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Collaboration through Research: The Multimethod Church-Based Assessment Process

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COLLABORATION THROUGH RESEARCH: THE MULTIMETHOD CHURCH-BASED ASSESSMENT PROCESS[1]

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The Multimethod Church-Based Assessment Process (MCAP) is a systematic assessment and consultation process developed to help congregations to better understand needs, resources, and ministry successes. Consultation with the MCAP is best understood as a relational endeavor that requires collaboration between the church leadership team and a mental health professional skilled in consultation methods, data analysis, and research methods. Potential uses and limitations of the MCAP are described.

Throughout the centuries individuals and families have been cared for within the context of the church (Benner, 1999), but in the mid-twentieth century many in pastoral positions shifted their practice of how to care for the soul away from the classical writers who had informed their tradition and began to seek the emerging psychological theories and treatments. There was a silence on the part of classic pastoral wisdom that lasted several decades (Oden, 1988)—a silence that was reinforced during the community mental health movement of the 1960s and 1970s when clergy were promoted as community mental health resources for psychological counseling (Mollica, Streets, Boscarino, Redlich, 1986). Repeated attempts to adapt the latest psychological theory into the ministry of soul care left Christian pastoral care in need of restudy and redefinition.

One reason that pastoral care will remain relevant, as it always has been, is that clergy and the churches they lead offer resources of hope and help to those in need of comfort, guidance, belonging, and social support. In recent years both psychologists (Crabb, 1999) and

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ministers (Frazee, 2001) have advocated the enriching benefits of authentic Christian communities. These communities provide a resource for spiritual, family, and psychological health that cannot be replicated in the psychotherapist's office.

The church can and should be a place where people experience healing community, yet any who have spent significant time in churches recognize that every congregation falls short of these lofty pastoral care goals. Churches are led by and filled with broken people, and often the potential of a beautiful healing community fades into the reality of conflict, bitterness, and division. Social trends toward individualism, coupled with the marketing of religion and religious enterprises, have led people to experience religious involvement without a high level of commitment to community life (Roberts, 1992). As an institution, the church must strive to balance the corporate and the individual, the spiritual and the psychological, and the historical and the contemporary.

Believing fully in what the church has to offer its people, the Center for Church-Psychology Collaboration (CCPC) was established in 1999 to put psychology at the service of the church (McMinn, Meek, Canning, and Pozzi, 2001). When the relevant skills and methods from psychology are subjected to the oversight and authority of local church leaders, a bridge is built that helps reclaim the connection between faith, community, and mental health that formed the basis of soul-care prior to modernity. In this context we seek to develop collaborative tools whereby mental health professionals and clergy can work together for the sake of developing and enhancing vital ministries.

Overall, psychologists have paid little attention to working with clergy (Weaver et al., 1997), and most of the scant attention given to clergy-psychologist collaboration pertains to referrals for clinical services (McMinn, Chaddock, Edwards, Lim, and Campbell; 1998). But there are other ways, such as consultation and assessment, that psychology can be used to partner with the church (Benes, Walsh, McMinn, Dominguez, and Aikins, 2000; Edwards, Lim, McMinn, and Dominguez, 1999; Pargament, Falgout, and Ensing, 1991).

MULTIMETHOD CHURCH-BASED ASSESSMENT PROCESS (MCAP)

The MCAP—a collaborative consultation and assessment system—was developed as an alternative to standardized church assessment tools. The MCAP is unique in that it provides a flexible, idiographic system that allows each church to craft a customized assessment for its particular needs and strengths. Each of the four words in the MCAP title—Multimethod Church-based Assessment Process—tells an important part of the story.

Multimethod

The MCAP employs various methods to help pastors arrive at answers to specific questions they have regarding their congregations. Using one method—a questionnaire, for example—to obtain information can be helpful, but often results in a limited understanding of a complex issue. The MCAP uses multiple methods by attempting to combine questionnaires, interviews, focus groups, and various other methods of collecting information to arrive at credible answers to the questions posed by the leaders of the congregation.

Church-Based

Clergy have often been left out of a full partnership when mental health professionals have attempted to serve the church. Too often collaboration between clergy and mental health professionals devolves into a one-way referral practice where pastors end up providing a way for counselors to earn income but in return do not receive much that truly benefits their congregations. The MCAP is a *collaborative* method that requires a full-fledged partnership between a mental health professional and clergy and ultimately benefits the health of a local congregation. The MCAP is done within a church congregation, under the authority of church leadership, for the sake of enhancing pastoral care ministries.

Assessment

A truism in the mental health professions is that effective treatment first requires effective understanding. How can we help someone clinically unless we first know what is wrong? The same is true of consulting. How can we make meaningful contributions to the health of a church congregation without first understanding the congregation? Good interventions have always been based on good assessments. Christian psychologists have been trained in assessment procedures, effective relational skills, research methods, interviewing skills, group dynamics, consultation, and report writing—all of which are employed in the MCAP.

Process

The key difference between the MCAP and other church-based assessment strategies has to do with defining which questions to assess in a particular congregation. Several excellent church-based assessment products are available, but most have a standardized set of questions that predetermines the focus of the assessment. Rather than developing standardized questions that are assumed to equally appropriate in various churches and settings, the MCAP is a standardized *process* that allows the pastor and mental health professional to work side-by-side in answering highly specific questions. For example, why is our small group ministry doing well, but our support group ministry is just barely limping along? What pressures and stresses do our immigrant and first generation Hispanic youth face in our bicultural church community? What sort of informal mentoring is being provided for young couples in our congregation, and are their needs for support being met?

THREE MCAP STAGES

The MCAP is comprised of a flexible three-stage model, as shown in Figure 1. Stage 1, Generating Specific Questions, involves discussing and clarifying the specific questions that led to the assessment in the first place (i.e., what does the church want to better understand?). This phase is an entry phase into the system, whereby observation and building relational networks are essential to setting the stage for a mutually collaborative effort. Generating specific questions occurs in the context of intentional conversation, followed by a written

understanding of the questions emerging from the conversation. These steps are repeated as needed until everyone agrees on which questions to assess. Stage 1 requires excellent relational skills—the success of the entire MCAP process is contingent upon establishing an effective collaborative relationship.

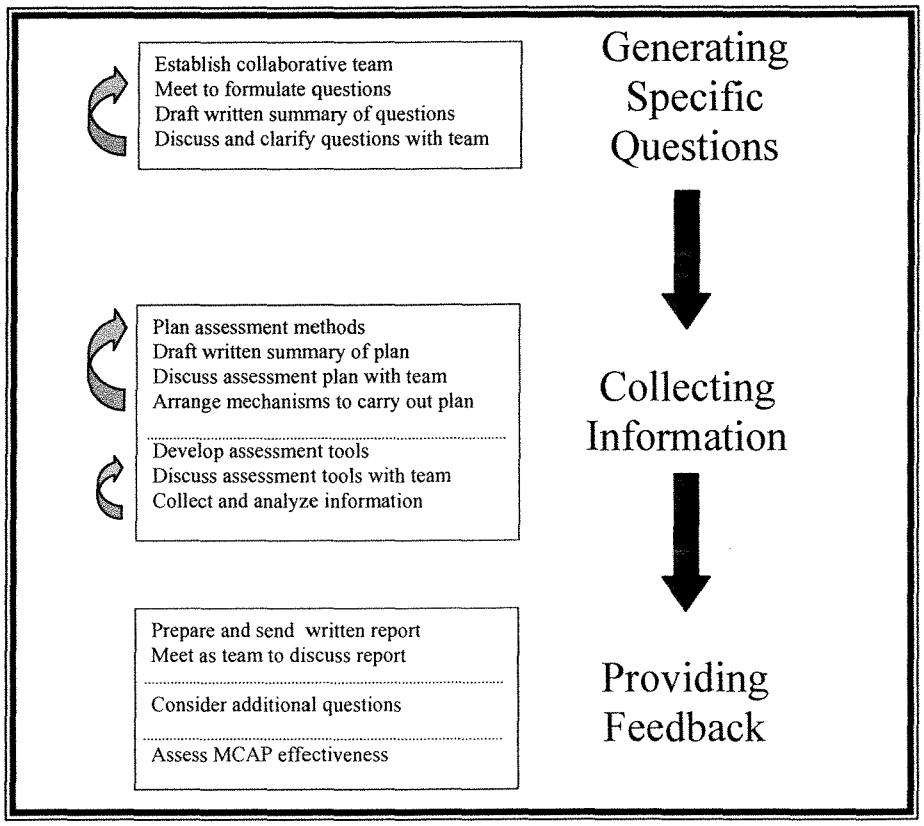

Figure 1. The MCAP process

In Stage 2, Collecting Information, a written plan is generated regarding which assessment methods are most appropriate for collecting information in the specific congregational context. There are many possible assessment methods—limited only by creativity, ethics, and logistics. For example, we have used methods such as in-person interviews, questionnaires via mail, focus groups, brief questionnaires distributed in a Sunday morning worship service, telephone interviews, email surveys, Internet questionnaires, and literature review. Then the assessor discusses the assessment plan with the team of leaders, working continually toward collaborative working relationships. Once the plan is agreed upon, the assessor works with the team to arrange mechanisms of carrying out the assessment plan. Again, this process is repeated as much as needed in order to obtain clear direction in support of the system's goals as well as to ensure a sense of ownership among congregational leaders. This stage requires technical expertise in questionnaire development, focus groups, interviewing, and data analysis (both qualitative and quantitative).

In Stage 3, Providing Feedback, a final written report is prepared and given to the team, and discussed collaboratively. At this time, as well as at any time throughout the assessment process, the assessor considers additional questions arising out of the assessment process that may be addressed in the future. Stage 3 requires word processing skills and a flare for succinct and effective writing.

MCAP APPLICATIONS

The MCAP has been used in various church and para-church organizations (see Savage, 2004). The main focus of these assessment projects has typically involved understanding parishioners' values, attitudes, and preferences regarding specific pastoral care ministries within the church. For example, we used the MCAP in a suburban congregation to evaluate the effectiveness of a small group ministry. Two other churches used the MCAP to help determine which support and recovery groups should be launched. In some contexts the MCAP has not been limited to pastoral care ministries. For example, one church wanted help understanding parishioner's responses to Sunday morning worship services. A multicultural inner-city church used the MCAP to help identify racial tensions and areas of satisfaction within the congregation. A Hispanic congregation used the MCAP to assess attitudes regarding the possibility of merging with an Anglo congregation. As these diverse examples illustrate, the MCAP provides a consultation structure but does not impose a particular set of questions. The local church defines the questions to be addressed with the MCAP.

ADVANTAGES AND DISADVANTAGES

The MCAP is an idiographic assessment and consultation system, based on a standardized *process* rather than a nomothetic assessment tool based on standardized instruments. We have emphasized the advantages of this approach, but there are disadvantages as well. The glaring disadvantage to idiographic assessment is the lack of having standardized instruments with established reliability and validity. Other disadvantages include the open-ended timeframe of the MCAP process, with projects varying in duration from several weeks to many months. A third disadvantage is that the flexible nature of the MCAP is not easily communicated to pastors who are typically expecting a standardized questionnaire with pre-existing questions and normative data. Shifting plans can feel cumbersome, but this flexibility is essential in order to tailor the evolving assessment project to the particular church context. Another disadvantage is the time involved in development of specific assessment measures. Since this work is essentially a new project in each environment, each instrument used in gathering data must be tailored to address the congregation's particular needs. This can be quite time consuming when compared to using a set of standardized instruments in all congregations.

Nonetheless, the advantages to the idiographic approach of the MCAP seem to justify the approach. The primary advantage is that the assessment can be focused on the precise questions raised by the pastoral team rather than assuming that every church should be assessed with a standard set of questions or inventories. This leads to gathering data that is

highly relevant to churches and clergy and a high level of shared ownership for the project (e.g., Savage, 2004).

Future Directions

It would be ideal to have systematic efficacy data to support the use of the MCAP. However, this requires that the MCAP lend itself to the assumptions of controlled outcome research. Due the idiographic nature of the MCAP, including the lack of any control group, systematic efficacy research is impossible. Thus, the most useful outcome data that can be collected is effectiveness data rather than efficacy data (Seligman, 1996). Whereas efficacy data uses controlled scientific study, effectiveness data assesses the satisfaction of consumers. By assessing effectiveness certain generalizations can be made about the actual process in specific congregations and these can be used to inform future efforts in other settings. For this reason, gathering satisfaction feedback from those pastors and mental health professionals using the MCAP is an important part of our ongoing development efforts.

Attention must also be given to careful training. Haphazard or incorrect use of the MCAP procedures might potentially lead to faulty conclusions or recommendations, and thereby mislead churches using the MCAP. MCAP training seminars are being offered as pre-conference workshops and at various sites throughout the country, and ongoing phone and email consultation is available through the Wheaton College CCPC for those who have been trained and are using the MCAP.

Conclusion

The church has provided care for souls throughout many centuries, and it can continue to be a place for connection and healing. One way contemporary churches provide this care is through ministries that can be evaluated and improved through methods such as the MCAP. The MCAP highlights one way in which clergy and mental health professionals can work together, beyond the traditional pattern of a pastor referring to a psychologist. In this model of partnership the pastor maintains the identity of shepherd to the congregation while working alongside a mental health professional in an effort to strengthen the faith community in the ways that the pastor judges most appropriate. This approach regards the church staff as experts, returning the emphasis on the church as a place for care, and using the skills of psychology to support the church.

References

Benner, D. (199). *The care of souls: Revisioning Christian nurture and counsel.* Grand Rapids, MI: Baker Books.

Benes, K. M., Walsh, J. M., McMinn, M. R., Dominguez, A. W., and Aikins, D. C. (2000). Psychology Serving the Church: Empowering those who shepherd God's People. *Professional Psychology: Research and Practice, 31,* 515-520.

Crabb, L. (1999). *The safest place on earth.* Nashville: Word Publishing.

Edwards, L. C., Lim, B. R. K. B., McMinn, M. R., and Dominguez, A. W. (1999) Examples of collaboration between psychologists and clergy. *Professional Psychology: Research and Practice, 30,* 547-551.

Frazee, R. (2001). *The connecting church: Beyond small groups to authentic community.* Grand Rapids, MI: Zondervan.

McMinn, M. R., Chaddock, T. P., Edwards, L. C, Lim, B. R. K. B., and Campbell, C. D. (1998) Psychologists collaborating with clergy. *Professional Psychology: Research and Practice, 29,* 564-570.

McMinn, M. R., Meek, K. R., Canning, S. S., and Pozzi, C. F. (2001). Training psychologists to work with religious organizations: The Center for Church-Psychology Collaboration. *Professional Psychology: Research and Practice, 32,* 324-328.

Mollica, R. F, Streets, F. J., Boscarino, J., and Redlich, F. C. (1986). A community study of formal pastoral counseling activities of the clergy. *American Journal of Psychiatry, 143,* 323-328.

Oden, T. C. (1988) Recovering pastoral care's lost identity. In Alden, L. and Ellens, J.H. (Eds.) (1988). *The church and pastoral care* (pp. 17-31). Grand Rapids, MI: Baker Book House.

Pargament, K. I., Falgout, K., and Ensing, D. (1991). The congregational development program: Data based consultation with churches and synagogues. *Professional Psychology: Research and Practice, 22,* 393-404.

Roberts, K. A. A sociological overview: Mental health implications of religio-cultural megatrends in United States (1992). In Pargament, K. I., Maton, K. I., and Hess, R. E. (Eds.) (1992). *Religion and prevention in mental health* (pp. 37-56). New York: The Haworth Press.

Savage, S. B. (2004). Psychology serving the Church in the United Kingdom: Church consultancy and pastoral care. *Journal of Psychology and Christianity, 22,* 338-342.

Seligman, M. E. P. (1996). Science as an ally of practice. *American Psychologist, 51,* 1072-1079.

Weaver, A. J., Samford, J. A., Kline, A. E., Lucas, L. A., Larson, D. B., and Koenig, H.G. (1997). What do psychologists know about working with the clergy? An analysis of eight APA journals: 1991-1994. *Professional Psychology: Research and Practice, 28,* 471-474.