is rapidly discovering that more and more of his time is being spent in counseling situations, the curricula of the various seminary programs have changed very little since they were designed (Jones, 1978). This is acutely frustrating especially to the novice minister because he is finding that religious counseling, the type of counseling for which he was best prepared, is not the type of counseling he is called upon to do most frequently (Hamilton, 1972).

CHAPTER III

STUDY DESIGN

I. INTRODUCTION

Past studies have been consistent in revealing that the majority of ministers surveyed thought their seminary preparation for the type of counseling they were most frequently asked to do was inadequate (Stephan, 1971; Hamilton, 1972; Givens, 1976; and Virkler, 1979). Virkler concluded from his study:

There is a need for periodic assessment of the counseling demands made upon ministers, and for developing a seminary counseling curriculum and a continuing education curriculum that reflects those needs (1979, p. 279).

This lack of periodic assessment of counseling demands made upon ministers and the development of a seminary counseling curricula that reflects those needs presents a serious limitation on the work of the church.

The purpose of this study was to characterize current health counseling practices of the church of Christ minister and to identify areas of needed health counseling competencies which should be addressed during professional preparation of the minister. With this purpose in mind, this researcher proceeded to obtain this information by conducting a survey of a stratified sample randomly drawn from the population of active, local ministers of the churches of Christ in the states of Arkansas, California, Oklahoma, Tennessee, and Texas.

II. SELECTION OF SUBJECTS

The subjects which made up the sample for this study came from the population of active, local ministers of the churches of Christ who resided in the states of Arkansas, California, Oklahoma, Tennessee, and Texas. The study was delimited to these states because they contained the largest percentages of local congregations of the churches of Christ in the United States. These five states also contained the largest percentage of schools, colleges, and universities that trained ministers and were supported by the churches of Christ in the United States.

Because no directory of the church of Christ ministers existed it was decided to utilize the latest directory available which listed all the local congregations of the churches of Christ by state. The churches which were located in the states of Arkansas, California, Oklahoma, Tennessee, and Texas were consecutively numbered. It was found that these states contained a total of 5,305 churches. The random, proportional stratified sampling technique was used to obtain a sample of churches that would represent 5 percent of this population of 5,305. These churches were stratified only by state. Simple mathematical computations were used to ensure that the sample was proportionate.

After randomly entering a table of random numbers, 266 churches (5 percent of the population) were selected. Table 3-1 shows the breakdown of this sample by state. The

TABLE 3-1. Population Distribution and Derived Sample Size of Church of Christ Ministers, 1980-1981

State	Assigned Numbering	Total Churches in State	Percent of Popula- tion	Random Proportional Stratified Sampling Size	Percent of Sample
Arkansas	1- 651	651	12.3	33	12.3
California	652-1,202	551	10.3	28	10.3
Oklahoma	1,203-1,805	603	11.4	30	11.4
Tennessee	1,806-3,310	1,505	28.4	75	28.4
Texas	3,311-5,305	<u>1,995</u>	<u>37.6</u>	<u>100</u>	<u>37.6</u>
TOTAL		5,305	100.0	266*	100.0

*Sample size equals 5 percent of population.

questionnaire was then addressed to the minister in care of the church selected. If the church had more than one minister, only one was to answer the questionnaire. If the church did not have a person serving as minister, that church was to indicate this and return the unanswered questionnaire.

III. INSTRUMENTATION

Previous related studies by Givens (1976), Virkler (1979), and Stephan (1971) had incorporated the use of a questionnaire. However, none of these questionnaires would lend themselves to the collection of data desired by this study. Therefore, a questionnaire was specifically designed for use in this study (Appendix A).

The final form of the questionnaire evolved after it had been submitted to a selected 11-member jury. This jury consisted of four health professionals, three full-time church of Christ ministers, and four academic or administrative personnel employed by church of Christ supported colleges or universities (Appendix B). The task of this jury was to aid in the validation of the questionnaire. Specifically, they were to determine if the questionnaire would measure what it had been designed to measure. The jury members were encouraged to make comments and suggestions concerning directions, answering procedures, and specific items. Critical, constructive evaluation of this

questionnaire identified instrument deficiencies. Suggestions for improvement were made to eliminate these perceived deficiencies.

A total of three revisions were made. While the format of the questionnaire remained the same throughout these revisions, the number of items included were increased. Several changes were made in the wording of the items to improve on reader clarity. These word changes were made in an attempt to rid the instrument of any ambiguous terms which might have caused biased responses. For example, it was suggested by the jury that the phrase "seminary training" be changed to "ministerial training" because "seminary training" was a term that was not generally used among the churches of Christ. Also, the question, "Have you participated in any coursework (i.e. seminars, workshops college classes, etc.) in the areas listed since your initial training?" was added in an attempt to eliminate any bias that such participation may have had on the degree of competency the minister had in health counseling situations. Such a question also gave strength to areas of needed training in the preparation of the minister.

Two additional types of counseling cases were added to the original list: smoking and spiritual growth. Although drug education was listed, the jury suggested that smoking should be listed separately as was alcohol problems because of its commonplace among counseling cases. It was pointed

out that "spiritual growth" was needed to differentiate between "doctrinal" cases which was listed. While both types of counseling cases were biblically based, it was suggested that they were two separate counseling areas. It was reasoned that doctrinal counseling would teach doctrine while "spiritual growth" suggested counseling that helped a person live with doctrine.

The revised questionnaire consisted of 17 items. The first seven items solicited demographic information from the minister. Question eight and nine revealed whether or not counseling was thought to be an important aspect of their ministry and the percentage of their work time that was spent in counseling situations. The final eight questions of the instrument were designed in such a way that they could be applied to a list of specific types of counseling cases. Such a design allowed this researcher to compare specific responses of the various items and categories quickly and easily. Also these last eight items asked for specific information which provided direction for accomplishing the purpose of the study.

IV. DATA COLLECTION

The questionnaire was mailed to each minister in the study sample. A cover letter explaining the purpose of the study, instructions for answering the questionnaire, and an addressed, stamped envelope for use in returning the

survey were included in this mailing. In an effort to better ensure an optimum return rate, permission was obtained from the elders of the Laurel Church of Christ in Knoxville, Tennessee, to utilize their church office as a collection point for the return of these questionnaires. These elders also wrote a letter of introduction to be included in the initial mailing of the instrument. Within this letter they indicated their support of this research and encouraged each minister to participate in the study as requested.

A postcard was mailed to those ministers who had not completed and returned the questionnaire within the three week interval following the initial mailing. It was hoped that this postcard would serve as a reminder and a stimulus to return the questionnaire.

A third mailing was sent after a second three week interval had elapsed since the mailing of the postcard. This mailing included another letter from this researcher pointing out the purpose of the study and its importance, a second copy of the questionnaire, and a self-addressed stamped envelope for returning the questionnaire. A deadline was specified within this letter.

Appendix C contains copies of these letters.

V. ANALYSIS OF DATA

The data were tabulated from the individual questionnaires prior to the cut-off date of January 16, 1980. Initially the data were presented in basic summary form revealing percentages and most common answers for the entire sample. This was done to give an overall report of the minister in general. However, in order to address the research questions as stated in the problem of the study in Chapter I, the original sample was broken down in each of the following ways:

1. by type of ministerial training or education received.
2. by size of local church presently serving.
3. by length of time in ministry.
4. by age.
5. by size of community in which the church was located.
6. by state.

The data were then computed and reported in a manner that would represent each of these various breakdowns. Kendall's coefficient of concordance, W , was used to determine if agreement existed among and between each of these breakdowns or sub-samples.

For the sake of comparison, sub-groups had to be established and identified within each category of the original parent sample. To compare responses of ministers

according to the type of training or education they had received in preparation for the ministry, the following groups were identified:

Group A--ministers who had graduated from a two year school.

Group B--ministers who had graduated from a four year college or university.

Group C--ministers who had graduated from both a two year school and a four year college or university.

Group D--ministers who had attended but not graduated from a school, college, or university.

Group E--ministers who had never attended a training institution.

To compare responses of ministers according to the size of the congregation they were serving, the following sub-groups were identified:

Group A--250 members or less

Group B--251-500 members

Group C--501 members and above

To compare responses of ministers according to the professional experience of the minister, the following subsamples were identified:

Group A--1-5 years of experience

Group B--6-10 years of experience

Group C--11-15 years of experience

Group D--16-20 years of experience

Group E--21-25 years of experience

Group F--over 25 years of experience

To compare responses of ministers according to the age of the minister, the following sub-samples were identified:

Group A--21-30 years of age

Group B--31-40 years of age

Group C--41-50 years of age

Group D--51-60 years of age

Group E--over 60 years of age

To compare responses of ministers according to the size of the community in which the church is located, the following sub-samples were identified:

Group A--less than 5,000

Group B--5,000-15,000

Group C--15,001-30,000

Group D--30,001-60,000

Group E--60,001-100,000

Group F--over 100,000

As previously mentioned, the Kendall coefficient of concordance, $\underline{W}$, was used to determine the extent to which there was agreement among the various groupings of the ministers. The main advantage of using $\underline{W}$ in these comparisons was that it established a coefficient of association for more than two variables, thus demonstrating the amount of agreement among persons or groups according to any

number of dimensions (Champion, 1970). The Spearman rank correlation coefficient, r_s , was used when a coefficient of association was needed for only two variables.

The chi-square statistic was used to determine if any relationships existed among the nominal level data. This statistic was used with comparisons of both two independent sample data and k-independent sample data.

An alpha level of .05 was used in all comparisons.

VI. CURRICULUM DEVELOPMENT

Once the major needed health counseling competencies of the minister as perceived by the study sample were identified, a conceptual health curriculum was developed. This conceptual curriculum was designed in such a way that it could be implemented in both two year and four year training institutions. This curriculum consisted of unit concepts, sub-concepts, and student objectives. This design was selected because it could be adapted to various teaching styles and methods. It could also be adapted to either the quarter system or the semester system of education simply by adjusting its sequence. This curriculum design would also allow the instructor freedom of choice in content, evaluation methods and the use of supplementary and media resources.

VII. SUMMARY

Two hundred and sixty-six ministers of the churches of Christ were randomly selected to participate in this study using the random, proportional stratified sampling technique. A questionnaire was designed. The survey questionnaire was mailed to each minister in the study sample during the month of November, 1980. A cover letter explaining the purpose of the study, a letter of introduction and approval by the elders of the Knoxville, Tennessee, Laurel Church of Christ, the questionnaire, and an addressed, stamped envelope for use in returning the survey were included in this mailing. A follow-up postcard requesting that the questionnaire be answered and returned was sent to those not completing and returning it after three weeks had elapsed since the initial mailing. A third mailing was mailed three weeks after the second mailing. This mailing included another cover letter which further explained the purpose of the study, a copy of the questionnaire, and another self-addressed, stamped envelope. No data were included in the study after the January 16, 1981 deadline.

Data were tabulated and grouped to answer the research questions of the study using the SAS-79 computer package. Statistical treatment of the data included use of the Kendall coefficient of concordance, The Spearman rank correlation coefficient, and the chi-square statistic. An alpha level of .05 was used in all statistical comparisons.

A conceptual health education curriculum was then designed based on the data and comparisons made to meet the perceived health counseling needs of the minister.

CHAPTER IV

ANALYSIS OF THE DATA

I. INTRODUCTION

In this chapter the data were analyzed from the administration of the questionnaire to 266 ministers. Using the random, proportional stratified sampling technique the questionnaire was mailed to 33 ministers in Arkansas, 28 ministers in California, 30 ministers in Oklahoma, 75 ministers in Tennessee, and 100 ministers in Texas.

Of the initial 266 questionnaires, 137 (52 percent) could be accounted for after the return deadline of the third mailing. Twenty-nine (20 percent) of the 137 questionnaires returned could not be used in the study for the following reasons:

1. Seven ministers refused to participate in the study.
2. Seven congregations returned the questionnaire stating that they had no minister.
3. Six questionnaires were returned by the post office after the third mailing stating that the addressed congregation had disbanded.
4. Nine questionnaires were rejected because responses were too incomplete.

Data from the remaining 108 questionnaires were recorded on computer cards and analyzed utilizing the computer program package, Statistical Analysis System (SAS-79).

II. SAMPLE DESCRIPTION

Table 4-1 depicts the distribution of the 108 ministers utilized within this study by state. This distribution compares favorably with the distribution hoped for as a result of random, proportional stratified sampling. The states of Arkansas and Tennessee contributed a lower proportion of ministers to the sample than was expected. The other states yielded a slightly higher percentage of the sample than was anticipated.

TABLE 4-1. Distribution of Church of Christ Ministers Participating in the Study by State, 1980-1981

State	Number of Responses	Percent of Sample
Arkansas	12	11.10
California	13	12.04
Oklahoma	15	13.89
Tennessee	23	21.30
Texas	45	41.67
TOTAL	108	100.00

The ministers participating in this study represented various community sizes. However, as Table 4-2 indicates, more ministers (37.96 percent) were serving congregations that were located in communities of less than 5,000

population. The second largest group (17.59 percent) represented communities of 5,000 to 15,000 population. Those ministers working in communities with a greater than 100,000 population comprised the third largest proportion of the sample. The smallest represented community size was that with a population in the 60,000 to 100,000 range.

TABLE 4-2. Distribution of Church of Christ Ministers Participating in the Study by Community Size, 1980-1981

Community Size	Number of Responses	Percent of Sample
< 5,000	41	37.96
5,000- 15,000	19	17.59
15,001- 30,000	13	12.04
30,001- 60,000	9	8.33
60,001-100,000	8	7.41
> 100,000	18	16.67
TOTAL	108	100.00

The data indicated that the majority (64.82 percent) of the ministers who participated were serving churches with 250 members or less. Table 4-3 depicts the breakdown by congregation size.

TABLE 4-3. Distribution of Church of Christ Ministers Participating in the Study by Congregation Size, 1980-1981

Congregation Size	Number of Responses	Percent of Sample
250 and less	70	64.82
251-500	31	28.70
501 and above	7	6.48
TOTAL	108	100.00

The average years of preaching experience was computed to be 17.61. The minister with the least amount of experience indicated that he had been preaching full-time for the past two years. The minister with the most preaching experience stated that he had been preaching full-time for the past 50 years. Table 4-4 shows the distribution of the sample by actual preaching experience. Those ministers who had greater than 25 years preaching experience made up 22.43 percent of the sample. The next largest groups were those ministers who had 11 to 15 years preaching experience, 6 to 10 years preaching experience, and 21 to 25 years preaching experience, respectively. The 16 to 20 years preaching experience group had the fewest number of ministers.

The average amount of local experience with the present congregation was found to be 4.61 years. The minimum amount

of local experience was one year while the maximum amount of local experience was 24 years.

TABLE 4-4. Distribution of Church of Christ Ministers Participating in the Study by Amount of Preaching Experience, 1980-1981

Years Preaching Experience	Number of Responses	Percent of Sample
1- 5	14	13.08
6-10	20	18.69
11-15	22	20.56
16-20	9	8.41
21-25	18	16.82
> 25	24	22.43
No Response	1	---
TOTAL	108	100.00

The average age of the sample of ministers was 41.88 years. The youngest minister participating in the study was 23 years of age. The oldest participating minister was 68 years of age. The largest age group, as indicated by Table 4-5, was that group consisting of ministers between the ages of 31 and 40 which represented 33.02 percent of the sample. The second largest age group, those ministers aged 41 to 50, made up 24.53 percent of the sample. The fewest number of responses came from the group of ministers who were more than 60 years of age.

TABLE 4-5. Distribution of Church of Christ Ministers Participating in the Study by Age Group, 1980-1981

Age Group	Number of Responses	Percent of Sample
21-30	19	17.93
31-40	35	33.02
41-50	26	24.53
51-60	20	18.87
> 60	6	5.66
No Response	2	---
TOTAL	108	100.00

It was discovered that 81 percent of the sample had received some type of formal training in preparation for the ministry. The remaining 19 percent indicated that they had received no formal training for the ministry. A grouping according to educational background was desired for comparative reasons. Table 4-6 indicates the number of ministers with various educational backgrounds. The majority (58.33 percent) of the ministers participating in the study had graduated from a four year college or university. Overall, 77.78 percent of the sample had graduated from a school, college, or university.

TABLE 4-6. Distribution of Church of Christ Ministers Participating in the Study by Educational Background, 1980-1981

Education Group	Number of Responses	Percent of Sample
Two year graduates	11	10.19
Four year graduates	63	58.33
Two year and four year graduates	10	9.26
Attended only	19	17.59
Never attended	5	4.63
TOTAL	108	100.00

In response to the question, "Do you perceive counseling to be an important aspect of your ministry?" 91 percent of the ministers stated that it was. The majority of the sample (64.82 percent) indicated that they spent up to 20 percent of their work time in counseling situations. Table 4-7 shows overall response to the above question concerning amount of time spent in counseling situations. Ministers who spent more than 20 percent of their time counseling made of 35.18 percent of the sample. The remaining 64.82 percent of the ministers spent 20 percent or less of their work time in counseling situations.

TABLE 4-7. Distribution of Church of Christ Ministers Participating in the Study According to Time Spent Counseling, 1980-1981

Percent Time Spent Counseling	Number of Responses	Percent of Sample
0-20	70	64.82
21-40	30	27.78
41-60	7	6.48
61-80	1	.93
TOTAL	108	100.00

III. PRESENTATION OF DATA

When asked to rank order the actual types of counseling cases that they were involved with from those most counseled to those least counseled, the following pattern emerged. Marital problems were counseled the most by the minister followed by spiritual growth, doctrinal, pre-marital, mental or emotional, patient counseling, death education, smoking, suicide, child abuse, and venereal disease. The following areas received mention under the heading of "other": parent-child relationships, leadership counseling, family relationships, life goals and purposes, homosexuality, and racial status problems.

Table 4-8 shows the varied responses of the sample when they were asked to indicate the appropriate number of

TABLE 4-8. Response of Church of Christ Ministers to Item #11 of Questionnaire, "Circle the Approximate Number of Persons You Counsel In This Area Per Year." Reported in Percentages, 1980-1981

Counseling Area	N	Number of Persons Counseled Per Year					
		1-10	11-20	21-30	31-40	41-50	> 50
Venereal Disease	61	98	2	0	0	0	0
Suicide	72	94	6	0	0	0	0
Child Abuse	66	94	5	2	0	0	0
Alcohol	94	89	10	0	1	0	0
Drug Use and Abuse	77	87	5	4	1	0	3
Smoking	78	83	13	4	0	0	0
Aging	81	74	17	5	2	0	1
Sex Education	80	68	23	5	1	1	3
Mental or Emotional	88	65	19	7	5	2	2
Death Education	82	61	21	10	2	2	4
Pre-Marital	96	55	29	7	4	2	2
Patient Counseling	80	48	26	9	5	5	8
Marital	99	47	27	4	7	3	11
Doctrinal	98	27	30	12	7	6	18
Spiritual Growth	94	20	26	13	9	12	21

persons counseled in the different areas per year. By arranging the counseling areas in descending order under the column heading of 1 to 10 persons counseled per year, those areas in which the least amount of people came to the minister for counsel were easily recognized. The ministers counsel fewer people in the areas of venereal disease, suicide, and child abuse respectively. Those counseling areas which were drug related were areas in which fewer persons sought help from the minister. However, in the areas of patient counseling, marital counseling, doctrinal counseling, and spiritual growth, more than 50 percent of the ministers reported that they counsel more than 10 persons per year. In these same four areas, 25 percent or more of the ministers reported that they counsel more than 20 persons per year.

Table 4-9 depicts the age groups most often counseled by ministers in each counseling area. The 10-20 year old age group received the most counseling in the areas of pre-marital counseling, drug use, venereal disease, sex education, and smoking. The 21-30 year old age group received the most counseling in the areas of alcohol, doctrinal, marital problems, suicide, child abuse, and spiritual growth. The 31-40 year old age group led all other age groups in seeking counsel in the area of mental and emotional health. The 51-60 year old age group received more patient counseling than the other groups. As expected,

TABLE 4-9. Response of Church of Christ Ministers to Item #12 of Questionnaire,
"Circle the Age Group that is Most Often Counseled in Each Area."
Reported in Percentages, 1980-1981

Counseling Area	N	Age Groups Counseled						
		10-20	21-30	31-40	41-50	51-60	> 60	
Venereal Disease	58	88	10	0	2	0	0	0
Sex Education	74	81	15	4	0	0	0	0
Drug Use and Abuse	76	76	22	0	1	0	0	0
Pre-Marital	93	72	27	1	0	0	0	0
Smoking	71	38	28	20	8	6	0	0
Suicide	65	26	45	11	12	5	2	2
Alcohol	91	20	26	21	22	9	2	2
Spiritual Growth	97	8	49	26	16	1	0	0
Mental or Emotional	85	7	33	34	19	6	1	1
Child Abuse	61	7	66	25	3	0	0	0
Death Education	76	4	5	1	5	32	53	53
Doctrinal	93	3	53	28	13	2	1	1
Aging	76	1	9	0	0	25	64	64
Marital	98	0	49	43	5	3	0	0
Patient Counseling	74	0	12	16	26	30	16	16

the age group of 60 and over received more counseling in the areas of aging and death education.

A major concern of this study was whether or not the ministers surveyed felt that their training for the ministry adequately prepared them to counsel in the area listed. They had already indicated that they were counseling in the areas listed, but had they been adequately prepared to do such counseling? With the exception of doctrinal and spiritual growth areas, over 50 percent of the ministers who responded indicated that they were not adequately trained to counsel in the areas listed. Table 4-10 shows the actual response in percentage form and then allows the reader to compare the response to the actual rank order of most often counseled areas to the least often counseled areas. For example, 59 percent of the ministers stated that they were not adequately trained to counsel in the area of marital problems but it was the area that they were most often asked to provide counsel. Fifty-four percent of the ministers stated that they had not been adequately trained to offer counsel in the area of pre-marital problems, which had been identified as the fourth most counseled area. Similarly, 81 percent of the ministers felt that they had not been adequately trained to offer counsel in the area of mental or emotional problems, yet it was the fifth most often counseled area. Only in the counseling areas of spiritual growth and doctrinal problems did the majority of

the ministers feel that they had been adequately trained to offer counsel.

TABLE 4-10. Response of Church of Christ Minister to Item #13 of Questionnaire, "Did Your Training for the Ministry Adequately Prepare You to Counsel in This Area?" Reported in Percentages and Contrasted to Most to Least Counseled Area, 1980-1981

Counseling Area	N	Response		Rank Order From Most To Least Counseled Area
		Yes	No	
Marital	102	41	59	1
Spiritual Growth	98	78	22	2
Doctrinal	102	86	14	3
Pre-Marital	99	46	54	4
Mental or Emotional	95	19	81	5
Patient Counseling	89	39	61	6
Death Education	91	41	59	7
Alcohol	98	28	72	8
Drug Use and Abuse	88	19	81	9
Aging	90	30	70	10
Sex Education	88	36	64	11
Smoking	86	38	62	12
Suicide	87	18	82	13
Child Abuse	83	13	87	14
Venereal Disease	84	14	86	15

Although the majority of the ministers indicated that they had not been adequately trained to counsel in the health related areas listed, most felt adequate to very adequate in offering such counsel. Table 4-11 shows the percentage response of the minister to the question, "How adequate do you feel counseling these types of cases?" Totals were computed so that the four original categories of very adequate, adequate, inadequate, and very inadequate could be collapsed into two categories and simply labeled total adequate and total inadequate. This was done so that statistical procedures could be properly performed.

Collapsing these categories revealed that 93 percent of the ministers felt adequate to counsel doctrinal problems. Eighty-nine percent of the ministers felt adequate to offer counsel in the area of spiritual growth. In the counseling areas of pre-marital counseling and smoking, 77 percent of the ministers felt adequate to counsel others. On the other end of the spectrum, 35 percent of the ministers felt adequate to counsel in the area of suicide.

As Table 4-12 indicates, an overwhelming majority of the ministers surveyed said that they would recommend that educational programs be required in all areas that were listed. These programs would be required while the minister was in formal training for the ministry. The lowest percentage of positive response was found in the venereal disease category, only 82 percent of the ministers would

TABLE 4-11. Response of Church of Christ Ministers to Item #14 of Questionnaire, "How Adequate Do You Feel Counseling These Types of Cases?" Reported in Percentages, 1980-1981

Counseling Area	N	Total ¹		Total ²		Very Inadequate	Inadequate	Very Adequate	Inadequate	Very Adequate	Inadequate
		Adequate	Very Adequate	Adequate	Very Adequate						
Doctrinal	103	93	53	40	7	4	3				
Spiritual Growth	100	89	48	41	11	5	6				
Pre-Marital	100	77	21	56	23	3	20				
Smoking	83	77	20	57	23	0	23				
Sex Education	86	75	13	62	26	3	26				
Patient Counseling	87	72	13	59	29	6	23				
Marital	104	70	15	55	30	6	24				
Death Education	87	67	20	47	33	3	33				
Aging	87	61	10	51	39	8	31				
Alcohol	99	55	7	48	44	10	34				
Drug Use and Abuse	86	50	8	42	50	10	40				
Venereal Disease	79	45	8	37	56	22	34				
Child Abuse	80	44	5	39	56	20	36				
Mental or Emotional	93	41	6	35	58	14	44				
Suicide	83	35	6	29	65	22	43				

¹Sum of columns "very adequate" and "adequate"

²Sum of columns "very inadequate" and "inadequate"

require this program. In all other categories, 87 percent or more of the ministers recommended that educational programs be required during ministerial training.

TABLE 4-12. Response of Church of Christ Ministers to Item #15 of Questionnaire, "Would You Recommend that Educational Programs be Required in This Area During Ministerial Training?" Reported in Percentages, 1980-1981

Counseling Area	N	Response	
		Yes	No
Marital	106	99	1
Doctrinal	105	99	1
Pre-Marital	103	99	1
Spiritual Growth	103	97	3
Patient Counseling	96	97	3
Mental or Emotional	101	96	4
Death Education	96	95	5
Alcohol	101	94	6
Drug Use and Abuse	95	94	6
Suicide	95	93	7
Aging	93	90	10
Sex Education	95	89	11
Child Abuse	94	89	11
Smoking	91	87	13
Venereal Disease	93	82	18

Question 16 of the questionnaire asked the respondents to rank order the listed counseling cases from their highest felt need to their lowest felt need. Table 4-13 reveals the overall rankings given to each category. The five highest felt needs of the ministers were in the counseling areas of marital problems, spiritual growth, pre-marital problems, doctrinal problems, and mental or emotional problems, respectively. The counseling areas of venereal disease, smoking, child abuse, and suicide were the lowest felt needs, respectively.

When asked if they had participated in any coursework (i.e. seminars, workshops, college classes, etc.) in the areas listed since their initial training, the response was varied. The largest percentage of the ministers (74 percent) had participated in coursework in the counseling areas of doctrine and spiritual growth. Seventy-one percent of the ministers reported that they had participated in coursework dealing with the marital counseling areas. Less than 60 percent of the ministers had participated in the other 12 counseling areas. The area of venereal disease attracted the lowest percentage (18 percent) of the ministers. Table 4-14 shows the precise response in each area.

TABLE 4-13. Counseling Areas Ranked From Highest Felt Need to Lowest Felt Need as Perceived by Church of Christ Ministers, 1980-1981

Counseling Area	Rank Order
Marital	1
Spiritual Growth	2
Pre-Marital	3
Doctrinal	4
Mental or Emotional	5
Alcohol	6
Drug Use and Abuse	7
Patient Counseling	8
Death Education	9
Aging	10
Sex Education	11
Suicide	12
Child Abuse	13
Smoking	14
Venereal Disease	15

TABLE 4-14. Response of Church of Christ Ministers to Item #17 of Questionnaire, "Have You Participated in Any Coursework (i.e. Seminars, Workshops, College Classes, etc.) in the Areas Listed Since Your Initial Training?" Reported in Percentages, 1980-1981

Counseling Area	N	Response	
		Yes	No
Doctrinal	101	74	26
Spiritual Growth	97	74	26
Marital	105	71	29
Pre-Marital	101	57	43
Drug Use and Abuse	92	54	46
Alcohol	98	49	51
Mental or Emotional	95	48	52
Sex Education	90	47	53
Patient Counseling	90	44	56
Death Education	94	43	57
Aging	91	40	60
Suicide	90	29	71
Child Abuse	87	28	72
Smoking	86	22	78
Venereal Disease	88	18	82

IV. STATISTICAL TREATMENT OF THE DATA

A primary interest of this study was to find out if the variables of age, state, congregation size, community size, educational background, and preaching experience had any effect upon the rank orders assigned by the ministers regarding questions 10 and 16 of the questionnaire. Specifically, the question to be answered was, "Does agreement exist among the ministers in the ranks assigned to the counseling cases?" Kendall's coefficient of concordance was used to determine if agreement existed. A chi-square test was then made to determine the power of the derived coefficient. An alpha level of .05 was applied in all comparisons.

The technique used to determine the Kendall coefficient of concordance was that described by Siegel (1956).¹ The formula used to compute the Kendall coefficient of concordance, $\underline{W}$, for k-independent samples was:

$$W = \frac{S}{\frac{1}{12} k^2 (N^3 - N)}$$

where:

S = sum of squares of the observed deviations from the mean of the summation of ranks

k = number of sets of rankings

N = number of counseling cases ranked

¹For a complete step-by-step method of computing $\underline{W}$ see Siegel (1956).

The chi-square formula used to determine the significance of the relationship, $\underline{W}$, was:

$$\chi^2 = k(N-1)\underline{W}$$

This chi-square value was then compared to a table of critical chi-square values at the .05 level of significance with $N-1$ degrees of freedom.

Agreement was found to exist in each comparison when attention was focused on question 10 of the questionnaire which dealt with the ranks assigned to the listed counseling areas according to actual counseling experience of the minister. Table 4-15 presents a summary of the derived coefficients of concordance and the strength of this agreement. Although an alpha level of .05 was utilized, it is worth noting that all tests were significant at the .001 level. Tables depicting the ranks from which the coefficients were computed are presented in Appendix D.

Agreement was also found to exist in each comparison when attention was focused on item 16 of the questionnaire. This item provided a ranking of all counseling areas according to the felt needs of the minister answering the questionnaire. Table 4-16 presents a summary of the derived coefficients of concordance and the strength of this agreement. Again, all were significant at the .001 level. Tables showing the ranks from which the coefficients were computed are presented in Appendix E.

TABLE 4-15. Summary of the Kendall Coefficient of Concordance Assigned According to the Church of Christ Minister's Actual Counseling Experience, 1980-1981

Variable	<u>W</u>	χ^2	P
State	.9399	66.06	.001
Community Size	.9102	76.44	.001
Congregation Size	.9105	38.24	.001
Age Group	.8443	58.80	.001
Preaching Experience	.8974	75.38	.001
Educational Level	.8939	62.30	.001

TABLE 4-16. Summary of the Kendall Coefficient of Concordance Assigned According to the Church of Christ Minister's Felt Needs, 1980-1981

Variable	<u>W</u>	χ^2	P
State	.9077	63.54	.001
Community Size	.9082	76.44	.001
Congregation Size	.8920	37.38	.001
Age Group	.8410	58.80	.001
Preaching Experience	.9236	77.58	.001
Educational Level	.9122	63.70	.001

It was also found that agreement existed at the .001 level of significance between the actual experience (item 10) rankings and the perceived needs rankings (item 16). The Spearman rank correlation coefficient was used in this comparison because k was equal to two. The technique used to determine the Spearman rank correlation coefficient was that described by Siegel (1956). The formula used to compute the Spearman rank correlation coefficient, r_s , for two independent samples was:

$$r_s = 1 - \frac{6\sum d^2}{N^3 - N}$$

where:

d^2 = the difference between the two ranks squared

N = the number of counseling cases ranked

The t formula used to determine the significance of the relationship, r_s , was:

$$t = r_s \sqrt{\frac{N-2}{1-r_s^2}}$$

This t value was then compared to a table of critical two-tailed t values with $N-2$ degrees of freedom.

Table 4-17 reveals that a high degree of agreement was found to exist using r_s . The t test rendered this correlation coefficient of .9572 significant at an alpha of .001.

The chi-square statistic was used to determine if a significant relationship existed between the responses of

TABLE 4-17. A Comparison of Rankings of Counseling Areas According to Actual Counseling Experience to Rankings According to Perceived Felt Needs as Ranked by Church of Christ Ministers, 1980-1981

Counseling Area	Rank By Counseling Experience	Rank By Perceived Felt Need	<u>d</u>	<u>d</u> ²
Marital	1	1	0	0
Spiritual Growth	2	2	0	0
Doctrinal	3	4	-1	1
Pre-Marital	4	3	1	1
Mental or Emotional	5	5	0	0
Patient Counseling	6	8	-2	4
Death Education	7	9	-2	4
Alcohol	8	6	2	4
Drug Use and Abuse	9	7	2	4
Aging	10	10	0	0
Sex Education	11	11	0	0
Smoking	12	14	-2	4
Suicide	13	12	1	1
Child Abuse	14	13	1	1
Venereal Disease	15	15	0	0
				$\Sigma \underline{d}^2 = 24$

$$r_s = 1 - \frac{6 \Sigma d^2}{N^3 - N}$$

$$r_s = 1 - \frac{144}{3360}$$

$$r_s = 1 - .0428$$

$$r_s = .9572$$

$$t = r_s \sqrt{\frac{N-2}{1-r_s^2}}$$

$$t = .96 \sqrt{\frac{13}{.083}}$$

$$t = .96 (12.515)$$

$$t = 12.01^*$$

*Significant at .001

items 13 and 14, items 13 and 15, items 14 and 15, items 14 and 17, items 15 and 17, and items 13 and 17. Because in many of these comparisons the observed and expected frequencies were small and because the N was so large that use of the Fisher's Exact Test was impractical, the chi-square technique described by Siegel (1956) was used. For large N's the formula recommended for computing a 2 x 2 chi-square, χ^2 , was:

$$\chi^2 = \frac{N(|AD-BC| - \frac{N}{2})^2}{(A+B)(C+D)(A+C)(B+D)}$$

where:

N = number of respondents

A = observed frequency in cell a

B = observed frequency in cell b

C = observed frequency in cell c

D = observed frequency in cell d

This formula proved to be much more conservative than the more conventional χ^2 formulas. The computed χ^2 was entered into a two-tailed χ^2 table of critical values with (r-1) (c-1) degrees of freedom to determine significance.

Table 4-18 provides a summary of these chi-square values.

Using an alpha of .05, it was found that a significant relationship existed between adequacy of training and a feeling of adequacy in counseling in 9 of the 15 counseling cases listed when item 13 was compared with item 14 of the

TABLE 4-18. Summary of Chi-Square Values Utilizing Church of Christ Ministers' Response to Items #13, #14, #15, and #17 of Questionnaire, 1980-1981

Counseling Area	13 x 14 χ^2	13 x 15 χ^2	14 x 15 χ^2	14 x 17 χ^2	15 x 17 χ^2	13 x 17 χ^2
Alcohol	6.201*	1.112	.080	4.701*	1.534	1.962
Aging	10.931*	.000	.052	9.265*	.560	2.392
Pre-Marital	1.604	.004	.451	.348	.024	.677
Drug Use and Abuse	16.189*	.449	.215	3.542	2.247	4.135*
Doctrinal	.175	1.223	2.940	.001	.328	.030
Marital	5.898*	.029	.231	.182	.220	.000
Mental or Emotional	4.142*	.119	.041	18.654*	2.220	3.545
Venereal Disease	13.067*	1.832	3.313	7.775*	2.827	.387
Death Education	9.688*	.015	.845	1.844	.357	3.448
Patient Counseling	3.825	.169	.016	.736	1.038	2.201
Suicide	6.997*	.449	.112	6.388*	1.733	1.922
Child Abuse	2.108	.217	.018	10.208*	2.358	.040
Sex Education	3.673	1.145	.117	1.586	2.114	.750

TABLE 4-18 (continued)

Counseling Area	13 x 14 χ^2	13 x 15 χ^2	14 x 15 χ^2	14 x 17 χ^2	15 x 17 χ^2	13 x 17 χ^2
Smoking	4.778*	.401	.010	.916	.026	.010
Spiritual Growth	.175	1.318	.097	1.754	5.620*	.012

*Significant at .05

13 = Did your training for the ministry adequately prepare you to counsel in this area?

14 = How adequate do you feel counseling these types of cases?

15 = Would you recommend that educational programs be required in this area during ministerial training?

17 = Have you participated in any coursework (i.e. seminars, workshops, college classes, etc.) in the areas listed since your initial training?

questionnaire. The counseling areas of pre-marital, doctrinal, patient counseling, child abuse, sex education, and spiritual growth did not show a significant relationship between adequacy of training and a feeling of adequacy in counseling. Specifically it was observed that more ministers than were expected who stated that they had not received adequate training also stated that they felt inadequate to offer counsel. It was also observed that more ministers than were expected who stated that they had received adequate training also indicated they they felt adequate in providing counsel. This trend prevailed in all situations with the exception of the counseling cases of doctrinal and spiritual growth. Although the relationship in the areas of patient, suicide, and sex education counseling were not significant, they were approaching significance. However, in the cases of doctrinal and spiritual growth counseling, the minister felt adequate to offer counsel regardless of adequacy of training. The observed frequencies used to compute these values are given in Appendix F.

When felt adequacy of training (item 13) was compared with educational program recommendations (item 15), no significant relationships existed at the .05 level. While this may seem distorted or disturbing at first, investigation of the observed versus expected values within the chi-square cells adds strength to the study. The results of this chi-square application indicated that the ministers

recommended that educational programs in all counseling areas listed be required during ministerial training whether they felt they had been adequately prepared themselves or not. Expected and observed frequencies used to compute the chi-square values are listed in Appendix F.

No significant chi-square values resulted when felt counseling adequacy (item 14) was compared with education program recommendation (item 15). In all instances the ministers recommended educational programs be required regardless of felt counseling adequacy. Expected and observed frequencies used in computing the chi-square values can be examined in Appendix F.

As Table 4-18 indicated, significant relationships were found to exist in the counseling areas of alcohol, aging, mental or emotional problems, venereal disease, suicide, and child abuse when felt counseling adequacy (item 14) was compared with extra-curricular coursework or training received (item 17). These chi-square statistics revealed that those areas which showed a significant relationship were instances when fewer ministers who felt inadequate counseling in that area participated in extra-curricular coursework than was expected. Also there were instances when more ministers who felt they were adequate counseling in the specified areas participated in extra-curricular coursework than was expected. Observed and expected cell frequencies can be viewed in Appendix F.

The fifth column of Table 4-18 contains the computed values of chi-square when recommendation of required educational programs (item 15) was compared with participation of extra-curricular coursework or training (item 17). As indicated, there were no significant relationships at the .05 level, with the exception of the area of spiritual growth. A look at the expected and observed cell frequencies showed that the minister recommended educational programs be required during ministerial training regardless of participation in extra-curricular work or not. Again, the observed and expected cell frequencies for this set of comparisons can be found in Appendix F.

The last column of Table 4-18 contains the computed chi-square values which resulted when felt adequacy of training (item 13) was compared with extra-curricular coursework or training received (item 17). The only counseling area that showed a significant relationship was that of drug use. In that case fewer ministers who stated that their training for the ministry had not prepared them to counsel in the area of drug use had participated in extra-curricular work than was expected. Conversely, more ministers who stated that they had been adequately trained indicated that they had participated in extra-curricular work than was expected. Appendix F also contains the expected and observed frequencies of this comparison.

The chi-square statistic was also used to determine if

percentage of time spent counseling was significantly related to felt adequacy of training (item 13), felt adequacy of counseling (item 14), and participation of extra-curricular coursework (item 17). Because this set of comparisons yielded no small expected or observed cell frequencies, the chi-square technique employed by the statistical analysis system computer package (SAS-79) was used to compute chi-square.

Table 4-19 indicates that no significant relationships existed when percentage of time spent counseling was compared to felt adequacy of training (item 13). Whether the minister felt that his training had been adequate or not had little or nothing to do with percentage of time spent counseling.

When percentage of time spent counseling was compared to felt adequacy of counseling of the minister (item 14), significant relationships at the .05 level of significance were found to exist in mental or emotional counseling cases and death education counseling cases. In both instances more ministers than were expected, who stated that they spend 20 percent or less of their time in counseling situations, indicated that they felt inadequate counseling in these areas. Also more ministers than were expected of the group that spend more than 20 percent of their time in counseling situations stated that they felt adequate counseling persons with these types of problems.

TABLE 4-19. Summary of Chi-Square Comparisons of Percent Time Counseling to Items #13, #14, and #17 of the Questionnaire

Counseling Area	A x B χ^2	A x C χ^2	A x D χ^2
Alcohol	.422	.433	10.980*
Aging	.185	1.586	9.591*
Pre-Marital	.012	.224	12.241*
Drug Use and Abuse	.312	.052	10.031*
Doctrinal	1.195	.067	.363
Marital	.245	2.826	6.933*
Mental or Emotional	.724	6.094*	10.418*
Venereal Disease	1.031	2.193	2.203
Death Education	1.963	4.235*	3.140
Patient Counseling	.410	3.738	7.716*
Suicide	.021	2.274	5.338*
Child Abuse	.000	.379	7.338*
Sex Education	.028	.022	11.220*
Smoking	.480	.607	4.475*
Spiritual Growth	.880	.324	.1789

*Significant at .05 level

A = Percent time counseling

B = Did your training for the ministry adequately prepare you to counsel in this area?

C = How adequate do you feel counseling these types of cases?

D = Have you participated in any coursework (i.e. seminars, workshops, college classes, etc.) in the areas listed since your initial training?

As Table 4-19 indicates, significant relationships existed in 11 of the 15 counseling cases when percent time counseling was compared to participation in extra-curricular work. The counseling areas of doctrine, spiritual growth, venereal disease, and death education produced no significant relationships. In each comparison that produced a significant relationship, more ministers who stated that they spent 20 percent or more of their time in counseling situations had taken extra-curricular work than were expected.

Expected and observed frequencies of chi-square values reported in Table 4-19 are located in Appendix F.

Finally, the chi-square statistic was used to determine if significant relationships existed between counseling adequacy and the variables of preaching experience, age group, and educational level. Again, the SAS-79 computer package was used. However, because small observed and expected frequencies did occur in some comparisons a rule stated by Siegel (1956) was strictly followed. If the expected value in any cell of a chi-square comparison having greater than one degree of freedom was less than one, the test was rendered non-applicable.

Table 4-20 shows that preaching experience had no significant relationship to felt counseling adequacy of the minister except in the area of patient counseling. In that comparison it was found that more of the lesser experienced group, zero to five years, felt inadequate to offer patient

TABLE 4-20. Summary of Chi-Square Values Comparing Counseling Adequacy to Preaching Experience, Age Group, and Educational Level

Counseling Area	A x B χ^2	A x C χ^2	A x D χ^2
Alcohol	4.578	5.043	.708
Aging	6.324	6.096	19.381*
Pre-Marital	3.964	3.346	1.513
Drug Use and Abuse	5.011	5.860	7.743
Doctrinal	NA	NA	NA
Marital	5.780	2.634	1.011
Mental or Emotional	10.428	8.024	4.241
Venereal Disease	3.777	8.854	.916
Death Education	9.200	3.905	3.384
Patient Counseling	21.436*	4.268	3.695
Suicide	4.851	10.488*	7.414
Child Abuse	3.338	6.824	2.044
Sex Education	3.571	4.268	NA
Smoking	3.782	NA	8.582
Spiritual Growth	NA	NA	NA

*Significant at .05

NA = Not applicable because contained cells with
fe < 1

A = How adequate do you feel counseling these types
of cases?

B = Preaching experience

C = Age group

D = Educational level

education counseling than were expected.

The only instance that age group of the ministers was found to be significantly related to felt counseling adequacy was in the area of suicide counseling. More of the younger ministers, age group 20 to 25 years of age, felt inadequate to offer suicide counseling than was expected.

Aging was the only counseling area in which a significant relationship occurred between the minister's felt counseling adequacy and his educational level. Fewer of those ministers who had graduated from a two year school in preparation for the ministry felt adequate to offer counsel in the area of aging than was expected.

Expected and observed cell frequencies of the chi-square computations from which Table 4-20 was derived may be examined in Appendix F.

CHAPTER V

SUMMARY, FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

I. SUMMARY

Purpose of the Study

The purpose of this study was to characterize current health counseling practices of the church of Christ ministers and to identify areas of needed health counseling competencies which should be addressed during professional preparation of the minister.

Importance of the Study

The church has a great potential for aiding the health professional in educating the public in the area of health education. However, this potential has in the past been advocated primarily in principle, not in practice. In principle in that both organized religion and health education share a common goal: that of enhancing positive physical, mental, social, and spiritual growth of the individual. Overlooked in practice because the two have respected the individuality and independence of the other and have not attempted a joint effort in pursuing their goals.

This is not to say that in order to obtain optimum health one must be zealous in religion or spirituality; however, if one is to practice the ideals of spirituality,

that same person must also practice the concepts advocated by the health educator. As a result of this reality, the minister is in a strategic position to aid in health education. This study has indicated that the minister spends much time counseling people with health-related problems as well as those of a spiritual nature. Therefore, the minister does in fact function as a health educator.

This study was concerned with identifying those health competencies which, if developed in the professional preparation of the minister, would enable that minister to become a better health educator and counselor. It has become commonplace among health educators to provide for health needs and interests in an effort to produce positive health behavior and attitudes. The same approach has been used in this study. Not so much to identify the health education needs and interests of the minister per se but to identify the health needs and interests of those who come to the minister for counsel. In this manner, health counseling competencies could be identified and suggested as a necessary part of the prospective minister's training.

Procedure Followed

The target population of this study was church of Christ ministers within the states of Arkansas, California, Oklahoma, Tennessee, and Texas. These states were selected because of their large population of churches of Christ. These five states also contained the largest percentage of

schools, colleges, and universities that trained ministers and were supported by the churches of Christ. Utilizing the random, proportional stratified sampling technique, the ministers of 266 churches were selected to participate in the study.

A questionnaire was developed and mailed to all 266 ministers via the church address. Three mailings were initiated in an attempt to include all ministers in the study. Of the 266 ministers solicited, 52 percent responded. Of this percentage, 108 questionnaires were included in the data collection and analysis.

The questionnaire consisted of 17 items, eight of which requested response to 15 different counseling areas, was coded and the responses were recorded on computer data cards. These data were then grouped according to the independent variables of state, congregation size, community size, age of the minister, amount of preaching experience, and educational background of the minister. The statistical tests of Kendall's coefficient of concordance, Spearman's rank correlation coefficient, and chi-square were utilized to determine amount of association and relationship.

II. FINDINGS

The findings of this research are summarized as follows:

1. The minister is most frequently called upon to

offer counsel in the health-related areas of marital problems, pre-marital problems, mental or emotional problems, patient counseling, death education, alcohol problems, drug use, and aging.

2. The majority (65 percent) of the ministers surveyed spent 20 percent or less of their work time in counseling situations. The remaining 35 percent spent more than 20 percent of their time in counseling situations.

3. In the opinion of the ministers surveyed, their ministerial training did not adequately prepare them to offer health counsel.

4. Although the ministers stated that their ministerial training had not adequately prepared them to offer health counsel, the majority of these ministers felt adequate to offer such counsel. The only exceptions were in the counseling areas of mental or emotional health, venereal disease, suicide, and child abuse.

5. As perceived by the minister, health instruction in the areas of marital relations, pre-marital counseling, mental or emotional health, alcohol education, drug use or abuse, and patient counseling are the most needed areas to be included in ministerial training programs.

6. There were no differences among the ministers concerning the types of actual health counseling done in respect to the independent variables of state, community size, congregation size, age, preaching experience, and educational level.

7. There were no differences among the ministers concerning the types of health counseling education which they perceived to be needed in respect to the independent variables of state, community size, congregation size, age, preaching experience, and educational level.

8. Agreement existed between the types of health counseling actually done by the minister and the types of health education which they perceive to be needed by the prospective minister during ministerial training.

9. There was a significant relationship between adequacy of training for the ministry and felt counseling adequacy of the minister related to alcohol, aging, drug use, marital, mental or emotional, venereal disease, death education, suicide, and smoking counseling cases.

10. No significant relationships existed between adequacy of training for the ministry and the minister's educational program recommendations for ministerial training.

11. There were no significant relationships between the minister's felt counseling adequacy and educational program recommendations for ministerial training.

12. Significant relationships in alcohol, aging, mental or emotional, venereal disease, suicide, and child abuse counseling cases existed between felt counseling adequacy and participation in extra-curricular coursework or training by the minister.

13. With the exception of the counseling area of

spiritual growth, no significant relationships existed between educational program recommendations for ministerial training and participation in extra-curricular coursework or training by the minister.

14. With the exception of the category of drug use, no other significant relationships existed between adequacy of training for the ministry and participation of extra-curricular coursework or training by the minister.

15. There were no significant relationships between percentage of time spent in counseling situations and felt adequacy of training for the ministry.

16. Significant relationships existed in the counseling areas of mental or emotional problems and death education when percentage of time spent in counseling situations was compared to felt adequacy of counseling.

17. Significant relationships existed in all counseling areas with the exceptions of doctrinal, venereal disease, death education, and spiritual growth when percentage of time spent in counseling situations was compared to participation in extra-curricular coursework or training by the minister.

18. A significant relationship existed in the counseling area of patient counseling when felt counseling adequacy of the minister was compared to the variable of preaching experience.

19. A significant relationship did exist between felt

counseling adequacy of the minister and the variable of age group in the area of suicide counseling.

20. A significant relationship existed between felt counseling adequacy of the minister and the variable of educational level in the counseling area of aging.

III. CONCLUSIONS

On the basis of the findings, the following conclusions were drawn:

1. The minister is a health counselor.
2. The schools, colleges, and universities that train ministers do an inadequate job in preparing the ministers to counsel in health-related areas.
3. Ministers offer health counsel whether they feel qualified to do so or not.
4. For the most part, if the minister does feel qualified to offer health counsel, it is as a result of prior experience or extra-curricular training and not as a result of initial training for the ministry.
5. The types of health counseling cases which are brought to the minister are common to all ministers regardless of the independent variables of state, community size, congregation size, age, preaching experience, and educational level.
6. Health education is a desired program of study by the minister to be included in his initial preparation for the ministry.

IV. RECOMMENDATIONS

The following recommendations are offered by this researcher after careful study of the findings and in accordance with the stated conclusions of this study:

1. Those who coordinate the professional preparation of the minister should stay attuned to the needs and interests of the prospective minister, especially in the area of health education.
2. Periodic investigations should be carried out so that the training program can change as needed to best provide those competencies that the minister is expected to possess.
3. Efforts should be directed toward providing effective seminars, short courses, etc. in the area of health education that will promote professional growth by the minister who is already involved in full-time work.
4. The minister should not offer counsel in an area in which he does not feel competent to do so.
5. Further study should be conducted that would reflect the health counseling competencies that the church member expects of the minister.
6. Research should be conducted to determine the minister's attitude toward health counseling.
7. Similar studies should be conducted among ministers of other religious groups to determine if similar deficiencies in ministerial training exist.

8. Further research should be directed by the health educator in an effort to refine an instrument that could be shown to be valid and reliable in assessing the types of health education needed by the prospective minister.

9. If the questionnaire which was designed for use in this study be used in future studies, attention should be given to the following recommendations:

a. The number of categories under the question, "What is the size of the congregation you are presently serving?" be increased.

b. The categories listed for the question, "What percentage of your work time is spent in counseling situations?" be revised.

c. The question, "Would you participate in a seminar, workshop, or short course focusing on the counseling areas listed if they were made available by those coordinating ministerial training programs?" be added as item 18 of the questionnaire.

CHAPTER VI

EPILOGUE

The purpose of this study was to characterize current health counseling practices of the church of Christ minister and to identify areas of needed health counseling competencies which should be addressed during professional preparation of the minister. This was done after designing a questionnaire to gather the necessary data, administering that questionnaire to 266 randomly selected church of Christ ministers in the states of Arkansas, California, Oklahoma, Tennessee, and Texas, and then analyzing the collected data so that all research questions could be answered. Having satisfied the purpose of this study, it is fitting that attention be given to the writing of an epilogue. Such will be the purpose of this chapter. Frankness and candor will be used in commenting on the frustrations and problems incurred as a result of the uniqueness of the topic pursued, the design of a suggested conceptual health curriculum for use in the professional preparation of the minister, and the future role health education can play in the church setting.

It is uncanny how the excitement of doing something new within one's professional field can yield a feeling that this newness will be readily accepted and proclaimed from the rooftops as being the answer that has long eluded

other researchers who have traveled this same path. This excitement can easily blind the young researcher to pitfalls that lie in the path ahead. However, having traveled the path of the researcher and having climbed out of several pitfalls, the excitement has been transformed into a soberness which allows for realistic reflections.

The uniqueness of this research endeavor held many hidden problems. The church has enjoyed an independence from other disciplines for such a long time that it may be guilty of being over suspicious of any outside effort to improve a situation that has long been overlooked and allowed to exist. Such was the feeling that came as a result of promoting this research.

This feeling may have been intensified as a result of delimiting this study to a religious group that very strictly adheres to a philosophy of being autonomous in every respect. This autonomy is revered to the point that many within the church of Christ see any attempt of change as being radical or an attempt to give rise to "denominationalism." With this in mind it is with little surprise that this research effort was met with resistance from several within the church who did not take the time to understand or see the importance of this study.

Having received sufficient encouragement from superiors, colleagues, and prominent leaders of the religious group selected for the study, this researcher was surprised

and bewildered that many of the ministers refused to participate. Although only seven ministers communicated to this researcher that they would not participate in the study, one might wonder if the 48 percent that did not return the questionnaire might have shared the sentiments of these seven. Such statements as, "Show me book, chapter, and verse where the Bible authorizes such a study!" or "The minister is a gospel preacher only and not a counselor!" or "The Bible has the answer to every possible counseling situation that exists!" can momentarily take the wind out of any well-intentioned researcher.

To compound this already perplexing situation, one minister published an article in one of the church supported periodicals which has a nationwide audience within the church of Christ brotherhood advocating that the minister was not to counsel at all. He argued that to do so would infringe upon the authority of the elders of the church. Undoubtedly, this article had an adverse effect upon the return rate of the questionnaire as well.

As a result of such happenings, it is easily understood how this researcher could feel as though he was the devil's advocate. However, as mentioned, this was only a temporary feeling because there were ministers who felt that a research endeavor such as this one was long overdue. Their positive statements and letters of encouragement were like a breath of new life. It was the response of these

ministers which caused this study to be termed a success and allowed the researcher to focus on the problem at hand.

One can only speculate as to whether or not these same problems would have been incurred had the target population been of another religious affiliation. Having been confronted with the problems mentioned, this investigator gained considerable insight into the complexities that can be created when an attempt to utilize the church for promoting health education is made. And, having affirmed that the church can become a practical and invaluable horizon for the promotion of health education amidst these complexities, it was with a positive attitude that this research ended.

It is important that research be continued in this area. During the decade of the eighties there will be an increase in people becoming more concerned with the "wellness movement." Terms such as "holistic health" are becoming more popular in the vocabulary of the American. The public is beginning to show through lifestyle that health concepts are not only being sought but they are being practiced. Indications of expanding health education are also becoming more evident. Renewed interest in religion is also occurring. The combination of these interests indicate that the minister has the potential of becoming an effective health educator and counselor. As a result, the health profession can make great strides in

providing better health programs by using the church setting as an ally. Just as health education is becoming commonplace in the public school systems as a result of continued efforts by the health professional during the fifties, sixties, and seventies, the same can happen within the church setting. However, perseverance and continued research must take place.

This study suggests that there is a need for establishing guidelines for the development of a curriculum that could serve as a starting point in establishing health education programs in the ministerial training schools. However, it must be remembered that any suggested curriculum at this point could at best be considered a recommendation. The reasoning is that although this study identified those health-related areas that were most needed by the prospective minister, it did not identify specific concepts or behavioral objectives that would best provide for those needs. Nevertheless, it would be most unfortunate to communicate to the ministerial training schools programs that should be included within the training without giving some direction as to how it could be done. This writer feels that the lack of such recommendations has been a shortcoming of past studies.

Item 16 of the questionnaire, "Rank order these cases from your perceived highest felt need to the lowest," revealed the greatest need for study was in the following

health-related areas: marital relations, pre-marital problems, drug abuse, patient counseling, death education, aging, and sex education. Therefore, a conceptual unit of approach was suggested for teaching those units.

The areas of marital problems, pre-marital problems, and sex education were grouped together under the heading of human sexuality because of their close relationship to one another. Because of the magnitude of the drug spectrum, alcohol studies should be taught separate from drug abuse. The following sequence is suggested: mental and emotional well-being, drug education, alcohol education, human sexuality, aging, patient counseling, and death education. If individual courses of study cannot be incorporated for each of these topics, it is suggested that a minimum of three courses be offered. The first would be designed to give attention to mental and emotional well-being, drug education, and alcohol education. The second would be designed to focus on the topic of human sexuality. The third would revolve around the concepts representing the topics of aging, patient counseling, and death education.

To present an in-depth curriculum guide would be a major work in itself. However, a suggested outline including concepts, sub-concepts, and behavioral objectives is sufficient to give direction to the future development of a guide. An outline for use in developing a curriculum guide has been suggested by this writer (Appendix G).

The future is bright and optimistic regarding the union of health education and religion. The two complement one another in a dynamic way. While health education can improve the effectiveness of the church, the church in turn offers an invaluable horizon for the advancement of health education as an emerging profession. This is especially exciting to the health professional for this realization shows promise of reaching increased numbers of people who can benefit immensely from health education.

Amidst this excitement, it must be stressed that health education in itself cannot be considered a panacea for eliminating all of the health-related problems of today. However, it can be considered a positive step toward the prevention of many. Health education cannot and should not be considered as a course of study which in itself entitles one to counsel; however, it can provide the prospective minister who is trained in counseling skills the knowledge base which can improve the quality of future health counseling. For this reason, programs of health education such as the one suggested will continue to be beneficial to the prospective minister. But dedication to such a program coupled with periodic evaluation by the competent professional must prevail if the minister is to meet the health needs of those who confidently come for counsel.

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APPENDICES

APPENDIX A

THE WYLIE INVENTORY

THE WYLIE INVENTORY

Instructions: Please answer the following questions by checking the most appropriate blank.

1. What is the size of the community in which the local congregation you are serving is located?
☐ less than 5,000 ☐ 5,000-15,000 ☐ 15,000-30,000
☐ 30,000-60,000 ☐ 60,000-100,000 ☐ over 100,000
2. What is the size of the congregation you are presently serving?
☐ 250 and under ☐ 251-500 ☐ 501 and above
3. How long have you been actively preaching? ☐ years
For this congregation? ☐ years
4. How old are you? ☐ years
5. Did you receive formal training for the ministry?
☐ yes ☐ no
6. What school or schools did you graduate from in preparation for the ministry?
☐ 2-year preacher training school
Name
☐ 4-year Christian college
Name
☐ Other, name
7. If you did not graduate, what school did you attend and for how long?
☐ 2-year preaching school
Name How long?
☐ 4-year Christian school
Name How long?
☐ Other, name How long?
8. Do you perceive counseling to be an important aspect of your ministry?
☐ yes ☐ no
9. What percentage of your work time is spent in counseling situations?
☐ 0-20% ☐ 21-40% ☐ 41-60% ☐ 61-80% ☐ 81-100%

INSTRUCTIONS: Please respond to the following questions by applying each to the listed types of counseling cases.

Types of counseling cases. If your counseling experience reveals one that is not listed, add it under other.	10. Rank order from most to least counseled areas according to your past experience. 1 = Most 15 = Least Counseled	11. Circle the approximate number of persons you counsel in this area per year. > = greater than	12. Circle the age group that is most often counseled in each area. > = greater than	13. Did your training for the ministry adequately prepare you to counsel in this area?	14. How adequate do you feel types of cases? 1 = Very Inadequate 2 = Inadequate 3 = Adequate 4 = Very Adequate	15. Would you recommend that programs be required in this area during ministerial training?	16. Rank order these cases from your perceived highest felt need to the lowest. 1 = Highest 15 = Lowest Felt Need	17. Have you participated in any coursework (i.e. seminars, workshops, college classes, etc.) in the areas listed since your initial training?
Alcohol Problems		1-10 11-20 21-30 31-40 41-50 > 50	10-20 21-30 31-40 41-50 51-60 > 60	Yes No	1 2 3 4	Yes No	Yes No	
Aging		1-10 11-20 21-30 31-40 41-50 > 50	10-20 21-30 31-40 41-50 51-60 > 60	Yes No	1 2 3 4	Yes No	Yes No	
Pre-Marital		1-10 11-20 21-30 31-40 41-50 > 50	10-20 21-30 31-40 41-50 51-60 > 60	Yes No	1 2 3 4	Yes No	Yes No	
Drug Use or Abuse		1-10 11-20 21-30 31-40 41-50 > 50	10-20 21-30 31-40 41-50 51-60 > 60	Yes No	1 2 3 4	Yes No	Yes No	
Doctrinal		1-10 11-20 21-30 31-40 41-50 > 50	10-20 21-30 31-40 41-50 51-60 > 60	Yes No	1 2 3 4	Yes No	Yes No	
Marital Problems		1-10 11-20 21-30 31-40 41-50 > 50	10-20 21-30 31-40 41-50 51-60 > 60	Yes No	1 2 3 4	Yes No	Yes No	
Mental or Emotional		1-10 11-20 21-30 31-40 41-50 > 50	10-20 21-30 31-40 41-50 51-60 > 60	Yes No	1 2 3 4	Yes No	Yes No	
Venerical Disease		1-10 11-20 21-30 31-40 41-50 > 50	10-20 21-30 31-40 41-50 51-60 > 60	Yes No	1 2 3 4	Yes No	Yes No	
Death Education		1-10 11-20 21-30 31-40 41-50 > 50	10-20 21-30 31-40 41-50 51-60 > 60	Yes No	1 2 3 4	Yes No	Yes No	
Patient Counseling		1-10 11-20 21-30 31-40 41-50 > 50	10-20 21-30 31-40 41-50 51-60 > 60	Yes No	1 2 3 4	Yes No	Yes No	
Suicide		1-10 11-20 21-30 31-40 41-50 > 50	10-20 21-30 31-40 41-50 51-60 > 60	Yes No	1 2 3 4	Yes No	Yes No	
Child Abuse		1-10 11-20 21-30 31-40 41-50 > 50	10-20 21-30 31-40 41-50 51-60 > 60	Yes No	1 2 3 4	Yes No	Yes No	
Sex Education		1-10 11-20 21-30 31-40 41-50 > 50	10-20 21-30 31-40 41-50 51-60 > 60	Yes No	1 2 3 4	Yes No	Yes No	
Smoking		1-10 11-20 21-30 31-40 41-50 > 50	10-20 21-30 31-40 41-50 51-60 > 60	Yes No	1 2 3 4	Yes No	Yes No	
Spiritual Growth		1-10 11-20 21-30 31-40 41-50 > 50	10-20 21-30 31-40 41-50 51-60 > 60	Yes No	1 2 3 4	Yes No	Yes No	
Other		1-10 11-20 21-30 31-40 41-50 > 50	10-20 21-30 31-40 41-50 51-60 > 60	Yes No	1 2 3 4	Yes No	Yes No	

APPENDIX B

LIST OF PANEL MEMBERS

LIST OF PANEL MEMBERS

1. Dr. Tony Adcock
Health and Physical Education
Freed-Hardeman College
Henderson, Tennessee
2. Al Behel, Minister
Laurel Church of Christ
Knoxville, Tennessee
3. Herbert Byrd, II, Minister
Laurel Church of Christ
Knoxville, Tennessee
4. Dr. Roy Deaver, Vice President
Tennessee Bible College
Cookeville, Tennessee
5. Dr. Jack S. Ellison
Division of Health and Safety
The University of Tennessee
Knoxville, Tennessee
6. Dr. Paul Faulkner
Director of Family Counseling
Abilene Christian University
Abilene, Texas
7. Dr. Bill Flatt
Registrar and Professor
Harding Graduate School of Religion
Memphis, Tennessee
8. Dr. Warren J. Huffman
Division of Health and Safety
The University of Tennessee
Knoxville, Tennessee
9. John Waddey, Minister
Karns Church of Christ
Knoxville, Tennessee
10. Dr. Bill C. Wallace
Division of Health and Safety
The University of Tennessee
Knoxville, Tennessee
11. Dr. Thomas B. Warren
President of Graduate Studies
Tennessee Bible College
Cookeville, Tennessee

APPENDIX C

LETTERS SENT WITH QUESTIONNAIRE

Laurel Church of Christ

Kingston Pike at Cherokee Blvd.

P. O. Box 10683

Knoxville, Tennessee 37919

Elders

JOHN A. BROWN
CHARLES SMITH

Ministers

AL BEHEL
Minister
HERB BYRD
Educational Director
LEANDER MOORE
Minister to the Deaf
KEN SNELL
Cannon Minister

November 13, 1980

Greetings:

A review of the literature has revealed that the local minister is viewed as a counselor whether he wants to be or not. People come to him with problems stemming from drug abuse, mental or emotional disorders, sexual maladjustments, teenage pregnancies, pre-marital sex, alcoholism, smoking, venereal disease, and aging. All of these are health related problems and are very real. For example, teenage pregnancies are occurring in epidemic numbers today. Venereal disease is the second most common communicable disease in our country. Also, someone is attempting suicide every minute of the day with approximately 70 succeeding. Sixty percent of these stem from alcohol abuse. We could go on but we think that you can see what we are talking about. Many of the people who are caught up in these and similiar problems come to the preacher first for help. What they do next depends on what kind of help they receive.

One of our members, Wayne E. Wylie, is presently conducting a survey to determine the health areas that our preachers are being expected to provide counsel. Experienced ministers such as yourself are the ones who can best answer that question by filling out the enclosed questionnaire. Once Bro. Wylie has determined those health areas that are most needed by our ministers, he is going to develop a conceptual health education model that can be incorporated in our preacher training schools and universities throughout the land.

We have given serious consideration to this endeavor that Bro. Wylie has undertaken and agree that the church will benefit greatly from it provided that all who read this letter participate diligently. We hope that you will take the next few minutes and answer the enclosed questionnaire returning it to us in the envelope provided. Much time, effort, and money have already been invested in this project; please don't allow it to have been spent in vain.

May you always be faithful to His service,

John Brown
Elder

Tom Hill
Elder

Charles Smith
Elder

John Brown

Tom Hill

Charles Smith

The University of Tennessee
Knoxville
School of Health, Physical Education and Recreation

Division of Health and Safety
1914 Andy Holt Avenue
Knoxville, Tennessee 37916

(615) 974-5041

November 7, 1980

Dear Sir:

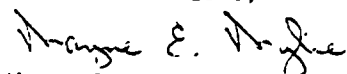
I am presently involved in a research project which strives to identify areas of needed health counseling competencies as perceived by experienced ministers such as yourself. Based on these perceived needs a conceptual health education curriculum model will be developed for use in the training of our future ministers. Many within the brotherhood sincerely feel that this study will do much to improve the ability of the beginning minister to better deal with people in his ministry.

Although you were randomly selected from churches in the states of Arkansas, California, Oklahoma, Tennessee, and Texas; your input is vital to the study. A short questionnaire has been developed and included in this mailing for you to complete and return in the self-addressed, stamped envelope which you will also find in this mailing. I know that you are a very busy person; therefore, I am pleased to assure you that this entire process will only require approximately 15 minutes of your time. Complete anonymity will be maintained and no direct reference will ever be made to your responses.

Your input is vital to the success of this study! Please take time to answer this questionnaire and return it today. I along with others within the church, am convinced that the information that you give will aid in improving the training that our ministers need in meeting the needs of those people who come to them for help.

Thank you so very much for your time. May God bless you richly in your service for Him.

In Christian love,


Wayne E. Wyllie

December 8, 1980

Dear Fellow-Worker:

I realize that this is a very busy time of the year but I find that I must ask for 15 minutes of your time. The response rate of the questionnaire that I sent three weeks ago has been encouraging but slow. To those of you who have already completed it in full and mailed it back, I thank you. To those of you who have not completed it and returned it, I plead with you to do so within the next 10 days. This study cannot proceed without your input!

Also, I would like to ask you to become partners with me in this project by praying for its successful completion. I, along with many others, am convinced that the church will benefit from this study by identifying those areas that our schools of preaching can include in the curriculum to better prepare our future preachers. Please take the time to complete the questionnaire and return it to me today. Best wishes to you and thank you!

In Christian love,

Wayne E. Wylie

Laurel Church of Christ

Kingston Pike at Cherokee Blvd.

P. O. Box 10683

Knoxville, Tennessee 37919

December 30, 1980

Elders

JOHN A. BROWN
THOMAS K. HILL
CHARLES O. SMITH

Ministers

AL BEHEL
Minister

HERB BYRD
Educational Director
LEANDER MOORE
Minister to the Deaf
KEN SNELL
Campus Minister

Dear Sir:

Once again I find that I must correspond with you in hopes that you will take a few minutes and respond to the questionnaire that I sent to you the week of November 16. Because your participation is so vital to this project I have decided to invest in this third mailing. Too much time, money, work, and prayer has gone into this project to allow it to be fruitless!

I have tried to think of reasons why you have not responded. Many sleepless nights have passed as a result. Also many conversations with other preachers have taken place to see if they could come up with the answer. As a result I have formulated some ideas.

First of all, I realize that some of you probably intended to respond to the questionnaire but misplaced it. I am enclosing another copy of the questionnaire and another self-addressed stamped envelope. If you did misplace the first one, will you please take the time to fill this one out and mail it today?

Secondly, some of you have simply been too busy to answer the questionnaire and return it. I know that time is precious. However, I do know that if I could visit with you in person you would not refuse to seeme. Please consider this as a personal visit from me and give it the time that you would give me.

Thirdly, many of you may not have understood the purpose of this study; therefore, you have failed to see the importance of such a work. The purpose of this study is to identify needed health counseling competencies of the prospective preacher as perceived by active, local preachers such as yourself and then to develop a conceptual health education curriculum model to be included in our preacher training schools. In no way is it intended to undermine the work of the elders. In fact as a result of the responses you give, I plan to make the same educational material available to the elders. Hopefully this will appear in book form at a latter date.

Although some may argue as to whether or not the preacher should counsel or not, research indicates that he is being asked to counsel more and more in health related areas. More and more members of the church are seeking help from the church to solve their physical, mental, and social problems. Granted many of these are referred to the elders as they should be;

(over please)

-2-

however, you and I both realize that there are some cases that can not wait for the elders. I'm referring to those instances when crises occur, when a beloved member comes and needs some form of immediate comfort, when the elders ask for your help, and most especially when a person such as an alcoholic or a potential suicide victim comes to the church building for the first time seeking help. Depending on what type of help the latter receives from the preacher during this very critical time often determines whether that person will come back to hear the gospel preached. We must also remember that those congregations that do not have elders depend very heavily upon the minister to fulfill their needs.

The amount of counseling provided by the preacher varies from church to church but it does happen either directly or indirectly! All that I am trying to do is to complete this phase of a study which will ultimately provide prospective preachers, full time preachers, and elders a better knowledge base from which to counsel from in the health related areas listed on the questionnaire. However, I am very dependent upon you to tell me which health related areas you think need the most attention if such a course is implemented in our preacher training schools!

It is my prayer that you will respond to this third request to complete the questionnaire and return it today. January 20, 1981 is the very latest that I can wait for your reply. Please, please respond. May God bless you in His service.

In Christian love,

Wayne E. Wylie

Wayne E. Wylie

APPENDIX D

COMPUTATION OF KENDALL'S COEFFICIENT OF CONCORDANCE
ACCORDING TO THE CHURCH OF CHRIST MINISTER'S
ACTUAL COUNSELING EXPERIENCE

TABLE D-1. Computation of Kendall's Coefficient of Concordance by State According to the Church of Christ Minister's Actual Counseling Experience, 1980-1981

Counseling Area	State					Rank Sum
	AK	CA	OK	TN	TX	
Alcohol	6	9	7	7	8	37
Aging	9.5	8	11	13	10	51.5
Pre-Marital	5	5	4	5	4	23
Drug Use and Abuse	13	10	6	9	9	47
Doctrinal	2	1.5	3	3	3	12.5
Marital	3	1.5	1	1	1	7.5
Mental or Emotional	4	6.5	5	6	5	26.5
Venereal Disease	15	15	15	15	15	75
Death Education	8	6.5	8	8	7	37.5
Patient Counseling	7	4	9	4	6	30
Suicide	12	13	13	12	13	63
Child Abuse	14	14	14	14	14	70
Sex Education	9.5	12	10	10	11	52.5
Smoking	11	11	12	11	12	57
Spiritual Growth	1	3	2	2	2	10
Σ Ranks					600	

$$\begin{array}{ll}
 S = 6579.5 & \underline{W} = .9399 \\
 k = 5 & \chi^2 = 65.79 \\
 N = 15 &
 \end{array}$$

TABLE D-2. Computation of Kendall's Coefficient of Concordance by Community Size According to the Church of Christ Minister's Actual Counseling Experience, 1980-1981

Counseling Area	Community Size						Rank Sum
	< 5,000	5,000-15,000	15,000-30,000	30,000-60,000	60,000-100,000	Over 100,000	
Alcohol	6	7	9	6	11	10	49
Aging	9	9	12	13	6.5	12	61.5
Pre-Marital	4	4	3	4	3	4	22
Drug Use and Abuse	10	10	11	7	12	7	57
Doctrinal	2	2	1	2.5	5	2	14.5
Marital	3	1	2	1	1	1	9
Mental or Emotional	5	5	6	8	4	5	33
Venereal Disease	15	15	15	15	15	15	90
Death Education	7	8	8	9	8	8	48
Patient Counseling	8	6	4	5	6.5	6	35.5
Suicide	13	13	14	11	13	11	75
Child Abuse	14	14	13	14	14	14	83
Sex Education	11	11	7	10	10	9	58
Smoking	12	12	10	12	9	13	68
Spiritual Growth	1	3	5	2.5	2	3	16.5
Σ Ranks							720

$$S = 9175$$

$$\bar{W} = .9102$$

$$k = 6$$

$$\chi^2 = 76.44$$

$$N = 15$$

TABLE D-3. Computation of Kendall's Coefficient of Concordance by Congregation Size According to the Church of Christ Minister's Actual Counseling Experience, 1980-1981

Counseling Area	Congregation Size			Rank Sum
	< 250	251-500	> 501	
Alcohol	8	8	9	25
Aging	10	10	12	32
Pre-Marital	4	4	5	13
Drug Use and Abuse	9	9	8	26
Doctrinal	2	2	3	7
Marital	3	1	1	5
Mental or Emotional	6	5	2	13
Venereal Disease	15	15	15	45
Death Education	7	7	13	27
Patient Counseling	5	6	6.5	17.5
Suicide	13	12	11	36
Child Abuse	14	14	10	38
Sex Education	11	11	6.5	28.5
Smoking	12	13	14	39
Spiritual Growth	1	3	4	8
Σ Ranks				360

$$S = 2294.5$$

$$\underline{W} = .9105$$

$$k = 3$$

$$\chi^2 = 38.24$$

$$N = 15$$

TABLE D-4. Computation of Kendall's Coefficient of Concordance by Age According to the Church of Christ Minister's Actual Counseling Experience, 1980-1981

Counseling Area	Age					Rank Sum
	20-30	31-40	41-50	51-60	> 60	
Alcohol	8	7	9	8	12.5	44.5
Aging	9	13	11	7	10	50
Pre-Marital	4	4	4	4	6.5	22.5
Drug Use and Abuse	11	8	8	12	14.5	53.5
Doctrinal	2	3	2	3	3.5	13.5
Marital	3	1	1	1	6.5	12.5
Mental or Emotional	7	5	5	9	3.5	29.5
Venereal Disease	15	15	15	15	14.5	74.5
Death Education	5	9	7	6	8	35
Patient Counseling	6	6	6	5	1	24
Suicide	13	11	12	13	12.5	61.5
Child Abuse	14	14	14	14	11	67
Sex Education	12	10	10	10	3.5	45.5
Smoking	10	12	13	11	9	55
Spiritual Growth	1	2	3	2	3.5	11.5
Σ Ranks						600

$$S = 5907.5$$

$$\underline{W} = .8440$$

$$k = 5$$

$$\chi^2 = 58.8$$

$$N = 15$$

TABLE D-5. Computation of Kendall's Coefficient of Concordance by Preaching Experience According to the Church of Christ Minister's Actual Counseling Experience, 1980-1981

Counseling Area	Years Preaching Experience						Rank Sum
	1-5	6-10	11-15	16-20	21-25	> 25	
Alcohol	5	8	7	9	8	10	47
Aging	8	10	10	10	11	8	57
Pre-Marital	4	4	4	6	4	4	26
Drug Use and Abuse	11	9	9	4	9	12	54
Doctrinal	2	2	3	3	2	2	14
Marital	3	3	1	2	1	1	11
Mental or Emotional	6	6	5	5	6	6	34
Venereal Disease	15	15	15	15	15	14	89
Death Education	7	7	8	7	7	7	43
Patient Counseling	12	5	6	12.5	5	5	45.5
Suicide	13	13	13	11	12	13	75
Child Abuse	14	14	14	14	13	15	84
Sex Education	9.5	12	11	8	10	9	59.5
Smoking	9.5	11	12	12.5	14	11	70
Spiritual Growth	1	1	2	1	3	3	11
						Σ Ranks	720

$$S = 9045.5 \quad \underline{W} = .8974$$

$$k = 6 \quad \chi^2 = 75.38$$

$$N = 15$$

TABLE D-6. Computation of Kendall's Coefficient of Concordance by Educational Level According to the Church of Christ Minister's Actual Counseling Experience, 1980-81

Counseling Area	Educational Level					Rank Sum
	A	B	C	D	E	
Alcohol	6	8	8	6	10.5	38.5
Aging	12	9	10	10	12	53
Pre-Marital	3	4	3	4	7	21
Drug Use and Abuse	8	10	11	8	3	40
Doctrinal	4	2	4	2	1	13
Marital	2	1	1	3	2	9
Mental or Emotional	5	5	5	7	5.5	27.5
Venereal Disease	14.5	15	15	15	13	72.5
Death Education	10	7	7	9	8.5	41.5
Patient Counseling	8	6	6	5	4	29
Suicide	13	13	12	13	15	66
Child Abuse	14.5	14	13	14	14	69.5
Sex Education	8	11	9	11	10.5	49.5
Smoking	11	12	14	12	8.5	57.5
Spiritual Growth	1	3	2	1	5.5	12.5
Σ Ranks						600

A = 2 year graduate

S = 6257

B = 4 year graduate

k = 5

C = 2 and 4 year graduate

N = 15

D = Attended only

$\underline{W}$ = .8939

E = Never attended

χ^2 = 62.3

APPENDIX E

COMPUTATIONS OF KENDALL'S COEFFICIENT OF CONCORDANCE BY
THE CHURCH OF CHRIST MINISTER'S FELT NEEDS

TABLE E-1. Computation of Kendall's Coefficient of Concordance by State According to the Church of Christ Minister's Felt Needs, 1980-1981

Counseling Area	State					Rank Sum
	AK	CA	OK	TN	TX	
Alcohol	8.5	5	5	6	6	30.5
Aging	10	9	13	13	9	54
Pre-Marital	4	4	4	2	2	16
Drug Use and Abuse	6	8	6	7	7	34
Doctrinal	3	1.5	3	3	4	14.5
Marital	1	3	1	1	1	7
Mental or Emotional	5	6	7	4	5	27
Venereal Disease	15	15	14	15	14	73
Death Education	7	10	12	9	10	48
Patient Counseling	11	7	10	8	8	44
Suicide	13	12	8	10	12	55
Child Abuse	12	13	11	11	13	60
Sex Education	8.5	14	9	12	11	54.5
Smoking	14	11	15	14	15	69
Spiritual Growth	2	1.5	2	5	3	13.5
Σ Ranks						600

$$S = 6354$$

$$k = 5$$

$$N = 15$$

$$\underline{W} = .9077$$

$$\chi^2 = 63.54$$

TABLE E-2. Computation of Kendall's Coefficient of Concordance by Community Size According to the Church of Christ Minister's Felt Needs, 1980-1981

Counseling Area	Community Size						Rank Sum
	< 5,000	5,000-15,000	15,000-30,000	30,000-60,000	60,000-100,000	Over 100,000	
Alcohol	5	5	7	7	8	7	39
Aging	9	7.5	11	8	10	11	56.5
Pre-Marital	3	3.5	3.5	4	1	2	17
Drug Use and Abuse	7	10	9	5	7	5	43
Doctrinal	4	3.5	2	3	4	4	20.5
Marital	1	1	1	1	2	1	7
Mental or Emotional	6	7.5	3.5	6	5	6	34
Venereal Disease	14	15	15	14	15	14	87
Death Education	11	9	8	10	11	8	57
Patient Counseling	8	6	6	11	9	9	49
Suicide	13	12	14	9	13	12	73
Child Abuse	10	13	12	13	14	13	75
Sex Education	12	11	10	12	6	10	61
Smoking	15	14	13	15	12	15	84
Spiritual Growth	2	2	5	2	3	3	17
Σ Ranks							720

$$S = 9155.5$$

$$\underline{W} = .9083$$

$$k = 6$$

$$\chi^2 = 76.44$$

$$N = 15$$

TABLE E-3. Computation of Kendall's Coefficient of Concordance by Congregation Size According to the Church of Christ Minister's Felt Needs, 1980-1981

Counseling Area	Congregation Size			Rank Sum
	< 250	251-500	> 500	
Alcohol	5	7	5	17
Aging	9	11	8.5	28.5
Pre-Marital	3	2	2	7
Drug Use and Abuse	7	6	3	16
Doctrinal	4	4	7	15
Marital	1	1	1	3
Mental or Emotional	6	5	4	15
Venereal Disease	15	14.5	15	44.5
Death Education	10	10	6	26
Patient Counseling	8	9	8.5	25.5
Suicide	13	12	13	38
Child Abuse	12	13	12	37
Sex Education	11	8	10	29
Smoking	14	14.5	14	42.5
Spiritual Growth	2	3	11	16
Σ Ranks				360

$$S = 2248$$

$$\underline{W} = .8920$$

$$k = 3$$

$$\chi^2 = 37.38$$

$$N = 15$$

TABLE E-4. Computation of Kendall's Coefficient of Concordance by Age According to the Church of Christ Minister's Felt Needs, 1980-1981

Counseling Area	Age					Rank Sum
	20-30	31-40	41-50	51-60	> 60	
Alcohol	5	6	6	7	5.5	29.5
Aging	9.5	10	11	11	10	51.5
Pre-Marital	3	2	2	4	2	13
Drug Use and Abuse	9.5	7	5	5	3	29.5
Doctrinal	4	4	4	1	9	22
Marital	1	1	1	3	4	10
Mental or Emotional	6	5	7	6	8	32
Venereal Disease	14	14	15	14	12	69
Death Education	7	9	9	13	15	53
Patient Counseling	8	8	10	8	5.5	39.5
Suicide	13	12	12	10	14	61
Child Abuse	12	13	13	9	11	58
Sex Education	11	11	8	12	13	55
Smoking	15	15	14	15	7	66
Spiritual Growth	2	3	3	2	1	11
Σ Ranks						600

$$S = 5887$$

$$\underline{W} = .8410$$

$$k = 5$$

$$\chi^2 = 58.80$$

$$N = 15$$

TABLE E-5. Computation of Kendall's Coefficient of Concordance by Preaching Experience According to the Church of Christ Minister's Felt Needs, 1980-1981

Counseling Area	Years Preaching Experience						Rank Sum
	1-5	6-10	11-15	16-20	21-25	> 25	
Alcohol	5	6	7	3	6	7	34
Aging	10	10	11	10	12	9	62
Pre-Marital	4	3	2	2	3	3	17
Drug Use and Abuse	7	8	7	4	5	6	37
Doctrinal	2	4	3	5	4	4	22
Marital	1	1	1	1	1	2	7
Mental or Emotional	8	5	5	7	7	5	37
Venereal Disease	15	15	14	14	15	15	88
Death Education	6	9	10	9	11	11	56
Patient Counseling	9	7	7	11	8	8	50
Suicide	12	12	12	13	13	12	74
Child Abuse	11	13	13	12	10	13	72
Sex Education	14	11	9	8	9	10	61
Smoking	13	14	15	15	14	14	85
Spiritual Growth	3	2	4	6	2	1	18
						Σ Ranks	720

$$S = 9310 \quad \underline{W} = .9236$$

$$k = 6 \quad \chi^2 = 77.58$$

$$N = 15$$

TABLE E-6. Computation of Kendall's Coefficient of Concordance by Educational Level According to the Church of Christ Minister's Felt Needs, 1980-1981

Counseling Area	Educational Level					Rank Sum
	A	B	C	D	E	
Alcohol	5.5	6	7	6.5	4	29
Aging	9.5	10	12	9	10	50.5
Pre-Marital	1.5	3	1	4	5	14.5
Drug Use and Abuse	8	7	6	6.5	6.5	34
Doctrinal	4	4	4.5	1	1	14.5
Marital	1.5	1	3	3	3	11.5
Mental or Emotional	5.5	5	4.5	5	8	28
Venereal Disease	15	14	14.5	15	9	67.5
Death Education	9.5	9	11	10	11	50.5
Patient Counseling	7	8	10	8	6.5	39.5
Suicide	13	13	9	12	14	61
Child Abuse	14	12	13	13	12.5	64.5
Sex Education	11	11	8	11	12.5	53.5
Smoking	12	15	14.5	14	15	70.5
Spiritual Growth	3	2	2	2	2	11
Σ Ranks					600	

A = 2 year graduate

S = 6385.5

B = 4 year graduate

k = 5

C = 2 and 4 year graduate

N = 15

D = Attended only

$\underline{W}$ = .9122

E = Never attended

χ^2 = 63.70

APPENDIX F

OBSERVED AND EXPECTED CELL FREQUENCIES
OF CHI-SQUARE COMPARISONS

TABLE F-1. Observed and Expected Cell Frequencies of Chi-Square Comparisons of Item #14 and Item #13 of Questionnaire, 1980-1981

Counseling Area	N	14		13		14		13		14		13		14		13	
		Inadequate/Yes		Inadequate/No		Adequate/Yes		Adequate/No		Adequate/Yes		Adequate/No		Adequate/Yes		Adequate/No	
		O	E	O	E	O	E	O	E	O	E	O	E	O	E	O	E
Alcohol	95	6	11.94	36	30.06	21	15.06	32	37.94								
Aging	83	3	10.34	30	22.66	23	15.66	27	34.34								
Pre-Marital	96	7	10.06	14	10.94	39	35.93	36	39.06								
Drug Use and Abuse	81	0	7.70	39	31.30	16	8.30	26	33.70								
Doctrinal	99	6	6.15	1	.85	81	80.85	11	11.15								
Marital	99	6	11.88	22	12.66	36	30.12	35	40.88								
Mental or Emotional	89	6	10.31	45	40.69	12	7.69	26	30.31								
Venereal Disease	75	0	6.01	41	34.99	11	4.99	23	29.01								
Death Education	83	5	12.14	23	15.86	31	23.86	24	31.14								
Patient Counseling	83	5	9.42	18	13.58	29	24.58	31	35.42								
Suicide	79	5	9.87	47	42.13	10	5.13	17	21.87								
Child Abuse	73	3	5.65	38	35.78	7	3.97	25	25.03								
Sex Education	82	4	8.20	17	12.80	28	23.80	33	37.20								
Smoking	79	3	7.52	15	10.48	30	25.48	31	35.52								
Spiritual Growth	95	7	8.00	3	2.00	69	68.00	16	17.00								

Item 13 = Did your training for the ministry adequately prepare you to counsel in this area?

Item 14 = How adequate do you feel counseling these types of cases?

TABLE F-2. Observed and Expected Cell Frequencies of Chi-Square Comparisons of Item #13 and Item #15 of Questionnaire, 1980-1981

Counseling Area	N	13		15		13		15		13		15	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
		O	E	O	E	O	E	O	E	O	E	O	E
Alcohol	97	26	24.39	0	1.61	65	66.61	6	4.39				
Aging	87	25	24.52	2	2.48	54	54.48	6	5.52				
Pre-Marital	98	45	45.53	1	0.47	52	51.47	0	0.53				
Drug Use and Abuse	86	16	14.88	0	1.12	64	65.12	6	4.88				
Doctrinal	100	86	86.13	1	0.87	13	12.87	0	0.13				
Marital	101	41	41.58	1	0.42	59	58.42	0	0.58				
Mental or Emotional	94	18	17.23	0	0.77	72	72.77	4	3.23				
Venereal Disease	83	12	9.83	0	2.17	56	58.17	15	12.83				
Death Education	89	35	34.38	1	1.62	50	50.62	3	2.38				
Patient Counseling	88	33	32.84	1	1.16	52	52.16	2	1.84				
Suicide	86	16	14.88	0	1.12	64	65.12	6	4.88				
Child Abuse	82	10	9.93	1	1.07	64	64.07	7	6.93				
Sex Education	86	30	28.12	1	2.88	48	49.88	7	5.12				
Smoking	83	28	26.52	3	4.48	43	44.48	9	7.52				
Spiritual Growth	97	74	72.68	1	2.32	20	21.32	2	0.68				

Item 13 = Did your training for the ministry adequately prepare you to counsel in this area?

Item 15 = Would you recommend that educational programs be required in this area during ministerial training?

TABLE F-3. Observed and Expected Cell Frequencies of Chi-Square Comparisons of Item #14 and Item #15 of Questionnaire, 1980-1981

Counseling Area	N	14		15		14		15		14		15	
		Inadequate/No O	Adequate/Yes E	Inadequate/No O	Adequate/Yes E	Inadequate/No O	Adequate/Yes E	Inadequate/No O	Adequate/Yes E	Inadequate/No O	Adequate/Yes E	Inadequate/No O	Adequate/Yes E
Alcohol	98	41	40.81	2	2.19	52	52.19	3	2.18				
Aging	85	31	30.80	3	3.20	46	46.20	5	4.80				
Pre-Marital	99	22	21.78	0	0.22	76	76.22	1	0.78				
Drug Use and Abuse	84	41	40.95	2	2.05	39	39.05	2	1.95				
Doctrinal	102	7	6.93	0	0.07	94	94.07	1	0.93				
Marital	102	29	28.72	0	0.28	72	72.28	1	0.72				
Mental or Emotional	92	51	50.70	2	2.30	37	37.30	2	1.70				
Venereal Disease	78	33	36.38	10	6.62	33	29.61	2	5.38				
Death Education	86	29	27.65	0	1.35	53	54.35	4	2.65				
Patient Counseling	86	25	24.42	0	0.58	59	59.58	2	1.42				
Suicide	82	49	49.12	4	3.88	27	26.88	2	2.12				
Child Abuse	79	40	40.66	4	3.34	33	32.34	2	2.66				
Sex Education	84	19	19.90	3	2.10	57	56.10	5	5.90				
Smoking	80	16	16.63	3	2.38	54	53.38	7	7.63				
Spiritual Growth	99	11	10.67	0	0.33	85	85.33	3	2.67				

Item 14 = How adequate do you feel counseling these types of cases?

Item 15 = Would you recommend that educational programs be required in this area during ministerial training?

TABLE F-4. Observed and Expected Cell Frequencies of Chi-Square Comparisons of Item #14 and Item #17 of Questionnaire, 1980-1981

Counseling Area	N	14		17		14		17		14		17	
		Inadequate O	Adequate/Yes E	Inadequate O	Adequate/Yes E	Inadequate O	Adequate/Yes E	Inadequate O	Adequate/Yes E	Adequate/No O	Adequate/Yes E	Adequate/No O	Adequate/Yes E
Alcohol	95	16	21.76	28	22.23	31	25.23	20	25.77				
Aging	85	6	13.20	28	20.80	27	19.80	24	31.20				
Pre-Marital	97	11	12.70	11	9.30	45	43.30	30	31.70				
Drug Use and Abuse	83	18	22.77	24	19.22	27	22.22	14	18.77				
Doctrinal	98	5	4.47	1	1.53	68	68.53	24	23.47				
Marital	101	20	21.39	10	8.61	52	50.61	19	20.39				
Mental or Emotional	88	15	25.50	36	25.50	29	18.50	8	18.50				
Venereal Disease	74	3	8.13	40	34.86	11	5.86	20	25.14				
Death Education	84	9	12.43	20	16.57	27	23.57	28	31.43				
Patient Counseling	81	9	11.26	15	12.74	29	26.74	28	30.26				
Suicide	78	11	16.30	42	36.69	13	7.69	12	17.31				
Child Abuse	76	6	12.74	38	31.26	16	9.26	16	22.74				
Sex Education	80	7	9.98	14	11.03	31	28.03	28	30.98				
Smoking	77	2	3.97	16	14.03	15	13.03	44	45.97				
Spiritual Growth	93	6	8.28	5	2.72	64	61.72	18	20.28				

Item 14 = How adequate do you feel counseling these types of cases?

Item 17 = Have you participated in any coursework (i.e. seminars, workshops, college classes, etc.) in the areas listed since your initial training?

TABLE F-5. Observed and Expected Cell Frequencies of Chi-Square Comparisons of Item #15 and Item #17 of Questionnaire, 1980-1981

Counseling Area	N	15		17		15		17		15		17	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
		O	E	O	E	O	E	O	E	O	E	O	E
Alcohol	97	47	45.03	44	45.97	1	2.97	5	3.03				
Aging	89	33	31.46	47	48.54	2	3.54	7	5.46				
Pre-Marital	99	57	56.42	41	41.58	0	0.58	1	0.42				
Drug Use and Abuse	90	48	45.73	36	40.54	1	3.27	5	2.73				
Doctrinal	99	74	73.25	24	24.75	0	0.75	1	0.25				
Marital	104	74	73.29	29	29.71	0	0.71	1	0.29				
Mental or Emotional	94	46	44.04	44	45.95	0	1.96	4	2.04				
Venereal Disease	85	14	11.20	54	56.80	0	2.80	17	14.20				
Death Education	91	38	38.86	48	49.14	1	2.14	4	2.86				
Patient Counseling	88	40	38.64	45	46.36	0	1.36	3	1.67				
Suicide	87	25	22.99	55	57.01	0	2.01	7	4.99				
Child Abuse	85	23	20.56	53	55.44	0	2.44	9	6.56				
Sex Education	88	39	36.34	39	41.66	2	4.66	8	5.34				
Smoking	84	17	16.29	55	55.71	2	2.71	10	9.29				
Spiritual Growth	96	72	69.75	21	23.25	0	2.25	3	0.75				

Item 15 = Would you recommend that educational programs be required in this area during ministerial training?

Item 17 = Have you participated in any coursework (i.e., seminars, workshops, college classes, etc.) in the areas listed since your initial training?

TABLE F-6. Observed and Expected Cell Frequencies of Chi-Square Comparisons of Item #13 and Item #17 of Questionnaire, 1980-1981

Counseling Area	N	13		17		13		17		13		17	
		Yes/ O	Yes/ E	Yes/ O	Yes/ E	Yes/ O	Yes/ E	No/ O	No/ E	No/ O	No/ E	No/ O	No/ E
Alcohol	94	16	12.5	9	12.5	31	34.5	38	34.5	38	34.5	38	34.5
Aging	86	14	10.3	12	15.7	20	23.7	40	36.3	40	36.3	40	36.3
Pre-Marital	95	23	25.5	21	18.5	32	29.5	19	21.5	19	21.5	19	21.5
Drug Use and Abuse	83	13	8.9	3	7.1	33	37.1	34	29.9	34	29.9	34	29.9
Doctrinal	96	62	62.3	21	20.8	10	9.8	3	3.3	3	3.3	3	3.3
Marital	100	29	29.5	12	11.5	43	42.5	16	16.5	16	16.5	16	16.5
Mental or Emotional	89	12	8.1	4	7.9	33	36.9	40	36.1	40	36.1	40	36.1
Venereal Disease	78	3	1.8	7	8.2	11	12.2	57	55.8	57	55.8	57	55.8
Death Education	87	20	15.3	15	19.7	18	22.7	34	29.3	34	29.3	34	29.3
Patient Counseling	82	18	14.3	12	15.7	21	24.7	31	27.3	31	27.3	31	27.3
Suicide	81	7	4.3	7	9.7	18	20.7	49	46.3	49	46.3	49	46.3
Child Abuse	76	3	2.8	7	7.2	18	18.2	48	47.8	48	47.8	48	47.8
Sex Education	81	15	12.7	12	14.3	23	25.3	31	28.7	31	28.7	31	28.7
Smoking	78	6	6.3	23	22.7	11	10.7	38	38.3	38	38.3	38	38.3
Spiritual Growth	91	53	52.3	17	17.7	15	15.7	6	5.3	6	5.3	6	5.3

Item 13 = Did your training for the ministry adequately prepare you to counsel in this area?

Item 17 = Have you participated in any coursework (i.e. seminars, workshops, college classes, etc.) in the areas listed since your initial training?

TABLE F-7. Observed and Expected Cell Frequencies of Chi-Square Comparisons of Percent Time Counseling by Item #17 of Questionnaire, 1980-1981

Counseling Area	N	< 21%/Yes		< 21%/No		> 20%/Yes		> 20%/No	
		O	E	O	E	O	E	O	E
Alcohol	98	23	30.9	40	32.1	25	17.1	10	17.9
Aging	91	16	22.9	42	35.1	20	13.1	13	19.9
Pre-Marital	101	29	37.3	36	27.7	29	20.7	7	15.3
Drug Use and Abuse	92	26	33.2	35	27.8	24	16.8	7	14.2
Doctrinal	101	47	48.3	18	16.7	28	26.7	8	9.3
Marital	105	42	47.9	25	19.1	33	27.1	5	10.9
Mental or Emotional	95	22	29.5	39	31.5	24	16.5	10	17.5
Venereal Disease	88	8	10.5	50	47.5	8	5.5	22	24.5
Death Education	94	21	25.1	38	33.9	19	14.9	16	20.1
Patient Counseling	90	20	26.2	39	32.8	20	13.8	11	17.2
Suicide	90	12	16.8	46	41.2	14	9.2	18	22.8
Child Abuse	87	11	16.3	48	42.7	13	7.7	15	20.3
Sex Education	90	20	27.5	39	31.5	22	14.5	9	16.5
Smoking	86	9	12.8	49	45.2	10	6.2	18	21.8
Spiritual Growth	97	44	46.8	19	16.2	28	25.2	6	8.8

Item 17 = Have you participated in any coursework (i.e. seminars, workshops, college classes, etc.) in the areas listed since your initial training?

TABLE F-8. Observed and Expected Cell Frequencies of Chi-Square Comparisons of Percent Time Counseling by Item #14 of Questionnaire, 1980-1981

Counseling Area	N	< 21%/Inadeq.		< 21%/Adequate		> 20%/Inadeq.		> 20%/Adequate	
		O	E	O	E	O	E	O	E
Alcohol	99	30	28.4	34	35.6	14	15.6	21	19.4
Aging	87	25	22.3	32	34.7	9	11.7	21	18.3
Pre-Marital	100	14	14.9	51	50.0	9	8.0	26	26.9
Drug Use	86	29	28.5	28	28.5	14	14.5	15	14.5
Doctrinal	103	5	4.7	64	64.3	2	2.3	32	31.7
Marital	104	24	20.3	44	47.7	7	10.7	29	25.3
Mental or Emotional	93	41	35.4	20	25.6	13	18.6	19	13.4
Venereal Disease	79	31	27.8	19	22.2	13	16.2	16	12.8
Death Education	87	23	18.7	33	37.3	6	10.3	25	20.7
Patient Counseling	87	20	16.1	36	39.9	5	8.9	26	22.1
Suicide	83	37	33.8	15	18.2	17	20.2	14	10.8
Child Abuse	80	30	28.7	21	22.3	15	16.3	14	12.7
Sex Education	86	15	14.7	40	40.3	8	8.3	23	22.7
Smoking	83	14	12.6	41	42.4	5	6.4	23	21.6
Spiritual Growth	100	8	7.1	57	57.8	3	3.8	32	31.1

Item 14 = How adequate do you feel counseling these types of cases?

TABLE F-9. Observed and Expected Cell Frequencies of Chi-Square Comparisons of Percent Time Counseling by Item #13 of Questionnaire, 1980-1981

Counseling Area	N	< 21%/Yes		< 21%/No		> 20%/Yes		> 20%/No	
		O	E	O	E	O	E	O	E
Alcohol	98	19	17.6	45	46.4	8	9.4	26	24.6
Aging	90	18	17.1	39	39.9	9	9.9	24	23.1
Pre-Marital	99	30	29.7	34	34.3	16	16.3	19	18.7
Drug Use and Abuse	88	12	11.0	45	46.0	5	6.0	26	25.0
Doctrinal	102	56	57.8	11	9.2	32	30.2	3	4.8
Marital	102	26	27.2	40	38.8	16	14.8	20	21.2
Mental or Emotional	95	10	11.6	51	49.4	8	6.4	26	27.6
Venereal Disease	84	6	7.6	47	45.4	6	4.4	25	26.6
Death Education	91	20	23.2	37	33.8	17	13.8	17	20.2
Patient Counseling	89	21	22.4	36	34.6	14	12.6	18	19.4
Suicide	87	10	9.7	43	43.3	6	6.3	28	27.7
Child Abuse	83	7	7.0	46	46.0	4	4.0	26	26.0
Sex Education	88	20	20.4	36	35.6	12	11.6	20	20.4
Smoking	86	20	21.5	36	34.5	13	11.5	17	18.5
Spiritual Growth	98	47	48.9	16	14.1	29	27.1	6	7.9

Item 13 = Did your training for the ministry adequately prepare you to counsel in this area?

APPENDIX G

SUGGESTED CONCEPTUAL HEALTH CURRICULUM TO BE INCLUDED
IN THE PROFESSIONAL PREPARATION OF THE MINISTER

FOREWORD

The minister is in a strategic position to offer health counsel. Research indicates that the minister is a health counselor. Research also indicates that although the minister is expected to offer health counsel, his professional preparation is lacking in educational opportunities which educate him in health education. It is advocated by this writer that the following suggested conceptual health curriculum would be most beneficial to ministers if included in their professional training program for the ministry.

Concepts, sub-concepts, and behavioral objectives have been suggested for the health topics of mental and emotional well being, drug use and abuse, alcohol education, human sexuality, aging, patient counseling, and death education. The design in which these guidelines are presented allows for flexibility in teaching methodology, learning activities, and evaluation procedures. However, it does provide specific direction in presenting a cognitive knowledge base which will enable the prospective minister in becoming a competent health counselor.

TOPIC: MENTAL AND EMOTIONAL WELL-BEING

Concept: Mental health is far more than the absence of mental or emotional illness; rather, it is the way that each person harmonizes their desires, ambitions, ideals, feelings, abilities, and conscience in order to meet the demands of life.

Sub-Concept #1: The minister can greatly benefit by reviewing the structures of personality through the concepts of id, ego, and superego.

Behavioral Objectives:

1. The prospective minister will be able to describe and explain the three portions that make up personality.
2. The prospective minister will be able to identify these personality components in real life situations.

Sub-Concept #2: The minister must recognize that emotional needs and behavior are similar but unique for each individual.

Behavioral Objectives:

1. The prospective minister will be able to describe what is meant by the term emotion.
2. The prospective minister will list and explain basic emotional needs which must be satisfied for all individuals.
3. The prospective minister will describe the importance of security in achieving a high level of mental or emotional well-being.

Sub-Concept #3: There are many different degrees of emotional health.

Behavioral Objectives:

1. The prospective minister will identify ways that an individual can improve upon the ability to deal constructively with reality.
2. The prospective minister will discuss what is meant by stress and suggest ways to deal with it.
3. The prospective minister will list and describe the different components of "good emotional health."
4. The prospective minister will be able to discern between maturity and immaturity.
5. The prospective minister will identify those common elements which tend to form values.
6. The prospective minister will list and describe the different types of defense mechanisms common to man.

Sub-Concept #4: The rising incidence of mental or emotional problems demand that positive steps be taken to better understand and prevent such problems.

Behavioral Objectives:

1. The prospective minister will demonstrate an understanding of the scope of mental or emotional disorders.
2. The prospective minister will be able to list and define the most common emotional problems.
3. The prospective minister will discuss the

complexities of emotional disorganization.

4. The prospective minister will be able to identify and discern between the different levels of emotional disorganization.

5. The prospective minister will discuss and characterize the individual who is severely emotionally disturbed.

Sub-Concept #5: With the increase in incidence of mental or emotional problems has come improved methods and facilities for their treatment.

Behavioral Objectives:

1. The prospective minister will list and discuss the most successful types of treatment available for the emotionally ill.

2. The prospective minister will demonstrate an awareness of the facilities within the typical community which can provide aid to the emotionally ill.

TOPIC: DRUG EDUCATION

Concept: It is important that the minister realize and understand that the use and abuse of drugs result from a complexity of factors.

Sub-Concept #1: Drug education programs can provide cognitive information that may favorably influence the decision-making skills of the individual.

Behavioral Objectives:

1. The prospective minister will be able to define the term drug.
2. The prospective minister will be able to describe the types of drug dependence.
3. The prospective minister will discern the difference between drug use and drug abuse.
4. The prospective minister will identify and discuss the major actions and effects of drugs.
5. The prospective minister will be able to explain the major effects sought by those who use drugs.

Sub-Concept #2: An awareness of the spectrum and continuum of drug actions can enhance a better understanding of the drug problem.

Behavioral Objectives:

1. The prospective minister will be able to describe the spectrum and continuum of drug action.

2. The prospective minister will be able to list and discuss the effects of narcotics, volatile solvents, tranquilizers, cannabis drugs, hallucinogens, cocaine, and amphetamines.

Sub-Concept #3: Psychological and sociological aspects of drug abuse must be understood by those who attempt to aid the abuser in recovery.

Behavioral Objectives:

1. The prospective minister will describe and discuss the psychological and sociological aspects of drug abuse.

2. The prospective minister will identify personal and societal attitudes that may adversely affect the recovery of the drug abuser.

3. The prospective minister will list and explain the types of therapy available for use in helping the drug abuser.

TOPIC: ALCOHOL EDUCATION

Concept: It is imperative that we as individuals are alerted to the fact that the most prevalent and potentially dangerous drug consumed in the United States is the socially accepted drug called alcohol.

Sub-Concept #1: A knowledge of the history of alcohol is invaluable to the individual who wants to help resolve the problem of alcohol abuse.

Behavioral Objectives:

1. The prospective minister will be able to describe the wide variety of patterns of alcohol use that evolved from past cultures.
2. The prospective minister will demonstrate an understanding of the temperance movement which led to prohibition.

Sub-Concept #2: The alcohol industry is an important facet of the alcohol spectrum which must be recognized.

Behavioral Objectives:

1. The prospective minister will be able to identify the role that the alcohol industry plays in the promotion and use of alcohol.
2. The prospective minister will be able to describe the many uses of alcohol.
3. The prospective minister will identify the characteristics of non-distilled beverages and distilled beverages.

Sub-Concept #3: The minister cannot effectively counsel an alcohol problem without an understanding of the physical and behavioral effects that consumption of alcohol produces.

Behavioral Objectives:

1. The prospective minister will be able to describe the process called alcohol metabolism.
2. The prospective minister will identify influences that affect alcohol absorption rate of the body.
3. The prospective minister will discuss the many physical effects that alcohol may have upon the body.
4. The prospective minister will be able to comprehend the behavioral modifications that may occur as a result of alcohol use.
5. The prospective minister will discuss what the term tolerance implies.
6. The prospective minister will be able to discern between physical and psychological dependence to alcohol.

Sub-Concept #4: The effective alcohol counselor must have a knowledge of the American drinking practices.

Behavioral Objectives:

1. The prospective minister will be able to list the most common reasons for drinking alcohol.
2. The prospective minister will list and discuss reasons for abstaining from drinking alcohol.
3. The prospective minister will be able to describe

the various statistical drinking patterns in regard to applicable independent variables.

4. The prospective minister will be able to discuss the many reasons which have stimulated increased teenage drinking.

Sub-Concept #5: The minister must have an understanding of what is meant by alcoholism to be an effective alcohol counselor.

Behavioral Objectives:

1. The prospective minister will be able to define alcoholism.

2. The prospective minister will list and discuss the stages of alcoholism.

3. The prospective minister will describe effective methods of rehabilitation treatment available for the alcoholic.

4. The prospective minister will be able to define what is meant by the term delirium tremens.

5. The prospective minister will list and describe facilities and local organizations devoted to helping the alcoholic.

TOPIC: HUMAN SEXUALITY

Concept: Human sexuality is a reality that exists with every human being in one way or another; therefore, it is very important that we as human beings know and understand as much about it as possible.

Sub-Concept #1: Human sexuality is an essential part of a person's education.

Behavioral Objectives:

1. The prospective minister will be able to discuss reasons why it is important to understand the many aspects of human sexuality.
2. The prospective minister will describe existing conditions which make it difficult for some parents to discuss human sexuality in the home.
3. The prospective minister will list ways in which the church can aid in teaching positive concepts toward human sexuality.
4. The prospective minister will identify barriers that the church has been guilty of establishing in conjunction with understanding human sexuality.
5. The prospective minister will discuss the implications that the media has placed on human sexuality which have led to an improper understanding of the subject.

Sub-Concept #2: A vital part of understanding human sexuality is having a thorough knowledge of the male and female sexual anatomy.

Behavioral Objectives:

1. The prospective minister will be able to list and discuss the physiological functions of all parts of the male reproductive system.

2. The prospective minister will list and discuss the physiological functions of all parts of the female reproductive system.

Sub-Concept #3: Most human sexual behavior is normal.

Behavioral Objectives:

1. The prospective minister will be able to identify those sexual behaviors which are considered normal.

2. The prospective minister will identify and discuss those sexual behaviors which are labeled abnormal.

3. The prospective minister will be able to list and discuss the most common reasons that individuals give for engaging in prostitution.

4. The prospective minister will be able to intelligently discuss the main issues behind the homosexual controversies.

5. The prospective minister will demonstrate techniques of helping those with abnormal sexual problems.

6. The prospective minister will be able to identify

those community resources that can aid in the treatment of sexual problems.

Sub-Concept #4: The decision to engage in pre-marital sexual intercourse is too often made as a result of peer pressure; whereas, the person should be allowed to intelligently make that decision without peer pressure.

Behavioral Objectives:

1. The prospective minister will be able to list and discuss factors that should be considered prior to making a decision about pre-marital sexual intercourse.

2. The prospective minister will be able to discuss the term "double standard" and determine whether or not it exists in the community.

3. The prospective minister will demonstrate an awareness of legal factors which are involved in teenage pre-marital intercourse.

Sub-Concept #5: The decision to marry is a very profound one and should be considered very carefully.

Behavioral Objectives:

1. The prospective minister will list and discuss poor reasons for deciding to marry.

2. The prospective minister will identify and explain the many factors which should be considered before marriage.

3. The prospective minister will be able to recognize

and explain the danger signals of a courting relationship.

Sub-Concept #6: Because each child should be a wanted child, it is extremely important that each couple be aware of the many different types of contraceptives which are available.

Behavioral Objectives:

1. The prospective minister will be able to list and discuss the types of birth control available without a doctor's prescription or supervision in terms of cost, action, advantages, disadvantages, and reliability.

2. The prospective minister will be able to list and discuss the types of birth control which require a doctor's prescription or supervision in terms of cost, action, advantages, disadvantages, and reliability.

3. The prospective minister will be able to discuss the pros and cons of sterilization as a method of birth control for males and females.

Sub-Concept #7: The decision to have children is one that should be carefully considered by both parents because of the adjustments which will have to be made.

Behavioral Objectives:

1. The prospective minister will be able to describe the effects that deciding to have children has on a couple.

2. The prospective minister will discuss the importance of planning for children.

3. The prospective minister will recognize possible threats that children could pose to the marriage relationship.

Sub-Concept #8: One of the greatest characteristics of successful marriages is that of good communication between the partners.

Behavioral Objectives:

1. The prospective minister will be able to list ways in which communication skills can be strengthened in a marriage relationship.

2. The prospective minister will discuss the importance of being a good listener in the marriage relationship.

3. The prospective minister will describe how effective communication leads to other characteristics such as trust, tenderness, and friendship.

TOPIC: AGING

Concept: For too many years the aged have been misunderstood, overlooked, neglected, and sometimes abused physically and psychologically by the American public.

Sub-Concept #1: The number of elderly people in the United States has rapidly increased in the past decades.

Behavioral Objectives:

1. The prospective minister will be able to define the meaning of gerontology and will be able to discuss the scope involved with this definition.

2. The prospective minister will demonstrate an understanding of the history of gerontology.

3. The prospective minister will be able to describe the aging population in terms of present demographics.

Sub-Concept #2: There are many changes and adaptations which occur in later life that must be understood by the public.

Behavioral Objectives:

1. The prospective minister will explain the most popular biological theories related to the aging process.

2. The prospective minister will be able to describe the physiological changes that occur with aging.

3. The prospective minister will be able to discuss and identify psychological factors involved with the aging process.

4. The prospective minister will be able to suggest positive ways that an individual can adapt to changes that occur as a result of aging.

Sub-Concept #3: The aged do not cease to be socialistic in nature; rather, the need for interaction with other human beings remains necessary for the satisfaction of their needs.

Behavioral Objectives:

1. The prospective minister will be able to list and explain those elements of socialization that are common to all age groups.

2. The prospective minister will be able to identify the problems of socialization which confront the aged.

3. The prospective minister will be able to list and explain the functions of those formal organizations available for the aged.

4. The prospective minister will be able to suggest ways in which the family relationship can be strengthened for the aged.

Sub-Concept #4: There seems to be an increasingly close tie between old age and religion.

Behavioral Objectives:

1. The prospective minister will be able to identify and discuss the dimensions of religiosity that exist in the lives of the elderly.

2. The prospective minister will list and explain effective ways that the church can aid the aged.

3. The prospective minister will discuss why religion seems to be more important to the aged than any other age group.

4. The prospective minister will suggest proposed programs that the church can effectively develop and maintain which will provide a sense of worth and dignity for the aged individual.

TOPIC: PATIENT COUNSELING

Concept: There are specific needs that are unique to those persons confined as a result of disease that the minister can learn to attend to.

Sub-Concept #1: To be an effective patient counselor a knowledge of the nature of communicable diseases is essential.

Behavioral Objectives:

1. The prospective minister will be able to discuss the theories of communicable disease.
2. The prospective minister will be able to identify the basic types of disease producing organisms.
3. The prospective minister will be able to list and recognize the various stages common to communicable diseases.
4. The prospective minister will list and define the "lines of defense" which help protect the body against disease.
5. The prospective minister will be able to describe the different types of immunity.

Sub-Concept #2: More needs to be understood concerning degenerative and non-communicable diseases by those who counsel patients.

Behavioral Objectives:

1. The prospective minister will discuss the three major categories of heart disease.
2. The prospective minister will be able to state reasons why it is important that the time to begin prevention for coronary heart disease is during the teenage years.
3. The prospective minister will describe the process of cancer development.
4. The prospective minister will list positive measures of cancer prevention.
5. The prospective minister will describe the different types of treatment available for cancer.
6. The prospective minister will discuss the cause and treatment of diabetes.

Sub-Concept #3: The minister must possess an understanding of the patient/physician/counselor relationship.

Behavioral Objectives:

1. The prospective minister will be able to identify characteristics of a good physician/counselor relationship.
2. The prospective minister will list ways in which he can most effectively aid the patient in understanding the events that are occurring at that time.
3. The prospective minister will recognize the limits of his abilities in aiding the patient.

Sub-Concept #4: A comprehension of communication skills is vitally needed to effectively counsel family members of the patient.

Behavioral Objectives:

1. The prospective minister will list and discuss common basic needs of family members of the patient, especially the terminally ill.
2. The prospective minister will identify ways that he can aid in improving communication skills between the family and the patient.

TOPIC: DEATH EDUCATION

Concept: Although much has been done in an effort to better understand death, it still poses a universal fear for mankind.

Sub-Concept #1: There are several attitudes toward death which are influenced by the cultural history of a person.

Behavioral Objectives:

1. The prospective minister will be able to describe death as it is perceived by various other cultures.
2. The prospective minister will discuss the attitudes that are common concerning death.

Sub-Concept #2: An understanding of the stages of death proves to be beneficial in developing an understanding of death.

Behavioral Objectives:

1. The prospective minister will be able to list and discuss the stages of death as defined by Kubler-Ross.
2. The prospective minister will be able to recognize each of the stages of death in a terminally ill patient.
3. The prospective minister will suggest ways which the terminally ill can best be approached when in differing stages of death.

Sub-Concept #3: The church has an excellent opportunity to play a leading role in the development of programs of service for the terminally ill.

Behavioral Objectives:

1. The prospective minister will identify ways that the local church can develop programs of service for the terminally ill.

2. The prospective minister will list and discuss the administrative implications which will occur if a program of service for the terminally ill is adopted by the church.

3. The prospective minister will identify the categories of service personnel necessary for a program of service to help the terminally ill.

Sub-Concept #4: It is imperative that the helping profession be aware of the many needs that the family members experience when losing a loved one to death.

Behavioral Objectives:

1. The prospective minister will list and discuss the common needs that are experienced by family members of a terminally ill patient.

2. The prospective minister will describe how it is possible for a time of mourning to be transposed into a time for growing.

3. The prospective minister will identify those

communication skills that are needed to communicate to the terminally ill and their families.

4. The prospective minister will discuss the importance of the funeral to the remaining family members.

VITA

Wayne Edward Wylie was born in Breckenridge, Texas, on August 13, 1949. He attended elementary schools in that city and was graduated from Breckenridge High School in May 1967. In September of 1968 he entered Cisco Junior College in Cisco, Texas. His course of study was interrupted the following fall as he was drafted by the United States Army. After a two year tour of duty he reentered Cisco Junior College where he received an Associate of Arts degree in May of 1972. The following fall he entered Texas A&M University, and in August 1974 he received a Bachelor of Science degree in Educational Curriculum and Instruction. In the fall of 1974 he accepted employment with Bryan High School as a health teacher and also began study toward a Master of Education degree in Health Education. This degree was awarded by Texas A&M University in August 1975.

After serving four years as the coordinator and instructor of the health education program at A&M Consolidated High School in College Station, Texas, he entered the Graduate School of The University of Tennessee, Knoxville, in September 1979. He received the Doctor of Education degree with a major in Health Education and collaterals in Public Health and in Educational Administration and Supervision in June 1981.

He is married to the former Pamela Wolfe of Breckenridge, Texas, and they have three children.