Pastors' Awareness of Clinical Pastoral Education in the Three Adventist Divisions in Sub-Sahara Africa

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ABSTRACT

The study investigated the level of Clinical Pastoral Education using a sample of 304 pastors in the East-Central Africa (ECD), West-Central Africa (WAD), and Southern Africa-Indian Ocean Divisions (SID) of the Adventist Church. Data from the self-constructed questionnaire was analyzed using SPSS 27 and SmartPLS 4.0 for statistical treatment. The pastors in the three Divisions exhibited a high level of CPE awareness with WAD having a higher level followed by SID and ECD. They affirm that CPE is essential for enhancing pastoral ministry, improves the management of emotions, and enhances intrapersonal and interpersonal skills. This phenomenon could be explained by the fact that there's an ongoing emphasis on Clinical Pastoral Orientation training on the continent as well as the presence of CPE training at AUA and Babcock. Concerning CPE training, ECD has 2.84%, WAD has 6.4% while SID has 3.91% of pastors that have taken at least a unit of CPE as of February 2025. In general, out of 7,585 pastors on the continent of Africa, only 302 representing **3.98%** have at least **one** Unit of CPE as of February 2025. There is no significant difference in the level of CPE awareness when age is considered. The Adventist University of Africa (AUA) and other theological institutions to embrace the establishment of the CPE center as a continental training hub for graduate students in the theological seminary and integrate CPE into standard ministerial curricula. CPE be a must-do training for all seminarians. AUA-CPE center to source ministry partners to offer scholarships or donations to sponsor CPE participants. The 3 Adventist Divisions on the continent of Africa to examine denominational policies and collaboration with government agencies to strengthen the structural implementation of CPE. For future research, a moderated mediation study on the functionality status of chaplaincy facets and CPE across Africa would be interesting. A comparative study with other continents could highlight global best practices and provide a roadmap for scaling up CPE training across African divisions.

Keywords: Clinical Pastoral Education. Clinical Pastoral Orientation. Pastor. East-Central Africa. West-Central Africa. Southern Africa-Indian Ocean Division.

INTRODUCTION

Clinical Pastoral Education

How does Clinical Pastoral Education (CPE) work? For the sake of ministry and personal growth, CPE is an interfaith professional education program that brings students and ministers into supervised encounters with people who are experiencing a crisis (Hirschmann et al., 2023). Out of an intense involvement with persons in need, and the feedback from peers and facilitators, students develop a new awareness of themselves as persons and of the needs of those to whom they minister. From theological reflection on specific human situations, they gain a new understanding of ministry. Within the interdisciplinary team process of helping persons, they develop skills in interpersonal and inter-professional relationships (Clevenger et al., 2021). The purpose of this specialized training, according to Ephesians 4:12 NIV, is to equip those called to ministry in particular institutional contexts, whether they be public or denominational. Psychological, religious, and educational philosophies are all incorporated into CPE (Deets, 2013).

Brief History of CPE

CPE is an interfaith professional education program. Students engage with people who are experiencing a crisis under supervision as part of a practice-based learning program and professional theological education. Its history provided by the literature (Deet, 2013; Hirschmann et al., 2022) points to Rev. Anton Boisen as its founder. Boisen achieved a BA in Modern Language from Indiana University in 1897 and a master's degree in forestry from Yale University in 1905. At Yale, he received a call to ministry and in 1908, he enrolled at Union Theological Seminary in New York. Boisen was ordained in 1912 (Deet, 2013). It was while at Indiana University that he experienced his first five psychotic episodes (Deet, 2013, p. 18) which had a later impact on his ministry. From 1922 to 1924, Boisen studied the psychology of religion at Andover Theological Seminary. Seminal literature (Stokoe, 1974; Deet, 2013, p. 18) mentioned Boisen started working with Richard C. Cabot, a noted author, physician, and parttime Professor of social ethics at Andover and the Episcopal Theological Seminary in Boston. Cabot was an early advocate of the importance of seminary students having a year of supervised clinical experience. In his submission, every student meant for ministry is to be given clinical training for pastoral work, just as the clinical training suitable for medical students during his internship.

Literature (Deet, 2013; Hirschmann et al., 2022) affirmed that in June 1925, he and Boisen began the first Clinical Pastoral Education program at Worcester State Hospital with the dual goals of providing improved patient care and supervising the clergyman's training. According to Deet (2013), one of Boisen's first CPE students was Flanders Dunbar. Flanders, known as the mother of holistic medicine, earned a degree in theology, philosophy, and medicine in seven years, including a PhD from Colombia University and a MD from Yale University. Deet (2013, p.19) affirms that Flanders and Boisen were instrumental in the formation of the Council for Clinical Training of Theological Students in 1930. Flangers spoke 15 languages and dialects by the time she was 22 years old (Stern, 2025).

What about the formation of the College of Pastoral Supervision and Psychotherapy (CPSP) and the Association for Clinical Pastoral Education (ACPE)? Deet (2013, p. 19) citing earlier sources mentions that in 1947 a meeting of the Council for Clinical Training, the Association of Mental Health Clergy was organized. In 1953, there were three associations involved in Clinical Pastoral Education namely the Council for Clinical Training, the Institute of Pastoral Care, and the Lutheran Advisory Committee. In the 1960s, the Association of Clinical Pastoral Educators was formed. In 1967, the Association of Clinical Pastoral Association was formed to consolidate the four organizations. In 1990, CPSP was formed by 15 clinically trained supervisors and pastoral therapists who desired a more collegial organization emphasizing community and mutual responsibility with less centralized governance. According to Hirschmann et al. (2022), CPE befits theology students to provide spiritual care (Paget, 2006, p. 18). Although CPE programs are offered in a variety of contexts, including congregations, social service organizations, prisons, and the military, the bulk of them take place in hospital centers. what is now known as clinical pastoral education is the result of this evolution. CPSP can be found in numerous countries abroad.

Theories for Adult Learning and CPE

CPE utilizes knowledge and insights from theology, behavioral sciences, and learning theories (Deet, 2013). First, there are adult learning theories. Deet (2013) lists five major educational philosophies that have impacted the theory and praxis of CPE. They include the liberal that focuses on the intellectual development of the mind, the progressive theory which emphasizes experiential and problem-solving approach to learning, the behaviorist which stresses the role of the environment in shaping behavior, the humanist places an accent mark on personal growth and self-direction. Finally, there is the radical which emphasizes the role of education in social change.

By application, Deet (2013) affirms that educators who adhere to liberal (arts) philosophy utilize didactics and critical reading and discussions. CPE utilizes didactics and group discussions. Behavioral adult educators favor contract learning and criterion-referenced testing. CPE uses Group covenants and learning goals from this theory. The proponents of progressive philosophy utilize a problem-solving scientific approach in designing of the curriculum. Humanistic adult educators focus on experiential learning, group discussion, and individual learning. CPE utilizes Action-Reflection-Action method, group processing, and weekly growth reports.

Radical philosophy utilizes dialogue, critical reflections, and group discussions in learning. CPE has mid-point and final evaluation and group processes. CPE practitioners can utilize an eclectic approach. John Dewey (1859 – 1952) posited that learning should be done through experience. Against the behaviorist approaches to psychology and learning, he came up with constructivism – that posited that an organism interacts with the environment through self-guided activity that coordinates and integrates sensory and motor responses

Secondly, CPE utilizes psychological theories of experts such as Sigmund Freud, Alfred Adler, Carl Rogers, Abraham Maslow, and Malcolm Knowles. Corey and Corey (2012) discussed Sigmund Freud (1856 – 1939) whose contributions in education and psychotherapy are immense. Fixation to the psychosexual stages whose discovered psychopathologies are manifested in adulthood. Freud's contribution is in catharsis where emotional release is therapeutic for people with emotional baggage. His contribution to CPE touches the tip of the iceberg notion. That emotions are the tangible manifestations of what is going on inside a person. The cardinal rule for clinical ministry is first to address the emotions before the spiritual. The Freudian Oedipus complex and Electra give birth to Dead Mother Syndrome among adults. Freud has hegemony in emotional therapy.

Alfred Adler's Individual Psychology is used in chaplaincy. From his accent mark on the significance of childhood experiences, literature (Adam et al., 2018; Doi et al., 2022; Li et al., 2019; Wesley et al., 2017) point to Adverse Childhood Experiences –the traumatic childhood experiences before 18 years that manifest adulthood as depression, anxiety, substance abuse, marital problems, and divorce. Adler gives us terms such as self-concept (the sense of who one is), the self-ideal (the sense of who one should be), the world-concept (the sense of what the natural and social world demands) and the ethical convictions (the sense of what is right and wrong) and the pathological inferiority complex. Adler gives us the importance of ordinal positions in families. Encouragement is from Adler.

Carl Ransom Rogers (1902- 87) stands out in the helping ministry. His theory was more fully espoused in Client-Centered Therapy and contended that whenever congruence, unconditional positive regard, and empathy are present in a relationship, psychological growth will invariably occur (Corey & Corey, 2012). Three concepts stand out as useful to chaplains. The first necessary and sufficient condition for therapeutic change is a congruent therapist. Congruence exists when a patient's organismic experiences are matched by awareness of them and by an ability and willingness to openly express these feelings. To be congruent means to be real or genuine, to be whole or integrated, and to be what one truly is. Secondly, positive regard is the need of the patient to be liked, prized, or accepted by the chaplain during ministry. The third necessary and sufficient condition of psychological growth is empathic listening. Empathy exists when the chaplain accurately senses the feelings of their clients and can communicate these perceptions so that clients know that another person has entered their world of feelings without prejudice, projection, or evaluation. Rogers has given us the emphasis the art of listening – with an eye, mind, and heart – verbal and non-verbal communication.

Abraham Maslow (1908-1970) or Abby has great contribution to CPE (Corey & Corey, 2012). He believed that all the resources for need gratification and self-actualization are within a person. His solution to overcoming evil was giving knowledge to help people gain ego-strength. His emphasis on choices and freedom has brought about relativism and self-autonomy, postmodern views of life. Existentialism emphasizes emptiness, and meaninglessness- these are consistent for the Bible mentions that man is spiritually hopeless without Christ. Another man who helped form modern psychology is Erick Fromm. It was from Fromm that we got the phrase "unconditional love." He taught that a person must love himself, accept himself, and esteem himself to reach his highest potential (Corey & Corey, 2012)

CPE's Group Processing using Question and Answer

From experience from my CPE journey, Genesis indicates the inception of group processing. Adam and Eve disobeyed God by eating the forbidden fruit, and as a result, God's likeness disappeared. The relationship and the character of God are the two elements that make up His image. The physical, mental, and moral attributes of God were lost by these first parents. It is now understood that a person's moral and mental qualities define their character. In a nutshell, character is lost quality in the cognitive and affective domains, or feelings and

thoughts. Additionally, their egalitarian relationship with God was lost. This attribute belongs to the family systems, dominion, stewardship, and man-social domains. When God examined the first two original counseling issues in Genesis—nakedness and shame/condemnation—group processing began.

God examined the first two counseling concerns in Genesis, namely nakedness and shame/condemnation, which encompasses what we now understand to be anxiety, guilt, dread, despair, and alienation. This is how group processing got started. Questioning Adam and Eve in groups for the first time was done by God. Question-and-answer sessions are still used in most counseling theories, including Cognitive Behavioral Therapy (CBT), to facilitate processing (Alpert et al., 2021). God saw their need and made a move. He slaughtered a lamb to atone for their nudity and covered their shame. Subsequently, the Old Testament offerings addressed alienation and condemnation, alluding to Jesus as the Lamb of sacrifice. Gratitude is the opposite of guilt. These days, we can overcome shame by integrating spirituality and psychology. Group processing is used in CPE for pastoral competence, pastoral reflection, and pastoral identity formation. Peer group interactions, student-supervisor contracts for learning, and supervised ministry practice are the main foci of CPE.

Learning Covenant and Reading Reports

From these books, the intern writes a reading report on each of these books and discusses how these books impacted them. The CPE unit spends the first week on introduction that ranges from didactics, group covenant, and orientation to the facility (hospital, prison, military installation, school). It involves the making personal Learning covenant. Each intern is self-directed to develop these goals with supervisory input and guidance. The learning goals are to address both professional and personal goals. The professional goal deals with growth as a minister and chaplain. The personal goal espouses spiritual formation, emotional and physical health (Deet, 2013, p. 64). Each intern presents these goals to the group. These goals become the covenant between the intern, group, and supervisor. The group covenants to provide congruent and authentic feedback, critique, and assist each person reach the

Clinical Seminars/Didactics

According to Deets (2013), after the interns have developed and presented their learning goals, they are offered weekly clinical reports whose aim is primarily for the development of self-awareness. Hirschmann et al. (2023), CPE fosters an understanding of Pastoral Competence (function and skills, as well as knowledge of theology and behavioral sciences), Pastoral Formation (personal and pastoral identity issues), and Pastoral Specialization (specific area of competence and knowledge). The subject areas include the prophetic role of chaplaincy, theological reflection, the clinical method of learning, conducting therapeutic conversations and providing ministry to those in crisis, family dynamics; transference, countertransference, displacement, and projection; and compassion. There are different approaches to didactics. Clevenger et al. (2021) observed that some centres have programs with a strong emphasis on didactics with a belief that CPE residents need to have a body of knowledge and content. On the other hand, other centers have a weak commitment to and believe that relational skills are more important than knowledge. The authors raise a question - Is there a core curriculum that should be taught across CPE programs? (Clevenger et al., 2021. p.3)

The Clinical Case Presentations/ Verbatims.

According to Hirschmann et al. (2023), CPE employs the clinical way of learning - focusing on ideas, feelings, and internal processes to improve students' ability to be mindful. According to Deet (2013), verbatims are an essential component of the clinical method of learning. This is achieved through this method of learning—Action, Reflection, and New Action— as the foundation, and enhances personal growth through self-awareness and self-reflection.

After writing verbatim, from memory, stories of spiritual care contacts, CPE participants analyze the information and usually offer their thoughts on the psychological, sociological, cultural, and theological dynamics that were present during the visit. The verbatim includes all exchanges and interactions, whether spoken or unspoken, between the client and the CPE participant (Szilagyi et al., 2024). The learner subtly

highlights their difficulties through the verbatim. In addition, the learning paradigm usually comprises one-on-one individual supervision with the Certified Educator and a process group. This contact involves both transference and countertransference. Each student learns the advantages and disadvantages of receiving candid criticism.

Miller calls it co-creative experience (Miller, 2023). Hirschmann et al. (2023), the group goes over the text aloud while providing comments to the students who brought it. The intern can reflect theologically on their pastoral experience and utilize the critique of both supervisors and peers to learn ways that the pastoral interview could have been more valuable for the patient. Transference and countertransference usually pop up in the encounters. They also allow trainees to learn more about themselves as they are involved in the ministry event—their listening and responding skills, their strengths and limitations; and how their personal history and religious history, values, and biases impact their ministry. The verbatim is organized into eight sections. First, is the background information. The intern introduces the visit – when and where of the pastoral visit stating whether it is a routine visit, follow-up, referral, code or death.

Deet (2013, p. 70) affirmed that the patient is identified by age, gender, diagnosis, and medication, especially for hospital setups. Pseudonyms are used due to privacy issues. The second part entails the known facts to assess the patient's spiritual and other needs, and the intern identifies their plan or objective for the visit. According to Deet (2013), in part three, the intern describes the observations at the beginning of the visit – physical environment and the patient. The intern takes note of the patient – noting the patient's posture, appearance, and facial expressions, non-verbal and verbal communication. The physical environment is described – for example, the room lights, ventilations, bed, furniture, and infotainments. Part four has the intern recording the actual dialogue, interruptions, delays in separate paragraphs introduced by 'C' for 'Chaplain' and 'P' for 'patient'. Part five has the evaluations. It is a discussion of the issues found these themes: theological, psychological, and sociological concerns. The intern is asked to evaluate the learning points, and insights gained from the encounter.

The group will utilize the verbatim to process the intern – assessing the missing information, gaps, inattentiveness, assumptions, transference and countertransference, links, mannerisms, slips from personal baggage and adverse childhood experiences (Finkelhor, 2018; Doi et al., 2021; De Venter et al., 2013). This group processing feels like peeling an onion in front of your eyes but builds competence and skills at triggering the intern's feelings to the surface and empowering them. The group compares the life trajectory of the intern and the patient's. The group will then utilize the religious background, theological knowledge, and sociocultural backgrounds to assist the intern to growth.

According to Evans-Tameron in the paper ACPE Theory Paper in consonance with Deets (2013) opined that CPE's clinical method of learning—Action, Reflection, and New Action—enhances pastoral skills, helps address personal growth in terms of self-awareness and self-reflection. It fosters an understanding of Pastoral reflection, formation, competence, and specialization.

According to Kalish (2021), CPE studies the human document as the textbook. The catchphrase A Health Minister, Health Ministry is the centerpiece. Through the process of group and individual supervision, a clinical pastoral student gains knowledge by characterizing, dissecting, assessing, and considering pastoral relationships, human encounters, and acts of ministry. This practical course enables participants to apply their academic knowledge to real-world scenarios and learn how to handle the challenges of offering pastoral and spiritual care to clients.

CPE is a tool to deal with emotional baggage. Falk (2023) noted the best practices in CPE coverage. It is best achieved through hospital-based settings, classroom didactics, clinical hours spent with both patients and staff in various hospital settings, large and small group processes, a one-on-one session - supervision with a certified CPE supervisor, significant reflective writing, participation in specialized training, preaching in chapels and conducting ceremonies and ordinances, and participating in increasingly challenging simulated patient experiences with observation and feedback. CPE handles emotions, but it does not analyze or diagnose thoughts or behavior. In this therapeutic ministry, the golden rule is to attend to emotional issues before

spiritual ones. This is where CPE is positioned. When it comes to attending to patients' spirituality and emotions, CPE is outstanding.

Living Human Document

CPE's textbook is the Living Human Document whose mantra as A Health Minister, Health Ministry makes the centerpiece of the training. Falk (2023) pointed out that CPE improves the ability to manage emotions. CPE promotes self-reflection, helps people become more conscious of their identities as ministers and how their beliefs, values, presumptions, strengths, and shortcomings affect the pastoral and spiritual care they provide. According to Szilagyi et al. (2024), CPE develops confidence, reflective practice, listening and attending skills, diversity in chaplaincy care, and spiritual assessment. The gains of CPE include chaplaincy capabilities, emotional intelligence, and self-efficacy. CPE model has numerous advantages and effectiveness.

As a CPE supervisor, I can attest to the excellent way in which CPE addresses emotional trauma, toxic shame, and baggage from the past. I now recognize the value of the many mental health therapies and methods. Although the goal of counseling psychology is to prevent psychopathologies in thought, emotion, and behavior, a normal mind is incapable of processing thoughts.

CPE prepares pastors for ministry in crisis (Oluwalana, 2024). My experience as a psychotherapist affirms that clinical psychology, on the one hand, assesses, evaluates, and diagnoses psychopathology in a sick mind, and uses medication and psychotherapies to address maladaptive ideas and behavior. Without considering emotions, psychiatry treats psychopathology with medication. The spiritual and emotional aspects of all the therapies are not fully utilized in the protocols. Spirituality is not part of treatment and is undervalued. Although CPE does not diagnose thoughts and behavior, it processes emotions. The cardinal rule in this clinical ministry is to address first the emotional concerns before the spiritual. CPE is a pastoral ministry that makes use of the patient's religious heritage, theological understanding, and knowledge of behavioral sciences to empower them. CPE stands out when it comes to addressing the emotions and spirituality of patients.

Recent studies by Hirschmann et al. 2023) supported the superiority of CPE. The core of the CPE educational paradigm is case-based learning, which is carried out in small groups with an average of twelve participants. Encouraging participants to deepen their pastoral reflection, pastoral identity development, pastoral competence, and pastoral specialization is the aim of all CPE processes. This supervised program encourages trust and honesty in addition to helping the participants adjust to structural changes at work and connect with their emotions (Deet, 2013).

Deets (2013) observed that CPE addresses the pressing concerns of a postmodern generation and impacts individuals, congregations, and communities. CPE is more than training clergy and seminarians for clinical ministry as chaplains; many religious groups and denominations require candidates for ordination to complete a unit of CPE.

A recent study (Hirschmann et al., 2023) claims that CPE employs the clinical way of learning. They found that CPE helped students rediscover their emotions and improved their capacity for self and others-accountability and honesty. Additionally, it was successful in reducing participants' concerns about changes to the system as a whole and improving their capacity to adapt to them. Because it focuses on relational, person-centered, and emotionally intelligent leadership approaches, the students have a follow-up program to maintain their relationships and learning together. CPE emphasizes focusing on ideas, feelings, and internal processes to improve students' ability to be mindful (Hirschmann et al., 2023, p. 5180).

Besides, CPE promotes self-reflection, which helps people become more conscious of their identities as ministers and how their beliefs, values, presumptions, strengths, and shortcomings affect the pastoral and spiritual care they provide. The procedure enhances the people's self-assurance, emotional fortitude, and a more profound understanding of their spirituality. CPE is a training that is essential to all Chaplaincy care within the denominational or public arena at all levels of service to God and humanity. The competencies befit

them for ministry in Hospitals, Campuses, Correctional facilities, Military installations, and the corporate world.

Clinical Setting, Participants, and Schedule

In general, whether under the auspices the major organization, the professional organization of the curriculum is generally similar. Deet (2013) listed the pertinent ingredients include, 1/ the program must not be less than 400 hours of supervised theory and practical learning, group processing, and visits (Deet, 2013). Each makes several pastoral visits to patients, caregivers, or medical personnel. The participant engages with numerous local pastors who visit their congregants with varied degrees of ministry competency during that period, many of whom are not trained in CPE. 2/ The program must have pastoral supervision by a certified CPE diplomate in CPE supervision or by a supervisor-in- training under the supervision of a diplomate. 3/ A detailed reporting and evaluation of the practice of ministry (Heppner et al., 1999, pp. 241- 42).

Others include, 4/ a process model for learning must be utilized, 5/ sufficient number of trainees (3 interns and a maximum of six per group; some use 6 – 12) to offer a variety of experiences and small enough to provide time for each chaplain intern to enter a creative interpersonal process for growth and learning, 7/ the content must be used from all disciplines which enhance the trainees' integration of theological understanding and knowledge of behavioral sciences with personal and pastoral functioning, 8/ there must be personal and professional goals. Each chaplaincy intern is asked to set two or three personal and professional goals during the CPE unit. At least six clinical case presentations or (also called verbatims) are made. The verbatims are word-by-word retelling the interactions during the pastoral visit. 9/ There are two self-evaluations, a midterm self-evaluation and a final self-evaluation based on the set goals.

According to Deet (2013), each candidate describes the CPE journey citing specific information from the clinical case interactions to support their conclusions. The CPE supervisor evaluates the intern using the intern's own report and supervisor's skilled judgement. At the end of the unit, the intern is given a course evaluation to evaluate the specifics of the CPE unit – didacts, clinical assignments, verbatims, assigned readings, theological reflections, interpersonal sessions with the supervisor, and videos – indicating whether there were significant and why. The interns are also asked to comment on elements that were not useful for them. The major questions addressed based on the specific need - include and not limited to intrapersonal dynamics, community relationships, spiritual formation, anger, transference and countertransference, bioethics, multicultural diversity, and wholistic approaches.

First Unit Textbooks

Deet (2013), lists the four required textbooks for the interns in the first unit of CPE:

1. Heije Faber and Ebel van der Schoot: The Art of Pastoral Conversation: Effective Counseling Through Personal Encounter (Nashville: Abington Press, 1980)
2. Myron C. Madden, The Power to Bless (New Orleans, LA: Insight Press Inc., 1999).
3. Henri J. M. Nouwen, The Wounded Healer (New York: Doubleday, 1979).
4. Suzanne Rice Deets, From Mourning Into Joy: Healing in the Grief Process, Grief Workbook (Portsmouth, VA: Suzanne Rice Deets, 2007).

The Two Inter-Personal Relations Conferences

Inter-personal Relations/Conferencing (IPR)

Deet (2013) observed that this weekly Inter-Personal Relations requirement is one of the most difficult yet beneficial aspects of the CPE process. Participants are expected to provide constructive and direct feedback to one another on personal conflicts, observed behaviors, and attitudes that could be problematic in a clinical setting, as well as any other issues or grievances that the student may have with a supervisor or fellow student. This is not for the timid; it is a professional confrontation that goes beyond any occupational performance assessment.

Interpersonal Relations Group

Deet (2013) opined that at the end of every clinical seminar, there is a time of group interaction and reflection termed Interpersonal Relations Group (IPR), facilitated by the supervisor. The IPG with the supervisor gives the peer group the opportunity to explore issues that were stimulated by either didactics, or verbatims, or current experiences in the pastoral ministry

The Midterm and Final Evaluations

According to Deet (2013) CPE members must complete a comprehensive midpoint and endpoint assessment report on their professional and personal performance and reflection on every unit. The requirements are well explained. These are the mid-unit and final evaluations. The interns in the mid-unit evaluation must then present their report before the supervisor and fellow CPE participants for comments. Each participant is evaluated by the CPE Supervisor after the session. Following a few weeks of uneasy, clumsy attempts at real constructive criticism, the group has improved significantly in dealing with issues that could, at the very least, make the ministry more effective or less dangerous. The areas of growth are discussed between the supervisor and intern. In the End-point Evaluation, the intern notes their strengths and growing edges in pastoral care. Each intern reads their evaluations. This a must-be-present session. CPE is recommended for pastors.

Anderson (2004) listed the five essential Es of Clinical Pastoral Education: 1/ Encounter, (2) Engage, (3) Experience, (4) Embrace, and (5) Empower are the ones they are. In clinical pastoral ministry, participants and supervisors work to experience a range of viewpoints, have meaningful conversations with patients and communities, go through significant spiritual growth experiences, treat people with respect, empathy, and unconditional love, and give others the social, emotional, and spiritual empowerment so they can live victorious lives.

The studies on CPE have population and evidence gaps. Deets (2013) questioned the future of CPE. Clevenger et al., 2021questioned if there a core curriculum that should be taught across CPE programs in the world. Szilagyi et al. (2024) observed that CPE is not established in England and lacks standards that births professional inequalities and inconsistencies.

In response to the population and evidence gaps, the study aimed at assessing the extent of the level of awareness of CPE among Adventist pastors in Sub-Saharan Africa using a quantitative descriptive design.

Research Questions

The study aimed to determine the level of awareness of CPE among Adventist Pastors in Sub-Sahara Africa. Specifically, the study seeks to address the following questions:

1. What is the level of awareness of Clinical Pastoral Education among pastors in Sub-Sahara Africa?
2. Is there a significant difference in the level of awareness of CPE among Pastors in in Sub-Sahara Africa when personal profile is considered?

Hypotheses

The study will test the following null hypotheses: There is no significant difference in the level of CPE when personal profile is considered.

METHODOLOGY

The section highlights the research design, population and sampling technique, personal profile, instrumentation, data gathering procedures, ethical considerations, and data analysis procedures.

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Research Design

This study was a quantitative study specifically employing descriptive and inferential statistics to analyze the relationships by applying the Partial Least Square Structural Equation Modeling (PLS-SEM-4.0). This research design attempts to understand the kind of relationships occurring naturally between variables (Hayes, 2018). In this study, the awareness of CPE was sought and how it related to personal profiles in terms of age and territory of work.

Population and Samples and Sampling Techniques

This research involved pastors within the 3 Adventist Church divisions in Africa – East-Central Africa (ECD), West-Central Africa (WAD), and Southern Africa-Indian Ocean (SID) Divisions. According to the statistical Report from the Office of Archives, Statistics, and Research (2024), ECD had 3,760, SID had 2,041 and WAD had 1,784 ordained and licensed ministers spread across the 38 Unions. The sample taken involved clergy working as pastors in the district, local church, Conference and Union department directors, and those working the chaplaincy facets (Schools, prisons, healthcare, and Disciplined forces).

Purposive sampling was used to select the Unions. The selection criteria for the Unions whose Conferences/Fields/ Missions to participate included the following: 1/ The entity must have more than 130 ordained pastors, 2/ must be using English as the major language to avoid translations, 3/ must have the number of ordained pastors greater than licensed ministers. These criteria will utilize West Congo Union having 3 entities with 137 ordained pastors, the West Kenya Union Conference with 6 entities having 344 ordained pastors, and the East Kenya Conference having 11 Conferences/Fields/ Missions with 308 ordained pastors – all in ECD territory. SID territory will have the Indian Ocean Union with 10 Conferences/Fields/ Missions having 134 ordained pastors, the Malawi Union with 3 entities with 169 ordained pastors, and the Southern Africa Union with 8 entities having 202 pastors. WAD territory will have the Northern Ghana Union with 11 entities having 166 ordained ministers. Other Unions include the Eastern Nigeria Union with 16 entities having 155 ordained and the Southern Ghana Union with 12 Conferences/Fields/ Missions having 133 ordained pastors (Office of Archives, Statistics, and Research, 2024).

The formula for calculating a sample for proportions of populations according to Cochran (1963) who developed Equation 1 to yield a representative sample for proportions.

$$n_0 = \frac{Z^2pq}{e^2}$$

This is valid where n_0 is the sample size, Z2 is the abscissa of the normal curve that cuts off an area α at the tails (1 - α equals the desired confidence level, e.g., 95%)1, e is the desired level of precision, p is the estimated proportion of an attribute that is present in the population, and q is 1-p.

The value for Z is found in statistical tables which contain the area under the normal curve.

$$n_0 = \frac{Z^2pq}{e^2} = \frac{(1.96)^2(.5)(.5)}{(.05)^2} = 385$$

Given that the total number of ordained pastors is 3736 as of 2015, the sample size will be calculated thus,

$$n = \frac{n_0}{1 + \frac{(n_0 - 1)}{N}}$$

n = 385 divided by (1 + (385 – 1) over N

385 divided by ((1 +(384 over 7585))
385 divided by (1+0.0506) = 385 divided by 1.0506)
n = 385 over 1.0506
n = 366 was the targeted sample size

Convenience sampling was used to pick the pastors from the Conferences, Fields, or missions. With a consent form attached and necessary permits, whoever was willing to respond to an email or WhatsApp message participated. The participants responded to the online questionnaire on Google Forms. The study had a final sample size of 304 pastors.

Personal profile.

This contained variables such as age, sex, and their current workstation. The results indicated the following. In terms of age, the participants (n=304) distribution indicated that 65.1% were aged above 40 while 34.9% were below 39 years. In terms of sex, 96.1% were males while 3.9% were females. In terms of the Division of work, 23.7% are from WAD, 33.6% are SID, and 42.8% hailed from ECD.

In terms of training, 57.6% have not taken CPE while 42.4% have at least one unit of CPE. On CPE, this finding is contrary to existing data based on the number of pastors from the 3 Divisions (ECD, WAD, and SID) who have done CPE. ECD has 107 out of 3760 pastors, WAD has 115 out of 1784 pastors, while SID has 80 out of 2041 pastors that have done CPE. In general, out of 7,585 pastors on the continent of Africa, only 302 representing 3.98% have at least one Unit of CPE as of February 2025. Besides, it becomes more interesting since out of the participants, 42.4% indicated to have done while 57.6% of pastors have not done at least one Unit of CPE. This phenomenon could be explained by the fact that there's an ongoing emphasis on Clinical Pastoral Orientation training on the continent as well as the presence of CPE training at AUA and Babcock.

Table 1 Demographic profile of the respondents

Profile	Variable	Frequency	Percent
Sex	Male	292	96.1
	Female	12	3.9
Age	Below 39 years	106	34.9
	Above 40 years	198	65.1
Division	East-Central Africa Division (ECD)	130	42.8
	West-Central Africa Division (WAD)	72	23.7
	Southern Africa-Indian Ocean Division (SID)	102	33.6
Taken CPE	Yes	129	42.4
	No	175	57.6
Current Workstation	District/ Church Pastor	179	58.9
	Director Union/ Conference/ Field	73	24
	In a Chaplaincy Facet (School, Hospital, Prisons, Disciplined Forces)	52	17.1

As for the current workstation, 58.9% are District/ Church Pastors, 24% are Directors at Union/ Conference/Field/Mission, and 17% are working in Chaplaincy Facets (School, Hospital, Prisons, Disciplined Forces).

Instrumentation

Self-constructed questionnaire or Pastor's Woundedness was based on literature. The questionnaires were subjected to external and internal validation by experts and statistical processes and had good statistical properties. The instruments' external validation was carried out by three specialists from the Adventist University of Africa. To verify internal consistency, the Cronbach alpha for each variable in the instrument was calculated. With SPSS, the Cronbach Alpha was computed. For coefficients to be acceptable, the Cronbach Alpha at or greater than 0.7 would indicate an acceptable reliability.

Clinical Pastoral Education scale

This refers to an interfaith professional theology education and practice-based learning program that places students in supervised interactions with people who are experiencing a crisis. CPE makes use of educational, religious, and psychological theories. Encounter, Engage, Experience, Embrace, and Empower are the five key Es on which it functions. The CPE tool had 7 items and reliability of Cronbach's alpha of 0.963. This means that the CPE scale had excellent internal consistency.

Ethical Considerations

Given that the respondents were from a homogenous population, approval from the University's Ethics Review Board was secured, and then from Kenya's National Commission for Science Technology and Innovation (NACOSTI). A consent form to request permission to participate in the study was embedded in the online Google Forms. It made clear to participants that this was a voluntary activity. They were guaranteed the freedom to exit after reading the consent form or whenever they so wanted. Confidentiality and anonymity of participants were ensured. A participant who experienced emotional disruptions during data collection was assured of online psychological first aid as well as free counseling sessions by the principal investigators who have CPE skills, being a Supervisor of Clinical Pastoral Education.

RESULTS AND DISCUSSION

This section presents the meaning and implications of the results of all the questions. The findings in the tables below foster a better understanding of the study. In response to the question - What is the level of awareness of Clinical Pastoral Education among pastors in Sub-Sahara Africa?

Table 2 The Pastor's Level of Awareness of Clinical Pastoral Education **(CPE)**

Items	M	SD	Scaled Respo	Verbal Interpre
In my View				
1. CPE is essential for enhancing my pastoral care skills	3.08	1.071	Agree	High
2. CPE is essential for improving my ability to manage my emotions	3.06	.998	Agree	High
3. CPE adequately prepares me for crisis intervention in ministry	3.12	.947	Agree	High
4. CPE is a tool to help me deal with emotional woundedness in my life.	3.12	.935	Agree	High
5. CPE empowers a pastor to deal with today's ministry intrapersonal issues	3.17	.971	Agree	High

6. CPE can enhance my self-awareness in pastoral ministry	3.15	.940	Agree	High
7. I recommend CPE to all pastors	3.23	.989	Agree	High
Level of Awareness of CPE	3.132	0.978	Agree	High

Scoring system: 4:00 – 3.50= Strongly Agree=Very High; 3.49 – 2.50= Agree=High; 2.49 -1.50=Disagree= Low; 1.49 – 1.00= Strongly Disagree=Very low.

The results demonstrate that the pastors' level of awareness of Clinical Pastoral Education is High (M = 3.132, SD = .978). This means that pastors in Africa are aware of CPE. This is contrary to the literature. This phenomenon could be explained by the fact that there's an ongoing emphasis on Clinical Pastoral Orientation training on the continent as well as the presence of CPE training at AUA and Babcock. Besides, 8 out of 10 pastors affirmed that CPE is a tool to help them deal with emotional woundedness while 85.2% said that CPE could empower them to deal with today's ministry intrapersonal and interpersonal issues. Again 8 out of 10 pastors can recommend CPE to all pastors.

However, CPE is not established on the continent of Africa. This is concinnity to the literature. First, Szilagyi et al. (2024) who observed that CPE is not established in England and lacks standards that births professional inequalities and inconsistencies. Few pastors have benefited from it. Secondly, this finding is concinnity to existing data based on the number of pastors who have done CPE from the 3 Divisions (ECD, WAD, and SID). ECD has 107 out of 3760 pastors, WAD has 115 out of 1784 pastors, while SID has 80 out of 2041 pastors that have done CPE. In general, out of 7,585 pastors on the continent of Africa, only 302 representing 3.98% have at least one Unit of CPE as of February 2025.

Hirschmann et al. (2022) affirmed CPE's dual goals of providing improved patient care and supervising the clergyman's training hinged on the Action, Reflection, and New Action, A Health Minister, Health Ministry whose textbook is the Living Human Document. CPE model has numerous advantages and effectiveness. According to Falk (2023), CPE promotes self-reflection, which helps people become more conscious of their identities as ministers and how their beliefs, values, presumptions, strengths, and shortcomings affect the pastoral and spiritual care they provide. According to Szilagyi et al. (2024), CPE develops confidence, reflective practice, listening and attending skills, diversity in chaplaincy care, and spiritual assessment. The gains of CPE include chaplaincy capabilities, emotional intelligence, and self-efficacy.

Differences in Level of CPE Awareness Considering Personal Profile

The tables present the answer to the research question: Is there a significant difference in the level of awareness of CPE among Pastors in Sub-Sahara Africa when personal profile is considered?

Table 6 One-Way ANOVA Results on CPE Awareness by Territory

Territory	M	SD	F	Sig.
East-Central Africa Division	2.5474	.5758	1.072	.344
Southern Africa-Indian Ocean Division	2.5809	.5588		
West-Central Africa Division	2.6644	.4630		

The ANOVA results suggest that CPE awareness across the Divisions does not differ significantly ($F_{2,301}$ = 1.072, $p > .05$. Since the Levene Statistic is not significant, equal variance was not assumed. To check for individual differences between groups, post-hoc comparisons using Dunnett's T3 was selected. The test indicated that the mean score for ECD pastors (M =2.547, SD = .575) was not significantly different from Pastors of SID (M = 2.580, SD = .558). However, the pastors in WAD (M =2.664, SD = .463) had a significant

difference compared to other territories. The mean differences were not significant at the 0.05 level. The hypothesis that there is no difference in CPE awareness across the different territories in Sub-Sahara Africa (ECD, WAD, and SID) is supported.

The results demonstrate that the pastors' level of awareness of Clinical Pastoral Education is High with 85.2% affirming that it is a tool to help them deal with emotional woundedness while 85.2% said that CPE could empower them to deal with today's ministry intrapersonal and interpersonal issues. This phenomenon could be explained by the fact that there's an ongoing emphasis on Clinical Pastoral Orientation training on the continent as well as the presence of CPE training at AUA and Babcock.

The Differences in CPE Awareness Considering Age

The tables presented in this part answer research question 5: Is there a significant difference in the level of CPE when personal profile is considered? Specifically, there was an investigation on Pastors' awareness of CPE and personal profile in terms of age.

Table 7 T-test results Comparing Ages Below 39 years and Above 40 years old on CPE Awareness

				Levene's Test for Equality of Variances		t-test for Equality of Means						
				F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
		Mean	SD								Lower	Upper
Clinical Pastoral Education	Below 39 years old	3.20	.862	0.14	.905	.925	302	.356	.099	.107	-.111	.308
	Above 40 years old	3.10	.898									

An independent sample t-test was conducted to compare CPE Awareness for pastors aged Below 39 years and Above 40 years old. There was no significant difference t(222.390), = .937, p = .350) in the scores with the mean score for ages Below 39 years (M = 3.20, SD =.862) higher than ages Above 40 years (M = 3.10, SD = .898). The magnitude of the difference in the means (mean difference = .099, 95% CI: -.109 to .309) was not significant. Hence, the hypothesis that there is no significant difference in the level of CPE awareness when age is considered is supported. This means that the younger and older pastors were aware of the importance of CPE in ministry.

This finding is contrary to existing data based on the number of pastors from the 3 Divisions (ECD, WAD, and SID) who have done CPE. ECD has 107 out of 3760 pastors, WAD has 115 out of 1784 pastors, while SID has 80 out of 2041 pastors that have done CPE. In general, out of 7,585 pastors on the continent of Africa, only 302 representing **3.98%** have at least **one** Unit of CPE as of February 2025 (Adventist Archives 2024; Adventist Chaplaincy Institute, 2024). Besides, it becomes more interesting since out of the participants (N = 304), 42.4% indicated to have done while 57.6% of pastors have not done at least one Unit of CPE. The implication is that pastors need to have CPE training.

Awareness alone does not help the pastors. CPE's history (Hirschmann et al., 2022) indicated profound benefits to pastors who train. CPE enhances personal growth through self-awareness and self-reflection. It fosters an understanding of Pastoral Competence (function and skills, as well as knowledge of theology and behavioral sciences), Pastoral Formation (personal and pastoral identity issues), and Pastoral Specialization (specific area of competence and knowledge).

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

This section presents the meaning and implications of the results of all the questions. The findings in the tables below foster a better understanding of the study.

Summary of Findings

In general, results bespeak that the pastors' level of awareness of Clinical Pastoral Education in the three Divisions (ECD, WAD, SID) is high. On Clinical Pastoral Education (CPE) in ministry, 8 out of 10 affirmed that it is a tool to help them deal with emotional woundedness while 8 out of 10 said that CPE could empower them to deal with today's ministry intrapersonal and interpersonal issues. Eight five percent can now recommend CPE to pastors.

Concerning CPE training, ECD has 2.84%, WAD has 6.4% while SID has 3.91% of pastors that have taken a unit of CPE. In general, out of 7,585 pastors on the continent of Africa, only 302 representing **3.98%** have at least **one** Unit of CPE as of February 2025.

The investigation if CPE Awareness differs across the different territories in Sub-Sahara Africa, namely East-Central Africa (ECD), West-Central Africa (WAD), and Southern Africa-Indian Ocean Divisions (SID), there is no significant difference. In terms of age, CPE Awareness does not differ across the Ages Below 39 years and Above 40 years old.

Conclusions

The pastors in the three Divisions (ECD, WAD, SID) exhibited are aware of the presence of CPE on the continent. They have affirmed that it is a tool to help them deal with emotional woundedness and could empower them to deal with today's ministry intrapersonal and interpersonal issues. They can recommend CPE to pastors.

Recommendations

Given that the Pastors are aware of CPE, with 8 out of 10 affirming that it is a tool to help them deal with emotional woundedness while 8 out of 10 declared that CPE can empower them to deal with today's ministry intrapersonal and interpersonal issues and 85% willing to recommend it to fellow pastors; and given that only **3.98%** have at least **one** Unit of CPE as of February 2025, the study recommends the following.

First, the Adventist University of Africa (AUA) and other theological institutions to embrace the establishment of the CPE center as a continental training hub for graduate students in the theological seminary. The other national theological seminaries will be satellite centers for CPE to integrate CPE into standard ministerial curricula. CPE be a must-do training for all seminarians in Sub-Saharan Africa.

Secondly, AUA-CPE center to source ministry partners to offer scholarships or donations to sponsor CPE participants. Thirdly, the 3 Adventist Divisions on the continent of Africa (ECD, WAD, SID) to examine denominational policies and collaboration with government agencies (healthcare, correctional, National Police Service, National Youth Service, Defense Forces and educational institutions to strengthen the structural implementation of CPE.

Fourthly, for the Christian church organizations and other religious groups, let them embrace CPE for their adherents. CPE functions beyond the religious divide.

Fifth, for the Christian church organizations and the Adventist Church in particular, let the persons in charge of clergy (Ministerial Secretaries) to experience at least a Unit of CPE and further create and operationalize protective mechanisms that combine spiritual and psychological treatment to deal with pastoral issues. Let CPE be a requirement for ordination and the ordained pastors to have a Unit of CPE. Let, ministerial credentials and ministerial license pastors with a chaplaincy facet in their areas of jurisdiction experience a week-long Clinical Pastoral Orientation (CPO) as an enhancement tool for ministry. The clergy transitioning from parish/district ministry or seminary to a chaplaincy facet to undergo a week-long orientation exercise as part of continuous professional development. A. minister transitioning from any church entity – the local parish/church, a Conference/Diocese, a Union, and even higher – into a chaplaincy facet to require a Unit of CPE or CPO. Finally, the Chaplaincy directors at all ecclesiastical levels and Chaplains working in universities and hospitals – to be Board Certified and Ecclesiastically endorsed.

For future research, a moderated mediation study on the functionality status of chaplaincy facets and CPE across Africa would be interesting. A comparative study with other continents could highlight global best practices and provide a roadmap for scaling up CPE training across African divisions.

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