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Implementation of a Program to Improve the Continuity of Mental Health Care Through Clergy Outreach and Professional Engagement (C.O.P.E.)

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There are over 260,000 religious congregations in the United States. They and their clergy are de facto providers of mental health care. Recent models promoting collaboration between clergy and psychologists advocate that shared religious values underlie effective working relationships. This view may impede collaboration with the majority of psychologists, who are not religious, excluding congregants from needed expertise. The Clergy Outreach and Professional Engagement (C.O.P.E.) model was developed and implemented to facilitate continuity of care across a diversity of caregivers. Handouts based on National Institute of Mental Health prevention science categories and case examples illustrate when and how clergy and clinicians would collaborate. The authors introduce and define the term *burden reduction* to describe a C.O.P.E. outcome. They consider this clinical work *religion inclusive* rather than faith based.

Keywords: service delivery, Latino, African American, systems thinking, chaplain

There are more than 260,000 religious congregations in the United States (Jones et al., 2002). These congregations—and their clergy—are a de facto part of the continuity of mental health care in the United States (Regier, Narrow, Rae, & Manderscheid, 1993; Shifrin, 1998; Wang, Berglund, & Kessler, 2003). This article describes the initial implementation of a prevention-science-based paradigm to improve the continuity of mental health care through reciprocal collaboration between clergy and mental health profes-

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sionals. Materials to disseminate this clinical and prevention intervention are included.

We have found that clinicians and clergy perform distinct functions that, although they only occasionally overlap, are complementary (Milstein et al., 2005). Clinicians provide professional treatment to relieve individuals of their pain and suffering and move them from dysfunction to their highest level of functioning. They also intervene, when possible, to prevent the relapse of mental disorders. In most cases, assuming resources are available, the less clinicians see of those under their care, the more successful the clinicians are. With some serious and persistent mental illnesses, clinical relationships—although they will wax and wane—will last through the patients' lives (Adair et al., 2003; Bachrach, 1981).

Clergy and religious communities provide a sense of context, support, and continuity before, during, and after treatment (Pargament & Maton, 2000; Shifrin, 1998). Indeed, the better a person is functioning, the more that person can participate in the life of the congregation (Govig, 1999; Jernigan, 1970). Unlike clinicians, clergy expect and hope to see their congregants as often as possible through the course of their lives. Clergy may know multiple generations within a single family. They will officiate at ceremonial events, at times following the lives of some family members from birth, through the school years, to marriage, and until death. Through their relationships with congregants, clergy acquire comprehensive information, which (with consent) they could share with clinicians. In collaboration with clinicians, the clergy's personal familiarity and experience can be invaluable to facilitating appropriate and continuous mental health care for their parishioners by "contextualizing" the patient's illness and life history (Ware, Tugenberg, Dickey, & McHorney, 1999, pp. 398–399).

Since 1976, the journal *Professional Psychology: Research and Practice (PPRP)* has published nearly a dozen articles examining the roles of clergy in mental health care delivery. Two articles examined the public's perceptions of the efficacy of clergy in multiple roles compared with the efficacy of physicians and mental health care providers (Schindler, Berren, Hannah, Beigel, & Santiago, 1987; Wilkinson, 1978), and nine described collaboration between clergy and psychologists (Benes, Walsh, McMinn, Dominguez, & Aikins, 2000; Budd, 1999; Edwards, Lim, McMinn, & Dominguez, 1999; Levenberg, 1976; McMinn, Aikins, & Lish, 2003; McMinn, Chaddock, Edwards, Lim, & Campbell, 1998; McMinn, Meek, Canning, & Pozzi, 2001; Plante, 1999; Weaver et al., 1997).

The first collaboration article published in *PPRP* described outreach to rural fundamentalist clergy by a psychologist who did not share their faith (Levenberg, 1976). He developed a program to "employ a nonthreatening avenue of approach to effect working referral relationships" (p. 556). Other successful settings for collaboration, not restricted to clinicians and clergy with shared faith and values, have included a suburban community mental health center (Anderson, Robinson, & Ruben, 1978), a state university counseling center (Aten, 2004), and the Air Force (Budd, 1999). Several additional examples of multidisciplinary work may be found at the Web site of an organization called Pathways to Promise (www.pathways2promise.org). In these models, clergy and clinicians provide complementary care, with each focusing on his or her own expertise to meet the needs of the individual (Milstein, 2003). Here is an example of such an interdisciplinary collaboration in response to a death in the Air Force (Budd, 1999): "The military chaplains often perform the funeral services, both chaplains and mental health professionals provide crisis counseling on scene, and mental health providers often take on any individuals needing ongoing support or psychotherapy" (p. 555).

Other psychologists have recommended that instead of multifaith collaboration, it would be best for religious subgroups of psychologists to seek collaboration with clergy of the same religion. Examples include consultation within a Roman Catholic church community (Plante, 1999), an integrated community-based prevention and treatment program across a large rural Catholic diocese in southern Nebraska (Benes et al., 2000), and a center financially endowed to promote the integration of psychology and Christianity through urban and international programs of collaboration with faith-based communities (McMinn et al., 2001). The most recent article about clergy collaboration published in *PPRP* (McMinn et al., 2003) presented survey data from conservative Christian clergy (Chaddock & McMinn, 1999) and proposed a two-level collaboration hierarchy. Psychologists whose personal religiosity and theology were consonant with those of their clergy collaborators were considered to have "advanced competence" (McMinn et al., 2003, p. 201); they collaborated in an active, integrative manner. This was in contrast to nonreligious psychologists, who were considered to have "basic competence" (p. 201); they interacted through more distal referral and consultation.

A goal to improve clinical care through an expectation of shared personal faith and values between clergy and clinicians may instead constrict the care available to persons with mental health problems. Compared with the general public, psychologists are far less likely to affiliate with any organized religion (Bergin & Jensen, 1990) and are less likely to have received personal religious education (Shafranske & Malony, 1990). Whereas persons ages 45 to 60 (the Baby Boomers) have increased their religious affiliation as they have grown older (Roozen, McKinney, & Thompson, 1990), mental health professionals have shown a decrease in religious affiliation (Shafranske & Malony, 1990). Therefore, religiously restrictive models for collaboration could exclude referrals to professionals with the optimal expertise to care for the clergy's parishioners.

Furthermore, the clinical necessity of shared faith (Johnson & McMinn, 2003) is questioned by psychotherapy research (Beutler, Machado, & Neufeldt, 1994; McCullough, 1999; Worthington, McCullough, Sandage, & Kurusu, 1996). One study rigorously compared the work of religious psychotherapists with the work of nonreligious psychotherapists in treating religious Christians (Propst, Ostrom, Watkins, Dean, & Mashburn, 1992). This study found that nonreligious therapists providing religiously informed psychotherapy achieved the best clinical outcome for religious Christian patients. Religious therapists providing nonreligious psychotherapy achieved the next best outcome. Although these data were surprising to the researchers, they were not anomalous. The interactions remained consistent across a 3-month follow-up, and patient improvement persisted through a 2-year follow-up. The researchers also noted that these results were consistent with previous work suggesting that intermediate value similarity led to the best therapeutic outcome (Beutler, Crago, & Arizmendi, 1986).

Moreover, two recent nationwide surveys of Christian clergy found little support for shared values desired by clergy as a prerequisite to collaborate with clinicians. In a January 2004 survey, Christian clergy described their willingness to collaborate with either a male or a female psychologist trained at one of three

types of institution: public university, Christian college, or Protestant seminary (McMinn, Ammons, et al., 2005). Rather than a clear preference, the researchers found great variance in the clergy's willingness to collaborate. One minister ruled out collaboration, stating, "I came to the conclusion that Christianity and psychology are on different pages. I cannot blend the two together" (p. 13). Another minister was concerned that the collaborating psychologist would be too theologically conservative: "I would not refer people to her or consult with her if she taught a patriarchal view of marriage or insisted mental/emotional problems were the result of personal sin" (p. 13). In a January 2005 survey, ministers of the Southern Baptist Convention, a predominantly conservative denomination, answered a survey examining specific characteristics that would influence their collaboration with psychologists (McMinn, Runner, Fairchild, Lefler, & Suntay, 2005). The researchers concluded that even these conservative clergy were not "looking for collaborators that fit in neat demographic categories or go by particular labels" (p. 307). Rather, they concluded, collaborators should focus on "the time-honored work of building an effective relationship" (p. 308).

The research reviewed above led us to ask these three questions:

1. How can we build effective collaborative relationships across this diversity of psychologists and clergy?

2. How then can reciprocal collaboration facilitate and sustain the continuity of mental health care provided to individuals with multiple levels of functioning?

3. How also can collaboration facilitate and sustain healthy functioning for the majority of persons who are members of religious communities?

We propose a *religion-inclusive* model. Our religion-inclusive model reflects Kelly and Strupp's (1992) finding that "matching of patients with the therapists by religious orientation would involve not so much the therapists' personal religious convictions as their ability to understand and deal sensitively with their patients' specific religious values" (p. 39). The religion-inclusive model has two steps. The first is to assess the role of religion in an individual's life. The second is to educate oneself about that religious tradition. With consent, this includes contact with the patient's own clergy. We have found that an inclusive, respectful model of interaction can involve a wide array of clergy and clinicians who collaborate to improve and maintain the emotional well-being of persons in our mutual care.

Description of the Program

Since 1998, we have developed a multidisciplinary, multifaith, and research-focused program titled Clergy Outreach and Professional Engagement (C.O.P.E.). The program was initiated at a community mental health center affiliated with an urban medical school in a primarily African American community (Milstein, Sims, & Liggins, 1999). Glen Milstein and Amy Manierre (a clinical psychologist and an ordained American Baptist minister and certified chaplain, respectively) extended the program's outreach at a suburban, primarily European American, 229-bed psychiatric facility with extensive ambulatory services that is also a teaching facility in the department of psychiatry of a major urban medical school. The C.O.P.E. program has recently moved to an urban public university in a primarily Latino and African American community.

The C.O.P.E. program facilitates reciprocal collaboration between clinicians and community clergy, regardless of their religious traditions. We approach our interprofessional relationships using the resource collaborator model (Tyler, Pargament, & Gatz, 1983), which recommends that "participants acknowledge their own and each other's resources and limitations, share their resources, and recognize their reciprocal gains" (p. 388). We share a single outcome measure of successful collaboration: the emotional well-being of the persons in our mutual care.

Two central ideas guide the C.O.P.E. program. The first is that clergy (with their discrete expert knowledge about religion) and clinicians (with their discrete expert knowledge about mental health care) can better help a broader array of persons with emotional difficulties and disorders through professional collaboration than they can by working alone (Gorsuch & Meylink, 1988; Milstein, 2003). The second idea—which we emphasize in all programming—is that to perpetuate collaboration, clergy and clinicians must find their work eased by C.O.P.E. One must design programs so that they result in *burden reduction* for each group.

We define *burden reduction* as follows: a reduced need for one group of service providers to deliver direct care as a result of sharing expertise with service providers from another group or profession. The objective of C.O.P.E. is to improve the care of individuals by reducing the caregiving burdens of clergy and clinicians through consultation and collaboration. Burden reduction could also be applied to collaboration with families (Milstein, Guarnaccia, & Midlarsky, 1995; Razali, Hasanah, Khan, & Subramaniam, 2000).

C.O.P.E. Handout Development and Use via Prevention Science

We used the four prevention categories from the National Institute of Mental Health (NIMH; Gordon, 1987; National Advisory Mental Health Council Workgroup on Mental Disorders Prevention Research, 1998, 2001; see Figure 1) to develop two handouts: one designed for mental health professionals (Figure 2) and the other for clergy (Figure 3). These handouts describe four stages of care; they illustrate when it would be appropriate for clergy to contact clinicians and for clinicians to contact clergy.

Figure 1 provides the NIMH prevention category definitions under their headings. In this diagram, the comparative size of the areas of the rectangles illustrates the proportion of the population targeted to receive each prevention intervention. The level of shading in each rectangle shows the level of risk of impairment to the people receiving the intervention. As one goes down the four categories, the proportion of the population is therefore progressively smaller, whereas the level of risk to the individual is progressively greater: (a) universal, (b) selective, (c) indicated, and (d) relapse and comorbidity prevention. The universal stage describes facilitation of healthy lifestyles rather than clinical treatment of dysfunction (Seligman & Csikszentmihalyi, 2000).

We created Figure 2 to educate mental health professionals about the roles of clergy across these prevention categories. It shows how the multiple professional roles of clergy mirror the four NIMH prevention categories: (a) Universal: clergy understand the normative context of people's experience (Shifrin, 1998; Ware et al., 1999), (b) selective: clergy—and their congregations—are

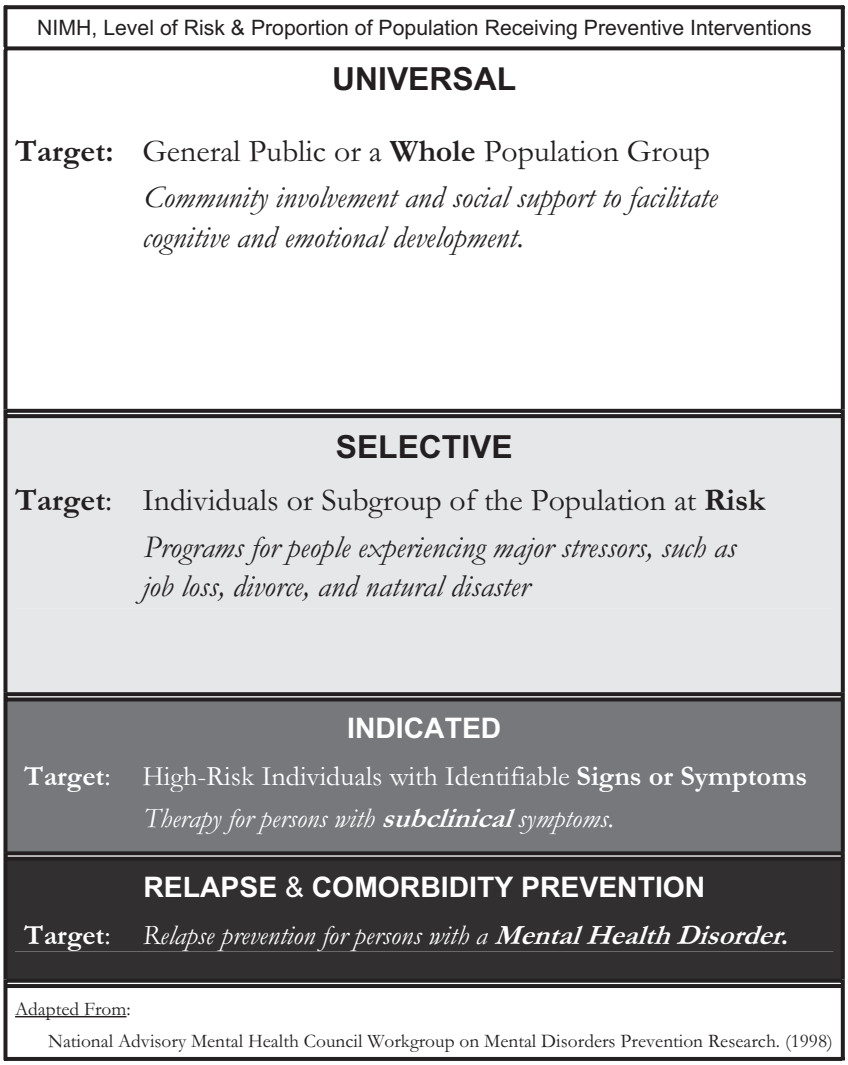

Figure 1. National Institute of Mental Health (NIMH) prevention science categories with examples of types of prevention interventions. Adapted from *Priorities for Prevention Research at NIMH* (NIH Pub. No. 98-4321), by National Advisory Mental Health Council Workgroup on Mental Disorders Prevention Research, 1998, Rockville, MD: NIMH.

sources of social and emotional support in times of stress (Pargament, 1997), (c) indicated: clergy are de facto gatekeepers for persons who need assessment by a mental health professional to determine whether they require clinical intervention and care (Wang et al., 2003), and (d) relapse and comorbidity prevention: clergy provide community reinforcement for adherence to treatment. Religious organizations also provide support to families of persons with mental illness (Govig, 1999; Milstein et al., 1995).

We created Figure 3 to use in outreach programs with local clergy and lay congregation leaders. This single sheet allows us to visually and conceptually describe a hierarchy of mental health needs of persons in their communities. The sheet follows the NIMH prevention categories without using their technical language. The shading, the font color, and the content of the rectangles communicate when to collaborate. The diagram begins with an unshaded box, which recognizes the mental health support provided by the clergy and their congregations and acknowledges that these normative relationships do not require the presence of clinicians. The increased shading represents increasing severity of psychological distress. The switch from statements to questions, as well as the switch in font color from black to white in the third box, represents situations that would involve contact with mental health clinicians by clergy.

The first stage described in Figures 2 and 3 recognizes that healthy adults may further their psychological well-being by taking part in the "generative" activities of the church, synagogue, mosque, temple, etc. (de St. Aubin, McAdams, & Kim, 2004; Erikson & Erikson, 1997; McAdams & de St. Aubin, 1998) and that they may benefit from many other positive social support aspects of religious community involvement (Gottlieb, 1983; Myers, 2000). In the second stage, when there are emotional difficulties (e.g., a person is bereaved by the loss of a

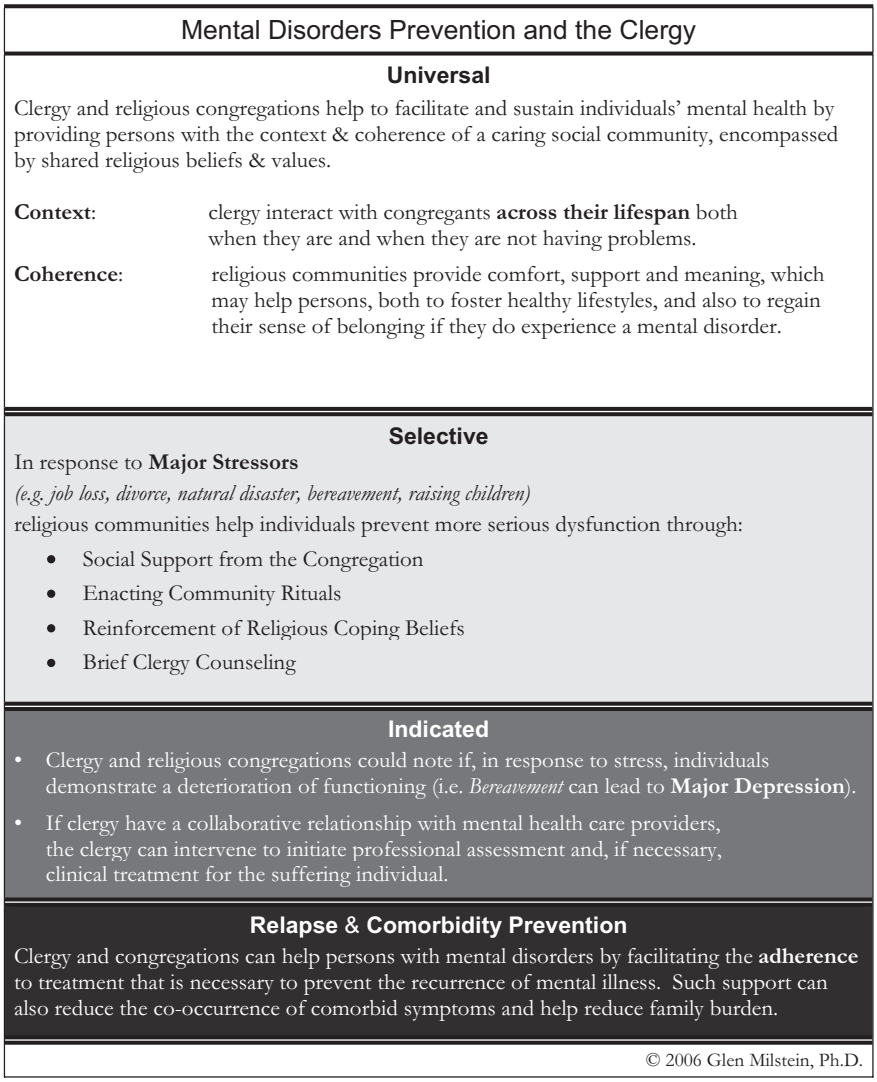

Figure 2. Handout for mental health professionals' "inreach."

spouse), the clergy and religious community provide social support that can help the individual cope (Pargament, 1997). Depending on the wisdom traditions (Hopkins, Woods, Kelley, Bentley, & Murphy, 1995) and theological orientation of an individual's religion, at this stage the congregation may provide faith-based rituals of support. These first two stages describe normative parts of the multifaceted duties of clergy (Blizzard, 1956; Milstein et al., 2005).

Epidemiological data show that bereavement greatly increases the risk of depressive episodes, which may well require clinical intervention (Bruce, Kim, Leaf, & Jacobs, 1990). Clergy, as persons who regularly comfort grieving families, could be the first to recognize signs of clinical depression. At the third stage, the clergy could be instructed to call on the clinician's expertise to determine whether the congregant has a major depressive disorder or other clinical needs (Holmes & Howard, 1980; Weaver & Koenig, 1996). Now the parishioner may need to receive professional mental health care to reduce disorder and to regain function (New Freedom Commission on Mental Health, 2003). In our dialogues with Christian clergy—and in national surveys of imams (Ali, Milstein, & Marzuk, 2005) and rabbis (Milstein, Midlarsky, Link, Raue, & Bruce, 2000)—clergy recognized a distinction between bereavement and depression but did not know how to collaborate with mental health professionals. The C.O.P.E. program is designed to provide burden reduction to clergy at this stage by facilitating referrals to clinicians.

In the fourth stage, the patients' symptoms subside and function increases, but they remain at risk for relapse. At this stage, religious involvement can help persons both improve and maintain their mental health (Braam, Beekman, Deeg, Smit, & van Tilburg, 1997; Kennedy, Kelman, Thomas, & Chen, 1996; Koenig, George, & Peterson, 1998; Milstein et al., 2003). This stage is an opportunity for what Rosen (2006) called "role restoration" (p. 23) and a return to the first stage. This may provide burden reduction to clinicians by diminishing relapse.

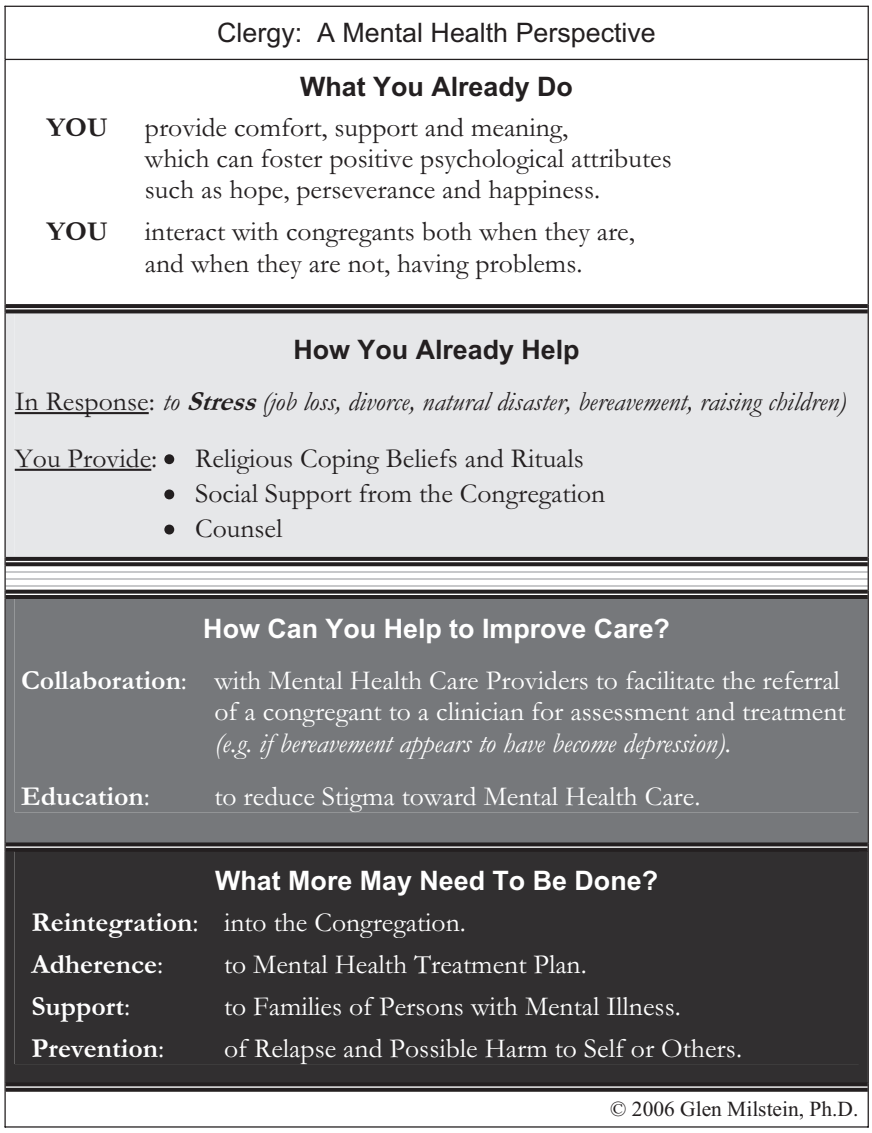

Figure 3. Handout for clergy outreach.

Implementation of the C.O.P.E. Program

Clinician "Inreach"

Before engaging clergy through community outreach, we began work with our fellow clinicians through an institutional inreach. We first described the multiple roles of religion in people's lives and how religion and spirituality could contribute to people's emotional well-being (Pargament, 1997; Shifrin, 1998; Sullivan, 1998). We then sought to explain how working with clergy could actually reduce clinicians' professional burden. The Department of Pastoral Care and Education in our hospital presented a grand rounds that reviewed the historical role of chaplains as members of the clinical team (Hart & Matorin, 1997; VandeCreek, Parker, & Carl, 1998) and spirituality groups as part of patient treatment (Hopkins et al., 1995). Practical models for clinician and clergy collaboration were also presented (Gorsuch & Meylink, 1988; Milstein, 2003; Tyler et al., 1983).

We then conducted a targeted inreach to the social work staff, as these clinicians are primarily responsible for carrying out patient discharge plans. During the inreach to the social work department, we described the importance of persons' religious communities and the possible utility of including patients' clergy in their discharge planning (with patient consent). The availability of this additional community resource provides a burden reduction to clinicians who wish to minimize the chance for their patients' relapse. The hope is that the person will eventually return to and remain in the first stage of normative community involvement (Figure 2). This inreach effort led to the development of religion-inclusive intake questions designed to assess levels of religious involvement and, when applicable, the patients' religious affiliations in the community. These forms were completed by the social workers during intake and led to an increase of time spent by the chaplain providing spiritual and religious information for use by hospital clinicians

as well as the direct involvement of some community clergy in the discharge planning of patients.

Clergy Outreach

Once we sensitized our own institution, we began to conduct our outreach program. We first attended the monthly meetings of a local interdenominational group of clergy. The clergy welcomed our participation in their group and, over time, described the complex and at times isolating burden of their profession. At the request of the clergy group, hospital personnel led discussions on borderline personality disorder and depression, as well as historical views of the *Diagnostic and Statistical Manual of Mental Disorders* toward homosexuality. The hospital also hosted an interethnic clergy dialogue, and Amy Manierre participated in a citywide September 11th commemoration led by community clergy.

We also invited local Muslim, Orthodox Jewish, and Jehovah's Witness representatives to the hospital to share information about their particular religious traditions and to engage with interested clinicians in discussions about their mental health perspectives and concerns. Through these didactic sessions, moderated by the chaplain, our clinicians gained a greater understanding of the cultural priorities of these groups, and we built bridges between the clinical and religious lives of those persons in our collective care.

The hospital hosted a half-day symposium titled *Practical Solutions for Responding to the Challenging Congregant.* More than 30 clergy attended the symposium, as did representatives from each professional discipline within our hospital. One goal of the program was to describe to clergy the resources available at the hospital and allow them to directly question clinicians from all units. The clergy in attendance included Catholic priests, Orthodox rabbis, and Protestant ministers.

A second goal was to present the four stages (Figure 3) of clergy action based on the NIMH prevention model (Gordon, 1987; Milstein & Bruce, 2000; National Advisory Mental Health Council Workgroup on Mental Disorders Prevention Research, 1998). With this model, we demonstrated both that we recognize the important role of clergy in the continuity of people's mental health care and that collaboration could reduce their counseling burden.

During the symposium, we asked the clergy to write a brief paragraph about any particularly challenging congregant they wished to discuss. This allowed clergy to engage clinicians in the third stage (Figure 3) of the C.O.P.E. model by providing a preliminary assessment of their congregant difficulties. We collected these forms at the end of the symposium. Five different clergy asked for assistance. Two of the clergy described persons who appeared to have psychotic disorders. Two described persons who appeared to have Axis II difficulties, and one described a troubled family. This resulted in three meetings with the clergy, one for each category of problem.

Virginia L. Susman, the associate medical director of the hospital, led the meetings. Clergy who described congregants who appeared to have similar problems met in a seminar format with our clinical and pastoral care staff. The clergy briefly described their congregants. Then the consultation focused on basic understanding of clinical syndromes and potential intervention strategies. Because most counseling by clergy is a responsibility they carry out alone, these seminars offered them a rare opportunity to compare with one another examples of their parishioners' problems and their counseling experiences.

One area of discussion was how to balance an individual parishioner's counseling needs with the collective needs of the congregation. A second area the clergy discussed was the importance of—and strategies for—limit setting with congregants. A third topic of our discussion was ways to distinguish religious devotion from scrupulosity and obsessive behaviors, given that whereas obsessive–compulsive disorder is often expressed with religious content, religion is not a determinant of the disorder (Tek & Ulug, 2001). These discussions offered the clergy peer support and helpful clinical information, which the participants subsequently praised.

Further requests for consultation came after the C.O.P.E. program was written about in our local paper (Lombardi, 2000). Clinicians asked us to evaluate whether some patients' behaviors were normative within their religion. We then consulted denominational clergy, with whom we had developed working relationships, to help with the evaluation as necessary. Clergy also called on us to assess whether congregants' behavior might require clinical care. We then consulted clinical specialists at the hospital to help with the evaluation. Two case examples of reciprocal collaboration with clergy are described below. The first describes outreach to clergy by clinicians. The second describes consultation with clinicians by clergy. The names have been changed.

Case Examples of C.O.P.E.

Clergy Outreach by Clinicians

Connie was a 39-year-old European American single woman with psychiatric diagnoses of major depressive disorder, recurrent, and borderline personality disorder. Not long after our inreach seminar for hospital social workers on assessing spirituality and religious involvement, the pastoral care department received a social work referral for Connie. Connie's proposed discharge date had been postponed because she became too symptomatic for a safe discharge. Her religion-inclusive assessment revealed that she relied strongly on her faith and evangelical church affiliation for social and spiritual support. The team hoped that religious community support might help Connie cope with her rescheduled hospital discharge. At the request of the social worker, the chaplain met with Connie and asked her whether her pastor could be contacted and included in her discharge planning. Connie consented to this, recognizing that she would need her pastor's support during this transition.

The chaplain called her clergy, Pastor Tom, to invite him to this meeting. Pastor Tom was apprehensive about meeting with the clinical team. He was uncertain whether the team would respect and understand his evangelical beliefs. The chaplain assured him that the team shared his goal to help Connie become a healthy and contributing member of society when she returned to his congregation. Pastor Tom acknowledged that Connie was a very difficult congregant, stating that at coffee hour after service, Connie once told a parishioner that she was planning her suicide but asked that it be kept in confidence. The person told Pastor Tom but felt that he had violated Connie's trust. The pastor recognized that Connie's behavior was disruptive to the church but was uncertain how to proceed. The chaplain and the clinical team considered this

pastoral concern when preparing for their meeting with Pastor Tom and Connie.

When he arrived at the hospital, Pastor Tom was greeted by the chaplain and then taken to a meeting with Connie's social worker. Pastor Tom discussed his ministry to Connie with the treatment team as well as his concerns about her return to his church. The team explained to Pastor Tom that many of Connie's behaviors were symptoms of her borderline personality disorder and that it is important to set limits for people suffering with this illness. The following contract was created to help Connie and Pastor Tom when she returned home:

> I hereby agree to the following terms:
>
> - I will not give information to members of the congregation and then ask them to withhold this information from others.
> - I will attend a weekly Bible study group agreed upon with Pastor Tom.
> - I am aware that Pastor Tom will call 911 if I discuss suicidal intent with him or anyone else in my congregation.
> - I will call Pastor Tom with questions regarding my religious beliefs/Bible passages, anytime Monday through Friday from 9 a.m. to 5 p.m.
> - I will be truthful with Pastor Tom and with other members of my congregation.

Soon after this meeting, Connie was discharged as planned. She continued in treatment at an outpatient day program, which she completed. This process can be seen as a move from the third to the fourth stage of C.O.P.E. (Figures 2 and 3).

We called Pastor Tom to follow up on this outreach effort 4 years later. He said that he referred to the contract several times after Connie first returned to the church. He found this was a useful tool in holding Connie accountable for her actions. Pastor Tom felt that this encounter also helped him support Connie's goal of becoming healthy and added that she had not been hospitalized since. For now, Connie is in the first stage of C.O.P.E. (Figures 2 and 3). Pastor Tom said he feels that creating a care team of people who understand the issues and goals for a difficult congregant is consistent with his Biblical principles and enhances the ministerial outreach of his church.

Clinical Consultation by Clergy

A Catholic priest who received training in the C.O.P.E. model described a second example. Father James works in a predominantly Latino, Spanish-speaking parish. He was summoned to the apartment of a woman, Maria, who he was told was in distress. He reported that when he arrived, in the middle of the afternoon, he found her clothed only in a nightgown and speaking quickly and excitedly. She told the priest that she had had a vision of the devil attacking her; she tried to call a friend but could not use the phone. She said that the vision had left before the priest arrived, and now she felt comfort and ease in his presence. He asked Maria whether she received any medical care. She gave him the phone number of her social worker, whom he called. The social worker then thanked Father James and sent an evaluation team. The woman, who had a history of bipolar disorder, was hospitalized that afternoon. Father James described his tension and concern that he had "ratted out" a parishioner. After further discussion with Glen Milstein, he asked a fellow priest, Father Roger, who is a chaplain at their local hospital, to visit Maria. Two weeks later Maria was out of the hospital and returned to church services. She told Father James how grateful she was for his interest and particularly for the visit from Father Roger.

Father James later said that before his exposure to C.O.P.E. he would have quickly left the apartment and called the police. By calling Maria's social worker, he helped transition Maria from the second to the third stage of C.O.P.E. (Figures 2 and 3). By asking Father Roger to visit Maria, Father James was able to engage the mental health care system and moved Maria from the third to the fourth stage, maintaining continuity in his parishioner's life.

The importance of visitation from members of one's church was confirmed by a Baptist minister in a predominantly African American community, who reported that after her exposure to C.O.P.E., she—for the first time (and with the congregant's permission)—recommended that members of the church who were visiting the hospital should also visit the psychiatric unit. The parishioner, who had been hospitalized before but never visited, was very grateful.

Summary

The first step in our C.O.P.E. program was to conduct an inreach to our own institution to educate our clinical staff to recognize the importance of religion and religious communities for individuals under our care. To ensure a continuity of care as well as an exchange of knowledge from the community to the hospital and back to the community, it was indispensable to have a staff chaplain who could maintain relationships with local clergy and "translate" between the clergy and clinicians (VandeCreek et al., 1998).

Our work follows the resource collaborator model and seeks reciprocal collaboration (Pargament & Maton, 2000; Tyler et al., 1983). Our goals are the same as those described in the first article on collaboration with clergy, published over 30 years ago, in *PPRP* (Levenberg, 1976): "Employ a nonthreatening avenue of approach to effect working referral relationships" (p. 556). Through a gradual, religion-inclusive approach, we have facilitated collaboration between expert clinicians and a wide diversity of clergy, including Armenian Orthodox; Catholic; Ethical Culture; Hindu; Muslim; Orthodox, Conservative, Reconstructionist, and Reform Jewish; as well as evangelical and mainline Protestant.

In the C.O.P.E. model, clinicians need not wait for clergy to initiate a dialogue. Outreach to clergy also need not be limited to institutions. Individual psychologists can begin their own C.O.P.E. program by contacting local interfaith clergy groups and asking to attend their meetings. Clinicians could also begin a C.O.P.E. program by entering into a dialogue with a local hospital chaplain (Milstein et al., 1999). One can organize the collaboration discussions with the handouts provided in this article (Figures 2 and 3). The key to success is to develop ongoing reciprocal relationships (McMinn & Dominguez, 2005; Meylink & Gorsuch, 1988; Piedmont, 1968), which can offer burden reduction to both clinicians and clergy.

To describe the C.O.P.E. continuity of care model, we use the term *religion inclusive* rather than *faith based*. The term *religion inclusive* incorporates the spectrum of care—as well as the breadth of collaborators—described above. We recognize that religion is not primarily a clinical activity (Funder, 2002; Milstein, 2004), and we recognize the importance of faith-based rituals of support for some religious persons' emotional well-being (Shifrin, 1998; Sul-

livan, 1998). We proffer that in the first two stages of C.O.P.E. (Figures 2 and 3), it is clergy who are the religious experts; it is clergy who in many traditions serve their congregations through an ordained vocation, and it is therefore clergy who best facilitate religious rituals. It is in the third stage of C.O.P.E. that psychologists, as experts in mental health care, provide professional assessment and interventions to persons from religious communities. Regardless of the clinicians' own religiosity, they can provide psychotherapy, which may be inclusive of religious themes informed by consultation with an individual patient's clergy (with consent). In the fourth stage of C.O.P.E., clergy and clinicians use their individual expertise to prevent relapse.

Collaboration with clergy and religious institutions is an opportunity, not a panacea. Several projects, such as C.O.P.E., have found positive outcomes through diversity-inclusive religious collaboration (Anderson et al., 1978; Aten, 2004; Budd, 1999; Levenberg, 1976). Yet religious disappointment and struggles can harm a person's well-being, manifested by anxiety, depression, suicidality, and medical comorbidity (Exline, Yali, & Sanderson, 2000; Fitchett, Rybarczyk, DeMarco, & Nicholas, 1999; Goodstein, 2003; Hill & Hood, 1999; Krause, Ingersoll-Dayton, Ellison, & Wulff, 1999; Wolfe, Jaffe, Jette, & Poisson, 2003). Certainly, it would be a mistake to uncritically seek collaboration if patients have such a history or are in any way disinclined to inform their clergy of their treatment. We must assess and treat each patient individually, without an assumption that religion is good or bad (Pargament, 2002).

Our collaboration with religious leaders has expanded the scope of our clinical work, and C.O.P.E. has shown great promise for improving the continuity of mental health care through burden reduction for both clergy and clinicians. Future research could further examine clinical outcomes of collaboration, and, when possible, compare the efficacy of different collaboration models facilitated with different populations by an array of clergy and clinicians. Another goal is to try to reduce stigma toward mental illness and increase the willingness to seek mental health care at the community level through intervention in churches, synagogues, mosques, temples, etc. (Corrigan & Penn, 1999; Milstein et al., 2005). C.O.P.E. describes a de facto system of care. It therefore could be useful to implement a systems thinking methodology for future studies (Leischow & Milstein, 2006; Midgley, 2006; Sterman, 2006).

In examining the clinical value of C.O.P.E., we return to our primary outcome measure for success: the emotional well-being of the persons in our collective care. Dissemination of an empirically validated model that improves the continuity of mental health care through clergy outreach and professional engagement could benefit millions of people who attend the more than 260,000 religious congregations across the United States.

References

Adair, C. E., McDougall, G. M., Beckie, A., Joyce, A., Mitton, C., Wild, C. T., et al. (2003). History and measurement of continuity of care in mental health services and evidence of its role in outcomes. *Psychiatric Services, 54,* 1351–1356.

Ali, O., Milstein, G., & Marzuk, P. (2005). The imam's role in meeting the counseling needs of Muslim communities in the United States. *Psychiatric Services, 56,* 202–205.

Anderson, R. G., Robinson, C., & Ruben, H. (1978). Mental health training and consultation: A model for liaison with clergy. *Hospital and Community Psychiatry, 29,* 800–802.

Aten, J. D. (2004). Improving understanding and collaboration between campus ministers and college counseling center personnel. *Journal of College Counseling, 7*(1), 90–96.

Bachrach, L. L. (1981). Continuity of care for chronic mental patients: A conceptual analysis. *American Journal of Psychiatry, 138,* 1449–1456.

Benes, K. M., Walsh, J. M., McMinn, M. R., Dominguez, A. W., & Aikins, D. (2000). Psychology and the church: An exemplar of psychologist–clergy collaboration. *Professional Psychology: Research and Practice, 31,* 515–520.

Bergin, A. E., & Jensen, J. P. (1990). Religiosity of psychotherapists: A national survey. *Psychotherapy: Theory, Research, Practice, Training, 27,* 3–7.

Beutler, L. E., Crago, M., & Arizmendi, T. (1986). Research on therapist variables in psychotherapy. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy* (3rd ed., pp. 257–310). New York: Wiley.

Beutler, L. E., Machado, P. P. P., & Neufeldt, S. A. (1994). Therapist variables. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 229–269). New York: Wiley.

Blizzard, S. W. (1956). The minister's dilemma. *Christian Century, 73,* 508.

Braam, A. W., Beekman, A. T., Deeg, D. J., Smit, J. H., & van Tilburg, W. (1997). Religiosity as a protective or prognostic factor of depression in later life: Results from a community survey in the Netherlands. *Acta Psychiatrica Scandinavica, 96,* 199–205.

Bruce, M. L., Kim, K., Leaf, P. J., & Jacobs, S. (1990). Depressive episodes and dysphoria resulting from conjugal bereavement in a prospective community sample. *American Journal of Psychiatry, 147,* 608–611.

Budd, F. C. (1999). An Air Force model of psychologist–chaplain collaboration. *Professional Psychology: Research and Practice, 30,* 552–556.

Chaddock, T. P., & McMinn, M. R. (1999). Values affecting collaboration among psychologists and evangelical clergy. *Journal of Psychology & Theology, 27,* 319–328.

Corrigan, P. W., & Penn, D. L. (1999). Lessons from social psychology on discrediting psychiatric stigma. *American Psychologist, 54,* 765–776.

de St. Aubin, E., McAdams, D. P., & Kim, T.-C. (2004). *The generative society: Caring for future generations*. Washington, DC: American Psychological Association.

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

Erikson, E. H., & Erikson, J. M. (1997). *The life cycle completed* (extended ed.). New York: Norton.

Exline, J. J., Yali, A. M., & Sanderson, W. C. (2000). Guilt, discord, and alienation: The role of religious strain in depression and suicidality. *Journal of Clinical Psychology, 56,* 1481–1496.

Fitchett, G., Rybarczyk, B. D., DeMarco, G. A., & Nicholas, J. J. (1999). The role of religion in medical rehabilitation outcomes: A longitudinal study. *Rehabilitation Psychology, 44,* 333–353.

Funder, D. C. (2002). Why study religion? *Psychological Inquiry, 13,* 213–214.

Goodstein, L. (2003, January 12). Decades of damage: Trail of pain in church crisis leads to nearly every diocese. *New York Times,* p. 1.

Gordon, R. (1987). An operational classification of disease prevention. In J. A. Steinberg & M. M. Silverman (Eds.), *Preventing mental disorders: A research perspective* (pp. 20–26). Bethesda, MD: National Institute of Mental Health.

Gorsuch, R., & Meylink, W. D. (1988). Toward a co-professional model of clergy-psychologist referral. *Journal of Psychology and Christianity, 7*(3), 22–31.

Gottlieb, B. H. (1983). Social support as a focus for integrative research in psychology. *American Psychologist, 38,* 278–287.

Govig, S. D. (1999). *In the shadow of our steeples: Pastoral presence for families coping with mental illness.* New York: Haworth Pastoral Press.

Hart, C. W., & Matorin, S. (1997). Collaboration between hospital social work and pastoral care to help families cope with serious illness and grief. *Psychiatric Services, 48,* 1549–1552.

Hill, P. C., & Hood, R. W. (1999). *Measures of religiosity.* Birmingham, AL: Religious Education Press.

Holmes, C. B., & Howard, M. E. (1980). Recognition of suicide lethality factors by physicians, mental health professionals, ministers, and college students. *Journal of Consulting and Clinical Psychology, 48,* 383–387.

Hopkins, E., Woods, Z., Kelley, R., Bentley, K., & Murphy, J. (1995). *Working with groups on spiritual themes.* Duluth, MN: Whole Person Associates.

Jernigan, H. L. (1970). Pastoral care and the crises of life. In H. J. Clinebell Jr. (Ed.), *Community mental health: The role of church and temple.* Retrieved July 20, 2005, from http://www.religion-online.org/showchapter.asp?title=798&C=1001

Johnson, W. B., & McMinn, M. R. (2003). Thirty years of integrative doctoral training: Historic developments, assessments of outcomes, and recommendations for the future. *Journal of Psychology & Theology, 31*(2), 83–96.

Jones, D. E., Doty, S., Grammich, C., Horsch, J. E., Houseal, R., Lynn, M., et al. (2002). *Religious congregations and membership: 2000.* Retrieved February 28, 2006, from http://www.glenmary.org/grc/RCMS_2000/findings.htm

Kelly, T. A., & Strupp, H. H. (1992). Patient and therapist values in psychotherapy: Perceived changes, assimilation, similarity, and outcome. *Journal of Consulting and Clinical Psychology, 60,* 34–40.

Kennedy, G. J., Kelman, H. R., Thomas, C., & Chen, J. M. (1996). The relation of religious preference and practice to depressive symptoms among 1,855 older adults. *Journals of Gerontology, Series B: Psychological Sciences and Social Sciences, 51*(6), P301–P308.

Koenig, H. G., George, L. K., & Peterson, B. L. (1998). Religiosity and remission of depression in medically ill older patients. *American Journal of Psychiatry, 155,* 536–542.

Krause, N., Ingersoll-Dayton, B., Ellison, C. G., & Wulff, K. M. (1999). Aging, religious doubt, and psychological well-being. *Gerontologist, 39,* 525–533.

Leischow, S. J., & Milstein, B. (2006). Systems thinking and modeling for public health practice. *American Journal of Public Health, 96,* 403–405.

Levenberg, S. B. (1976). Building consultative relationships with rural fundamentalist clergy. *Professional Psychology, 7,* 553–558.

Lombardi, K. S. (2000, April 30). Helping clergy help the anguished. *New York Times,* p. 1, Section 14WC.

McAdams, D. P., & de St. Aubin, E. (1998). *Generativity and adult development: How and why we care for the next generation*. Washington, DC: American Psychological Association.

McCullough, M. E. (1999). Research on religion-accommodative counseling: Review and meta-analysis. *Journal of Counseling Psychology, 46,* 92–98.

McMinn, M. R., Aikins, D. C., & Lish, R. A. (2003). Basic and advanced competence in collaborating with clergy. *Professional Psychology: Research and Practice, 34,* 197–202.

McMinn, M. R., Ammons, J., McLaughlin, B. R., Williamson, C., Griffin, J. W., Fitzsimmons, C. R., et al. (2005). Collaborate with whom? Clergy responses to psychologist characteristics. In M. R. McMinn & A. W. Dominguez (Eds.), *Psychology and the church* (pp. 9–17). Hauppauge, NY: Nova Science.

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

McMinn, M. R., & Dominguez, A. W. (2005). Introduction. In M. R. McMinn & A. W. Dominguez (Eds.), *Psychology and the church* (pp. i–xiv). Hauppauge, NY: Nova Science.

McMinn, M. R., Meek, K. R., Canning, S. S., & 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.

McMinn, M. R., Runner, S. J., Fairchild, J. A., Lefler, J. D., & Suntay, R. P. (2005). Factors affecting clergy-psychologist referral patterns. *Journal of Psychology & Theology, 33,* 299–309.

Meylink, W. D., & Gorsuch, R. L. (1988). Relationship between clergy and psychologists: The empirical data. *Journal of Psychology and Christianity, 7*(1), 56–72.

Midgley, G. (2006). Systemic intervention for public health. *American Journal of Public Health, 96,* 466–472.

Milstein, G. (2003). Clergy and psychiatrists: Opportunities for expert dialogue. *Psychiatric Times, 20*(3), 36–39.

Milstein, G. (2004). [Review of the books *Handbook of religion and health* and *The link between religion and health: Psychoneuroimmunology and the faith factor*]. *American Journal of Geriatric Psychiatry, 12,* 332–334.

Milstein, G., & Bruce, M. L. (2000, November). *Mental disorders prevention and the clergy.* Paper presented at the meeting of the American Public Health Association, Boston.

Milstein, G., Bruce, M. L., Gargon, N., Brown, E., Raue, P. J., & McAvay, G. (2003). Religious practice and depression among geriatric homecare patients. *International Journal of Psychiatry in Medicine, 33*(1), 71–83.

Milstein, G., Guarnaccia, P. J., & Midlarsky, E. (1995). Ethnic differences in the interpretation of mental illness: Perspectives of caregivers. In J. R. Greenley (Ed.), *Research in community and mental health: The family and mental illness* (Vol. 8, pp. 155–178). Greenwich, CT: JAI Press.

Milstein, G., Kennedy, G. J., Bruce, M. L., Flannelly, K., Chelchowski, N., & Bone, L. (2005). The clergy's role in reducing stigma: Elder patients' views. *World Psychiatry, 4*(S1), 26–32.

Milstein, G., Midlarsky, E., Link, B. G., Raue, P. J., & Bruce, M. L. (2000). Assessing problems with religious content: A comparison of rabbis and psychologists. *Journal of Nervous and Mental Disease, 188,* 608–615.

Milstein, G., Sims, E., & Liggins, L. (1999). Community outreach by a mental health center: A dialogue with clergy. *Community Psychologist, 32*(1), 49–51.

Myers, D. G. (2000). The funds, friends, and faith of happy people. *American Psychologist, 55,* 56–67.

National Advisory Mental Health Council Workgroup on Mental Disorders Prevention Research. (1998). *Priorities for prevention research at NIMH* (NIH Pub. No. 98–4321). Rockville, MD: National Institute of Mental Health.

National Advisory Mental Health Council Workgroup on Mental Disorders Prevention Research. (2001). Priorities for prevention research at NIMH. *Prevention & Treatment, 4*(1).

New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America: Final report* (No. SMA-03–3832). Rockville, MD: Department of Health and Human Services.

Pargament, K. I. (1997). *The psychology of religion and coping.* New York: Guilford Press.

Pargament, K. I. (2002). The bitter and the sweet: An evaluation of the costs and benefits of religiousness. *Psychological Inquiry, 13,* 168–181.

Pargament, K. I., & Maton, K. I. (2000). Religion in American life: A community psychology perspective. In J. Rappaport & E. Seidman (Eds.), *Handbook of community psychology* (pp. 495–522). New York: Kluwer Academic.

Piedmont, E. B. (1968). Referrals and reciprocity: Psychiatrists, general practitioners, and clergymen. *Journal of Health & Social Behavior, 9*(1), 29–41.

Plante, T. G. (1999). A collaborative relationship between professional

psychology and the Roman Catholic church: A case example and suggested principles for success. *Professional Psychology: Research and Practice, 30,* 541–546.

Propst, L. R., Ostrom, R., Watkins, P., Dean, T., & Mashburn, D. (1992). Comparative efficacy of religious and nonreligious cognitive–behavioral therapy for the treatment of clinical depression in religious individuals. *Journal of Consulting and Clinical Psychology, 60,* 94–103.

Razali, S. M., Hasanah, C. I., Khan, U. A., & Subramaniam, M. (2000). Psychosocial interventions for schizophrenia. *Journal of Mental Health, 9,* 283–289.

Regier, D. A., Narrow, W. E., Rae, D. S., & Manderscheid, R. W. (1993). The de facto US mental and addictive disorders service system: Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry, 50*(2), 85–94.

Roozen, D. A., McKinney, W., & Thompson, W. (1990). The "Big Chill" generation warms to worship: A research note. *Review of Religious Research, 31,* 314–322.

Rosen, A. (2006). Destigmatizing day-to-day practices: What developed countries can learn from developing countries. *World Psychiatry, 5*(1), 21–24.

Schindler, F., Berren, M. R., Hannah, M. T., Beigel, A., & Santiago, J. M. (1987). How the public perceives psychiatrists, psychologists, nonpsychiatric physicians, and members of the clergy. *Professional Psychology: Research and Practice, 18,* 371–376.

Seligman, M. E. P., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist, 55,* 5–14.

Shafranske, E. P., & Malony, H. N. (1990). Clinical psychologists' religious and spiritual orientations and their practice of psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 27,* 72–78.

Shifrin, J. (1998). The faith community as a support for people with mental illness. *New Directions for Mental Health Services, 80,* 69–80.

Sterman, J. D. (2006). Learning from evidence in a complex world. *American Journal of Public Health, 96,* 505–514.

Sullivan, W. P. (1998). Recoiling, regrouping, and recovering: First-person accounts of the role of spirituality in the course of serious mental illness. *New Directions for Mental Health Services, 80,* 25–33.

Tek, C., & Ulug, B. (2001). Religiosity and religious obsessions in obsessive-compulsive disorder. *Psychiatry Research, 104*(2), 99–108.

Tyler, F. B., Pargament, K. I., & Gatz, M. (1983). The resource collaborator role: A model for interactions involving psychologists. *American Psychologist, 38,* 388–398.

VandeCreek, L., Parker, D., & Carl, D. (1998). The role of nonparish clergy in the mental health system. In H. G. Koenig (Ed.), *Handbook of religion and mental health* (pp. 337–348). San Diego, CA: Academic Press.

Wang, P. S., Berglund, P. A., & Kessler, R. C. (2003). Patterns and correlates of contacting clergy for mental disorders in the United States. *Health Services Research, 38,* 647–673.

Ware, N. C., Tugenberg, T., Dickey, B., & McHorney, C. A. (1999). An ethnographic study of the meaning of continuity of care in mental health services. *Psychiatric Services, 50,* 395–400.

Weaver, A. J., & Koenig, H. G. (1996). Elderly suicide, mental health professionals, and the clergy: A need for clinical collaboration, training, and research. *Death Studies, 20,* 495–508.

Weaver, A. J., Samford, J. A., Kline, A. E., Lucas, L. A., Larson, D. B., & 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.

Wilkinson, I. (1978). The public and the help-giving professions in Australia. *Professional Psychology, 9,* 692–699.

Wolfe, D. A., Jaffe, P. G., Jette, J. L., & Poisson, S. E. (2003). The impact of child abuse in community institutions and organizations: Advancing professional and scientific understanding. *Clinical Psychology: Science & Practice, 10,* 179–191.

Worthington, E. L., Jr., McCullough, M. E., Sandage, S. J., & Kurusu, T. A. (1996). Empirical research on religion and psychotherapeutic processes and outcomes: A 10-year review and research prospectus. *Psychological Bulletin, 119,* 448–487.

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