

Psychological Care for Persons of Diverse Religions: A Collaborative Continuum

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The purpose of this paper is to describe to psychologists and other clinicians a continuum of mental health care for persons of diverse religions. The continuum delineates boundaries between clinical care provided by mental health professionals and religious care provided by clergy, as well as describes pathways of collaboration across these boundaries. A prevention science based model of Clergy Outreach and Professional Engagement (COPE) is offered to guide this collaboration. The model describes a continuum that moves from the care already present in religious communities, through professional clinical care provided in response to dysfunction and returns persons to their own spiritual communities. One challenge for clinicians is that in addition to a wide diversity of beliefs and practices across religions, there is great ethnic diversity within religions. These diversities are reflected in varied correlations with mental health outcomes. Therefore, we recommend that clinicians assess religious beliefs and their cultural variations when designing religious inclusive psychotherapy specific to the client. There are ethical concerns as to the place of religion in clinical care. The “Resolution on Religious, Religion-Based and/or Religion-Derived Prejudice” adopted by the American Psychological Association has stated that it is not the role of professional psychologists to be spiritual guides. Through spiritual assessment of clients and strategic collaboration with religious leaders via COPE, mental health professionals can focus their efforts on clinical care that respects and incorporates the religious views of clients and does not attempt to recreate the lived religions of the clients’ communities.

Keywords: religion, continuity, recovery, military, stigma

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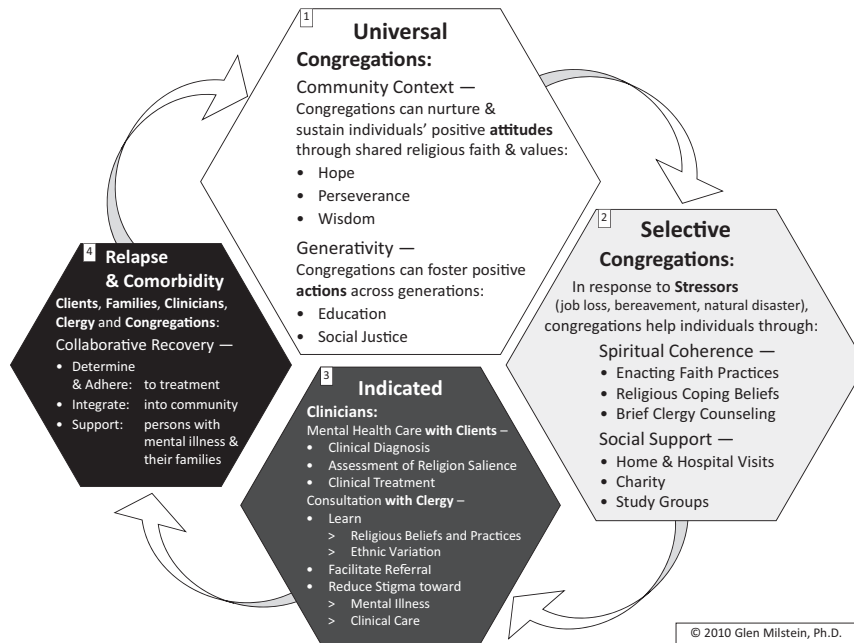


Figure 1. A continuum of care through Clergy Outreach and Professional Engagement (COPE).

four-part model of Clergy Outreach and Professional Engagement (COPE) that (1) recognizes the positive psychological attitudes developed through community membership and actions (Seligman & Csikszentmihalyi, 2000); (2) describes the spiritual and social support available to persons whose life stressors can be ameliorated within the context of their religious communities; (3) promotes professional clinical assessment and treatment for persons of diverse religions with serious emotional problems or mental disorders; and (4) supports the recovery of persons with persistent mental disorders, through ongoing collaboration between these individuals, their clinicians, and their religious communities. These dynamic and changing elements of collaboration along the COPE continuum facilitate clinicians' ability to assess, understand, and engage the many religious values of their clients (Kelly & Strupp, 1992; Milstein & Manierre, 2009).

This paper is presented in two sections. In the first section, we identify complex challenges to providing inclusive professional mental health care to persons of many different religions. In the second section, we proffer practical methods to improve clinical care to persons of diverse religions through collaboration between clinicians and clergy.

Challenges to Inclusive and Ethical Professional Practice

We begin with a description of the demographic diversity of religions in the United States and then review research documenting some of the positive and negative correlations between religion and mental health. We then discuss the "profound differences between psychology and religion/spirituality" described in the "Resolution on Religious, Religion-Based and/or Religion-Derived Prejudice" of the American Psychological Association (2008, pp. 432-433). From these differences will emerge a chal-

lenge: how can we ethically follow the guidelines of this resolution while also engaging the deeply held religious and spiritual beliefs and practices of our clients?

Prevalence and Diversity of Religions

In the United States, there is a large prevalence of religious participation, which encompasses a diversity of beliefs, practices, and ethnicities. Over 140,000,000 persons (50.2%) are congregants of at least one of the more than 260,000 religious congregations, which in turn affiliate with at least one of 149 different denominational groups (Jones et al., 2002). Each theologically distinct religious community (i.e. church, synagogue, mosque, temple) represents a spiritual congregation whose beliefs and practices are consistent with their faith and wisdom traditions (Hopkins, Woods, Kelley, Bentley, & Murphy, 1995).

The United States has great religious diversity. While the majority of people in the United States are Christian (76%), the percentage has gone down steadily since 1990 (86%). Now, there are emerging communities of Hindus, Muslims, and Buddhists. Since 1990, the number of Muslims and Buddhists in the United States has more than doubled, and the number of Hindus has more than tripled (Kosmin & Keysar, 2009).

Within religions, there is increasing ethnic diversity (Figure 2). Among Catholics over 70 years of age, 85% are White and 12% are Latino. Among Catholics aged 18 to 30, 47% are White and 45% are Latino. Among Protestants over 70 years of age, 83% are White, 12% are Black, and 2% are Latino. Among Protestants aged 18 to 30, 61% are White, 23% are Black, and 10% are Latino. Islam is the most ethnically diverse religion in the United States: 37% are White; 24% are Black; 24% are Asian, and 4% are Latino (Pew Forum on Religion & Public Life, 2008).

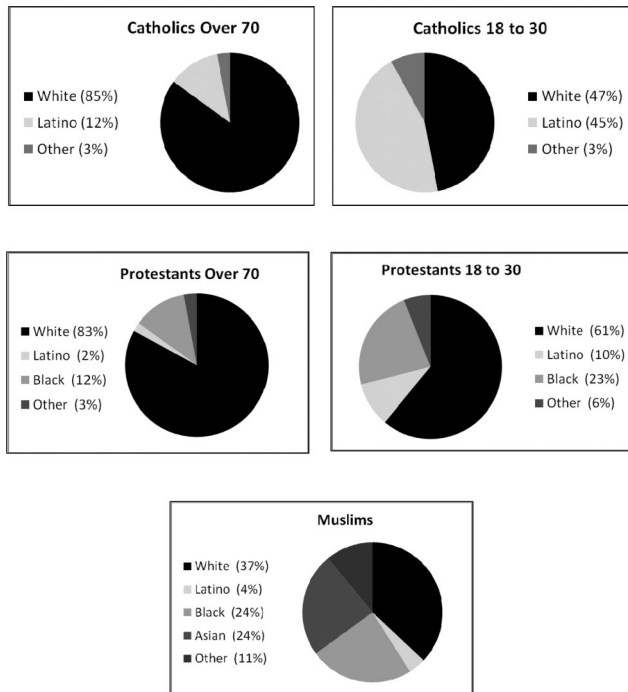


Figure 2. The changing ethnic diversity of Catholics and Protestants, as well as the ethnic diversity of Muslims in the United States. Figure created by the author using data from the *U.S. Religious Landscape Survey* (Pew Forum on Religion & Public Life, 2008).

Despite this increasing ethnic diversity within religions, there is little diversity within individual religious congregations (Chaves & Anderson, 2008). One study found that in 87% of congregations, 90% of the congregants were of the same ethnic group (Wedam, 1999).

What the above data illustrate is that it is incorrect to conceptualize religion as a single construct. The diversity of religions is defined by beliefs and practices as well as by culture and ethnicity. To understand the specific religious experiences of clients, clinicians must assess each client's religious affiliation, their level of personal identification, as well as their religion's denominational and ethnic influences. As the influence of religion on mental health can be both positive and negative, clinicians also need to review the client's personal religious history (Pargament, 2002).

The disparate influences of religions on mental health, helpseeking, and psychotherapy are described in multiple psychology texts. One example is "The Handbook of Psychotherapy and Religious Diversity," offering twelve chapters that describe distinct individual (or grouped) denominations and an additional four chapters examining specific ethnic influences in the religious context of individuals (Richards & Bergin, 2000). The website of the *Center of Excellence in Culturally Competent Mental Health* provides a series of "Cultural Profiles" that include information on the influence of religious and spiritual beliefs on interpretations of mental illness and subsequent helpseeking across diverse ethnicities (<http://ssrdqst.rfmh.org/cecc/index.php?q=node/5>). The *Southern Medical Journal* has published a series of brief articles in its "Eye on Religion" series, which describe religious practices and beliefs that pertain to health and helpseeking within several religions that

are not well-known across the United States. These include Hinduism (Mysorekar, 2006), Buddhism (Arond, 2006; Nakasone, 2007), and Bahá'í (Kourosh & Hosoda, 2007). Articles in the series also describe the interface of religious belief and health within Chinese (Visscher, 2006a) and Japanese (Visscher, 2006b) cultures. Although these websites, chapters and articles provide an overview of religious diversity pertinent to mental illness and treatment, they offer generalizations about beliefs and practices.

A more detailed and accurate picture is gleaned from local clergy whose religious interpretations and ethnicity both reflect and may influence the life of the mental health professionals' clients. Clinicians can turn to local clergy in order to learn specific information about religions, as well as about cultures different from their own. Such communication could, in turn, help clergy understand the role of psychology and psychotherapy in helping persons respond to emotional distress. Over time, clergy and clinician collaboration could help to combat the stigma that is prevalent toward mental illness and mental health care (Corrigan, 2004; Hinshaw, 2007; Milstein et al., 2005). Such an ongoing reciprocal relationship could also lead to increased referrals from clergy to clinicians.

Mental health professionals would make initial contact with clergy after both assessing that such outreach is important to the client and after receiving consent. Another option is for clinicians to contact local clergy as a professional courtesy, in order to begin a dialogue about the possibility for mutual education and collaboration in the future. Mental health professionals can offer information and screenings for anxiety and depression at religious community health fairs, clergy group meetings, parish nursing meetings, or other educational events. A resource for beginning these dialogues could be local hospital chaplains, who can then serve as conduits to local clergy (VandeCreek, Parker, & Carl, 1998).

Diversity of Religions and Mental Health Research

With much diversity across religions, what then is the nature of the relationship between religions and mental health? In a review of more than 1,600 studies, Koenig and his co-authors found that, in the aggregate, religious beliefs and practices were consistently positively correlated with health outcomes (Koenig, McCullough, & Larson, 2001). Yet, individual religions differ in the manner in which they correlate with mental health; furthermore, within religions, there can be variance attributable to age, gender, and ethnicity. Pentecostal Christians, for example, are at increased risk for major depression, but when these data are stratified by age the risks were lower for elderly members (Koenig, George, Meador, Blazer, & Dyck, 1994). A study of geriatric patients hospitalized with acute medical illness found religious beliefs to be both beneficial and harmful. Benevolent appraisals of God were associated with lower depression scores, but God as a punishing entity was positively related to depression (Koenig, Pargament, & Nielsen, 1998). A study of geriatric homecare patients found lower depression among persons who continued to attend services compared to those who stopped attending and those who had never attended. When compared by gender, these results were significant only for women and not for men (Milstein et al., 2003). In another study, persons who were unaffiliated with any religious congregation showed no increased risk for depression if they were European

American but significantly more if they were African American (Ellison, 1995). Therefore, the effects of religion may positively correlate with mental health, negatively correlate with mental health, or interact with gender and ethnicity in relation to mental health.

Consequently, there may be great complexity as clinicians proceed to assess the specific salience of individuals' religions within their mental health care. One goal of the COPE continuum is to assist clinicians to go beyond generalizations about religion and culture, in order to "[m]ove from a categorical approach to an understanding of the patient's self-construal of identity" (Lim, 2006, p. 262). What clinicians will learn from discussions about religion with clients, as well as with clergy, can become incorporated into the clients' mental health treatment plan, in accord with professional standards of care. These assessments and dialogues will expand the diversity of persons for whom clinicians can provide psychological services. In the second section we offer specific examples of religion assessment tools.

Religions and the Ethical Practice of Psychology

There are ethical concerns as to the place of religion in clinical care. On 16 August 2007, the Council of Representatives of the American Psychological Association (2008) adopted the "Resolution on Religious, Religion-Based and/or Religion-Derived Prejudice" (hence referred to as the *Resolution*). Within the *Resolution* are discussions of the circumstances in which the professional practice of Psychology would interact with religious thought and action, or alternatively, when the use of religious content would be outside the purview of the professional practice of Psychology. The *Resolution* reminds psychologists that although, "contemporary psychology as well as religious and spiritual traditions all address the human condition, they often do so from distinct presuppositions, approaches to knowledge, and social roles and contexts" (American Psychological Association, 2008, p. 432). It is, therefore, "outside the role and expertise of psychologists as psychologists to adjudicate religious or spiritual tenets" (American Psychological Association, 2008, p. 433). This need to distinguish religion expertise and the roles of clergy as different from clinical expertise and the roles of clinicians is further described in work co-authored by clergy and clinicians (Handzo & Koenig, 2004; Milstein & Manierre, 2009; Sloan et al., 2000). These writings highlight several ethical concerns, including dual therapeutic roles. If psychologists were to conduct religious rituals as part of their remunerated professional clinical practice, they risk usurping the authority and function of clergy and congregational life (Goldberg, 2008). While one may encourage a client to use a familiar religious ritual or belief to minimize psychological distress and support healing, enacting that ritual or adjudicating a belief on behalf of the client raises ethical concerns.

In a recent discussion of the ethical implications of the *Resolution*, four psychologists, with differing views, all agreed on the need for some boundary to be in place between religion and the professional practice of psychology; they offered several recommendations on how to delineate this boundary (Gonsiorek, Richards, Pargament, & McMinn, 2009). Gonsiorek (2009) designated clinical competence as the first necessary attribute of professional psychology. His view of professional ethics is that clinical competence derives from training, and any professional expertise must

be learnable. Therefore, a therapy technique that claims to require adherence to particular religious interpretations in order to achieve competence would be, "removed from the realm of psychological services and recast as ministerial" (Gonsiorek, 2009, p. 386). Gonsiorek also examined the ethics of billing for psychological services. He distinguished between professional psychotherapy techniques incorporating the religious language of their clients into their standard therapeutic interventions, from those therapies that become forums for shared religious rituals. Gonsiorek warns against, "a careless slide from religiously sensitive psychological services to primarily religious services" (2009, p. 388). As a way to avoid this slide, Richards (2009) described the work of clergy and chaplains as distinct from clinicians and suggests that, "Collaborative relationships with pastoral professionals can help psychologists keep their role boundaries clear so that they do not engage in ecclesiastical functions that are more appropriately performed by clergy . . ." (p. 390).

In order to promote further "reflection and dialogue" McMinn (2009, p. 394), suggested three questions that psychologists could ask themselves as they integrate religious language, beliefs, or practices into psychotherapy. McMinn's first question asked psychologists to ensure that their intervention was part of the clinical treatment plan. The second question asked psychologists to consider if the religion content they used in therapy would cause concern on the part of a third party payer. The third question asked psychologists to assure that they are not accountable to competing regulatory bodies. Licensed professional psychologists are responsible to the authority of their state, as well as the ethical guidelines of the American Psychological Association (American Psychological Association, 2002, 2008). The work of licensed professional psychologists is not subject to the authority of religious institutions.

McMinn (2009) and Pargament (2009) noted that some distinctions between spiritual and psychological concepts can be complex and hard to differentiate. Therefore, it can be difficult for a psychologist to draw a clear boundary, one that separates the use of religion that is within the ethical practice of professional clinical care from the use of religion that constitutes "ministerial" activity. Nevertheless, a goal of the *Resolution* is for psychologists to strive to find such a boundary.

Below we describe practical methods to identify and maintain boundaries between clinical and spiritual services while encouraging clinicians and clergy to collaborate across these boundaries in order to provide the care best suited to their expertise (Milstein, 2003).

Practical Solutions Through Collaboration, Assessment, & Treatment

In this section, we describe practical methods with which to provide clinical care to persons of diverse religions. We begin with an overview of a model of Clergy Outreach and Professional Engagement (COPE), which describes to clinicians the breadth of de facto mental health care provided by clergy and religious congregations, as well as helps mental health professionals to educate clergy on when to refer to clinicians. We review techniques to assess the salience of clients' religious beliefs and practices and provide an example of one well-regarded instrument for spiritual assessment (Puchalski, 2006; Puchalski & Romer,

2000). We then describe the uses of religion assessment and clergy collaboration to deliver what we have termed, "Religion Inclusive" mental health care (Milstein, Manierre, Susman, & Bruce, 2008).

A Continuum of Care Through Clergy Outreach & Professional Engagement (COPE)

The prevention-science based model of Clergy Outreach and Professional Engagement (COPE) facilitates mental health care across a continuum of clinical needs as well as delineates boundaries between the normative support offered by religious communities in the course of people's lives and those interventions offered by remunerated professionals in response to clinical disorders.

The four parts of COPE are derived from the four prevention science categories of the National Institute of Mental Health (NIMH; Gordon, Steinberg, & Silverman, 1987; National Advisory Mental Health Council Workgroup on Mental Disorders Prevention Research, 1998, 2001): (1) Universal; (2) Selective; (3) Indicated; and (4) Relapse & Comorbidity. These four (USIR) categories differentiate the proportions of the population who are the target of care and the levels of risk that persons have for dysfunction.

Figure 1 illustrates the four categories in three ways: first, the sizes of the hexagons represent the diminishing proportion of the population that pertains to each category; second, the amount of shading represents the relative level of impairment of the individuals who pertain to a category; and third, the circular placement of the hexagons and the arrows connote the opportunity for a dynamic continuum of care.

The development and initial implementation of the COPE model has been described previously (Milstein et al., 2008). Below we describe the four categories of the COPE continuum and the transitions that the continuum facilitates from congregational care, through clinical care, to collaborative care (Figure 1).

Universal

All persons pertain to this category, represented by the first and largest hexagon of Figure 1. Most persons in the United States are affiliated with a religious community (Association of Statisticians of American Religious Bodies, 2002). From a psychological perspective, these congregations provide a context for individuals to contribute to the well-being of their communities. In this category, positive values, such as hope, perseverance, wisdom, and self control, can be nurtured and sustained in religious communities (Dahlsgaard, Peterson, & Seligman, 2005; Seligman & Csikszentmihalyi, 2000). In the context of congregations, individuals can strive to improve the well-being of future generations through sharing religious beliefs and values, as well as through activities like volunteering, mentoring, and promoting social justice. Erik Erikson (Erikson & Erikson, 1997) termed this adulthood developmental task, *Generativity*, which he defined as, "productivity and creativity in the service of the generations" (p. 53). These beliefs and activities, in turn, are psychologically beneficial to us (Ayalon, 2008; Borgonovi, 2008; McAdams & de St. Aubin, 1998).

Selective

The second, smaller hexagon represents persons exposed to significant stressors at some point in their lives. Congregations are a source of spiritual and social support in times of stress (Gottlieb, 1983; Krause, 1998; Milstein & Manierre, 2009). One example of a significant stressor that is responded to by religious communities would be after the loss of a loved one. Congregations enact faith-based rituals of mourning to provide the congregants with spiritual coherence (Daaleman & Frey, 1998; Jacobs, 1992). Congregations' members visit people in their homes and provide spiritual support, social support, and instrumental support (financial help). Weekly worship and educational programs offer ongoing support to the bereaved, and some mourners will meet individually with their clergy for spiritual guidance and prayer. The spiritual coherence and social support of the selective category can be sufficient to return persons to the Universal category of functioning (Krause, 2002). This congregational assistance occurs without the professional services of clinicians. We call the continuum of the Universal and Selective categories the Mental Health Pathway (Figure 3). Examples of the Mental Health Pathway are below.

Each religion has specific beliefs and rituals, which respond to the stressors of individual congregants. For example, one ritual within Judaism is the recitation of the prayer of mourning, the *Kaddish*. When a Jew has lost a parent, the tradition is that a person prays in a group of no fewer than 10 people (usually restricted to men), three times a day, for one full year. As with the rituals of many religions, adherence to this rite varies by the individual and denominational traditions. As the mourner says the *Kaddish*, other congregants respond at specific moments, giving tangible psychological support. At the end of the year, the mourner can become one of the generative congregants who respond to the *Kaddish* of others.

Although Christian rituals vary, intercessory prayers for healing and comfort are consistently used for those ailing in the congregation. Prayers may be said from the pulpit or in a hospital room. Prayers may be led by clergy, friends, or family. Touch can be integral to prayer with hands placed on the sick person or anointing oil placed on forehead or hands of the afflicted. Often the Lord's Prayer concludes an intercessory prayer said in worship services. Communion may also be offered to the sick as a tangible reminder of the connection the communicant has with their faith community and their Christian belief.

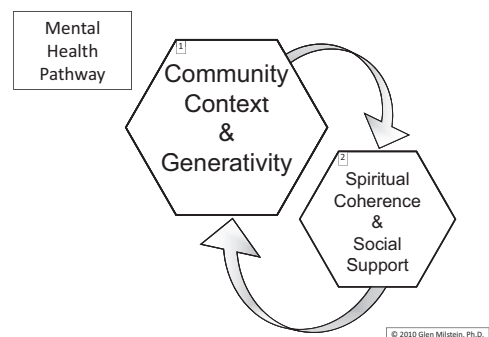


Figure 3. The Mental Health Pathway of COPE.

At the Unity of New York spiritual center for creative living, trained volunteer prayer chaplains are available after services to pray about anything from challenges to celebrations that a member may have. Volunteers are taught not to give advice or to counsel. The role of the volunteer prayer chaplain is to listen, to pray, and to hold in confidence what is heard (Burt, 2004). Chaplains have referral cards that are made available to those who may need professional service (e.g., mental health hotlines or clinics). If someone brings in more serious concerns (e.g., suicide or abuse), the chaplain will immediately refer these persons to a supervisory minister, who is trained to counsel in terms of spiritual needs and to make referrals to professional clinicians.

Within the Mental Health Pathway (Figure 3), religious communities can also provide a place of respite for persons coping with chronic mental illness (Govig, 1999; Shifrin, 1998). Mental health consumers, however, have noted that because of stigma in their religious congregations community support is often missing when a person has experienced psychological problems (Milstein et al., 2005). As one family member said, "Mental illness is a 'no casserole' disease" (United States Department of Health and Human Services, 2004a, p. 5). This means that although congregants frequently bring food in covered dishes to the homes of persons who have returned from the hospital after many types medical procedures, they do not give the same consideration to someone returning from a psychiatric hospitalization.

Congregations and their clergy could serve as bridge builders for persons in need of clinical care (Farrell & Goebert, 2008; Milstein et al., 2008; Richards, 2009). Efforts both to reduce stigma, as well as to increase continuity from within religious communities to professional mental health care will require active collaboration between clinicians, clients, and clergy.

Indicated

Some persons have significant psychological distress and/or dysfunction. These persons are in need of professional psychological assessment and professional clinical care for which psychologists are remunerated (American Psychological Association, 2002). For example, a prospective study of the elderly found that nearly a third of those recently widowed showed signs of serious depression (Bruce, Kim, Leaf, & Jacobs, 1990). Persons who would first recognize a serious dysfunction in the bereaved might well be those supporting the bereaved during their mourning. These include family, friends, fellow congregants, and clergy.

Clergy are de facto experts on the normative course of bereavement. Clergy regularly conduct funerals and visit with those who are grieving. Therefore, clergy are in a unique position to know when the emotional response of the mourner is a cause for concern, relative to how others grieve within their community (Weaver & Koenig, 1996). It is not necessary that clergy know diagnostic categories; it is sufficient for clergy to know that, if they have a concern, there are mental health professionals with whom they can consult. The opportunity for clergy to refer congregants to a clinician with whom the clergy have a professional and respectful relationship could reduce the professional burden of clergy (Farrell & Goebert, 2008; McMinn et al., 2005; Milstein et al., 2008). When a referral is received, it becomes the job of the clinician to assess the salience of religion in the life of the client (Puchalski, 2006). This knowledge may then inform the therapeutic goals, as

well as the content of the therapeutic interventions (Pargament, 2007; Propst, Ostrom, Watkins, Dean, & Mashburn, 1992).

People often go to seek counsel from their clergy before they seek help from mental health professionals. This includes persons with serious mental illnesses (Wang, Berglund, & Kessler, 2003). Therefore, it is important for clergy to educate their congregants in order to reduce the stigma of seeking professional mental health care. Reduced stigma can then facilitate referrals to mental health professionals who can, in turn, provide the necessary clinical treatment to persons with serious mental health needs, which is outside the expertise of clergy (Corrigan & Penn, 1999; Hinshaw, 2007; Milstein et al., 2005; United States Department of Health and Human Services, 2004a).

One resource that mental health professionals could provide to clergy to help them educate their congregations about mental illness is "Mental Health Ministry: A Toolkit for Congregations," authored by Pathways to Promise (2009). Pathways is a national interfaith organization that facilitates collaboration between clergy and clinicians (<http://www.pathways2promise.org/>). The toolkit is action-oriented, provides specific activities for each month of the year, and is available on the web (<http://www.pathways2promise.org/summit-2009/02.pdf>). Three other non-denominational organizations with curricula for religious communities to reduce stigma toward mental illness are the National Alliance on Mental Illness (www.nami.org/namifairnet), the Mental Health Ministries (www.mentalhealthministries.net), and the National Council of Churches USA (<http://www.shadowvoices.com/default.asp>).

Many individual religious denominations have developed curricula to educate congregants about mental illness within their congregations in order to lessen the stigma of seeking professional psychological assistance. One exemplary website is sponsored by The Presbyterian Serious Mental Illness Network (<http://www.pcusa.org/phewa/psmin.htm>); another website is sponsored by the National Catholic Partnership on Disability (<http://www.ncpd.org/ministries-programs/specific/mentalillness>).

The COPE continuum provides a framework for clinicians to collaborate with local clergy in order to learn in detail the cultural and religious aspects of their clients who belong to religious communities. In addition to religion information, the clergy's role as cultural experts will be increasingly necessary with the increasing diversity (Figure 2) of our citizenry (Pew Forum on Religion & Public Life, 2008). Clinicians, however, would not discuss clients with clergy without the clients' consent.

When professional treatment is successful, problems can resolve and the person restored to the Universal category. We call this continuum of the Universal, Selective, and Indicated categories the Treatment Pathway (Figure 4).

Relapse & Comorbidity

Some persons' mental illness is chronic. Clergy and members of their religious community come to know one another in a lived context, which (with consent) could provide valuable information to clinicians. Working together, this collaboration between individuals, their families, their clinicians, and their clergy has the opportunity to provide multiple supports, in order for the individual to adhere to care and to prevent relapse (Adair et al., 2003; Shifrin, 1998; United States Department of Health and Human

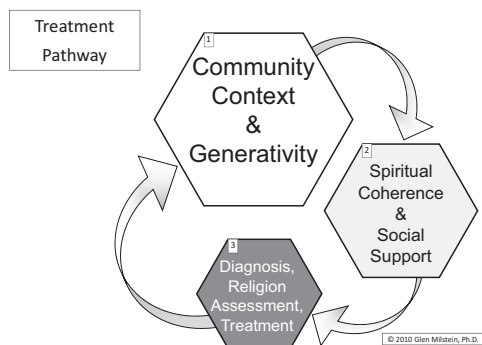


Figure 4. The Treatment Pathway of COPE.

Services, 2004b). Collaborative care would limit comorbid problems, as well as help mental health users realize and maintain their recovery and restore the functioning of the individual to the Universal category (Bellack, 2006; Richards, 2009; Rosen, 2006; Ware, Hopper, Tugenberg, Dickey, & Fisher, 2007; Ware, Tugenberg, Dickey, & McHorney, 1999). We call this continuum of the Universal, Selective, Indicated, and Relapse categories the Collaborative Recovery Pathway (Figure 5).

Tools for Assessment of Religion Salience

The COPE model, described above, illustrates a de facto continuum of care that religious persons with emotional problems may experience. When, in the second Indicated section (Figure 1), a client initiates professional care, the clinician will need to individually assess the salience of religion to that person. There are many assessment tools available to clinicians with greatly varying complexity and thoroughness. Richards and Bergin (2005) review several assessment protocols and rationales for assessing the salience of spirituality and religion. Pargament (2007) describes a multi-faceted assessment that grows in depth over time with the client. Common elements include questions of general spiritual concepts without connection to specific religious practice, such as peace, forgiveness, legacy, regret, and gratitude (Griffith & Griffith, 2002). As Pargament (2007) asked one client, "Have you ever had a time in your life when you felt deeply and fully alive?" (p. 216). The authors also describe the need to assess specific religious

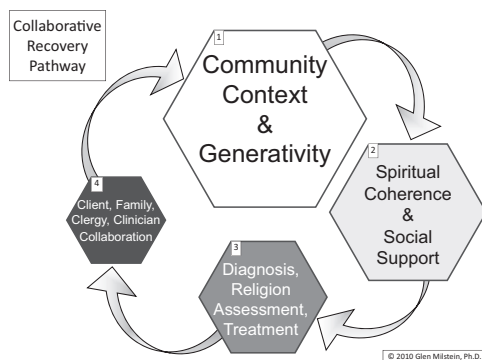


Figure 5. The Collaborative Recovery Pathway of COPE.

affiliation, practices, and the clients' personal ideas of how their religious beliefs and practices would be salient to their mental health care. There may also be times when clinical assessment indicates that religion is the source of negative experiences and even trauma (Exline, Yali, & Sanderson, 2000; Farrell & Taylor, 2000; Goodstein, 2003; Hinshaw, 2007; Pargament, Desai, McConnell, Calhoun, & Tedeschi, 2006). In these instances, it could be important that the client's own clergy not be consulted. It may, nevertheless, still be important for clinicians to consult with another clergy or a chaplain, in order to learn details about the religion itself, just as one would seek to gain a more specific understanding about other aspects of a person's culture (Geertz, 1973; Lim, 2006).

In Figure 6, we provide an example of one brief assessment that has been recommended as part of an overall cultural evaluation (Lim, 2006). The FICA Spiritual Assessment in Clinical Practice (Puchalski, 2006; Puchalski & Romer, 2000) provides a four-part guide: Faith, Importance, Community, and Action. The guide directs the clinician's assessment with clients concerning the salience of their religious and spiritual beliefs and practices and reflects on how the clients would like their psychologist to address these topics in their therapy. There is also a website with training modules for FICA (Puchalski, 2010).

After assessment, how can psychologists, within the ethical boundaries of Psychology, apply what has been learned and engage different clients across the diversity of their religious beliefs and practices?

The FICA® Spiritual Assessment in Clinical Practice

F – Faith, Belief and Meaning

- Do you consider yourself spiritual or religious?
- Do you have spiritual beliefs that help you cope with stress?
- What gives your life meaning?

I – Importance and Influence

- What importance does your faith or belief have in your life?
- Have your beliefs influenced you in how you handle stress?
- Do you have specific beliefs that might influence your healthcare decisions?

Note: Asses for both positive and negative religiosity.

C – Community

- Are you part of a spiritual or religious community?
- Is this of support to you? How?

A – Action / Address in Care

- How would you like me, your psychologist, to address these issues in your care?

Note: This may include referral to— or consultation with— chaplains, pastoral counselors, or the patients' own clergy.

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Figure 6. The FICA tool for taking spiritual history (Puchalski, 2006). Adapted with permission of the author.

Religion Inclusive Psychological Care

The 260,000 religious congregations in the United States represent scores of theologically and ethnically distinct religious communities (Jones et al., 2002). In this section, we briefly describe an approach to adapt the content of the professional psychologist's method of psychotherapy to be inclusive of the client's religious and spiritual beliefs and practices. This requires no religious belief on the part of the clinician. It does recommend careful assessment of the client and recommends consultation with religious leaders both to help guide treatment of religious clients, as well as to help clients reintegrate into their religious communities.

We have described the rationale for religion inclusive therapy in more detail previously (Milstein et al., 2008). Like other researchers, we recognize it is possible to train psychologists – regardless of their personal religious beliefs (or absence of belief) – to become sensitive and respectful toward their clients' religiosity and to consider including these beliefs and practices as an element of their psychotherapy (Hathaway, 2006; Pargament, 2007; Propst et al., 1992; Richards & Bergin, 2000).

There is no one religion inclusive psychotherapy. COPE is an adjunctive model that fits within the psychological expertise of the treating clinician. Inclusivity is achieved through the enactment of the COPE model and an assessment of religious salience and community supports that are available to that client.

The therapist begins by adding the client's religion as part of a multi-modal assessment that helps to determine the course of religion inclusive therapy. The assessment would include a religious history, current religious practices, beliefs, and support (Pargament, 2007; Puchalski, 2006; Puchalski & Romer, 2000). It may be that some of the person's own religious traditions can be incorporated into the content of the clinical intervention (Onedera, 2008), or the clinician could make use of the religious vocabulary of their clients in order to improve their clients' clinical outcomes (Propst et al., 1992). Although these skills do not require shared religiosity on the part of the clinicians and clients to achieve competence, the clinicians do need to actively assess the salience of religion to their clients (Figure 6), and mental health professionals could also benefit through dialogue with clergy.

An example of successful treatment between a clinician and client of diverse backgrounds was a Christian psychologist in the Air Force who was treating a Wiccan staff sergeant. The woman had recently been transferred to a rural southern base from a base in a large northern community. She felt a deep sense of social isolation, as she had been separated from the neopagan friends of her coven. After an assessment of her mental status and her spiritual history, the psychologist used a problem-solving therapy to assist her in maintaining spiritual coherence while stationed on this new military base. Through this counseling technique, the psychologist was able to help the staff sergeant to connect with a local neopagan community through the Society of Creative Anachronism that met at a local Unitarian church (Hathaway, 2006).

The application of Clergy Outreach and Professional Engagement (COPE) will differ in accord with the clinician's method of psychotherapy. COPE describes a plan of outreach to clergy, whose expert knowledge can provide to clinicians a depth of salient information across the increasing diversity of religious beliefs and practices (Figure 2). Through the FICA assessment (Figure 6) and consultation or collaboration with clergy, the pos-

sibilities to enrich and focus psychotherapy can be realized. Examples of the enactment of COPE can be found in previous work (Milstein et al., 2008).

Implications

We argue that by making a clear distinction between religion and professional clinical care, we encourage faith based beliefs and practices to be nurtured and enacted within the client's faith community of choice. In addition to providing clinical care beyond the scope of clergy counseling, COPE recommends that clinicians engage clergy to inform and improve the religious and cultural salience of psychotherapy. This recognition of a continuum that moves from the care already present in religious communities (Figure 3), through professional clinical care provided in response to dysfunction (Figure 4), and then collaborative care for persons within their own spiritual communities (Figure 5), can be inclusive of clients who pertain to a great diversity of religions. Through spiritual assessment of clients and strategic collaboration with religious leaders via COPE, psychologists focus their efforts on clinical care that respects and incorporates the religious views of clients and does not attempt to recreate the lived religion of their communities (Goldberg, 2008; Gonsiorek, 2009). We offer the COPE model as a guide to establish boundaries between religion and professional psychology, as well as pathways of collaboration across these boundaries.

One population with an increased need for community-based mental health care is found among the U.S. troops deployed for Operations Enduring Freedom and Iraqi Freedom (OEF/OIF) as they return from the conflicts in Afghanistan and Iraq. A study by the RAND Corporation (Tanielian & Jaycox, 2008) reported, "Assuming that the prevalence found in this study is representative of the 1.64 million individuals who have been deployed to Afghanistan and Iraq to date, we estimate that approximately 300,000 individuals currently suffer from PTSD [Post-Traumatic Stress Disorder] or major depression and that 320,000 veterans report having experienced a probable TBI [Traumatic Brain Injury] during deployment" (pg. xxi). The name of the report, "Invisible Wounds of War," emphasizes a constant problem with providing care to persons with mental illness: the stigma of an unseen wound.

As a result of this stigma, soldiers and veterans may be more open to seeking help from their military chaplains and community clergy than from mental health professionals. COPE can contribute to meeting the needs of veterans and others with mental health problems by teaching clergy how to facilitate referrals to mental health professionals, as well as by teaching clinicians to inquire about the role of religion in the lives of their patients and helping them to reintegrate into their religious community after acute care. There is also a role for collaboration between clinicians and clergy in maintaining recovery for persons with those chronic mental health difficulties that may persist among veterans (Figure 5). Research on the implementation of the COPE continuum could make use of systems science methodology (Midgley, 2006; Sterman, 2006).

Conclusions

If the COPE continuum can be viewed as a journey, it is traveled—at least in part—by most persons in the United States.

With more than 260,000 religious congregations, this is not one journey, but many. One purpose of this paper is to remind clinicians, even religious clinicians, to recognize the defacto mental health care provided to individuals through the spiritual and social support of their congregations. As the *Resolution* and others have articulated, it is not the role of the mental health professional to be a spiritual guide (American Psychological Association, 2008; Gonsiorek, 2009; Handzo & Koenig, 2004; Milstein & Manierre, 2009; Sloan et al., 2000). Our recommendation is that psychologists and other mental health clinicians recognize that their professional role is to be adjunctive in people's lives. Nevertheless, via the COPE model, clinicians can provide multiple services along the continuum of religious individuals' mental health care.

All persons have a developmental journey of identity formation. The role of the professional clinician is to provide empirically-based expertise, for which we are paid, in order to facilitate the health and strength needed by our patients for their journeys. When we are successful, our clients journey outside of our offices, our clinics, and our hospitals. Their journeys then lead back to their own church, synagogue, mosque, temple, or other sanctified places of rituals filled with diverse, personal, ineffable mysteries.

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