MENNONITE LIFE

OCTOBER 1966

An Illustrated Quarterly Published by Bethel College, North Newton Kansas

MENNONITE LIFE

October, 1966 *Volume XXI* *Number 4*

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Kern View Mental Hospital, Bakersfield, California

Printing and lay-out by Mennonite Press
North Newton, Kansas 67117

MENNONITE LIFE is an illustrated quarterly magazine published in January, April, July, and October by Bethel College, North Newton, Kansas. Second-class postage paid at North Newton, Kansas 67117.

SUBSCRIPTION RATES: One year, $3.00; Three years, $7.50; Five years, $12.50. Single issues, 75 cents.

IN THIS ISSUE

we feature a concern for mental health. This is an area of human responsibility that has too long been neglected by Mennonites as well as by humanity in general. That Mennonites became concerned is largely due to the fact that they were conscientious objectors in World War II and sought an alternative area in which to serve humanity. Some young men made their contribution in soil conservation, forest fire prevention, relief work and in hospital work. Taking care of the physical ailments in hospital work was a tradition which had been of long standing among Mennonites. There were only a few acceptable occupations among American Mennonites. In addition to agriculture and teaching, nursing the ill was one of them. Soon the medical profession became popular. Among those doing civilian public service work during World War II some became acquainted with the work and the conditions in mental hospitals in the various states of the country. The constituency became aware of a great need in this field and the opportunities it offered. It was not entirely foreign in Mennonite history to care for mental patients. Already in 1910, Bethania Mental Hospital had been established by the Mennonites of the Ukraine patterned after the one called "Bethel" at Bielefeld, Germany. In fifteen years it had a total of 991 patients, who had been served by five doctors, 164 nurses, and 353 additional staff members. (See pages 188-189.)

¶ At the close of World War II the Mennonite Central Committee found an avenue of service in the establishment of mental hospitals. Its early beginnings have been featured in various issues of *Mennonite Life* (April, 1947; July and October, 1954). Meanwhile this program has continued and spread from coast to coast. In addition to the early establishments like Brook Lane, Kings View, Prairie View and Oaklawn, new ones such as Kern View and Eden Mental Health Center are being added. Mennonite Mental Health Services, an agent of the Mennonite Central Committee, Elkhart, Indiana, serves to coordinate Mennonite mental health activities. These centers in Mennonite communities serve not only the Mennonites, but they offer help to anyone in need.

¶ Disasters caused by catastrophies in nature and as a result of unprecedented human conflicts can awaken the conscience of man and bring forth the will and the avenues for doing good and alleviating human suffering.

Medical Directors of Mennonite psychiatric centers: Mitchell Jones, Prairie View; Otto Klassen, Oaklawn Psychiatric Center; David Whitcomb, Brook Lane; and Charles Davis, Kings View.

The Role of the Church in Mental Health

By Ernest Boyer, Paul Mininger, Roy Just, H. A. Fast

THIS ATTEMPT TO describe the role of the church in the field of mental health takes place in the context of almost two decades of experience in operating mental hospitals. When the Mennonite Central Committee first entered the field of mental health services we did so without much reflection. There appeared to be work to do, we had been drawn into this work, and it simply seemed right to get involved. Our hopes and expectations were not clear but the hunch that mental patients would respond to treatment increasingly proved to be correct.

After nearly two decades of involvement in operating our own hospitals while our hospitals are operating from a strong base the time seems propitious to pay some attention to the ideological framework which was responsible for the opening of these hospitals in the first place. This framework may be the most important factor in the present strength. No institution can operate without an ideological base and this is especially true when the institutions are dependent upon a thinking public for support. Ideologies, however, need to be evaluated periodically. They must be tested with respect to their adequacy for the objectives of the institution, the extent to which they can be translated into operation, and the extent to which the ideologies fit into the total ideology of the supporting group.

In our description of the role of the church in the field of mental health we must try to bring into juxtaposition the ideological structure of the church and the experience that has come to us from the hospitals. Neither of these are constants, however. Our concept of the role of the church has changed in the past two decades and we have certainly learned some things from our experiences in the operation of the hospitals. Here we aim to summarize our experience and to prepare the way for the setting out of guidelines for our mental health program.

The Mennonite Mental Health Program is based on the assumption that the church's contribution to the field of mental health is both similar and dissimilar to that of other agencies serving the emotionally ill. This is as it should be, since the similarities give professional integrity to the program while the various

Statement of ownership and management as required by the Act of Congress of October 23, 1962, Section 4369, Title 39. As of October 1, 1966, *Mennonite Life* is owned and published quarterly by Bethel College, North Newton, Kansas. The owning corporation is a nonprofit educational organization, has no stock and security holders and carries the publishers' own advertising. Editor, Cornelius Krahn, North Newton, Kansas. John F. Schmidt, Assistant Editor, North Newton, Kansas. Signed, Hartzel Schmidt, Business Manager, North Newton, Kansas.

facets which comprise uniqueness justify the effort. Often, however, the issues are confused, and a careful analysis of the precise role of the church in the field of mental health is needed if objectives are to be clarified and significance added to our work.

With regard to similarity, it is taken for granted that a church-sponsored program of psychiatry strives for the highest professional quality. Our clinical centers like other psychiatric facilities, seek to offer the very best in clinical service. At all times they honor the legitimate standards imposed by the healing profession. Our hospitals eagerly accept new insights and all breakthroughs in knowledge both indirectly and directly related to the field of mental health. Therefore, in terms of the clinical service rendered and the utility of the facilities provided, a church-supported mental health program does not sacrifice quality.

There is, however, a difference between a church-based mental health clinic and a non-church institution. There are values in trying to understand the exact nature of this difference. First, such church institutions are unique because they are sponsored by a group of people united by a common faith and driven forward by a common religious concern. This observation is simple, yet pivotal, for it means that at these institutions those who serve are not moved by pity which degrades nor by a vaguely defined social commitment. Rather, all service offered is seen as an outward expression of gratitude to God. The existence of these clinics and that which is done there springs ultimately from a deep and compelling urge to minister to others of God's creation. In a real sense, then, the motive that sparks the church's mental health program is unique. The urge to serve is spiritual and these acts of kindness perceived by others, are in reality, acts of love extended in the name of Christ.

This unique motivation of a church-sponsored psychiatric program also carries over into its method of operation. The day by day activity of these hospitals may not differ sharply from the routine found at mental health clinics elsewhere. Similarities in procedures do exist. Nevertheless, since the institution is rooted in Christian love, the ways of behaving are unique—not so much in terms of specific techniques or clinical tactics, but rather in the quality of the relationship that exists among members of the psychiatric community as they work together to relieve suffering. In these settings the interpersonal encounters between staff and patients have an unusual dimension of depth and warmth. Professional services are extended in a context saturated by Christian compassion. The difference in method is subtle and yet significant, intangible but nonetheless real. At these clinics Christian compassion is not only assumed but is also considered to be a fundamental ingredient in the healing potential of the therapeutic community.

Finally, a church-supported mental health program differs from secular institutions because it conveys, even when this remains nonverbal, a unique message to those served. Without exploring in detail the church's view regarding the nature of man and his need for God, it should suffice to note that the church believes that without an encounter with the Divine, man lacks wholeness, and the church, through its institutions, is committed to the task of reconciling all men to God. Therefore a church-sponsored mental health clinic has not only an obligation but also an unusual opportunity to carry out the mission of the church.

In a psychiatric setting this mission will move forward in a variety of ways and will involve the leadership and cooperation of persons gifted and professionally trained in the art of healing. Further, the precise nature of the relationship that exists between emotional healing and the divine encounter is still vague, and caution must be exercised by all those who seek a meaningful union between the two lest premature conclusions are drawn from partial evidence. A church-sponsored mental hospital has a special degree of freedom from the domination of political interest groups and from ideologies which have proved sterile. This freedom permits the exploration of new frontiers in such areas as the psychosomatic field, religion and psychiatry, community health, the application of psychiatry to social ills and invites experimentation; all of which contributes to the uniqueness of its program.

The Mennonite mental health institutions will move forward as they are confident of a unique and significant ministry, while modest about their accomplishments, as the program remains selfless in motive, compassionate in method, and takes seriously the spiritual dimension in man's pursuit after health and in the message conveyed to those we serve.

MENTAL HEALTH ARTICLES IN

Mennonite Life

Grant M. Stoltzfus, "Mental Hospital Experience of Civilian Public Service," *M.L.*, April, 1947, 7-10.

Delmar Stahly and others, "Mennonite Programs for Mental Illness"; H. Clair Amstutz and others, "Observations by the Professions"; D. D. Eitzen and others, "Concerning Treatment of Mental Illness"; Jacob D. Goering and others, "Meeting Human Needs"; Paul Albrecht and others, "The Allied Resources and Services," *M.L.*, July, 1954, 118-139.

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Toward a Theology of Care

By Myron Ebersole

To PROPOSE a theology of care for the mentally retarded requires that we begin by accepting the humanity we share with him, admitting with Longfellow that "Every human heart is human" and longs for the same God for whom "our hearts are (also) restless." A theology of care for the retarded is not basically different from a theology for all of humanity. The Christian message remains the same redemptive love of God for all men.

A theology of special purpose is called for, nonetheless, not to unduly emphasize the distinctions between the "normal" and the "retarded" but to clarify the manner in which the grace of God ministers to the needs of this group of His children so often forgotten by their fellowmen. The theology which will guide our efforts in this field is not a strikingly new departure, but hopefully will reflect the life and intention of the church community which at this point in time comes to this area of human need. Such a theology is intended not to set the retarded child apart adding further to the separation he and his parents feel. Rather it is precisely the recognition that these who have experienced rejection are included in God's redemptive concern for all His children.

The existential questions posed by the presence of the retarded child give us a starting place for clarifying our theology. They are the questions of the child himself, though he may not verbalize them in this form. But they are also the questions of the parents and of any who recognize the presence of this limited small child of God. Among the questions that could be asked are (1) "What is my origin?" and (2) "Who am I?"

"What Is My Origin?"

The agonizing question posed by the child who wonders "Why did I have to be born? See what trouble I cause my folks,"[1] is echoed in the minds of thousands of parents. "Why did God let this happen?" Glib answers about the goodness of God's creative purpose will not do for parents who have heard on the one hand,

> May the Lord give you increase,
> You and your children!
> May you be blessed by the Lord
> Who made heaven and earth! (Psalm 115:14-15)

and on the other have experienced the disappointment of the birth of a child who cannot fulfill their hopes and who becomes the reason for their isolation from others.

John reports the disciples asking a similar question with regard to the man born blind:

> As he passed by, he saw a man blind from his birth. And his disciples asked him, "Rabbi, who sinned, this man or his parents that he was born blind?" Jesus answered, "It was not that this man sinned, or his parents, but that the works of God might be made manifest in him" (John 9:1-3 RSV).

The man born blind is clearly a prototype of a defective person and the incident bears remarkable parallel to the attitude of society toward the mentally retarded. There is an obscure judgment that the defectiveness is related to somebody's sin. This suggests a sense of guilt on the part of the person making this assumption. But further the preoccupation with negative judgment avoids responsible positive action. Jesus' response is concerned not with the intellectual or pseudo-moral aspects of the question but with the reality of human need, the need for responsive care and with God's redemptive concern rather than with negative judgment. He assumed there was "meaning" for the life of this defective person as for others. His "doctrine of man" was not altered by the defect.

Though Jesus' answer dealt with the basic moralism of their question as well as the purpose of the suffering of this man, the relationship of creation and meaning in life is not always clear. What is the Christian answer to imperfection and suffering? How do we relate the experience of giving birth to a retarded child to the reality of the providence of God the Creator

and sovereign Lord? Standing beside a loved one's grave, lying in a hospital bed, experiencing the ravages of war and considering the birth of a retarded child, one cannot but raise the question "What is the meaning of life?"

The reality of retardation forces us to seek an answer in congruence with the concept of God's providence. To say that the birth of a retarded child is God's will in a rigid predestinarian sense would not be consistent with the Christian understanding of God nor would it be a satisfying answer to a parent. Jesus made it clear in the incident mentioned above that it was also not an adequate answer to say that the birth defect of blindness was the result of sin. His message seems to indicate that the man's blindness was an occasion for the practice of faith rather than for explanation.

It is our nature, however, to ask questions and as one looks at the universe in which we live there are indications that in the midst of a general orderliness of creation departures from that order occur which result in suffering. They are sometimes called "acts of God" in legal terms. Tornadoes, earthquakes, and at one time in Colonial history even swamps were viewed as acts of God. But even these fit into the concept of the balances within created nature. The more specific problems related to human life—birth defects and differences in inherited potential—are not so easy to correlate with the creative purpose of a God who is also considered a God of love. The problem of evil as seen in the "natural" sphere is complicated by its relationship to the evil involved in man's responsibility inherent in his moral freedom. Man is interrelated in both spheres and the problems of his existence inevitably involve his longing for answers in both.[2]

It is within our power to relieve much of the suffering and evil in the world, though not all. The orderliness of creation is intertwined with human decision so that the connection between events that are inexplicable by reference to any spiritual laws is frequently associated with our sense of responsibility and guilt. Inevitably any suffering becomes a spiritual problem. Man becomes concerned about responsibility for causing suffering and if he is free of the guilt of causation, he is constrained by his nature to act; to alter the condition of suffering and to experience guilt when he does not act. The sins of omission and commission mentioned in the General Confession have their roots in our existence.

Some retardation can be understood and steps taken to prevent it. But man cannot understand all the mysteries of life. We cannot suppose that the three percent of the population who are mentally retarded are so because of God's deliberate choice although we can recognize that their birth occurs within the operation of the natural order which in its total structure is beneficient. God permits suffering even when we cannot say that in particular instances He wills it to occur.

At this point, we are still left to answer the parents of the retarded child and ourselves if we are sensitive. They can accept the general beneficence of creation, but theirs is a specific question. It is then that the church must speak most clearly, although the answer will not satisfy some. It is only faith that will satisfy man's need. Rational answers cannot take the place of a personal experience of God's love. The retardate, like the blind man, is born that God's will might be manifest. The man of faith knows that "in everything God works for good with those who love him" (Rom. 8:28 RSV). Man is not a mechanical being nor is he part of a mechanical system. Rather as part of a universe that is made up of natural law and human freedom and spiritual value, he will find the answer to his agonized query in the exercise of faith that throws light on the whole.

The meaning of life is bound up in the exercise of the ability to love and cherish and nurture as well as to explore the reasons behind the order and disorder he observes.

Mental retardation is the source of much sorrow and suffering and many very concrete problems. We would gladly eradicate it though it cannot be done at this point. We will devote our energies to this end but the solution to the individual existential question must be found not in providing intellectually satisfying answers, but in the community of faith which seeks solutions to human need. Once again the story of healing of the blind man serves to enlighten our search. Others in the community had stood by through many years while the man begged. Jesus' concern for the man was expressed immediately in the action that overcame the rational conclusion and rejection of the rest of the community. Gilkey says that ". . . meaninglessness is caused not so much by bad fortune as by inner alienation from our true selves and from one another; and the search for meaning thus entails the search for inner reconciliation and healing."[3] Jesus found in the man a responsive faith, sending him tapping his stick through the streets with an unscientific and unsightly potion spread on his eyes. The point of the story is not that the man received his sight but that he who accepts God's love will experience the manifestation of God's works within him (John 9:3). Petersen says:

> The man who in faith accepts the redemptive love of God, finds a fellowship with God through which he receives strength to take to himself the burdens of being human, of being a person who can be conscious of the greatest good as well as of the deepest tragedies.[4]

An adequate theological answer to this question of origin for the retarded will not be realized in any rational statement of the doctrine of creation but in

the experience of the fellowship of reconciliation. It cannot be taught in the narrow sense of conveying information but it can be communicated in the shared concern of the community that accepts the burden of this segment of humanity in the faith that God's intention in creation and in His providence is no less concerned for the retarded person than for others.

"Who am I?"

Closely related to the question of origins is the question of the personhood and identity of the retarded child, "Who am I?" Perhaps it should be enough to accept the purposefulness of creation. However, the attitudes which have been expressed toward the retarded require that we consider what the theology of personhood or the doctrine of man is able to contribute to our venture.

In contrast to the attitude of much of our culture which is typified by the use of derogatory terms to describe the retarded, the Christian attitude must be guided by Christ's identification with the "least ones" among the needy (Matthew 25). The subnormal, below average individuals were considered to be no less precious than "normal" people. These were fully human in the eyes of Christ. There can be no doubt that our experience with mental illness under the compulsion of Christ's teaching of compassion has moved us toward a more Christian anthropology—a recognition that the mentally ill were fellow human beings experiencing the same ambiguities other men experience but unable to bear the ambiguity in a "healthy" manner. Our concern for the mentally retarded comes from a similar source, a growing sense that the "objects" of our compassion are in reality "subjects," that is fellow-humans in need of God's grace and capable of responding in human mutuality.

While society has rejected the mentally retarded individual, those close to such persons have found them not to be subhuman but rather to be persons in their own right. Parents of one retarded child said they felt he had been sent for a special purpose and reported the growth of love and mutual concern in the whole family. Sigurd Petersen calls attention to the responsiveness, though limited, of even the most severely retarded bedfast and untrained boys and girls at Parsons State Hospital and Training Center. He goes on to say of the total group,

> The stuff of which our children and young people are made is the same as that making up all persons. These boys and girls crave recognition and love. They learn to love and hate. Their emotions run the gamut of all human feelings. They laugh, cry, get angry, feel guilty and become anxious. . . . They have a need to communicate and relate to others. . . . They have a need of possession, of the feeling of belonging and to be part of humanity. . . .[5]

The retarded themselves call for our recognition that they are significant persons who have value in their own right. If we make this assumption a whole range of questions is raised. Are they to be regarded as would be appropriate to their chronological age or as children (which to some degree their behavior would indicate)? How responsible may we hold them for their conduct? Are they to become members of the church? What are realistic standards of success? It is not that these are new questions. However, if we accept the thesis held by Petersen and many others that essentially the same doctrine of man applies to the retarded as to "normal" people, the questions must be raised with new seriousness and will be faced in varying degrees as we consider a program of care for them. L. A. Dexter, a sociologist, suggests that the expectations of society that he produce in competition with normal persons forces upon the retardate a negative self-image and role which in itself stands in the way of development of his capacities and causes him to live regarding himself as "worthless and contemptible."[6] If this is so, it is logical that a shift in values is necessary to be maximally helpful to the retardate. This sociological analysis which appears to be supported by experience in the training schools and other programs for the retarded lends weight to what I would suggest is basically a theological problem.

The problem is this, that the overly pessimistic view of man, the traditional emphasis on original sin, while referring to realistic negativity in human nature, results in an inaccurate weighting on that side of the scale. The resulting societal judgment of the retardate as a defective person stands in the way of his realization of the personal potential which is rightfully his.

Protestant Christianity has built strongly upon personal productivity as a standard of personal worth. The significance of an individual in our society is determined to a larger degree than we care to admit by their ability to produce in material terms. For the retarded and their families this has meant the anguish expressed in the following statement by a parent:

> It is so hard to say your child may grow up to be a dishwasher—to work with him day after day for only slight gain in order that he may learn by sweat and tears what others pick up casually or pass by with disdain. It is so hard neither to demand more of him than that which he can do nor less than that of which he is capable. It is so hard to be without rancor toward God or envy toward the more fortunate and yet train your son. Who has been so "sinned against" to guard in drudgery the health of those who have so much. It is so hard to accept for one's son the ministry of dishwasher.[7]

It is not possible to change an entire culture in a brief time nor with a single program. Yet a program for

the retarded that is based upon a Christian view of man must be broad enough that all may experience success within the range of their capabilities, and it ought to supplement the programs of society by giving concrete witness to the value of the person rather than his productivity. For some retarded persons the tying of a shoestring or giving a simple gift will represent a personal achievement of high worth. A shift in values to relate accomplishment to the worth of the person rather than vice versa is essential for the retardate who cannot compete in the "open market."

While sheltered workshops and job training and jobs for the handicapped are partial and healthy answers to this problem, it may be that confrontation with the full scope of the problem will require that we evaluate the degree to which our doctrine of man is based on productivity is essentially a materialistic measure, and that our program of care and habilitation be guided by a broader view of human worth. Man created in the image of God was told "be fruitful and multiply, and fill the earth and subdue it; and have dominion over the fish of the sea and over the birds of the air and over every living thing that moves upon the earth" (Genesis 1:28). The biblical basis for vocation and work is clearly established as man's responsibility. However, the establishment of personhood, the creation of man, was a prior act. The image of God refers to man's likeness to God in terms of "spiritual powers—the power of thought, the power of communication, the power of self-transcendence."[8] Although perhaps not to the same level when measured by "scientific" yardsticks, the retarded do experience the same qualities of humanness—they experience demand for consistency, relationship and meaning—which distinguish men from animals.

If this understanding is right our programs for the retarded should not be judged by their ability to make the retardate more successful in materialistic productivity but by increasing his achievement of a higher degree of the human qualities indicated by the biblical image of God. Wayne Oates suggests,

> The primary concern of the person who values personality above all other considerations is to see that both individuals and groups are at their best when they have adequate emotional access to their total sphere of interpersonal relationships. Spiritual growth is perceived by such a person in terms of the constant expansion of that sphere; that is, the removal of barriers of childish needs for omnipotence, family constriction, cultural idolatry, and every other "high thing" of temporal status that separates, isolates and insulates individuals and groups from the "largest family of mankind."[9]

Without forgetting the value of personal autonomy, this approach may enable a more wholesome acceptance of the mentally retarded and may challenge the "cultural idol" of individualism which has contributed to isolation and dehumanization in our society.

Jesus' experience with the blind man would again tend to confirm this valuation of the person in terms other than those set by society. The blind man as a "defective," in the eyes of his countrymen, could serve the high calling of having God's work made manifest in him in a way that no "whole person" could serve at that moment. A staff member at a state school remarked recently that the retarded have much to teach us in terms of giving service without expectation of rewards, of revealing much of the "raw material" of unsophisticated human feeling and behavior that is basic to human nature but obscured in "normal" culturally adjusted people.[10]

If the question "Who am I?" is taken seriously from a theological perspective on the nature of man our programs and our attitude toward the retarded will be guided by a regard for the individual and the contribution he makes as a fellow human being within the limits of his capabilities. If we can shift from a focus on the deficit side of the individual to an appreciation for the assets and capacities for human responsiveness we will be in a better position to accept and provide care for the mentally retarded. Coincidentally this view will most likely aid in the development of capacities of which they and we have often been unaware.

E. Paul Benoit has provided us with a helpful statement to summarize our thinking on the retarded person:

> It is sickly sentimentality to exult over mental retardation as if it were a good in itself. But it is perfectly human to rejoice over the existence of an individual who is retarded, because such a person represents reality and hence can be an object of will or desire for both God and man. Neither God nor man wants mental retardation for its own sake, but both God and man want and value the mentally retarded person.[11]

FOOTNOTES

1. Petersen, Sigurd, *Retarded Children: God's Children*, Westminster Press, Philadelphia, 1960. p. 55.
2. Harkness, Georgia, *The Providence of God*, Abingdon, N. Y., 1960. p. 89.
3. Gilkey, *ibid.*, p. 148f.
4. Petersen, *ibid.*, p. 121.
5. Petersen, *ibid.*, p. 26.
6. Dexter, Lewis Anthony, "A Social Theory of Mental Deficiency." *American Journal of Mental Deficiency*, Vol. 62, (1957-58) pp. 920-920.
7. Hungerford, Richard, "On Locusts: A Reprint," *American Journal of Mental Deficiency*, Volume 63, (1958-59), pp. 383-386, p. 385.
8. *Interpreters Bible*, Vol. I, p. 465.
9. Oates, Wayne, *The Religious Dimensions of Personality*, Association Press, N. Y., 1957. p. 289.
10. Personal conversation with Vaughn Scott, M.D., Fort Wayne State School, Fort Wayne, Indiana.
11. Benoit, Dr. Paul, quoted by Petersen, *ibid.*, p. 9.

Community Mental Health

By William Klassen

It is generally admitted that the church has a special obligation to the mentally ill. In part this obligation is accepted because in the earliest descriptions of the mission of the church the ministry to the mentally ill is explicitly stated.

In addition the church has always had a particular concern for the sick and although there are some chapters in the history of the relationship of the church to the mentally ill which make us blush, it has been credited with beginning the first mental hospitals, with continuing to instill hope in the lives of people and with continuing an active treatment program when many had given up to custodial care. It has also been credited with maintaining the kind of community life which continues to make it possible for people first to come to the church when they encounter mental retardation or mental illness.

At the present time, however, the church finds itself in a peculiar position. The advent of new therapy methods, new training programs, but especially the massive involvement of the federal government in the whole field of mental health raises the question whether the church has any particular mandate to work institutionally in the field of mental health. At first sight the simplest solution seems to be to turn over the treatment of the mentally ill to the professionals. Just as in the area of international relations so in the area of mental health we are told that the church should not enter into a field where it is obviously incompetent to take any position of leadership.

Such a position ignores the impressive history of the church in dealing with the mentally ill. Furthermore, if we follow this lead, are we not asking the professionals who also prefer to take their church membership seriously to compartmentalize various areas of their life? If in a context like that the chaplain is purely a figurehead, concerned about his "role" or his "image" is not the integrity of the church seriously violated to the detriment of the healing process?

There is a development on the national scene which promises to reshuffle the various elements of this problem completely. The passing of legislation in the past few years on comprehensive mental health centers and even more significantly the passing of legislation to provide for the staffing of these mental health centers, has implications for the church which have not yet received adequate discussion. Now, fortunately, the federal funds will not be used to build bigger institutions where through the conspiracy of distance the mentally ill can be removed from the "normal" communities. Instead, the mentally ill will continue to live among us and by participating in day hospitals, psychiatric units in community general hospitals, or simply in outpatient treatment they will continue to draw from the community resources for health and also contribute to them.

With these developments the local church will need to be much more directly involved in the ministry to the mentally ill. Yet the scandal of denominationalism will pinch most acutely at this point. Whatever the church can do for the mentally ill needs to be done together with all church groups and with a vigilant eye that no professional standards be compromised. The resources of one congregation or denomination are simply not great enough to tackle this mammoth problem. Rather than running away from it, however, in many communities it should surely be possible for the city or county council of churches to work through a designated committee in relating to the comprehensive mental health center, perhaps even getting one started. Only in this way will we be able to begin to meet the mental health needs of the urban setting. Perhaps only Christian commitment will halt the flow of the vitally needed social workers from the urban areas or prevent the psychiatric specialists from becoming enslaved by mercenary motives.

Since it has been demonstrated that those institutions for the mentally ill and the mentally retarded

which have a clearly conceived ideological base can more effectively minister to the total man, there should be no apologies in seeking to make religion an integral part of the community mental health center. This means, of course, that whatever the council of churches would seek to do in a given area would need to be done with the Roman Catholic and Jewish members of the community. Such evidence that the brokenness in community relationships can be overcome could only serve as a source of hope for the mentally ill who has his own brokenness to overcome.

It is clear that the church cannot abdicate its responsibilities in the field of mental health by merely turning it over to the "professionally trained." More and more people in the church are getting professional training in the field of psychiatry and related disciplines and such training is only to be encouraged. After all the church does not believe that God works against the laws He has put into His universe but rather that He works with and on the side of those who are professionally trained to care for the mentally ill. The false antithesis sometimes promoted between those who heal and those who pray, those who preach and those who practice is itself a part of our sickness which needs to be healed.

The church has on the whole eagerly embraced the new insights of psychiatry. What is needed now is a concerted effort to assist the increasing number of psychiatrists who are so inclined to take theology more seriously so that the values which have formed the center of Jewish-Christian thought may be more consciously integrated. In addition it would be exciting to see the churches in a community co-operate in establishing a center for the retarded or a comprehensive mental health center.

The greatest challenge for the church as the comprehensive mental health plan is implemented lies at the local, congregational level. The most serious part of this challenge is not that the church's prestige or reason for existence is being threatened. It is rather that people with genuine needs who can be helped may not be helped because churches continue to promote their own petty differences and thereby consume energy which ought to be used to assist in healing the divisions that mar our communities and our lives.

Change and Mental Health

By Otto D. Klassen

Our Changing Times

No one needs to be a historian or scholar to observe that we are living in a rapidly changing time. The truism of yesterday, that we live in a "shrinking world," has been replaced with "an expanding universe." "Rapid industrialization" has been replaced as a worry by "inevitable automation." As very real and vivid symbols of our fears we have learned to refer simply to "the Bomb," or even beyond that, "the Holocaust." The rapidly changing patterns of world power, from west to east, from "white" to Asian and "colored," the "population explosion," the "knowledge explosion" and with it, the need to develop high degrees of professional specialization, all give us the uneasy feeling that something is happening to our world, and we are unable either to stop or control it. It is brought quickly home to us in the phenomenal pace of change in travel and communication, and the rapid shift from a rural to an urban society. We are acutely aware of changing moral patterns, especially if we are parents, and we have come to accept such terms as the "breakdown of our moral fiber," and "the moral crisis." We notice, despite our modern means of production, the coexistence of abundance and famine remains. Despite our specialized knowledge, we are unsure how to live with one another, or, indeed, whether such will long be at all possible. Even in our church we find troubling change. As a people more accustomed to living apart from "the world," we find "ecumenicity" taking on new and vibrant meaning—even among us. We find the concept of

missions needing constant revision, at least in its applied sense. We find more "I-Thou" in theology and less "we-they" in our human relations. The government has taken up the Peace Corps, and the church has become interested in aggression ("nonviolent," of course).

It is clear that the boundaries by which we have lived are being changed. The world is shrinking, but the horizons are more distant. We are being thrown together, like it or not. The bases of our security are being shaken. Everything is being altered. Our fundamental values are being remodeled. We live within a sea of change so real and so far beyond our control that if we perceive our environment at all we live in fear.

There will be some who will point out that there have been prophets of gloom and disaster in every age, and yet civilization has withstood all of the ravages of nature and the self-destructive rages of *homo sapiens*. The inhabitants of every age have been acutely aware of change, and shaken by it. They have struggled with natural catastrophe and moral dilemma just as we do now, and have read into the events of their times the sure hand of God bringing retribution on a faithless generation.

Thus it seems, when we characterize our moment in history as "our changing times," we have to admit that it is not only just now, but that it has always been so, and that it likely will also be so in the future. Change is clearly characteristic of our habitat and existence. We must live with it. If it brings us fear, as it surely does, we must live with fear.

Change, Our Ally

Are we, then, helpless in the face of inevitable, massive change, or is there another side to the nature of change? Are we in an impossible predicament, or is there something redeeming about change which is obscured from our fearful point of view? I believe it is more nearly true to say that there is something wrong with our point of view, that change is not the enemy, but our ally.

It is characteristic of our need for those things that give us security that we want them to be available when we need them and where we need them. We want them to serve us like they have served us before; in other words, we want them to be stable, unchanged. Be it one's home, one's car, vocation, church, friends, parents, school or community, one's morality, we count on their stability, and we are upset if we find them changed or different than we had expected when we turn to them. Thus, we learn to equate unchangingness with security, change with instability.

On closer inspection, however, it becomes immediately apparent that failure to change would be worse —very much worse—than the changes which we find so common. We do not accept the homes, the cars or vocations of the preceding generation as satisfactory security symbols. Our friendships, too, have changed in ways which now serve our needs better than our childhood friends could. Church, school, community and family, even morality, all have changed with us through the years, and it would have been tragic had they not done so. It becomes perfectly obvious that change in all these areas is essential precisely because we, too, are changing. The capacity to change is not only important; it is essential to mental health and survival.

Consider, for a moment, the man who cannot change, or will not. Such a man is unable to learn, either from the unfolding universe or from other men. He cannot accommodate himself to new problems, except to apply old solutions. He is unable to adjust himself even to the changes, biologic, psychologic and social, which he himself undergoes. If he is able to survive, which he could only do with the help of others, he remains a man of such unswerving aim and purpose, in no wise influenced even by those closest to him, that he could only be labeled totalitarian or demagogue. While he may be lauded in some quarters for a time, a man of unswerving purpose must, in time, be considered a mortal enemy, be he criminal, politician, teacher, religious leader, or parent. Looking neither to the right nor to the left, finding no mutuality in his relationships, he hastens down the road of his own destruction hoping to drag us with him.

The capacity to change, then, is a cardinal principle of mental health. In a world faced with "the Holocaust," in a society whose moral fabric is in peril, where it seems so urgent to have answers that are certain, it is imperative, rather, that we be able to change our minds, to integrate such changes, and it may even be true that to do so quickly will be the key to our own survival and the survival of civilization. Change or perish!

The Family as an Organ of Change

What is the relationship of the family to social change? I would like to show that the family is the principle organ by which change becomes possible for each of us as individuals, the principle instrument for the integration of change.

Of all the institutions which we feel are threatened by change in these times, it would seem we should worry least about the family, for where could one find a social institution more practiced in change?

It is the very nature of the family to provide a context in which change can take place, and take place safely. The healthy family has always been a uniquely flexible organ, expanding to include more members, contracting to allow some to leave, accommodating both young and old, male and female, able to accept poverty or wealth, life or death. It provides the

milieu in which each of us, as individuals, pass through the long and complicated series of developmental changes all the way from initial helplessness through maturity to final helplessness and death, and it provides this not only for us, but for all those whom we hold dear. It does this now, it has "always" done so, and it appears to me that it will continue to do so in the foreseeable future.

The healthy family provides not only a safe environment for the assimilation of change, but it also provides unique mechanisms by which these changes can be integrated, woven into the very person of the family members, without disrupting seriously those things most near and most dear (and most security giving!). The family accepts helplessness and allows it to grow to independence. It tolerates ignorance and still fosters the growth of knowledge and understanding. It encompasses both love and anger at the most significant levels, dependency and rebellion, it takes us from savagery through varying but significant degrees of civilization, without destroying but actually building our creative sensitivities. And it does so, for each of us, each in its own time, according to our needs in such a way that we become persons, capable of giving and receiving love, adaptable to others and to a surprising number of life's knocks, in some way equal to many of the changes which life will require of us.

Where the social activists call for change in society, the family can actually provide it! Religionists call for a new moral integrity in man, and we try to respond, but little boys identifying with moral fathers weave moral integrity inextricably into the fabric of their persons. Sociologists and others may appeal to us for racial tolerance and social responsibility, but children growing to maturity in a family where their own uniqueness has been prized, as well as that of their siblings and their playmates, find themselves already acutely sensitive to the positive needs and values of others.

Thus, I contend, the family has long been concerned with change, and equal to it. Like a wet baby, it confidently expects change to come, and it thrives on it. So much does it accommodate changes that we have almost come to equate family life with these changes, e.g., marriage, childbirth, diapers, meals, "growing up" and "growing old," and death. If the demand for change comes to one member from outside the family, and is not directly felt by the others, in the healthy family the members rally, nonetheless, in support of that member's capacity to survive and integrate change.

Surely, you will say, families are not all so. Not all families achieve the happy equilibrium I have pictured. Selfishness, dogmatic inflexibility, using others for one's own ends, cruel and even violent nonsupport are also found in families. Indeed, many families do not even endure as families, but suffer dissolution due to human failure or natural tragedy. Admitting all of this, I would yet offer the contention that it is just when families or members of the family fail to accommodate change successfully, clinging rather to old securities, dead values or outmoded adaptations that such failures often result.

I am saying, then, that the family has always provided for change, that it provides an ideal medium for change, and that change integrated within the family context becomes in a unique way, a part of the person-fabric of the individual. Despite worries about changing family patterns, the family remains the principle and unique instrument for the integration of change by individuals and by society.

Change and the Church

The church, too, has been a uniquely viable institution, adapting to and surviving a large variety of often difficult circumstances over many centuries of changing history. It has included all kinds of people and offered them a sense of meaning and security which they could not otherwise find. Surely it had to be flexible, strong and relevant to endure these many years. While the Christian church is not nearly so old, the Hebrew-Christian church is nearly as old as the family as a social institution, and it demonstrates a capacity to encompass change which is truly impressive, though often ignored.

We tend to ignore the dynamic, changing character of the church because of our bias about change, and our customary attitude of equating change with instability. Young people, driven by internal needs to change and impatient with their elders who do not share those needs, sometimes choose to make the church the object of their angry rebellion, and seek to hasten change in its nature and structure. This is no real threat to the integrity of the dynamic church, but a source of its strength. Only when such rebellion takes the form of a complete separation has the church been damaged. For then it has lost a vital reason for self-examination, for creative inner tension, in a word, for change.

But when we are not rebelling against it, we want our church to represent what we can really count on, and we mistakenly feel that this should mean that the church will be unchanging. In our uneasiness about our own conceptions of our changing world, we take our best thoughts and build them into the very walls of the church structure, calling them, variously, doctrine, dogma or eternal verities. Defensively we fortify the "unchanging" nature of these ideas by attributing them to higher authority, even to God himself. When inevitable change comes, as it did to the Abraham who had to believe that God himself required the sacrifice of his son, or to the Hebrew people who had to take the steps to integrate the newer morality of

monogamy, we have to scramble a bit, suffer a disjointed generation or two, and we may even require a mystical experience to close the gap in our "logical" sequence.

There appears, then, to be something about our need for the church to be unchanging, despite its generally dynamic character, that fosters in our minds narrow attitudes of unchangingness, inflexibility, and single-minded pursuits of goals. While this can also be said of the family, or any social institution, it becomes more ominous in the church where many presuppositions are defended as unchallengeable because they derive their authority from on high. A father can, after all, be rather uneasily discredited, but not the heavenly Father. Please notice that I do not accuse the church *per se* of this inflexibility, for history amply demonstrates otherwise; rather, it is we, her members, who plaster her walls with flimsy efforts to reinforce our own, often weak and ever changing presuppositions. Whether we like it or not, the church does change and is changing; not only in reformations and times of revival, but constantly.

An ethnic religious group, like our own Mennonite church people, where religious essence and social practice are merged into one "whole" set of beliefs and practices, runs the risk of very special dangers in confusing eternal truth with contemporary practice. We, who have traditionally lived as a different people, set apart from the world, isolated together, developing our own distinctive idiom and dress, have often mistaken what is merely the temporal manifestation of cultural adjustment with what is eternally true, and by so doing we have opened ourselves to the experience of considerable uneasiness, cultural and personal anxiety when those temporal, cultural practices change, as they surely will.

An example comes to mind in the form of a story. It seems that a certain lady forgot her head covering as she attended a midweek prayer service. She got along fine until she realized its absence in the middle of a prayer. Unable to pray longer, she rushed out of the sanctuary. The only value to the story may be that it illustrates something that we also know: viz., in practice we do often fail to differentiate what is ethnic from what is basic. We know this whenever ethnic practices begin to change, and we suffer recurrent pangs of conscience just as though such practices were at the very heart of our religious life and expression!

I know, for instance, from my practice that there are quite a number of sensitive, creative souls in the Mennonite church who are troubled over changes in such practices as plain coats, uncut hair and the prayer covering. And such persons may be bothered either by the need to make such changes, the need not to make them, or both! Often, however, I notice that persons so troubled are more concerned about how they may be received by their fathers in Pennsylvania than how they may be received by their Father who is in heaven!

It would appear that things would go much easier in such circumstances if change could be conceived of as properly taking place within the family, and if the family could rally to the support of the individual so that, if worst comes to worst and a family member is caught praying without a covering, at least the channel to God need not be jammed, prayer could continue, and the family would retain its wholesomeness. Neither the individual, the family, nor the church can afford to have families divided because of changing ethnic practices, no matter that such practices have, at one time or another, received dogmatic support from the church!

Please note that I do not refer to these practices (plain coat, uncut hair, coverings) because I feel these are among the deepest and more significant issues either to the church or to the individual, but rather because they illustrate so well how ethnic reenforcement can create real problems even with smaller issues. The roots of these practices tap deeply into the very conscience of many of us, precisely because these practices have been deeply woven into the very

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fabric of real people as they grew up within families. If the theological certainty of these practices is now, or even if it never has been, not without room for debate, nonetheless the personal and cultural-ethnic quality has been certain, and it has certainly become part of real people. It has thus become enshrined in its own (living) temple! If we now plan to change these practices, as we quietly seem to be doing, I would like to suggest that we rally to each other's aid, that families not be allowed to be divided over issues which are no longer considered of the greatest essence, so that individuals need not risk the competence of their personality to satisfy their intellectual and spiritual honesty. Are we talking about this?

In conclusion, I would like simply to reiterate the points I have been trying to make as I have discussed the nature of change. Although there is much to convince us that we live in rapidly changing times when all of the institutions which we have come to depend on are undergoing important, even fundamental changes, it has always been thus. I have suggested that change is indeed inevitable, and that the capacity to change is a cardinal principle of mental health. The family is a unique social institution, in that it has always provided for change in the most fundamental way. The family provides an ideal medium for change, and change integrated within the family context uniquely becomes part of the person-fabric of the individual and of society. I have also developed, as a secondary point, the uniqueness of the Church as a flexible instrument capable of integrating change, and have pointed to liabilities especially inherent in ethnic church bodies where ethnic change can be confused with change of essential religious verities.

In a word, I have been advocating a view of change which would not consider it an enemy, but an ally. I should warn any of you, if there be such, who would accept my premises, "Let the Buyer Beware!", because if you embrace the dynamic processes of change you cannot know what your purchase will bring you.

Consultation for Psychiatrists

By William Klassen

The Ecumenical Institute, Geneva, Switzerland, study arm of the World Council of Churches, convened a consultation for psychiatrists and theologians at its study center (Bossey) from April 11-16, 1966. For almost five days a group of theologians, pastors, psychiatrists, and others in the behavioral sciences discussed the communal nature of illness and health. Of approximately 60 participants eleven were from the United States including three psychiatrists, three psychologists, and three theologians.

It was the purpose of the consultation to provide for an opportunity for dialogue between the disciplines represented. Under the exceptionally competent leadership of H. R. Weber, the associate director of the institute, major presentations were made from the medical, psychological, and psychiatric points of view, as well as from the theological and biblical side.

The actual work sessions began with some introductory remarks by Aarne Siirala of Waterloo, Ontario. Siirala's excellent book, *The Voice of Illness*, demonstrates his sensitivity to both the psychiatric and the theological dimensions of illness.

It might be said here that one of the serious weaknesses of the conference was that, whereas there has been a fairly extensive period of discussion between the psychiatrists and clergymen in North America, and considerable attention has been given to the topic of sociopathy in this country, no major opportunity was given on the program for any American presentation. Names like Riesman, Philip Rieff, and their equivalents in theology are apparently unknown in Geneva.

Each day began with a Bible study. Several hours were allowed for small study groups. Here it seemed that some very significant conversation was going on and, if anything, the time could have been consider-

ably increased for these study groups.

The high point of the conference came when P. Thoenes, a sociologist from the Netherlands, dealt with the topic, "The Sick and Healing Society: A Sociologist's Point of View." Thoenes made no pretense of being a Christian and spoke clearly from his own discipline. He kept intact the integrity of that discipline, and stressed the importance for social institutions to allow themselves the privilege of a demise, and also the slowness with which society will allow the deviant to become a real part of the social structure. Above all he had a sense of humor!

The Bible studies by H. R. Weber and Archbishop Anthony Bloom of England were much to the point of our consultation. Weber led us in an exciting study of "Christ's Victory Over the Transpersonal Powers" and although its value might have been enhanced by concentrating more on the way in which Jesus by healing demonstrated his victory over these powers, yet the point of view he took from the Apostle Paul also added a good dimension to our discussion. Bloom dealt with the topic "The Church as a Healing Community" and spoke personally of his own experience and in a very moving way introduced us to some points of Russian Orthodox doctrine relevant to the theme. Having been trained in medicine and now serving as archbishop, he embodied rather well the theme of which he was speaking.

The lecture "The Sick and Healing Society: A Theologian's Point of View" by G. Crespy was not as well received. Crespy dealt at some length with the theme of the one and the many, and the idea of corporate personality, but he followed Professor L. Ramlot in confining himself primarily to the Old Testament and to classical theology. At no point in the consultation did the New Testament idea of a healing community really find any serious treatment.

On Friday and Saturday some attention was given to the concrete projects in which healing is being worked at. A panel discussion on Friday presented the theme of cooperation of mental hospitals, society at large, and the church in the healing of the mentally ill. Otto Klassen, medical director of Oaklawn Psychiatric Center, Elkhart, Indiana, described the way in which Oaklawn was financed by local community, government and church funds, and how it continues to serve as a community agency while at the same time keeping a very firm base in the church. J. Langmeier of Czechoslovakia spoke honestly and very directly to some of the advantages and disadvantages of the mental health programs in his country and B. Martin of Switzerland spoke out of a wealth of experience as hospital chaplain in a large state hospital.

During the last day a representative of the WHO, Maria Pfister, and George Anderson of the Academy of Religion and Mental Health and A. H. Van Soest of the W.C.C. study on the healing church participated in a panel projecting the future steps for the dialogue.

The consultation itself was obviously the first of this magnitude and an important beginning. It was good to get people from various countries and cultures to discuss this kind of topic. Such consultations find it difficult to get psychiatrists and psychologists and a serious effort had been made in this case to have the distribution about half and half. They succeeded rather well. Thirty of the participants represented the nontheological disciplines.

The various blowups of participants freely invited by the chairman assisted greatly in clarifying the issues, forcing people to be clear and sharp in their categories, and it was demonstrated repeatedly that the Ecumenical Institute is the logical place for this kind of dialogue. The leaders resisted the temptation, yielded to by the Academy of Religion and Mental Health, to invite only people who agree that psychiatrists and theologians ought to get together. Nevertheless, the consultation would have been even more valuable if more people would have been there who had no specific relationship to the church. Fortunately the program allowed for smaller group discussions which again is not seen in the annual meetings of the Academy of Religion and Mental Health.

Yet it is clear that many of the things that happened at the consultation seemed a little trivial and mundane to the Americans. We were bored by the classic and obscurantist approach to theology in which the theologian takes advantage of the fact that he finally has the psychiatrist by the ear and now seeks to pour traditional theology into his brain. The different methodology of the theologian and the psychiatrist was not clearly enough recognized and far too little time was spent in analyzing case material.

Even more seriously the option of the church building its own mental hospitals freely available to all of society, or its own centers for mentally retarded in which professional and charismatic skills are blended together, was not given serious consideration. Yet the consultation was very much worthwhile. To be introduced to the kind of work that the Siirala brothers have done in Finland, or the kind of work tht Dr. Frank Lake is trying to do in his clinics in England was enlightening. It raises many questions about the extent to which psychiatrists and theologians can go beyond talking together to also work together but these need to be raised.

It seems rather clear that we need to have dialogue as well as opportunity to work together. At the present time it is doubtful that we have anything beyond token dialogue or token cooperation. The people who are suffering as a result of this are not the theologians or the psychiatrists so much as our parishioners and patients, the people who are unable to find a healing community.

A Community Mental Health Center and the Churches

By Elmer M. Ediger

In his article, "Functions of the Clergy in the Community Mental Health Centers," Dr. Pattison says, "On the one hand, despite the aura of mutual goodwill, I find little understanding at the grassroots level. Both the minister and psychotherapist stand worthy of the other, and only in isolated areas has an effective means of collaboration been developed."[1]

The history of Prairie View Mental Health Center, Newton, Kansas, would seem to confirm Dr. Pattison's note of realism as to what it takes to develop collaboration. Though vaguely defined, collaboration between the church and mental health professions was the underlying goal for the mental health services program sponsored by the Mennonite churches.[2]

Prairie View, along with its sister institutions, Brook Lane Psychiatric Center, Hagerstown, Maryland, Kings View Hospital, Reedley, California, and Oaklawn Psychiatric Center, Elkhart, Indiana, sponsored by the Mennonite Mental Health Services, Inc., developed as a result of a combination of factors. The Mennonite churches were heavily exposed to the needs of the mentally ill during World War II when conscientious objector members served their alternative service in state mental hospitals. By the end of the war, the church with its service philosophy and organizational know-how, was ready to launch some small psychiatric hospitals. And, psychiatry, fresh from World War II advances, had progressive milieu-oriented professionals ready to team up in such a program.

Prairie View, a private, nonprofit mental health center located on the edge of Newton, Kansas, a city of 15,000 population, was established as a psychiatric hospital with an outpatient department in 1954. It continues to be the primary responsibility of a local Mennonite board which includes community representation. Prairie View has become increasingly community-oriented and thus evolved from a hospital to a mental health center. Since 1963, it has contracted with neighboring counties to provide consultation and education as well as tax-subsidized outpatient services.

To understand the last five years of gradually increasing collaboration between Prairie View and community agencies, particularly the church, it should be noted that the first five years involved real difficulties. Prairie View was the third in the series of Mennonite-initiated hosptals, seven years after the first, and hence it began with the benefit of some experience in the mental health field. The sponsoring church constituency made a particularly large investment to get Prairie View launched.

Some of the earliest difficulties between center and church community probably arose from unrealistic expectations. The results of psychiatry were disappointing in given situations. Furthermore, psychiatrists didn't give "straightforward answers." Pastors from the supporting churches felt rejected, that they were "not welcome" at the hospital, that they were not "on the team" as they had originally expected to be.

From a professional point of view, there was the problem of confidentiality of information—how much to share with pastors about particular patients. Would giving ministers the requested information before visits really help them with whatever anxieties they were experiencing in the psychiatric setting? Questioning the ministers was interpreted as "treatment" which was not the object of their visit. Therapists were often perceived as "cold and impersonal," or "not accessible."

The exception to this above mentioned trend, however, was the minister who became a part of a religion and psychiatry study group, meeting twice a month over a noon meal at the hospital. Here, where a particular case was not involved, the process of developing understanding seemed to happen more naturally and in greater depth. Ministers learned that psychiatrists did not consider themselves perfect or as having some kind of magic which was unrelated to what ministers were doing. On the other hand, psychiatrists learned that theological questions were not unrelated to the assumptions behind their work; that there were some well-trained theologians from whom they could

learn; and that pastors often were heavily involved in seeing people with "mental health problems." Both began to realize that as they learned to accept each other as people with strengths and doubts, the theoretical orientation of psychiatry and theology became less a matter for polemical debate than a focus of mutually helpful study.

The experience with ministers who lost their enthusiasm for "team work" and felt rejected was similar to the experience with the general physicians of the community. There was a backlog of distance between psychiatrist and the general practitioner which had to be overcome. In any case, the physician and ministerial referral base for the hospital gradually deteriorated during Prairie View's first five years.

Weekly meetings for a whole year on the part of the executive committee of the board with key staff were an important part of the process which probably saved Prairie View from being a parallel to the institutions described in *Life and Death of a Mental Hospital*.[3] These meetings were probably also evidence of a strong underlying belief in the milieu approach of the hospital, an openness which had become the goal of the executive committee and the staff, and the relatively clear focus of ultimate responsibility in a board with a definite constituency.

From this confrontation came a realization that Prairie View would need to focus on meeting community needs, needs as experienced by helping agents of the community; that Prairie View would have to get into the stream of needs—the welfare office, the pastor's office, the doctor's clinic. More time was scheduled to be invested in the community visits, workshops, and exploratory periods of free consultations. This, together with considerable staff reorganization and the addition of some new staff, led to a gradual restoration of the confidence of ministers, physicians, and others during the second five years. A new professional staff person added every six months hardly kept up with the increasing demand for services.

This article, which is somewhat of a parallel to the more theoretical article of Dr. Pattison on "Functions of the Clergy in the Mental Health Centers," will also utilize the Caplan structure for analyzing Prairie View Center program experiences in relation to the clergy and the congregations. The goals and functions of the center as outlined by Caplan are: first, better community organization and healthful social relations; second, earlier case finding to avert serious interpersonal breakdowns; third, better treatment techniques for those already ill.[4]

Better Community Organization

The religion and psychiatry study groups of Prairie View, more accurately called book-conversation groups, have perhaps been the greatest single contribution to better understanding among ministers, college teachers, physicians, and lawyers of the community. These study groups have been in process for about ten years, many of them on the same schedule. More than a hundred different people have been involved over the years.

The format for the religion and psychiatry groups is relatively simple. The center supplies a convener, the group considers different study books, makes a selection in line with common interests, and accepts its own members. Generally the leader, on a rotating basis, makes a brief introduction to a chapter and the major portion of the time is spent in a free-wheeling type of discussion. Although there is no set pattern, the tendency is to vary from theological to the mental health professional authorship. Books have included works like Tillich's *The Courage to Be*; Buber's, *Between Man and Man*; Mowrer's, *The Crisis in Psychiatry and Religion*, and Brenner's, *The Elementary Textbook of Psychoanalysis*. As indicated earlier, the relationships developed as peers in the helping field have probably been a more significant result than any theoretical integration of theology and psychiatric theory.

One of the promising areas of collaboration at the primary level is with small groups in the church, particularly those which have a strong emphasis on interpersonal relations. In one local church the pastor initiated small groups to help some of the couples who were searching for more meaning in their lives. Groups met for an hour a week for eight weeks with a pastor and a psychologist, a member of his church, as coleaders. The groups were opened with a theologically-oriented thought such as "the good creation." The group tested this in their own experience, with help from each other to be honest in the process. The pastor had a number of such groups over a several-year period and found they gave real tone to the church fellowship and even the worship services. Here the mental health professional shared in realizing goals of the church by utilizing his own skills in supporting the interpersonal process but also participating as a believer.

Oaklawn Psychiatric Center of Elkhart, Indiana, has initiated a public forum, "Conversations on Life," which brings to the community authorities in the field of psychiatry and theology to speak on various practical issues.

One of the somewhat unexpected and less structured consequences of having a central health center in a given community are the "off time" contributions of the mental health personnel as individuals in the local church and community life. Prairie View staff are actively engaged in a wide variety of denominational programs in the community—youth programs, team teaching, deacon visitation after flood disaster. Staff members have been active in the formation of an interracial group, planning for an anti-poverty pro-

gram, a foreign films program, as well as the small group movement.

Interagency "Resource Councils" have recently been initiated by Prairie View in several of the counties to encourage more community involvement in the "after-care" of patients discharged from psychiatric hospitals. The aim will include encouragement of congregational groups to take special initiative in mental retardation, with mothers receiving Aid to Dependent Children, as well as the rehabilitation of discharged persons.

Early Case Finding

This secondary level has a preventative goal, its aim being to avert serious interpersonal breakdown. A few health centers have experimented in working almost exclusively through the existing helping agencies of the community. In one particular case, five professional persons were each assigned to about sixty helping agents in the community ranging from ministers, physicians, lawyers, policemen, to a bartender.[5] Each mental health representative sought to develop a regular circuit among his sixty contacts, seeing them once a month, if possible, to discuss whatever mutual concerns there might me: an alcoholic in the neighborhood, a general problem situation, or perhaps a recently discharged patient who had moved into the neighborhood. The mental health person served as a consultant or a collaborator, whatever the situation demanded. Many other mental health centers are seeking to do some of the same work, though perhaps to a less radical degree.

Several programs have evolved from Prairie View social worker consultations with the local probate judge. There is now a "Big Brother" program in which "fatherless" children are assigned to a Big Brother from the community. Churches and other agencies are enlisted to help locate Big Brothers in this community program. More recently the probate judge and the child psychiatrist from the center are serving as co-leaders of a mandatory group experience for delinquent adolescents for whom "nothing else has apparently brought results."

Through the promotion of a minister in the community to provide more services to the aging group, a pilot project has just been completed. People in various stages of the aging process were invited to become members of a group to talk about feelings and problems they were encountering in the retirement process. One of the groups met in the home for the aged with the head nurse and a center nurse acting as co-leaders. Another group met in a local church where the pastor and a social worker of the center were co-leaders of a group from that congregation. A third group met at the Prairie View Center where a minister from the community and a social worker were co-leaders.

The group based in the congregation seemed to be particularly successful. Not only did this group have a helpful experience, but the group process was enhancing and developing relationships which could continue much more naturally following the formal end of the group counseling program. Furthermore, it demonstrated the apparent need for this type of "outside help" to get this type of program going. The longer range goal is to help other congregations to launch similar groups and, if feasible, to help the church leadership to operate their own programs with the support of consultation.

As part of the process of seeking to develop more collaborative relationships with ministers, about three years ago the Prairie View Center wrote to all the ministers in the five-county area offering them free consultation to discuss, in person or by telephone, problem situations they were confronting. Few ministers took advantage of this service and most of those who did were those who had previously developed relationships with the center through study groups and the like.

Although response was limited, Prairie View is not giving up on making this type of consultation with pastors a worthwhile service. But there appear to be various stages through which relationships must evolve. It is anticipated that when a full-time chaplain joins the staff, this will facilitate such relationships. Brook Lane Psychiatric Center, with a full-time chaplain and a training program for a number of years, receives about forty calls a month from pastors for this type of consultation, in contrast to perhaps three or four a month at Prairie View.

Prairie View has set up courses on a college credit basis for teachers and nurses, to help them become more sensitive in their relaltion to their clients. Some years a course in developmental psychology was held for a group of ministers and deacons from a particularly conservative group. Later we learned that a good number of these "students" were teaching this same course to the other groups within their constituency!

Several group consultation arrangements have been set up at the Prairie View Center for ministers. As a result of a medical director and administrator visit to a given Ministerial Alliance, it was agreed to arrange a regular two-hour weekly consultation to the entire ministerial alliance group of eight members. At the same time, another group was formed, inviting ministers from various communities who in general did not know each other as well. The psychiatrist set up a structure so that it would not become group therapy. The focus of these discussions seemed to be "How did this problem come to you?" "What is your responsibility in the situation?" and "How can your responsibility be carried out?"

The group had considerable difficulty about the matter of confidentiality, particularly in the ministerial alliance group where it was difficult to air "dirty linen" in the presence of what might be "competing" church-

es. The type of problems dealt with included a church member wanting the pastor to visit a fellow member who was allegedly "running around with another woman," a tense board of deacons situation, and many home visit situations.

Both Kings View in California, and Brook Lane in Maryland, with full-time trained chaplains, have done considerable work in seminars for ministers. During the past three years, Brook Lane, for example, has conducted twelve-week seminars for 85 ministers of the area, covering pastoral care of emotionally distressed persons—children and adolescents, middle aged and aging—and crucial contemporary issues. Not only do they help ministers in early dealing with problem cases but evidence indicates they make referral to the center a much easier step where this is necessary.

Treatment and Rehabilitation

For those who are already ill, the comprehensive mental health center has a wide range of service: outpatient, inpatient, emergency home visits, consultations in general hospitals, day hospital, foster home care, sheltered workshop industrial therapy, and visiting nurse services for aftercare patients. How can the church participate?

Prairie View has been operating with a part-time chaplain for some time but will be having a full-time chaplaincy supervisor beginning later this current year. The chaplain is the most clearly focused representative of the church in the center itself although individual staff members may also be the "church" in the center. The full-time chaplain is to be the liaison with the clergy of the community and the leader of the specifically religious activities, to take religious histories, and to help the mental health team in the evaluation process. He is available for individual pastoral ministry which hopefully will help the person to incorporate his therapeutic experiences into his personal field of religious meaning. Current plans are to set up a parish-oriented clinical training program for pastors of the region.

Frequently, as the inpatient or day patient psychiatric teams seek ways of getting community partcipation in a given person's treatment, the minister is looked upon as one who can best guide the team on how to get things moving. Some pastors have been very helpful in developing job leads or inviting these persons to their home, seeking to develop a "friend in the community" type of relationship. Pastors have been helpful in trying to find volunteers for transportation, locating foster homes, and have been very effective in pastoral "social work" in the community. Thus far, Prairie View has not really taken the time to develop a good volunteer auxiliary, while both Oaklawn and Kings View have found these to be good avenues for church member participation in the treatment and rehabilitation program.

The home treatment program has been relatively small at Prairie View, but a major aspect of the Oaklawn program. Pastors have been a major resource in helping locate more than a hundred homes of the community which have been used thus far. There are other areas in which the professional staff of a psychiatric center may feel uncertain as to how to take hold in the community and where the pastor or other representatives of the church can be helpful in developing the potential. Currently, our center would very much like to see a person in the community who would be willing to open his hobby shop once a week to aftercare patients. As mental health centers become more clear and more comfortable in utilizing lay mental health counselors, there may be other opportunities for retired professional people, including ministers, teachers, and others.

Clergy-therapist relationships on individual inpatients are now apparently being handled on a satisfactory basis though there were complaints only a year ago. Clergy are now given briefings by the head nurse or one of the other therapists where requested. The nature of these depend upon previous relationships. Clergy-therapist relations on outpatients, particularly those involving both husband and wife in marital difficulties, have continued to present some problems. The "spiritual" and "nonspiritual" line of division is not adequate; a better personal understanding is necessary for collaboration in a given case.

As mental health centers seek to rehabilitate individuals into the community, it is not uncommon for the staff to wish that particular individuals could become identified in some group activity in the community such as a church fellowship. On the other hand, mental health staff members often find themselves wondering how therapeutic the church is or can be with such people. Some sick persons are unlovely people, hard to love.

Implications

The preceding section has been largely a description of one center and its experience with the churches. This center happened to be church sponsored. In most respects this should have been an advantage for the collaboration sought, but there were also some built-in expectations that created added difficulties. On the whole, it is assumed there are implications which should be broadly applicable to other community situations.

1. *Increasing effective collaboration between the clergy and the mental health professional, the church and the mental health center is both highly desirable and feasible.* At this point, the church is quite aware that in cases of severe emotional suffering, people want the help of the mental health profession, and increasingly this is true in relationship to consultation on complex social situations. Psychiatry, on the other

hand, with increasing interest in prevention has become impressed with the fact of the Joint Commission report that 42 percent of those seeking help turn first of all to their pastor.[6] And it would seem that increasingly there are psychiatrists who see the need for a theology to answer man's search for meaning. Many communities now have both mental health personnel and clergy. There are many problem situations which involve an impairment in the ability to give and to receive love.

2. *Essentially, the same process is necessary to develop collaboration between psychiatrist and physician or schoolteacher, judge, or minister.* Having mental health personnel who are Christians apparently can not short-circuit the process that needs to take place for developing collaboration. The problem does not seem to be primarily a matter of an inherent conflict between religion and psychiatry. There are differences in goals and methods and these need to be recognized. Focusing on functional collaboration in given situations does not require an attempt to master the theory and practice of the other profession though increased understanding may come as a by-product.

3. *The process which needs to take place for effective collaboration requires experiencing each other as humans, a growing respect for each other's helping role, and some functional division of labor.* Personal relations in the context of a somewhat neutral endeavor are helpful to overcome emotional defensiveness and prejudiced conceptions. The religion and psychiatry groups of Prairie View served this purpose. Psychiatrists no longer seemed so perfect, and ministers eventually exposed the doubts behind their supposed dogmatism. Writers such as Buber, Tillich, and Roberts who were studied, helped to give a depth and respect to both religion and psychiatry.

But some functional contract, spoken or unspoken, must gradually evolve for collaboration to take place. For example, the minister sees the mental health expert helping him with the "mental health facet" of his larger task. The mental health worker accepts this "limited" role in the minister's frame of reference. On the other hand, the minister may have to recognize that his own counseling as it relates to feelings is but a "limited goal" in the mental health worker's perspective of psychotherapy and psychiatric management. Some sense of peer relationship and some rationale would appear to be essential for collaboration to take place. For example, a mutual educational process.

4. *The mental health center can also help the church in some of its redemptive goals.* Although the focus of this paper has been largely that of the church helping to achieve the mental health center goals, the reverse is also valid up to a point. How therapeutic is the church, or how therapeutic can it be? If churches have a vision of what their fellowship might become, understand to some extent how the mental health professional and group skills might help develop some of this potential, it is possible that another level of collaboration could be demonstrated. The experience of Prairie View in providing co-leadership with the pastor to a small group of retired members in the congregation is a confirming experience in this regard. Community mental health centers, even though they are tax subsidized, can help to launch consultative services which extend into the church activities as well as other phases of community life.

FOOTNOTES

1. Pattison, E. Mansell, "Functions of the Clergy in Community Mental Health Centers," *Pastoral Psychology*, May, 1965, p. 21.

2. Clinebell, Howard J., Jr., *Mental Health Through Christian Community*, (Abingdon, 1965), pp. 19ff., presents a good statement on why mental health is a central concern of the church. The book as a whole attempts to provide a guidebook for maximizing a local church's mental health ministry.

3. Stotland, Ezra and Kobler, Arthur L., *Life and Death of a Mental Hospital* (University of Washington Press, 1965).

4. Pattison, *op. cit.*, p. 21.

5. As reported personally by Dr. D. F. Muhich, Director, Range Mental Health Center, Virginia, Minnesota.

6. *Action for Mental Health*. Joint Commission on Mental Illness and Health. Basic Books, 1961.

Books Dealing with Mental Health

(See Reviews, Page 190)

William Klassen, *The Forgiving Community*. Philadelphia: Westminster Press, 1966. $6.00.

Elaine Sommers Rich, *Tomorrow, Tomorrow, Tomorrow*. Herald Press, Scottdale, Pa., 1966. $2.00.

Send orders to *Mennonite Life*, North Newton, Kansas.

How the Vision Grew

By Larry Kehler

THERE ARE A multitude of mental health organizations in the world. These organizations have a variety of goals and purposes. Some seek to educate, thus laying the groundwork for the prevention of mental disturbances. Others place major emphasis on what is known as the clinical approach, that is the direct confrontation of healing resources with those whose ability to cope with life has broken down.

Mennonite Mental Health Services (MMHS) had its origin in World War II. During the war a number of young men, for conscience sake, sought alternatives to military service. Some of them were assigned by governmental authorities to massive state mental hospitals. In this unlikely seed bed some of the Society of Friends and a considerable number of Mennonite young men were brought to the conviction that mentally disturbed people could be helped, given a context of a community which would bring all of its healing powers to bear on the problem.

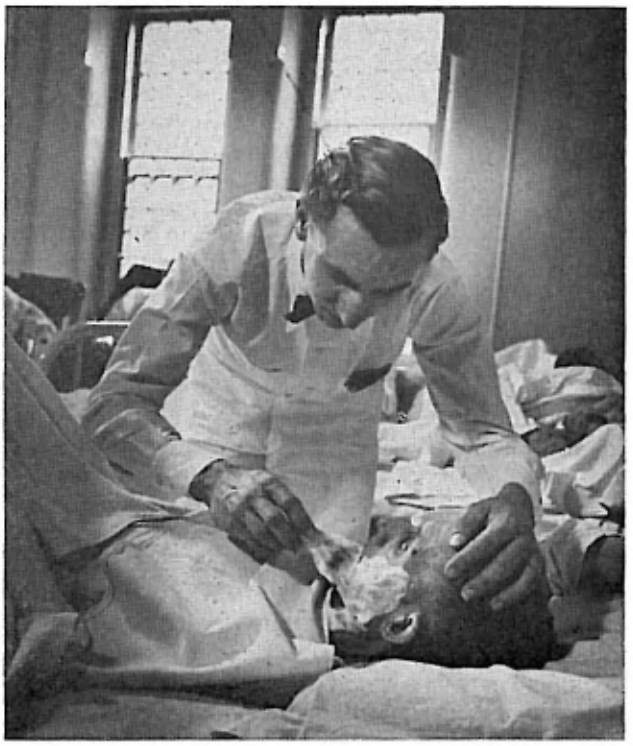
Happily their conviction coincided with the remarkable developments in the treatment of the mentally ill. There was the expose of the Topeka State Hospital in Kansas, for example, which led to a radical reform there and a convincing demonstration on the part of the state of Kansas that the mentally ill, given proper medical care, could respond and again take their place in society. In addition the advent of new drugs led to the creation of a milieu in which more rational forms of treatment and more humane methods of relating to patients could be developed.

Psychiatry continued to become more respectable, and clinical psychology, which moved increasingly into the practice of psychotherapy, also took its place as a major discipline in the restoration of the mentally ill. Social work which had experienced something of a crisis in its self-image, began now to move into the area of psychiatric social work and produced a large number of caseworkers in this field.

The religious dimension of the problem did not escape detection either. Largely through the personal struggles and difficulties of Anton Boisen a movement known as Clinical Pastoral Training came into being which has had a deep and lasting impact on theological education.

Out of all this emerged the team concept. It recognized that although the medically trained person continues to assume final responsibility for the treatment program, the problem of mental illness is often more than simply rooted in the brain. Many resources need

CPS boy in state mental hospital in CPS days.



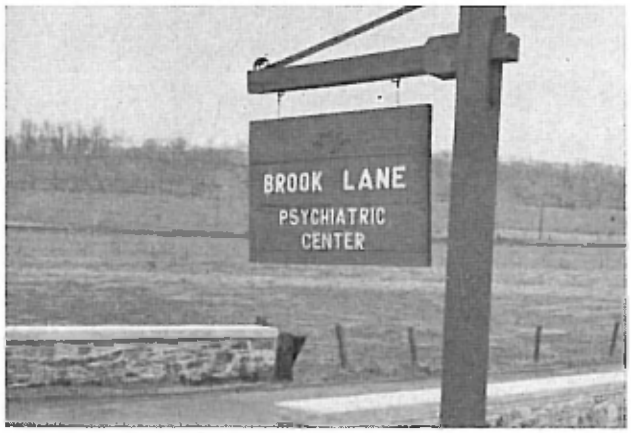
to be brought to bear on a particular case. If people are unable to cope with life because their thinking patterns are wrong, then it may well be that in certain cases people break down because they have developed rigid patterns of thinking about themselves, about their spouse, about God and the church, as well as the particular sex to which they belong.

From the involvement of individual Mennonite church members in the treatment of the mentally ill, however, there is a large step to the formation of its own hospitals. Various factors went into this next step. For one thing, the number of young people who had been exposed to the needs of the mentally ill and who decided to go into this kind of work on a non-professional level was quite modest. This meant that from the beginning the young people saw that the only way in which the needs of the mentally ill could be met was by getting the best training possible. A considerable number of young men who had worked as conscientious objectors in the mental hospitals decided to go into psychiatry, psychology, or psychiatric social work. Thus it was recognized that although tender loving care has a critical place in the healing process, it can never be substituted for professional skills and technical training.

This became clear particularly when the first mental hospital was built. Not having available a psychiatrist from its own ranks, the Mennonite Central Committee was faced with the question of whether a hospital should be built if it would have to be staffed primarily by non-church people. Although they were able to acquire a psychologist who was related to the church and there was an abundance of workers at the aide and nursing level, even up to this day it has been difficult to recruit and retain Mennonite psychiatrists. This has not always been a matter of concern. Experience has demonstrated, however, that a certain degree of affinity with the values of the church is indispensable if the healing resources of the church and the professionals are to be brought together.

Although pressures have sometimes been brought to bear upon the hospitals to minimize the professional aspect and emphasize more their church-relatedness, there have always been those who have felt that these two are not mutually exclusive and that they can, therefore, exist side by side. Our experience would certainly indicate that this is more than a wish or a dream. Indeed it is a reality.

The conscientious objectors' experience in mental hospitals led eventually to the establishment of mental health centers. The Mennonite Central Committee appointed a committee in June, 1945, to study this matter. This action was prompted, in part, by the recommendation of the 1945 session of the General Conference of the Mennonite Church of North America. Four months later the Mennonite Central Committee endorsed a study, the objectives of which were



This sign symbolizes the development which has occurred in the Mennonite mental health program.

". . . to ascertain the extent of mental illness and mental deficiency among our people, and thus the need for church-administered institutional care; second, to survey the types of institutional care which can best be provided; and, third, to present the informational bases upon which decisions can be made as to whether there should be a joint conference effort in this institutional program."

In December, 1945, the Mennonite Central Committee annual meeting recommended that voluntary service units in mental hospitals be continued and that young Mennonite doctors be encouraged to specialize in psychiatry. But they judged that the time was not yet ripe for Mennonite mental hospitals.

At a special meeting of the Mennonite Central Committee on October, 1946, a report by Elmer Ediger, suggesting the establishment of a Mennonite mental rest home at Leitersburg, Maryland, was adopted. The report suggested the use of an MCC-owned farm as the home for the first Mennonite mental health institution. A Civilian Public Service unit had been located here during the war. Work was begun in 1947 to renovate and erect the necessary building. During the same year, however, plans for a Mennonite mental institution in California were also developed. A site near Reedley, California, was purchased in June, 1948. Two thriving psychiatric centers now continue the work which began so inauspiciously at these locations.

It is the purpose of this report to introduce the reader to the current activities and operating philosophies of the Mennonite psychiatric centers. In the brief historical sketch above we have tried to show from whence we came. Now we want to see where we are today.

Mennonite voluntary worker in state mental hospital in CPS days.

The Psychiatric Centers

An Active Year

By Larry Kehler

BROOK LANE PSYCHIATRIC CENTER
Hagerstown, Maryland

Patient Statistics

There were 490 admissions during the twelve-month period, a new high in patient turnover. The largest group of patients remained in the hospital between 20 and 29 days, with a significant number staying three weeks or less. The average length of stay of those discharged during this period, excluding those under three days, was 27 days.

Building Program

Major effort was spent during 1965 in plant expansion. The hospital's new wing added about 3,500 square feet of space on two levels, providing a large day room, nursing office, staff lounge, rest rooms, medical treatment and examining room, recovery room, kitchenette, and storage and utility space. As part of the building project there has been a modernization of the existing hospital building, including a complete rebuilding of the bathrooms, exterior face-lifting, new windows, wardrobes, nurses' station, drug room, prestorage and utility space, and two additional beds to bring the capacity to 40 inpatients.

In the planning stages are a small unit for young children and possible restoration of the farm house, which dates back to 1840. While it has been a practice to get funds for such construction primarily from the church constituency, in this case the funds are being raised primarily by the local communities served by Brook Lane.

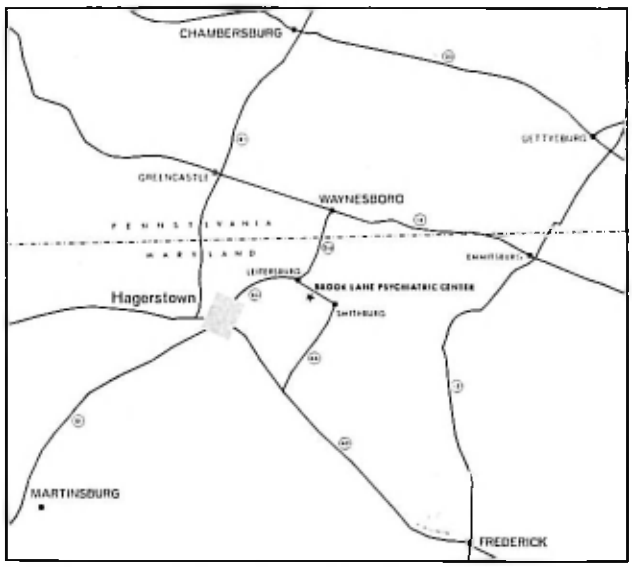
Program Developments

At the professional training level Brook Lane provides supervision for social work students from the University of Pennsylvania. A school psychologist recently spent a year at the center to obtain some clinical experience under the supervision of Brook Lane's clinical psychologist.

For the first time a psychiatric extern worked at Brook Lane for a summer with very positive results. The man selected had completed his second year of medical school and was involved in virtually every aspect of treatment from physical examinations to individual psychotherapy. He had opportunity to work with the entire clinical staff. The experience for him and for the clinical staff was such that it was repeated during the past summer.

Chaplaincy and Clinical Supervision

An ordained minister with a minimum of a Bachelor of Divinity degree serves for one year in a chaplain



The heart of the Brook Lane Psychiatric Center's program is the hospital.

Chapel at Brook Lane symbolizes the church's concern for the mentally ill.

residency supervised by the center's full-time director of pastoral care. His time is divided between Brook Lane and one or more cooperating institutions in the area. Brook Lane is approved for such training by the Southern Baptist Association for Clinical Pastoral Education. The chaplain is also an approved supervisor of clinical education for students attending Crozer Theological Seminary, Chester, Pennsylvania. In addition to this Brook Lane's attractive chapel was the locus for ministers' seminars conducted by the chaplain. By the end of 1965, ten twelve-week seminars had been completed, dealing with such areas as pastoral care of the emotionally distressed person, pastoral care of the middle-aged, pastoral care of the children and adolescents, marriage and family counselling, and other contemporary problems. Participation in these seminars is limited to approximately twelve ministers. In order to accommodate the large number of applicants, many of the series were repeated. Sixty-seven men, representing 16 denominations, were involved in these programs during the past year.

These seminars represent a very significant educational and training experience for the clergymen of the area, many of whom had no clinical training of any kind previously.

Outpatient Work and Consultative Services

Its increased staff enabled Brook Lane to do more outpatient work and to cooperate more closely with community agencies and organizations during 1965. For example, it provided professional staff on a part-time basis to mental health clinics in Hagerstown, Md., and Franklin County Pa. It also provided consultative services to four school districts in Franklin County, a state chronic disease hospital, a children's aid society, and a children's home.

The Bureau of Vocational Rehabilitation in Hagerstown has received a government grant to support a project to rehabilitate high school dropouts. They are looking to Brook Lane for professional services. The Bureau is also developing a project with prisoners and has requested a significant block of professional time to assist in this endeavor.

State Mental Health Legislation

Maryland has no legislation at present to provide mental health services in the counties, but there is hope that such legislation will be passed in 1966. The proposed bill provides for contracts between political subdivisions and nonprofit institutions already in existence. Brook Lane would be interested in such an arrangement.

Psychodrama used as part of Brook Lane's treatment program.

Psychodrama

The treatment of psychodrama has been increased and refined during the past year. This technique had

Brook Lane sponsors twelve-week seminars for ministers each year. They focus on pastoral care for various age groups, marriage and family counseling, and other problems.

been introduced during 1964, largely as a result of the special interest of the psychologist. A consultant in psychodrama spent a day at the center, working with the staff through lectures, demonstrations, discussions, and criticisms. The psychologist, G. Douglas Warner also attended special psychodrama institutes and workshops (notably at the Moreno Institute) to increase his own knowledge and skills in what has proved to be an effective and important addition to the inpatient treatment program.

Personnel

At the core of every psychiatric treatment program is the staff. In the mental health field there used to be a slogan, "brains before bricks." If it is a question of priority, this slogan certainly expresses it well. On the other hand, it is agreed that both brains and bricks are needed to establish a psychiatric center.

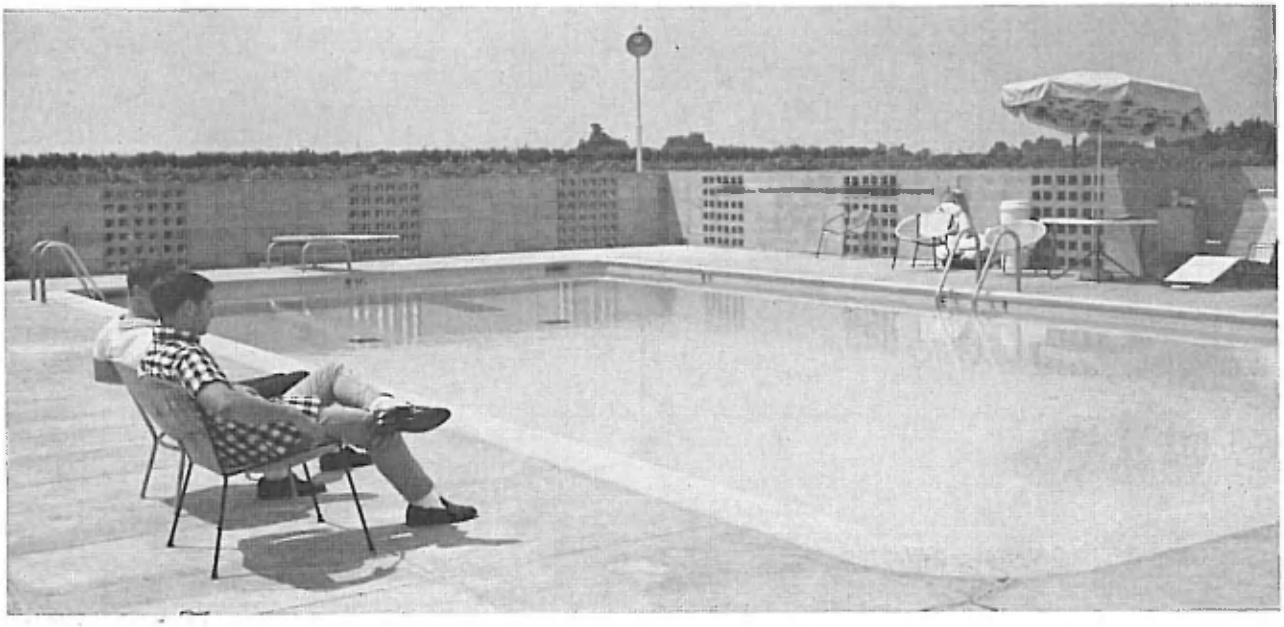
Behind the staff at Brooklane Psychiatric Center stands the board which for 1966 consists of the following: Amos Baer, chairman; Glenn Hoffman, M.D., vice-chairman; Norman Martin, secretary; Adam Martin, Grant Stoltzfus, Howard Musselman, Donovan Beachley, Sr., Christian Beiler, Abe Schmidt, Owen Guengerich, Howard Landis, Jr., Myron Livengood, Moses Slabaugh, and R. Clair Umble.

Two of the clinical staff members joined Brook Lane in 1965. Joseph P. Norris came from the Norristown Pennsylvania State Hospital. Ruth Kelly joined the staff in October as a social worker.

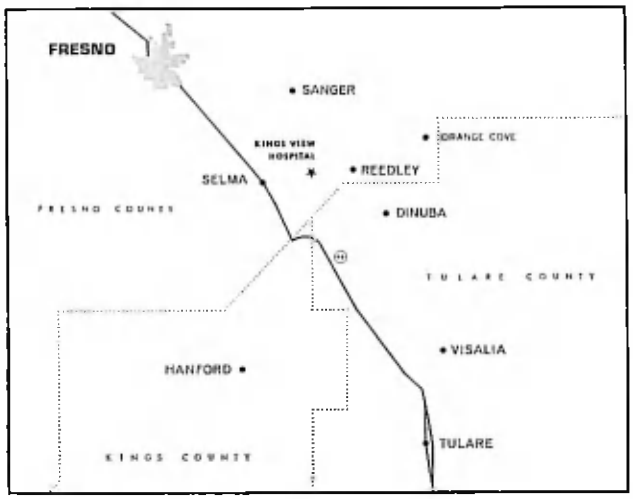
The professional staff for the year 1966 consists of the following:

Gene Schmidt, B.A., Administrator
Bethel College
David T. Whitcomb, M.D., Medical Director
Ohio State Medical School
Residency: Walter Reed Army Hospital
American Board of Psychiatry and Neurology, Certification
Paul Saraduke, M.D., Psychiatrist
Temple U. Medical School
Residency: Norristown (Pa.) State Hospital
Edmund V. Niklewski, M.D. Psychiatrist
Jefferson Medical College
Residency: Norristown (Pa.) State Hospital
Joseph P. Norris, M.D., Psychiatrist
Hahnemann Medical School
Residency: Norristown (Pa.) State Hospital
G. Douglas Warner, Ph. D., Clinical Psychologist
Temple U.
Maryland State Board of Examiners of Psychologists, Certification
Roy W. Harnish, M.S.W., Director of Social Work
U. of Pennsylvania
William B. Hunsberger, M.S.W., Social Worker
U. of Pennsylvania
Joseph R. Steiner, M.S.W., Social Worker
U. of Michigan
J. Ruth Kelly, M.S.W., Social Worker
U. of Michigan
Ellin Jaeger, M.S.W., Social Worker
Ohio State U.
Chester A. Raber, Th. D., Chaplain
Southern Baptist Theological Seminary
Paul D. Brunner, B.D., Chaplain Resident
Goshen College Biblical Seminary

Kings View swimming pool.



KINGS VIEW HOSPITAL
Reedley, California



Patient Statistics

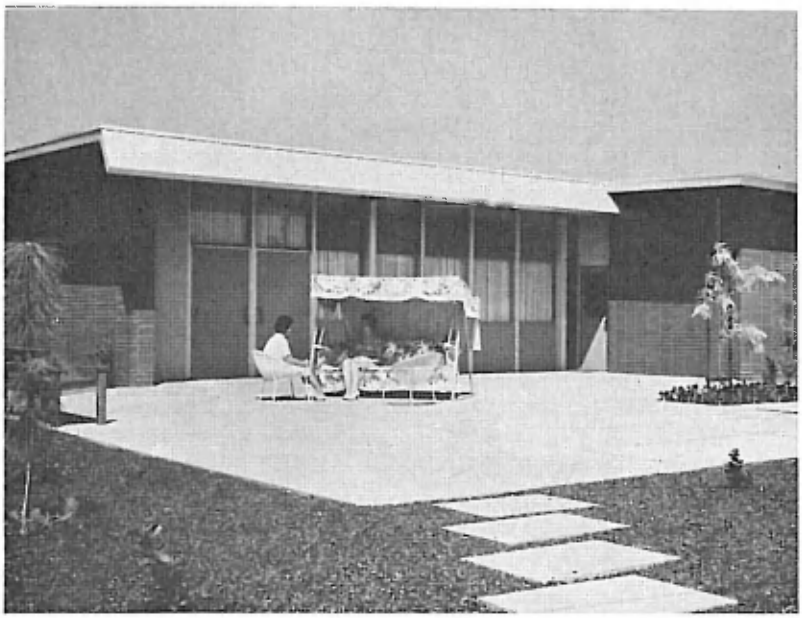
During 1965, the 55-bed Kings View facility operated at nearly 100 percent capacity. It registered 357 admissions and 341 discharges. The number of patient days, including inpatient and outpatient therapy and interviews, totaled 19,031 this year. Of these 13,306 were women and 5,725 men. Patients seen in individual therapy numbered 5,078 and in group therapy 7,393.

Outpatient Clinics

Outpatient clinics in Visalia, Tulare County, and Hanford, Kings County, are operated and staffed by Kings View. Financial assistance is given in these clinics to those patients qualifying for aid under county Short-Doyle standards. (The Short-Doyle Act for Community Mental Health Services was passed by the California Legislature in 1957 to provide funds for well-conceived local mental health services initiated by counties or cities.) Kings View has sought to tie into the Short-Doyle program ever since it was passed. One of the hospital's main reasons for wishing to contract with the nearby counties for psychiatric services was to provide help to those who are unable to afford the hospital's services. Furthermore, Kings View did not want to become isolated in its rural setting, serving only those from the local community who have the financial means to pay for its services.

"The integration of Kings View Hospital into county Short-Doyle programs," says Administrator Arthur Jost, "was to insure a community related program in the future and to involve the resources of Kings View Hospital in planning on a community-wide basis for supplementary rather than competitive services."

Kings View Mental Hospital, Fresno, California.



Kings View medical director, Charles Davis, during an interview.

The well-staffed kitchen of the hospital provides meals for the fifty-five patients and staff on duty.

The clinic at Hanford began operation under a contractual agreement with the Kings View County mental health advisory board in October, 1964. Kings View provides this outpatient facility with a half-time psychiatrist, a full-time social worker, and a part-time clinical psychologist.

In November, 1965, the hospital negotiated an agreement for services with the Tulare County mental health association. In addition to providing outpatient services at the Visalia clinic, the contract calls for the use of six beds at the hospital for inpatients. The outpatient clinic is presently staffed with a half-time psychiatrist and two full-time psychiatric social workers.

Educational Services

Kings View continued its affiliation program in nursing education last year. The Fresno state and city colleges alternated in the placement of students at the hospital.

Two seminar series specifically for ministers were provided during 1965 through the hospital's Department of Religious Services. Pastors were given guidance by hospital personnel on how they could assist individuals with emotional problems. Arrangements are also being made to have a student minister from the Mennonite Brethren Seminary in Fresno spend a summer at the hospital to observe and participate in its clinical program.

The Mennonite Brethren Seminary and Pacific College are exploring with Kings View's chaplain the possibility of his teaching introductory courses in such fields as mental health concepts and abnormal psychology.

Religious Services

Ministers from nearby towns are invited to lead the hospital's daily half-hour inspirational services, which are being attended by nearly half the patients. Arrangements have also been made with ministers representing various denominations and faiths to be available to counsel with patients who ask to see a minister of their own faith.

Therapy and the Therapeutic Community

Therapy is usually divided into two broad categories, somatic therapy and psychotherapy. The former includes the use of drugs and electric shock, the latter is treatment which takes place through the patient's relationships with other people. Both are used at Kings View.

The usual method of psychotherapy consists of confidential talks between patient and therapist, group discussions of individual problems, and guided recreational and occupational activities. Kings View believes, along with the MMHS psychiatry centers, that oppor-

tunities for therapy exist in every type of interaction at the hospital, not merely during periods formally set aside for it. It tries, therefore, to create an atmosphere among patients and staff which fosters the therapeutic process. This type of environment, in which every contact a patient has with other individuals or groups is seen as a potential help to him, is called the therapeutic community concept.

The hospital clinical staff believes that good communications between the staff and patients and among the staff members themselves is an important element in a truly therapeutic community. Good communication, however, has to be created and nurtured. Thrice weekly "community" meetings are held to enable the staff and patients to express their concerns and experiences. Regular meetings for the entire staff are also held.

The hospital recognizes that the nurse and the aide are the primary contacts that a patient has with the hospital staff. It attempts, therefore, to provide continuous training through formal and informal meetings for these members of the team.

The reason why Kings View places such strong emphasis on communication are (1) the recognition that negative feelings which are not expressed cause many of the emotional tensions which occur between people, (2) the belief that the patients must learn to recognize and express their own feelings, and (3) the need for the staff members' becoming aware of some of their own reactions to the patients' behavior.

Personnel

Kings View Hospital has a 14-man board of directors. The members are Daniel Horst, chairman; Victor Janzen, vice-chairman; John C. Penner, treasurer; Clayton Auernheimer, secretary; Edwin G. Wiens, J. J. Gerbrandt, Paul Engle, Harvey Dyck, Orland Friesen, John Bartel, Henry Brandt, Abe S. Ediger, Roy Fast, and David Mann. This board also administers Kern View Hospital, a new mental health facility being constructed at Bakersfield, Calif.

The clinical program is directed by four psychiatrists who are assisted by a clinical psychologist, and psychiatric social workers. The professional staff consists of the following:

Arthur Jost, B.A., Administrator
Fresno State College
Member of American College of Hospital Administrators

Charles A. Davis, M.D., Medical Director
Residency: Los Angeles County General Hospital
U.S. Public Health Service Hospital, Lexington, Ky.

J. Don Enterline, M.D., Clinical Director
Residency: Mayo Clinic, Rochester, Minn.
Palo Alto, Calif.
Agnews State Hospital, Agnews, Calif.

John D. Ainslie, M.D., Director of Research and Education
Residency: U.S. Public Health Service Hospital, Fort Worth, Texas
U.S. Public Health Service Hospital, Lexington, Ky.
Cincinnati General Hospital,
U. of Cincinnati Medical School
Louisville Child Guidance Clinic,
U. of Louisville College of Medicine

Gizella A. Shannon, M.D., Director of Outpatient Clinics
Residency: Hudson River State Hospital, Poughkeepsie, N. Y.

Jean J. Smith, Ph.D., Chief Psychologist
Michigan State U.

Charles A. Parman, M.S.W., Chief Social Worker
Kent School of Social Work

Robert L. Steiner, M.S.W., Social Worker
U. of Michigan

Norah Irvine, M.S.W., Social Worker
U. of California

Herman Weaver, S.T.M., Chaplain
Perkins School of Theology

Jim S. Gaede, M.S.W., Chief Social Worker
(Kings County Mental Health Clinic)
U. of Southern California

R. Blaine Petersen, M.S.W., Chief Social Worker
(Tulare County Mental Health Clinic)
U. of Utah

Dorothy Castiglione, M.S.W., Social Worker
(Tulare County Mental Health Clinic)
New York School of Social Work

Staff participates in group therapy planning session.

PRAIRIE VIEW
Newton, Kansas

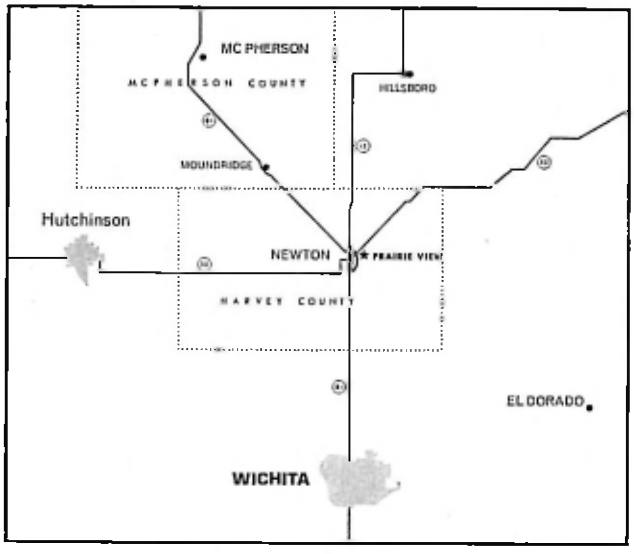
Patient Statistics

During the twelve months from October 1, 1964, to September 30, 1965, the hospital, which has a capacity of 40, had an average inpatient census of 33.5. It registered 196 admissions and 203 discharges during this period. Approximately 60 percent were first admissions. The median length of stay was 31 days, the average length 54 days. Twenty-four percent of the patients came from Harvey County and 23 percent came from outside the state.

The hospital also served 68 day patients for a total of 1,875 patient days during the year.

The staff gave a total of 6,264 psychotherapy interviews and 6,873 patient hours of group therapy during the 12 months. This included both inpatients and outpatients. One hundred and seventy-one persons were receiving outpatient care at the end of 1965. In addition the staff recorded 763 family interviews, 274 outpatient evaluations, and 149 psychological tests. The aftercare department had 50 patients on its list as of November 1, 1965.

Community Mental Health Services, an outpatient service which will be described in more detail later, had 46 patients as of November 1, 1965.



Operating Philosophy

Prairie View's operating philosophy was summarized as follows by its board of directors a few years ago:

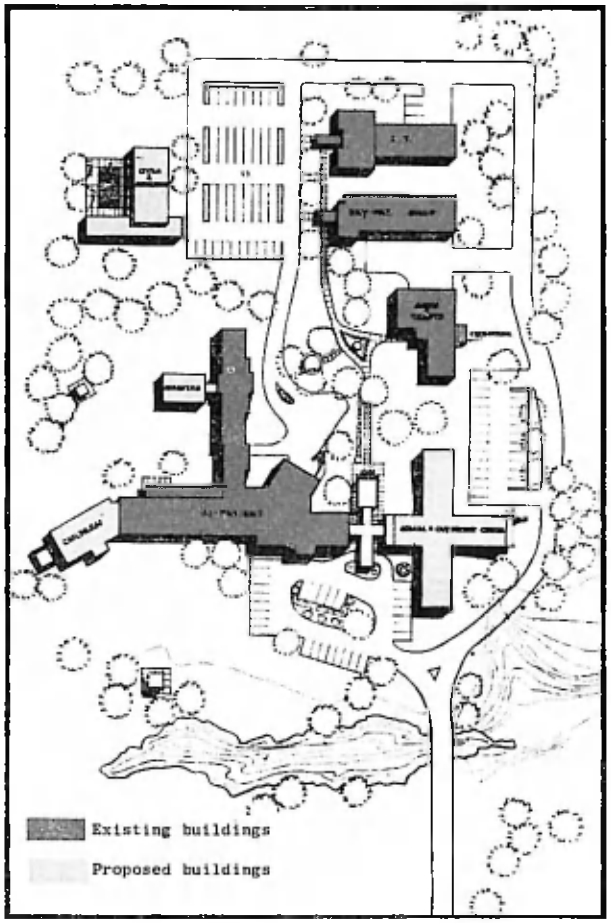
"The board is committed to help meet the Christian call our churches have experienced in their increased awareness of those suffering from mental illness.

"In a real sense the board wants to recognize this whole program as an on-going search of the church with psychiatry for the best way of meeting man's total needs in a psychiatric setting.

"The hospital recognizes and accepts the science of psychiatry as a means of healing the emotionally ill and seeks to employ the best skills available to serve this need. . . . (It) endeavors to provide its psychiatric services in an atmosphere of Christian concern, relationships, and principles."

Inpatient Service

Prairie View's lower age limit for inpatients is 14. It admits all diagnostic and symptom categories of emotional difficulty. The inpatient therapeutic program is based on the "therapeutic community" concept. The importance of the patient's taking as much responsibility as possible in helping himself is emphasized. The program aims to create a milieu in which a patient can best be able to come to know himself, particularly through his interaction with staff members and other patients. The activity program offers opportunities for constructive activity, facilitation of the patient's organizing of his own time, and a variety of relationships with others. Each patient in the hospital is assigned to a psychotherapy group which meets five



Existing and proposed buildings of Prairie View, Newton, Kansas.

days a week for one hour. Approximately half the patients have individual therapy in addition to the group therapy.

The patients have a voice in planning hospital activities through a patient council and all-patient meetings. Once a week the entire staff and the patients participate in a "community meeting" where the problems of living together in a small special community are discussed.

Drugs of various types are used for some of the patients. Electric shock treatment is available as an additional treatment modality, but it has been used only twice during the last two years.

Industrial Therapy

Prairie View's new 6,120 square foot industrial therapy building was completed during 1965. The building formerly used for this purpose is being remodeled for use as an arts and crafts area. The industrial therapy operation had $45,000 in sales during 1965. Patients were paid $5,827 in wages for the first 11 months. Inpatients and day patients worked a total of 5,433 hours during this period. The general philosophy is to operate on a realistic breakeven point, to pay the patients as near to the federally required hourly wage as possible, and to coordinate this program closely with the patient's total treatment.

Outpatient Services

The outpatient department has two teams, one specializing in adults, the other in children. Both also participate in other clinical services at Prairie View. The therapeutic program is based on a team approach to the patient and his family and their relationship to the community. The services available include individual and group psychotherapy, family social service, marriage counseling, play therapy, and medications.

Community Mental Health Services

Harvey and McPherson counties now have contracts with Prairie View's Community Mental Health Services (CMHS) to provide services to lower-income county residents on a graduated scale of fees based on ability to pay. Clinically CMHS is an integrated part of Prairie View's total treatment program, but administratively CMHS is separately incorporated. Its board of directors is drawn from various community agencies. This corporate structure is designed to allow proportionate representation from any county served by Prairie View. Harvey County began its contractual services with Prairie View in 1963, McPherson in 1965, and Marion County is scheduled to begin in 1967.

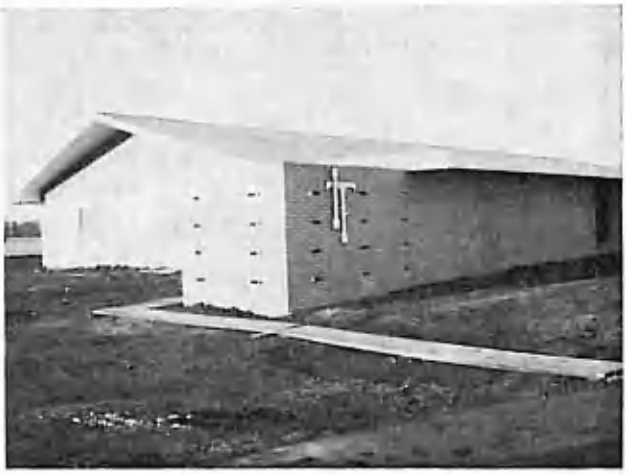
Consultation and Education

Consultative and educational services to individuals and institutions in the community are part of Prairie View's comprehensive program. Although one social worker is assigned as liaison between the Prairie View and community agencies, most of the professional members are involved in one facet or another of consultation and education. These contacts, which take a variety of forms, extend to the local welfare agency, schools, courts, clergy, medical clinics, homes for the aged, and colleges. Ten ministers from various denominations, for example, are spending two hours a week seeking to understand and deal with expectations of them as pastors. Additional educational activities include a weekly radio forum on which community leaders discuss various aspects of community life and its problems, college courses, study groups, and public meetings.

Aftercare Program

Through a grant from the National Institutes of Mental Health, Prairie View is carrying on an after-

Vernon Kliewer, child psychiatrist, preparing for the day.



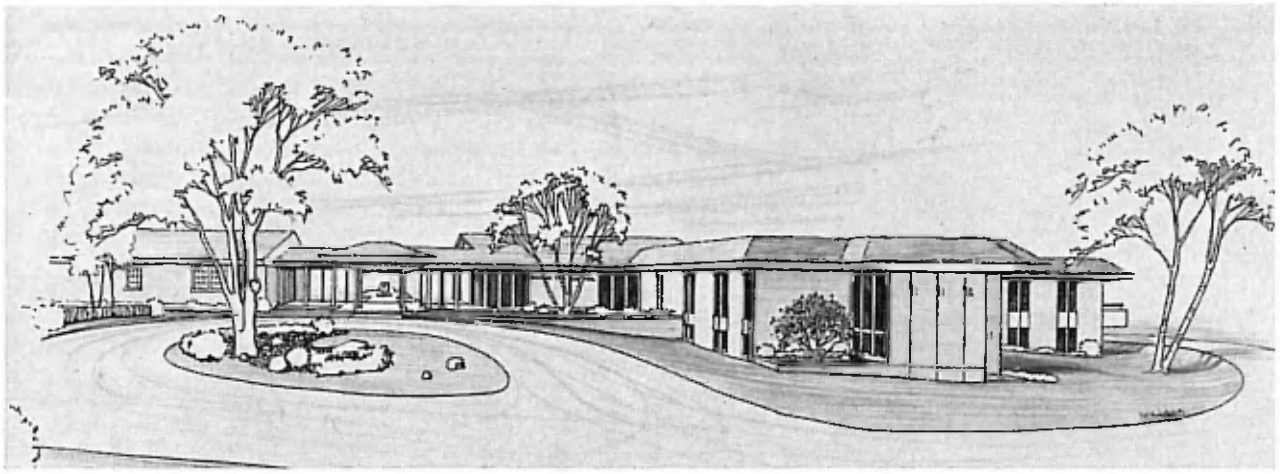
The most recent addition to the Prairie View campus is its new industrial therapy building (I.T.)

Margaret Cheatham (left) counsels with a mother concerning her high school child.

Harry Buller, a social worker, leads a classroom discussion.

Lucinda Martin, Prairie View's director of nursing; and Merrill Raber and Orlyn Zehr.

Home visits are made by aftercare nurse, Julie Neufeld.



Prairie View's proposed new clinic and office building.

care program in its area in cooperation with Topeka State Hospital. The aim of the NIMH-sponsored project is to demonstrate how local resources—in this case Prairie View as well as other resources in the community—can be helpful in the followup of state hospitalized patients. An important phase of the aftercare program is the home visiting nurse who assists in a monthly aftercare clinic and makes routine visits to the homes of new patients, and followup visits as needed.

Study on Aging

A feasibility study on a project on aging was initiated in 1965 and completed in 1966. A Schowalter Foundation grant was received for this research. This project demonstrated the feasibility of giving assistance to people in the aging process through group counseling, particularly in a natural setting such as a congregation. A further project in this field is anticipated.

Personnel

The board of directors, which meets quarterly, consists of Raymond Schlichting, president; Peter Wiebe, vice-president; Paul L. Goering, secretary; Mrs. Frankie Toevs, treasurer; Alvin Beachy, Harold Z. Bomberger, George Classen, Arnold G. Isaac, Melvin Jantz, H. J. Andres, Willis A. Nisly, George J. Rempel, Mahlon Wagler, Allen Wiggers, and Ray I. Witter.

The professional staff at Prairie View consists of the following:

Elmer Ediger, B.D., Administrator
Mennonite Biblical Seminary

W. Mitchell Jones, M.D., Medical Director
U. of Texas School of Medicine
Menninger School of Psychiatry
American Board of Psychiatry and Neurology, Certified in Psychiatry

Walter Lewin, M.D., Psychiatrist
Kansas U. Medical Center
Menninger School of Psychiatry
American Board of Psychiatry and Neurology, Certified in Psychiatry

Vernon Kliewer, M.D., Psychiatrist
Northwestern U. Medical School
Mental Health Institute
Certificate of Training
Children's Service Center of Wyoming Valley
Certificate of Training

William Wright, Ph.D., Psychologist
U. of Denver
Kansas Psychological Association, Certified in Psychology

Margaret Cheatham, Ph.D., Psychologist
Western Reserve U.
License in Clinical Psychology, Tennessee
Certified in Psychology, Pennsylvania, Kansas
The American Academy of Psychotherapists, Certification

Dean Kliewer, Ph.D., Psychologist
U. of Oregon

Orlyn Zehr, M.A., Social Worker
U. of Chicago

Harry Buller, B.D., M.S.W., Social Worker
Southern Baptist Theological Seminary
U. of Louisville

Orval Shoemaker, M.A., Social Worker
U. of Chicago

Merrill Raber, M.S.W., Social Worker
U. of Southern California

Harry Neufeld, M.S.W., Social Worker
George Warren Brown School of Social Work

Lucinda Martin, M.A., Director of Nursing
U. of Ottawa

Armin Samuelson, B.S., Activities Coordinator
Kansas State University

The administrator is responsible for Prairie View's overall operation, and the medical director is in charge of its medical and scientific work. Both meet regularly with the board of directors.

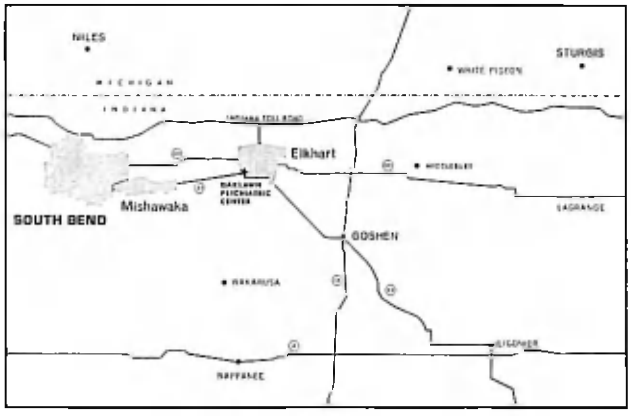
OAKLAWN PSYCHIATRIC CENTER
Elkhart, Indiana

Oaklawn Psychiatric Center, a nonprofit service sponsored by Mennonite and Church of the Brethren congregations in a four-state area in association with the Elkhart community, is governed by a board of 15 directors. The members are E. P. Mininger, M.D., chairman; Lester Rich, vice-chairman; Howard Rush, secretary; Paul Hoover, treasurer; Howard Bosler, M.D., Charles Ainlay, Joni Beachy, C. J. Dyck, Jesse Heise, M.D., Russell Liechty, Erie Sauder, Carl Smucker, Edwin Stalter, John Tomlonson, and Harry Weirich.

Patient Statistics

Oaklawn admitted 670 patients during the year, including 157 to the day care center and 103 to the psychiatric ward at the Elkhart General Hospital. At the end of the year the center had 793 active patients. Thirty-nine percent of the patients admitted in 1965 were referred by physicians, 12 percent by family or friends, 9 percent by other agencies, 6 percent by public schools, 5 percent by clergymen, 4 percent by courts, and 13 percent came on their own. Fifty-seven percent came from Elkhart County and 12 percent from outside the state.

The staff logged a total of 12,567 individual interviews and 497 group therapy sessions. The day care center, which serves the needs of people whose problems are somewhat more disabling than can be handled in an outpatient program, treated 185 patients during 1965 and provided 1,402 nights in community homes. Services for children and family treatment are expanding. During 1965 over one-fourth of Oaklawn's admissions were 19 years of age or younger.



Other Services

In addition to its outpatient, inpatient, and day care services, Oaklawn established aftercare and vocational assistance programs during 1965. The latter is for persons in the day care center who need help in clarifying their attitudes toward vocations and in finding suitable employment in the community. Under the aftercare program, which is carried on in cooperation with the office of the Indiana Commissioner for Mental Health, patients released from state hospitals come to the center for weekly group and activity therapy.

Four counties in northeastern Indiana—Noble, DeKalb, Steuben, and LaGrange — entered into an arrangement with Oaklawn during the year to subsidize services received by county residents at the center.

Consultation services were provided on a regular basis to Bluffton College in Ohio, a home for boys, and a local court. The center's staff served as consultants to five communities which are planning for mental health services. Various public school systems and church organizations also used this service.

The Oaklawn Forum

The Oaklawn Forum is a continuing dialogue between religion and the healing arts. The six "conversations on life" for the 1965-66 season focused on prejudice. Speakers included Viktor Frankl, Milton Rokeach, Hans Hofmann, George C. Merrill, William F. Lynch, and Louis Jolyon West. Nearly 200 attended each of these luncheon meetings.

Ministers Workshops

Seven two-day workshops for ministers were sponsored by Oaklawn during the year. Ten clergymen from various denominations attended each session. All of the workshops were on the theme "Studies in Problems of Living, Psychotherapy and Depression." Oaklawn's sponsorship of these sessions reflects its conviction that ministers represent a major resource in the struggle against emotional illness.

Women's Auxiliary

An Oaklawn Center women's auxiliary was organized during 1965. This group, in its initial year, undergirded the center's program by assisting in the securing of community homes, sponsoring a day-long women's conference attended by 200, and helping with patients in the day care center. They also helped make possible Oaklawn's response to the Palm Sunday tornadoes. Over 7,500 meals were served to disaster service volunteers by the Oaklawn kitchen staff. The auxiliary members also assisted as hostesses at the Oaklawn Forum series and at numerous other events.

Part of Oaklawn's professional staff: Alden Bohn, Melvin Funk, Otto Klassen (medical director), Melba Bechtel, Donald Munn, and Dennis Rupel.

Dining room in Oaklawn Psychiatric Center.

Among the facilities of Oaklawn Psychiatric Center are a beauty shop and a billiard table.

The activity department has equipment for a variety of projects, including weaving, painting, and woodworking.

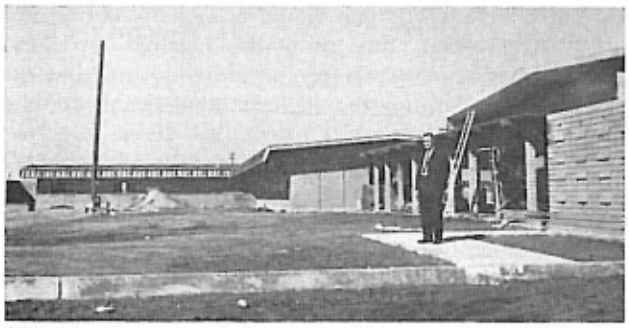
Medical Advisory Committee

A committee composed of six Elkhart County physicians was appointed in 1965 to serve in an advisory capacity to the medical director. The committee members come from Elkhart, Goshen, and Wakarusa.

An administrator is responsible for carrying out the policies of the board in the operation of the center and a medical director is responsible for all medical aspects of the center's activity. The professional staff is composed of the following:

Robert W. Hartzler, B.D., Administrator and Chaplain
Mennonite Biblical Seminary
Otto D. Klassen, M.D., Medical Director
U. of Illinois School of Medicine
Menninger School of Psychiatry
American Board of Psychiatry and Neurology, Psychiatry and Child Psychiatry
Dennis F. Rupel, M.D., Director, Day Care Center
Northwestern U. Medical School
Menninger School of Psychiatry
Leonard F. Smucker, Ph.D., Psychologist
U. of Southern California
Merrill-Palmer Institute
Melvin F. Funk, Ph.D., Psychologist
U. of Illinois
Walter J. Drudge, M.S.W., Department Chief, Psychiatric Social Work
U. of Tennessee
Donald Munn, M.S.W., Admissions Director
Michigan State U.
Alden Bohn, M.S.W., Social Worker
Ohio State U.
Margaret Jahnke, M.S.W., Social Worker
U. of Nebraska
Menninger Foundation
Ray Keim, M.S.W., Social Worker
U. of Pennsylvania
Donald Wismer, M.S.W., Social Worker
U. of Michigan
James Mason, O.T.R., Director, Adjunctive Therapies
Richmond Professional Institute
Miriam Weaver, R.N., Chief Nurse
Freda Sthair, R.N., Staff Nurse
Larry Yoder, M.A., Business Manager
Indiana U.

KERN VIEW HOSPITAL
Bakersfield, California



(*See also front cover*)

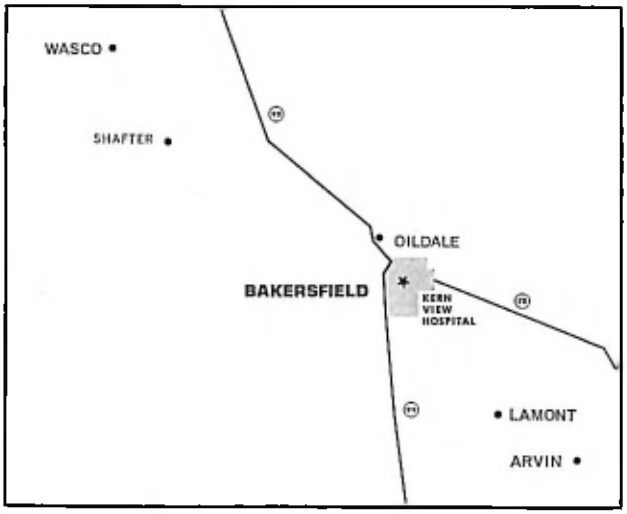
The ground breaking ceremony for the newest of the five Mennonite mental health centers in the United States took place in February, 1965. Construction on the $230,000 building for the Kern View Hospital was completed July 1, 1966, and the official opening followed soon after.

Several years ago, when the Greater Bakersfield Memorial Hospital began projecting plans for the development of a medical treatment center, psychiatric services were also included. They invited Kings View Homes, which operates the Kings View Hospital at Reedley, to establish a similar psychiatric center on the grounds adjacent to the Bakersfield hospital.

The Kings View board of directors was able to develop an attractive and realistic plan for building, staffing, and operating a psychiatric facility in Bakersfield, and, further, it was able to take advantage of the high priority held by Bakersfield for federal and state funds for the construction of a mental health center. It consequently leased a 4.4 acre site from the Greater Bakersfield Memorial Hospital Association.

Kern View's board of directors is the same as that of Kings View Hospital. Henry Hooge was appointed administrator of the hospital in 1965. The services of a well-qualified medical director and other professional staff members have been secured and a sizable grant under the new staffing act has been secured.

Kern View has a capacity of 25. Steps have already been taken to have a number of beds under a Short-Doyle contract.



Eden Mental Health Center

An Emerging Canadian Institution

By William Klassen

"The Mennonites have experienced a most remarkable awakening in regard to the needs of the mentally ill. The story of this awakening is a thrilling one, the story of a vision and of courage to follow its leading. The concern for the mentally ill was not new. It had expressed itself in significant early ventures. But it took World War II to give the vision and to present the challenge of a great need that sent Mennonites into this area of neglect."

These words by Dr. H. A. Fast encouraged the Mennonites of Manitoba, in the summer of 1957, to begin planning an institution for nursing and healing of the mentally ill.

The fact that the Mennonites of Manitoba came from South Russia, where they had institutional services for the mentally ill since 1911, provided additional impetus for the building of an institution in Manitoba as well as providing a model upon which to build. The hospital which began in South Russia in 1911 with 52 patients was almost doubled in capacity within a year. That hospital, while giving preference to Mennonites, accepted other patients. It was taken over by the government in 1925, and its services were terminated in 1927. During the last year of operation, the hospital's 204 patients consisted of 100 Russians, 87 Mennonites, and 16 Jews.

The beginning of the Eden Mental Health Center in Manitoba was given considerable impetus by legislation which made it difficult for the mentally ill in Manitoba to be sent to Ontario. Prior to the legislation, funds could be used to provide for Manitoba patients in Bethesda Hospital at Vineland, Ontario, but new legislation made it necessary for the mentally ill to be cared for in closer proximity to their home communities.

Much more significant was the basic change in the ideology of the institutional planners. In April, 1962, the committee which was planning for the mental hospital drew up an agreement with the director of psychiatric services for the province which explicitly stated that the institution would be primarily for the custodial care of patients who would not respond to the types of active treatment available in other mental hospitals. From time to time the facilities might be used as a halfway house or an aftercare institution. It was also assumed that the proposed hospital would accommodate selected patients who are presently in the Vineland, Ontario Hospital.

From the beginning it has been clearly stated that the director of psychiatric services would be in charge of the program, that he would have one of his staff psychiatrists visit the proposed hospital regularly to assure adequate care for the patients, and that the methods of operation would be most desirable for the welfare of the patients.

For two years this was the plan of the Eden Mental Health Center, but after vigorous discussion with men in the medical profession, clergy, and more study in 1964, it was decided to shelve the plans for a custodial home, and, with support from the provincial psychiatric department, it was agreed to draw up plans for a modern active treatment center with clinic and outpatient facilities.

The reasons for this turnabout in planning for the center are complicated. They certainly involve the attitude of the psychiatric services department, which at first may have been somewhat reluctant to push an active treatment concept partly because they hardly expected the Mennonites to have the skills and the trained men to carry on such a program and partly because the department itself had not fully committed itself to this concept. The Mennonites were apparently pushed in the direction of a more active treatment center by their own professional young people, the medical profession, and by the example of the U.S. Mennonites who have demonstrated that an active treatment center which uses the latest developments in medical science can be administered and operated by a church board.

In addition one should not discount the rapid ad-

vances being made in psychiatric services in Canada which were affecting the mental health planning of all the provinces. The exceptional institution at Yorkton, Saskatchewan, as well as the excellent periodical, *Canada's Mental Health,* give evidence of the forward movement in this area in Canada.

Fortunately the Canadian government and the medical profession have always taken a good attitude toward government involvement in this field and so the existence of Eden Mental Health Center at the time is in large measure due to the foresight and vision of the men in the department of psychiatry in Winnipeg, who have seen the potential of a cultural group operating a psychiatric clinic in its own community.

Another important step in the development of the Eden Center took place on July 25, 1964, when the constituent groups of the various Mennonite conferences and churches authorized the board to enter into an agreement with the government and incorporate Eden Mental Health Center. They accepted responsibility for an annual contribution of $1.50 per church member for ten years to finance the church's share of the construction cost.

The agreement provides for a 58-bed institution to be built in Winkler, Manitoba, with perhaps one half of those beds being designated as a day hospital area. The government will provide 75 percent of the construction cost and the remaining 25 percent will be carried by the church. The department of psychiatry will develop the treatment department into a fully modern community treatment center. The clinical department itself will operate under the direction of the director of psychiatric services in collaboration with the board.

The board has been giving considerable thought to its social and religious philosophy. It continues to express the conviction that the total community must be involved in the mental health program. Thus it recognizes that correcting the attitudes of the public toward mental illness, harnessing the resources of different associations for the development of information and referral, and establishing a social rehabilitation program is a large task.

Because much of the work of the mental health center will be a public relations task, it is hoped that the program can be administered and staffed by Mennonite personnel as much as possible. In this way the services pertaining to a therapeutic society will be sponsored and administered by people identifiable and identified with the religious and cultural group from which the patients come.

Running parallel to this clearer definition of the philosophical basis on which the program rests is a vigorous building program. Ground was broken on May 1, 1966, for a new $560,000 building which is architecturally attractive, spaciously adequate, and a tribute to the community. It is located on the outskirts of Winkler, a town which is near the center of the Mennonite population in southern Manitoba.

The biggest issue confronting Eden Mental Health Center is staff. It has been demonstrated by the Yorkton Center that brains and bricks must both go into a respectable program for the mentally ill, and that bricks are not unimportant in building a modern mental health institution. The most difficult matter, however, is to recruit a qualified and trained staff. The large number of young men from Canada selecting psychiatry, psychology, and psychiatric social work must be challenged with the possibility of working at Eden Mental Health Center. They must be convinced that the center is fully committed to a program of professional competence and that they will have the freedom there to express both their religious convictions and their professional skills in a way consistent with their training. This means that the Eden Mental Health Center has a job to do not only in keeping the constituency informed and keeping its relationship to government officials intact on a high level, but it also needs to have the confidence of the increasing corps of young professional people who are in training and looking forward to the time when they can work in a context where both professional skills and Christian commitment are taken seriously.

That chapter in the history of Eden Mental Health Center remains to be written but it is clear that the context is suitable for the writing of that chapter, the potential for board members and professional counsel is also available. There is no reason why that chapter cannot be the most exciting of all.

Mennonite Mental Health Services

When the Mennonite Central Committee first was asked to sponsor psychiatric facilities this was delegated to a Mental Health Committee. As the scope of the work grew Mennonite Mental Health Services was incorporated to serve as co-ordinating agency for the mental health work. From its inception until the summer of 1965 the office was located at Akron, Pa., and Delmar Stahly served as coordinator of Mental Health Services.

At present the following members serve on the Board of MMHS:

H. Clair Amstutz, M.D., Chairman, Goshen, Ind.
Howard Musselman, Vice-chairman, Orrtanna, Pa.
Roy Just, Hillsboro, Kan.
William Snyder, Treasurer, Akron, Pa.
Ernest Boyer, Albany, New York
Paul Mininger, Goshen, Indiana
Charles Neff, M.D., Upland, Calif.
John R. Mumaw, Harrisonburg, Va.
Ray Schlichting, Hillsboro, Kan.
Norman Loux, M.D., Sellersville, Pa.

The Board members of MMHS are appointed by the Mennonite Central Committee on an annual basis and represent the various professional resources found in the constituent groups of MCC. This Board in turn appoints the members of the local hospital boards in consultation with the area constituent groups and the executive committees of the local hospital boards.

During 1965-66 William Klassen served as director of MMHS under a special fifteen month assignment with specific responsibility in ascertaining greater clarity on the role of the church in the field of mental health.

In the study of the role of MMHS the Board has been assisted by a generous grant from the Schowalter Foundation. The role of MMHS is:

1. To serve as a channel of communication between the church and the clinical centers.
2. To recruit staff members from the church groups who are professionally trained and compatible to working in a church-related center.
3. To serve as liaison to state and federal governments for the various centers.
4. To use whatever means necessary to inform the constituency and the hospital of the issues in the rapidly developing field of mental health.
5. To sponsor pilot projects, e.g. the special camps held in the past two years for families with retarded children.
6. To assure strong representatives on the local boards of directors.

In order to accomplish its work, the MMHS Board meets at least twice a year. Its office is located at 2600 Oakland Avenue, Elkhart, Indiana.

Financial Reports

By William Klassen

MENNONITE MENTAL HEALTH SERVICES, INC. BALANCE SHEET

November 30, 1965

ASSETS

Current Assets:			
Cash in Bank			2,388.81
Fixed Assets:			
Brook Lane Psychiatric Center:			
Hospital Buildings	529,110.65		
Ground Improvements	13,481.37		
Land	5,000.00	547,592.22	
Kings View Hospital:			
Staff Housing Facilities	17,148.38		
Farm Buildings	5,322.02		
Hospital Buildings	740,956.71		
Land	25,600.00	797,027.91	
Prairie View			
Hospital Buildings	233,648.10		
Ground Improvements	3,322.74		
Land	19,250.00	256,220.84	
Oaklawn Psychiatric Center:			
Hospital Buildings	836,674.49		
Land	52,000.00	888,674.49	2,489,515.46
TOTAL ASSETS			2,491,904.27

LIABILITIES

Current Liabilities:			
Accrued Payroll Taxes	146.80		
Accounts Payable	3,892.52		
Oaklawn Psychiatric Center:			
Notes Payable—Short Term	396,000.00		
Brook Lane Psychiatric Center:			
Accounts Payable	11,227.44		
Notes Payable	90,000.00	501,266.76	
Fixed Liabilities:			
Kings View Hospital:			
Notes Payable against Staff Housing	7,000.00		
Notes Payable against Hosp. Bldg.	94,839.59		
Oaklawn Psychiatric Center:			
Bonds Payable	51,720.00		
Annuities Payable	22,970.75	176,508.34	677,775.10
M.M.H.S. Equity			*2,621.56
TOTAL LIABILITIES			675,153.54
NET ASSETS			1,816,750.73

*Indicates red

MENNONITE MENTAL HEALTH SERVICES, INC. STATEMENT OF OPERATIONS

December 1, 1964 to November 30, 1965

Income:			
Contributions (detail below)		9,301.00	
Repayments from Hospitals:			
Brook Lane Psychiatric Center	2,280.00		
Kings View Hospital	2,090.00		
Prairie View	2,280.00		
Oaklawn Psychiatric Center	2,090.00	8,740.00	
Schowalter Foundation		3,060.00	21,101.00
Expenditures:			
MCC Services and Facilities		2,700.00	
Oaklawn Services and Facilities		1,250.00	
Office Supplies and Postage		426.79	
Literature Production		246.57	
Telephone and Telegraph		495.77	
Staff Remuneration		9,070.27	
Staff Travel		1,811.48	
Member and Committee Travel		2,989.79	
Research and Study		2,050.71	
Miscellaneous		44.83	21,003.20
Excess of Income over Expenditures			97.80
Deficit December 1, 1964			*2,719.36
Deficit November 30, 1965			*2,621.56

Analysis of Contributions:

General Conference Mennonite Church	4,542.00
Mennonite Church	3,609.00
Mennonite Brethren	500.00
Brethren in Christ	300.00
Amish	250.00
Evangelical Mennonite Church	100.00
TOTAL CONTRIBUTIONS	9,301.00

*Indicates red

BROOK LANE PSYCHIATRIC CENTER BALANCE SHEET

November 30, 1965

ASSETS

Current Assets:			
Cash in Bank		27,387.10	
Petty Cash		200.00	
Accounts Receivable—Patients	94,912.32		
Less: Allow. for Uncollectable Accounts	14,376.01	80,536.31	
Other Receivables		5,286.17	
Inventories		15,592.46	129,002.12
Fixed Assets:			
Contributed Investments		42,206.86	
Auto Fleet	7,213.50		
Less: Allow. for Depreciation	4,891.45	2,322.05	
Equipment	63,356.89		
Less: Allow. for Depreciation	41,882.76	21,474.13	66,003.04
Other Charges:			
Prepaid Insurance		3,149.96	
Prepaid Expenses		22.00	3,171.96
TOTAL ASSETS			198,177.12

LIABILITIES

Current Liabilities:			
Cash in Bank (overdraft)		3,290.99	
Accounts Payable		3,103.63	
Accrued Payroll and Sales Taxes		4,925.06	
Voluntary Service Increment		7,111.94	
Pastoral Educational Program		928.78	
Patient Assistance	18,684.59		
Patient Assist.-Allocated	9,963.12	8,721.47	28,381.78
Other Credits:			
Accrued Insurance		1,721.25	
Deferred Income		75.00	1,796.25
TOTAL LIABILITIES			30,178.03
NET ASSETS			167,999.09

BROOK LANE PSYCHIATRIC CENTER
STATEMENT OF OPERATIONS

December 1, 1964 to November 30, 1965

HOSPITAL OPERATIONS

Income:			
Patient Fees	397,661.76		
Other Patient Income	3,299.80		
Other Income	26,098.96	427,060.52	
Expenditures:			
Salaries	280,323.60		
Activities	3,522.54		
Administration	45,373.71		
Dietary	25,074.04		
Nursing	16,435.57		
Publicity	1,071.44		
Pastoral Care	816.27		
Plant	23,132.09		
General	15,485.84		
Depreciation	8,400.00		
Other	12,295.98	431,931.08	
Net Loss on Hospital Operations			*4,870.56

NON-OPERATING

Income:			
Interest		104.04	
Pasture Rent		655.70	
Gift-in-Kind		351.75	1,111.49

EDUCATION AND DEVELOPMENT

Income:			
Contributions		21,026.67	
Expenditures:			
Solicitation Expense		9,360.11	
Net Gain from Education and Development			11,666.56
TOTAL Net Gain for Fiscal Year			7,907.49

*Indicates red

KINGS VIEW HOSPITAL
BALANCE SHEET

November 30, 1965

ASSETS

Current Assets:			
Cash in Bank		783.70	
Petty Cash		200.00	
Accounts Receivable—Patients	91,369.92		
Less: Allow. for Uncollectable Accounts	19,618.08	71,751.84	
Other Receivables		17.75	
Inventories		7,085.90	79,839.19
Fixed Assets:			
Equipment	144,230.91		
Less: Allowance for Depreciation	103,409.56	40,821.35	
Leasehold Improvements	27,880.74		
Less: Allowance for Depreciation	8,232.24	19,648.50	60,469.85
Other Charges:			
Unexpired Insurance		433.88	
Postage		31.33	465.21
TOTAL ASSETS			140,774.35

LIABILITIES

Current Liabilities:			
Accounts Payable—Patient Deposits	5,200.08		
Accounts Payable—Other	11,174.05		
Accrued Payroll and Sales Taxes	6,444.46	22,018.59	
Fixed Liabilities:			
Notes Payable	1,670.40		
Accounts Payable:			
Farm	3,200.00		
V.S. Increment	2,227.50		
Mennonite Aid	10,000.00		
M.C.C.	5,371.89	22,469.79	
Other Credits:			
Accrued Taxes	60.11		
Accrued Interest	695.47	755.58	
TOTAL LIABILITIES			46,043.96
Net Assets			94,730.29

KINGS VIEW HOSPITAL
STATEMENT OF OPERATIONS

December 1, 1964 to November 30, 1965

HOSPITAL OPERATIONS—INPATIENT

Income:			
Patient Fees	431,465.00		
Less: Uncollectable Accts.	2,578.05		
Blue Cross	1,432.80	427,454.15	
Staff and Visitors' Meals		8,321.91	
Outpatient Service Charges		18,265.00	
Other Income		133,890.98	587,932.04
Expenditures:			
General Nursing		165,427.84	
Activities		21,966.08	
Dietary		58,736.61	
Nursing Administration		16,889.99	
Medical Staff		71,738.76	
Medical Records		295.40	
Nonmedical Staff—Therapists		63,648.99	
Chaplain		7,576.28	
Housekeeping		24,749.28	
Administration		68,311.76	
Plant		32,323.79	
Other		29,420.16	
Deductions		7,486.18	568,571.12
Net Gain from Hospital Operations—Inpatient			19,360.92

HOSPITAL OPERATIONS—OUTPATIENT

Income:			
Patient Fees			82,797.82
Expenditures:			
Salaries		53,814.92	
Outpatient Service Charge		18,265.00	
Other		10,055.80	82,135.80
Net Gain from Hospital Operations—Outpatient			662.02

HOUSING FACILITIES

Income:			21,484.88
Expenditures:			22,599.25
Net Loss from Housing Facilities			*1,114.37

PRIVATE PRACTICE

Income:			6,551.50
Expenditures:			2,349.04
Net Gain from Private Practice			4,202.46

NON-OPERATING

Income:			
Contributions			13,410.09
TOTAL Net Gain for Fiscal Year			36,521.03

*Indicates red

PRAIRIE VIEW
BALANCE SHEET

November 30, 1965

ASSETS

Current Assets:			
Cash in Bank		34,124.83	
Petty Cash		400.00	
Accounts Receivable—Patients		120,815.62	
Less: Allow for Uncollectable Accts.	16,323.00	104,492.62	
Other Receivables		4,811.45	
Securities		700.00	
Inventories		23,786.68	168,315.58

Fixed Assets:			
Equipment	87,277.37		
Less: Allowance for Deprec.	56,284.86	30,992.51	
Buildings	18,557.94		
Less: Allowance for Deprec.	6,358.85	12,199.09	
Buildings and Improvements—Hospital	77,759.58		
Less: Allowance for Deprec.	2,139.86	75,619.72	
Ground Improvements	13,429.97		
Less: Allowance for Deprec.	523.68	12,906.30	131,717.62
Other Charges:			
Prepaid Insurance			2,456.65
TOTAL ASSETS			302,489.85
LIABILITIES			
Current Liabilities:			
Accounts Payable	11,452.87		
Professional Scholarships	120.00	11,572.87	
Other Credits:			
Accrued Expense	1,026.20		
Deferred Income	995.66		
Aftercare Unused Portion	9,188.09	11,209.95	
TOTAL LIABILITIES			22,782.82
Net Assets			279,707.03

PRAIRIE VIEW
STATEMENT OF OPERATIONS

December 1, 1964 to November 30, 1965

HOSPITAL OPERATIONS			
Income		463,378.08	
Expenditures			
Salaries	261,175.33		
Administration	10,799.02		
Dietary	23,929.60		
Nursing Service	7,008.97		
Activities	6,765.07		
Operations of Plant	14,766.20		
General Expense	36,902.67		
Professional Expense	73,425.19	434,772.05	
Net Gain from Hospital Operations			28,606.03
HOUSING OPERATIONS			
Income		2,843.75	
Expenditures		2,255.60	
Net Gain from housing Operations			588.15
NON-OPERATING			
Income		55,937.29	
Expenditures		33,767.78	
Net Gain from Non-operating			22,169.51
INDUSTRIAL THERAPY OPERATIONS			
Income		45,779.08	
Expenditures		49,166.92	
Net Loss from Industrial Therapy Operations			*3,387.84
Total Net Gain for Fiscal Year			47,975.85

*Indicates red

OAKLAWN PSYCHIATRIC CENTER
BALANCE SHEET

November 30, 1965

ASSETS			
Current Assets:			
Cash in Bank		14,901.61	
Petty Cash		150.00	
Temporary Investments		1,000.00	
Receivable—Patients			
Accounts Receivable	99,792.90		
Notes Receivable	9,095.42		
Less: Allow. for Uncollected Accounts	19,354.99	89,533.33	
Other Receivables		7,935.16	
Inventories		4,629.07	118,229.17
Fixed Assets:			
Equipment	78,656.93		
Less: Allow. for Deprec.	17,656.50	61,000.43	
Leasehold Improvements	764.43		
Less: Allow. for Deprec.	458.40	306.03	61,306.46
Other Charges:			
Accrued Interest Income		276.65	
Prepaid Insurance		856.45	
Prepaid Equipment Maint. Contracts		282.91	1,416.01
TOTAL ASSETS			180,951.64
LIABILITIES			
Current Liabilities:			
Accounts Payable	5,747.77		
Accrued Payroll Taxes	2,635.72		
Accrued Payroll Withholdings	486.35		
Notes and Loans Payable	36,000.00	44,869.84	
Other Credits:			
Accrued Expenses	883.00		
Restricted Receipts for Patient Care	837.04	1,720.04	
TOTAL LIABILITIES			46,589.88
NET ASSETS			134,361.76

OAKLAWN PSYCHIATRIC CENTER
STATEMENT OF OPERATIONS

December 1, 1964 to November 30, 1965

OPERATING FUND			
Income:			
Services to Patients at Elkhart General Hospital	14,360.00		
Services to Patients at Oaklawn	75,344.50		
Special Services to Day Patients	21,393.80		
Outpatient Services	160,473.80	271,572.10	
Less: Free Services, Patient Assistance, Uncollectable Accounts		24,920.38	
		246,651.72	
Other Income		39,024.86	285,676.58
Expenditures:			
Administrative and General		69,084.50	
Dietary		11,881.88	
Household and Property		33,060.41	
Church and Community Relations		4,797.12	
Finance and Fund Raising		275.33	
Psychiatry		49,752.95	
Psychology		21,034.00	
Social Service		48,547.41	
Medical Records		6,685.64	
Adjunctive therapy		23,413.23	
Nursing		10,414.40	
Supplementary Services		7,517.24	
Pastoral Care		149.44	289,413.55
Net Loss from Operating Fund			*3,736.97
PLANT AND DEVELOPMENT FUND			
Income:			
Contributions		58,885.70	
Expenditures:			
Development Expenditures		23,215.70	
Net Gain from Plant and Development Fund			35,670.00
TOTAL Net Gain for Fiscal Year			31,933.03

*Indicates red

Staff of Bethania mental hospital operated by Mennonites in South Russia.

The Birth of Mennonite Mental Health Services in Russia

Bethania was founded in 1910 and existed until 1927 when this area was flooded by the Dneprostroy power dam.

Civilian Public Service in World War II in America

They placed a bond of comradeship on the shoulder of the depressed and the discouraged; toward the old and the feeble they were kind; and they kindled a light of hope in the eyes of those for whom the world was too difficult.

A state hospital administrator's letter of appreciation for a CPS unit's work in his institution during World War II.

Books in Review

The Forgiving Community by William Klassen. Philadelphia: Westminster Press, 1966. $6.00.

"With all that has been written on forgiveness, it is somewhat striking that no one has heretofore assembled the Biblical evidence on the meaning of forgiveness" (p. 13). In this comment from the introduction to his book, *The Forgiving Community*, William Klassen pinpoints the need which his book is designed to fill. Answers to two basic questions are sought in this thoroughgoing study: First, what does the Bible say about forgiveness? And second, what are the implications of the Biblical concept of forgiveness for the contemporary church? Both in terms of purpose and methodology Klassen's work could be compared with John Bright's classic *The Kingdom of God*. Bright turned the searchlight of Biblical exegesis upon the kingdom concept, while Klassen has focused upon forgiveness.

The work is divided into four main parts: Forgiveness in the Old Testament; in pre-Christian Judaism; in the New Testament; and in the life of the contemporary church. Non-theologians may well be advised to begin their reading with part four and proceed backwards through the historical analysis. Motivation to stay with the rather meaty reading might come more rapidly for a larger group of readers if the New Testament sections are read first.

For this reviewer the impact of the volume came as he began to understand the central thrust of the New Testament concept of forgiveness. Klassen amasses considerable evidence from the scripture to support the thesis that God's forgiveness can only be realized through forgiving human relationships in the community of believers. On the basis of passages from Matthew, chapters 16 and 18, Klassen contends that the authority to forgive and retain sins *has been given to the church.*

> We have been told that the church is wherever the Sacraments are correctly administered and where the Word is truly preached. Some would add discipline to this, and still others insist that the church is where Christ is. The Biblical definition of the church provides us with only one mark of the church. *Christ is present where people pray for, and assure each other of, the forgiveness of sins. The mark of the authentic church is the ability to realize the forgiveness of sins in the community.* (p. 149, italics added.)

This community-oriented and almost humanistic concept of forgiveness may sound like heresy to some who may not recall that it was precisely this heresy which Jesus espoused, and which eventually led the Jewish leaders to put him to death. "Who is able to forgive sins, except one, God?" This was their retort when Jesus said to the paralytic, "Your sins are forgiven." (Mark 2:1-12).

From another frame of reference Klassen here is presenting a significant addition to the literature supporting the sixteenth century Anabaptist view of the church. If in fact the Scripture teaches that God's forgiveness actually is channeled through the corporate fellowship (community) of disciples, many of the ingredients of the Anabaptist vision become necessary derivaties: a believers' fellowship where repentance, confession of sins, discipline and mutual admonition are actually practiced.

Though the tools of Hebrew and Greek scholarship are much in evidence in the work (as should be expected from a specialist in Biblical hermeneutics), a seminary background is not a prerequisite for the reader. In addition to the writings of church fathers and theologians, the insights of philosophers, physicians, and behavioral scientists have not been neglected by Klassen. Extensive contacts with the Menninger Foundation in Topeka, Prairie View in Newton, and Mennonite Mental Health Services have also made possible a unique integration of Biblical concepts with insights drawn from the mental health disciplines. But the integration is not forced, and is localized in the section on "forgiveness in the life of the contemporary church." Sigmund Freud and O. Hobart Mowrer receive considerable attention (Freud somewhat favorably and Mowrer quite unfavorably) while some therapists who have contributed to our knowledge of related issues like guilt (Tournier), meaning (Frankl), and responsibility (Glaser) are not mentioned. Nor are the behavioristically oriented helping procedures (which totally ignore man's need for forgiveness) considered. Yet the basic purpose of the work —to examine the Biblical meaning of forgiveness—clearly is accomplished.

The reviewer sees *The Forgiving Community* as an extremely valuable contribution, not only for the theology student or pastor, but also for church workers, educators, clinicians, and others for whom an understanding of forgiveness is essential.

PRAIRIE VIEW — *Dean Kliewer*

Tomorrow, Tomorrow, Tomorrow by Elaine Sommers Rich, published by Herald Press, Scottdale, Pa., 1966, 93 pp. $2.00.

For an evening away from television and its banality, try this little book which describes intriguingly the experiences of a college sophomore who chooses a summer of voluntary service in a state mental hospital rather than a scholarship to a fine music camp and its associated opportunities. You will find the book full of the political intrigue of hospital administration, the results of poor wages and long hours for the hospital personnel, the frustrated efforts of grossly inadequate numbers of technically trained personnel such as social workers and psychiatrists, the problems of personal relationships within a VS unit and between VS workers and hospital personnel, and the high idealism and vision of youth on the "new frontier." You'll be glad you spent the evening with the author who speaks for Esther Miller at Lirioden Hospital.

The high idealism of Miss Miller, the VS worker, may seem almost idyllic at times. However, as one who directed the efforts of a unit of Civilian Public Service workers at such a hospital, I do not believe it too high. To keep this standard of idealism glowing and working for three years might just be another book! Perhaps this summer unit was beginning to get to the heart of the methods for improving care on mental hospital wards; they certainly worked at it with enthusiasm and with some degree of success.

One should not assume that there has been no progress in the care of the mentally ill since the time which this writer pictures for us. Modern drugs, the insights of such units as these, and the continuing studies in psychology and psychiatry have improved methods so that as one of my acquaintances has put it after years as a medical director of such a hospital, "Our hydrotherapy tubs have become horse troughs on the hospital farm." It is hoped that other antiquated methods likewise have been dropped in favor of newer and more civil methods infused with the t.l.c. (tender loving care) which such units as the one described in the book have been famous for.

Every young person who considers such service would do well to read this book. It is indeed challenging and inspiring. The tracing of such service through the daily routine of ward duty to a therapeutic program in which these young people "fresh off the farm" could find a real place should inspire the church to continue the challenge to voluntary service.

The few German phrases and sentences may create a problem for some readers but should not be a deterrent to reading with understanding. This is one of the best such books straight from the heart of such an experience.

ELKHART, INDIANA — *Loris A. Habegger*

First and Vital Candle by Rudy Wiebe. William B. Eerdmans Publishing Co., Grand Rapids, Michigan, 1966. 354 pp.

Rudy Wiebe's second novel gains strength and unity beyond that of his *Peace Shall Destroy Many* by narrowing the focus from an entire Mennonite community in a year crowded with shocks to the spiritual quest of a single non-Christian. Abe Ross, the hero of *First and Vital Candle,* ventures into a new land, like the Abraham of old. One of the most impressive things about the novel is the vivid detail with which Wiebe portrays the culture and physical environment of the Eskimos (in the first flashback) and of the Ojibwa Indians. Both of these non-Christian cultures are used to increase Abe's receptivity to the Gospel.

Long flashbacks in Abe's voice effectively trace his spiritual confusion to its source in the harsh, rigid "Christianity" of his preacher father. The weakest of the flashbacks is the chapter that superimposes a World War II memory on a college memory, neither of which is important enough to justify the reader's effort in untangling them. Wiebe's prose, which is rich and compressed throughout the novel, is so showy in this flashback, and in the opening scene set in Winnipeg, that it calls attention to itself more than to the hero's disorientation.

First and Vital Candle is skillful in presenting a Christian conversion without miracles, sentimentality, or pious preaching. The reality of the spirit appears in the superstitious Indian religion. But that religion, like Abe's enlightened courage, is insufficient to break the chain reaction of evil triggered by the greedy fur trader, Bjornesen. Only sacrificial love is strong enough, as it is embodied in the likeable, non-preaching missionary, Josh Bishop, and in the schoolteacher, Sally Howell. Although Josh is idealized, there is only one episode in which he becomes a mere mouthpiece for Christian ideas—his pacifist harangue of an Air Force officer, whose single function in the plot is to be thus lectured. Otherwise this novel is far more successful than *Peace Shall Destroy Many* in translating *ideas* about Christianity and peace into living characters. *First and Vital Candle* is a fresh and compelling creation.

NORTH NEWTON, KANSAS — *Anna K. Juhnke*

There Have to Be Six, A True Story of Pioneering in the Midwest, Amelia Mueller (Herald Press, Scottdale, Pa.) 1966, $3.50, 255 pp.

The author says of her book, "This is the story of a way of life that no longer exists, except in memory, for many of us who grew up on farms in the Midwest during the first half of this century." It is the story of the Mueller family. Papa is a dreamer, a venturer. No matter how hard he has just fallen, he is sure that a brighter future is just around the corner, awaiting the success of his latest undertaking. Mama is the balance wheel, finding the flaws in his grand schemes. She loves her home and roots, but she also loves her man and goes with him from Germany to the United States, from Kansas to Hamshire, Texas, to Deer Creek, Oklahoma, and back again to Halstead, Kansas. The six children share the ups and downs of family life. They help fight that enemy, "the Debt." They eagerly await the visit of the *Christkind* to their home at Christmas time. They share in the hard work and excitement of wheat harvest.

The story is simple, honest, well-written, spiced with humor. It portrays faithfully the heroism that has built the Mennonite communities of Kansas.

TOKYO, JAPAN — *Elaine Sommers Rich*

Why We Can't Wait by Martin Luther King. New York: Harper and Row, Publishers; 1964. 178 pp. $3.50.

The leader of the nonviolent direct-action Negro civil rights movement explains his philosophy while telling the story of Birmingham in the summer of 1963. King calls this the "Negro Revolution of 1963" and describes it as "the greatest mass-action on crusade for freedom in American history."

He describes the situation in Birmingham which made it a logical place for the attempt to seek change for the Negro, and tells why nonviolence was the weapon chosen to speed up the legal process. He explains the immediate and urgent necessity of creative action as channel for the normal healthy discontent of the Negro who is no longer willing to mark time in seeking the long-withheld rights and privileges which are honorably his.

The Birmingham demonstrators approved by the Southern Christian Leadership Conference for participation in the demonstrations were required to pass strict tests, to attend training sessions and sign commitment cards pledging their willingness to abide by the discipline of nonviolence. They succeeded amazingly in spite of great provocations.

Both the Birmingham demonstrations and the March on Washington that fall received moral and financial support from all over the world. The white churches became enthusiastically involved in the Washington March which, for the first time, gave an organized Negro operation press and television coverage and respect commensurate with its

importance, King reports, and this book is largely devoted to explaining their significance.

In conclusion King points out that planned "gradualism" in establishing equality for the Negro will no longer satisfy the Negro who realizes that his complete freedom is long overdue. But unplanned spontaneity would be a chaotic and equally unsatisfactory solution, so a challenging task faces the nation as it seeks solutions to the complex plight of the Negro. King suggests that among the vital jobs to be done is not only a radical readjustment of attitudes toward the Negro, but also a planned program to compensate the Negro for the handicaps he has inherited from the past. He proposes a "Bill of Rights for the Disadvantaged" to deal actively with the task of raising the Negro from backwardness, and includes in his proposal the same benefits for the forgotten white poor. Some of the economic provisions he suggests have already been incorporated in the government anti-poverty program since the book's publication.

Finally King suggests that the greatest contribution of the civil rights revolution, which benefits society along with the Negro, may be in the area of world peace where nonviolence may become the answer to the most desperate need of all humanity.

The book is worth reading for those who are interested in an understanding of the plight of the Negro in American society, for those who would seek to understand how nonviolent direct action has been used in implementing action in this cause, and for those who want to understand the thinking of the outstanding Negro leader of this movement.

Bluffton, Ohio — *Martha F. Graber*

Wolfgang Schäufele, *Das missionarische Bewusstsein und Wirken der Täufer, dargestellt nach oberdeutschen Quellen.* (Beitraege zur Geschichte und Lehre der reformierten Kirche, Band XXI), Neukirchener Verlag des Erziehungsvereins, G.m.b.H., Neukirchen, Germany, 1966, 356 pp., DM 34.

The author has studied assiduously all available printed sources and also had access to the still unpublished second volume of the Württemberg *Täuferakten* which contains a wealth of new material and would certainly deserve an early publication. In contradistinction to many a previous study on Anabaptism in Germany, this one approaches its subject with warm sympathy, even admiration, admitting that the author had encountered a similar phenomenon nowhere else but in apostolic Christianity as presented in the book of Acts. Hence he speaks quite appropriately of *"Pauline method of mission work"* as the only proper qualification of the subject under study.

And indeed, mission and proclamation (*Kerygma*), the call to all and everybody to turn away from the sinful life of the "world" and to accept the glorious path of discipleship —that was certainly one of the greatest achievements of Anabaptism from its very inception, and it was also its strongest impulse. What Wiswedel and Littell had presented more or less in outlines, Schäufele now unfolds in all its many aspects. One is almost overwhelmed by the wealth of testimonies concerning missionary activities of all the different Anabaptist groups, something utterly foreign to more contemporary territorial churches whose officials were completely unable to grasp the spirit of these activities which to them were nothing but covered sedition.

The book, originally a Ph.D. dissertation at Heidelberg University, is well composed and offers an exhaustive and careful description of both the "missionary consciousness" and the "missionary practice" of early Swiss-German-Austrian (Hutterite) Anabaptism. (The Netherlands and North Germany were not included in the study.) Chapter Two deals with the missionary consciousness of the Anabaptists, the subjective aspects so-to-speak of the phenomenon, mainly prior to 1560. Two phenomena stand here in the foreground: the "apostolic awareness" of being called which lead to leadership with charismatic authority, and the "eschatological tension," that is the certainty of the imminence of the *Parousia* which gave such tremendous dynamic impulse to the self-sacrificing work of the Anabaptist missioners. I am particularly intrigued by the use of the term "existential turning point" for the description of what we may otherwise call conversion or rebirth (in the sense of John 3:3). The use of the term "existential" in connection with the missionary drive (pp. 115, 117, 134, 218) is certainly more appropriate than that of "fanaticism" (*Schwärmertum*) of former Anabaptist historiography. Anabaptism was, mainly in its earlier phase, a movement carried away by strong eschatological expectations.

Chapter Three deals with the more practical aspects: the activities both before 1530 (the enthusiastic phase of the movement) and afterwards. Here the figure of Hans Hut looms largest and receives a very sympathetic treatment as a true apostle. One almost senses the vibration in the work of this strong and dedicated man who spread far and near the good news: "repent, be baptized and begin a new life in following the Master." It reminds one strongly of the message of Acts 2:38 and 17:30f. It found a ready echo everywhere where his restless wanderings led him. Excellent is the section on the Martyrs' Synod at Augsburg, August 1527, which gives us a dramatic picture of the almost unbelievable dynamics of the beginnings. The tragedy of relentless persecution finds ample attention and with it also the "theology of martyrdom." It is amazing how simple the message was which these men carried all over Central Europe and beyond. It was a call to repentance (the author speaks here of "existentielle Neubesinnung"), and then to obedience. There is, of course, plenty of theology implied but nowhere explicitly preached, in contradistinction to the practice of the churches of the Reformation.

The book is well written and scholarly presented (with 13 pages of bibliography), illustrating its topic from many aspects. I have little to say by way of criticism.

Kalamazoo, Mich. — *Robert Friedmann*

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