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Psychologists Collaborating With Clergy

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If a patient adheres to religious values and practices, should the treating psychologist get input from a clergyperson? How frequent is clergy–psychologist collaboration? What obstacles impede such collaboration? An exploratory survey questionnaire was sent to 200 clergy, 200 psychologists interested in religious issues, and 200 psychologists selected without regard to religious interests or values. Four themes were assessed: types of collaborative activities, frequency of collaboration, obstacles to collaboration, and ways to enhance collaboration. Strategies for promoting clergy–psychologist collaboration include challenging unidirectional referral assumptions, building trust through proximity and familiarity, and considering the importance of shared values and beliefs.

When did you last reflect on the range of other professionals with whom you have regular contact? Who was on the list? Other psychologists, a couple psychiatrists, a few social workers, some teachers (if you work with children), and some primary care physicians—and maybe some nurses? Any clergy?

The professional practice of psychology has changed over past decades, and the amount of professional collaboration has expanded (Cauley, 1997; Hargrove, 1997; Katon, 1995), including with primary care (Hinshaw & DeLeon, 1995; Kenkel, 1995; McDaniel, 1995), public policy leaders (Sullivan, 1997), labor unions (Sullivan & DeLeon, 1997), lawyers and judges (Collins & Bernstein, 1983; O'Shea & Connery, 1980), and so forth. Despite this general increased interest in collaboration, relatively little attention has been given to collaborating with clergy (Weaver, Samford, Kline, et al., 1997). In a recent survey of eight major journals of the American Psychological Association (APA) from the years of 1991 to 1994 (Weaver, Samford, Kline, et al., 1997), only one article describes such collaboration—an example of psychologists providing consultation to religious communities (Pargament et al., 1991).

However, the zeitgeist in professional psychology seems to be changing, and intellectual thought, in general, calls for greater awareness of religious issues. Whereas many psychologists have seemed to be critical of religion in the past, sometimes seeing religious thought as an antecedent to psychological disorders (e.g., Ellis, 1960, 1971), recent trends in the philosophy of science (Jones, 1994), the publication of convincing empirical evidence (Gartner, Larson, & Allen, 1991), and conceptual developments within clinical psychology (cf. Shafranske, 1996) have produced a climate where religious values can be considered more openly. This more open stance toward religion creates new possibilities of collaboration between psychologists and clergy (cf. Joanides, 1996). As psychologists become more sensitive to religious values in psychotherapy (Richards & Bergin, 1997; Shafranske, 1996), they will need to be increasingly aware of the religious resources available for themselves and those with whom they work. Collaborative relationships with clergy can help in this regard, just as collaborative relationships between psychologists and physicians are beneficial to psychologists' clients.

Mental health needs within religious communities can be overwhelming to clergy. Even in today's mental health marketplace, with a ubiquity of psychologists, psychiatrists, licensed professional counselors, marriage and family therapists, and licensed clinical social workers, many prefer to seek help first from clergy (Veroff, Kulka, & Douvan, 1981).[1] When Quackenbos, Privette, and Klentz (1985) surveyed randomly selected Florida residents, they found that 35% identified a pastoral counseling center as their first choice for counseling services—in comparison to only 13% identifying a psychologist, 23% identifying a psychiatrist, and 20% identifying a community mental health center as their first choices. Moreover, 79% of the respondents reported that religious values were an important topic in psychotherapy. Because of the prominence of religious commu-

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[1] More recent survey data from Connecticut residents suggests greater comfort with physicians and psychologists than with clergypersons as mental health providers (Murstein & Fontaine, 1993).

nities in American life, some have referred to organized religion as the "sleeping giant" when it comes to delivering mental health services.

As professional psychology becomes more sensitive to contextual and community variables in mental health, it is important to collaborate with religious communities—reaching people in their natural settings (Kloos, Horneffer, & Moore, 1995). In previous centuries, behavioral and social change has often occurred within a religious context, and it is only in the past century that secular professions have emerged explicitly for the "care of the soul (psyche)." As changes in health delivery systems make long-term psychotherapy less available in traditional fee-for-service settings, religious communities may well be faced with new challenges in mental health care. Ideally, religious communities and psychologists will collaborate to enhance personality change and adjustment among parishioners with chronic mental health needs (cf. Anderson, 1985; Kehoe & Ely, 1997; Walters & Neugeboren, 1995).

An important starting point in establishing mutual, two-way collaborative relationships is understanding the respective views of clergy and psychologists regarding such collaboration. If psychologists are to collaborate effectively with clergy, the perspectives of both groups must be evaluated and considered. Several theoretical articles have been written regarding clergy–psychologist collaboration (Gorsuch & Meylink, 1988; Meylink & Gorsuch, 1986, 1988), and one qualitative study has been reported (Kloos et al., 1995), but no quantitative or large-scale survey studies have been reported to date.

The Exploratory Study of Psychologists and Clergy

A questionnaire was sent in March 1997 to 600 respondents: 200 randomly selected members of APA Division 36 (Psychology of Religion), 200 randomly selected members of APA Division 12 (Clinical Psychology), and 200 randomly selected clergypersons.[2] Of the 600 questionnaires sent, 32 were undeliverable and 13 were returned incomplete because of retirement of the respondent. Of the 555 who could have responded, 245 returned completed questionnaires, resulting in a return rate of 44%. Of the 245 respondents, 56 (23%) were clergy, 76 (31%) were psychologist members of Division 12, and 113 (46%) were psychologist members of Division 36.[3] Respondents' ages ranged from 29 to 89, with an average age of 52. The majority of respondents were male, with just under one fourth being female. Half were Protestant, 20% Catholic, 13% Jewish, 21% reported other religious affiliation, and 12% reported no religious affiliation. The vast majority of respondents were European American (94%). Clergy were more likely than psychologists to be male (only 4 of 51 clergy respondents were female), be religiously affiliated, and have less formal education.

The survey questionnaire was first developed by McMinn and Campbell, and then refined by all the authors after discussing the questionnaire with a group of approximately 20 clergy.[4] The final questionnaire was based on four basic themes: types of collaborative activities ("Do you see the following activities as collaborative?"), frequency of collaboration ("How often do these activities occur in actual practice?"), obstacles to collaboration ("How prevalent are the following factors in hindering effective collaboration between psychologists and clergy"), and ways to enhance collaboration ("If you were considering a collaborative relationship with a [psychologist/clergyperson], how important would each of the following considerations be?"). For each of the four themes, respondents rated a list of items on a 5-point scale. For example, when rating how frequently certain collaborative activities occur, respondents rated each of 12 activities from 1 (*never*) to 5 (*always*).

A similar statistical procedure was used for each of the four themes. First, items on the list were ranked according to average overall ratings (see Table 1). Second, a repeated-measures multivariate analysis of variance (MANOVA) was computed to detect significant differences among ratings on the list of items, followed by profile analyses (using pairwise t tests) to determine which items on the ranked list were significantly different from the preceding items. A repeated measures effect was observed for each of the four themes: Theme 1, Wilks $\lambda = .46$, $F(11, 224) = 24.3$, $p < .001$; Theme 2, Wilks $\lambda = .22$, $F(11, 211) = 69.6$, $p < .001$; Theme 3, Wilks $\lambda = .47$, $F(10, 217) = 24.9$, $p < .001$; Theme 4, Wilks $\lambda = .15$, $F(10, 224) = 123.4$, $p < .001$. Third, the three respondent groups were compared in their response patterns on each item using a one-way analysis of variance (ANOVA). Because of the multiple hypothesis tests used for the between-subjects ANOVA, a standard alpha level of .05 was divided by the number of items on each list resulting in a conservative alpha of .005. For those items where group differences were found, post hoc Scheffé comparisons were computed using an alpha of .05. Adjacent item differences, respondent group differences, and significant comparisons are shown in Table 1.

Theme 1: Types of Collaborative Activities

For purposes of the questionnaire, *collaboration* was succinctly defined as both parties working together, each offering important expertise to solve a problem or help others. Respondents then rated 12 activities on the extent to which they represent collaboration between psychologists and clergy, ranging from 1 (*not at all*) to 5 (*definitely*). As seen in Table 1, overall

[2] Division 36 members were randomly selected from the membership directory of the APA because of their interest in religious issues, and Division 12 members were selected in a similar manner to provide a broad representation of clinical psychologists selected without regard to religious values. Because it was an exploratory survey, we were interested in seeing if differences would be found between Division 12 and Division 36 members in their perspectives regarding collaboration with clergy. Though it is possible that some respondents belonged to both Division 12 and Division 36, no effort was made to eliminate these individuals to maintain a representative sample of both divisions. Overlap between the two divisions appears to be minimal as there was no redundancy between the randomly selected Division 12 and Division 36 lists.

[3] One possible explanation for the relatively low response rate among clergy is that the random sampling procedure did not allow for a personalized mailing address, as it did for psychologists.

[4] Given the heterogeneity of items on the various sections of the questionnaire, high internal consistency was not an expectation or goal when constructing the questionnaire. Meeting with clergy to discuss the questionnaire was an effort to achieve ecological validity, though more traditional quantitative measures of reliability and validity are not available.

Table 1

Ranked Collaboration Ratings by Three Respondent Groups for Each of Four Research Theme Areas

Items	Overall		Div. 36		Div. 12		Clergy			
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*	Between-group differences
Theme 1: Types of collaborative activities										
Psychologist provides consultation	4.1	1.1	4.3	1.0	4.2	1.1	3.8	1.1	3.4	
Working together on a community service project	4.0[a]	1.1	4.1	1.2	4.2	1.0	3.5	1.1	6.1[b]	D36–Clg, D12–Clg
Clergy refers to psychologist	4.0	1.1	4.1	1.0	3.9	1.1	3.8	1.1	2.7	
Co-therapy	4.0	1.4	4.1	1.3	4.1	1.2	3.4	1.5	7.1[b]	D36–Clg, D12–Clg
Clergy provides consultation	3.9	1.2	4.1	1.1	4.0	1.2	3.4	1.4	5.4[b]	D36–Clg, D12–Clg
Psychologist presents seminar	3.9	1.1	4.1	1.0	3.7	1.1	3.5	1.3	7.2[b]	D36–12, D36–Clg
Psychologist leads support group	3.8	1.1	4.1	1.0	3.7	1.0	3.3	1.3	10.6[b]	D36–Clg
Psychologist refers to clergy	3.6[a]	1.3	3.9	1.1	3.6	1.1	3.0	1.5	9.9[b]	D36–Clg, D12–Clg
Clergy presents seminar	3.6	1.3	3.9	1.2	3.5	1.2	3.1	1.5	8.3[b]	D36–Clg
Psychologist evaluates religious group	3.5	1.2	3.8	1.2	3.4	1.1	2.9	1.3	11.4[b]	D36–Clg
Psychologist evaluates religious program	3.3[a]	1.4	3.6	1.3	3.3	1.3	2.6	1.4	10.2[b]	D36–Clg, D12–Clg
Psychologist having office in church	3.2	1.3	3.6	1.3	3.0	1.2	2.9	1.4	7.3[b]	D36–12, D36–Clg
Theme 2: Frequency of collaboration										
Working together on a community service project	3.1	1.0	3.2	1.0	3.2	0.9	2.9	0.9	2.8[b]	
Clergy refers to psychologist	3.1	0.8	3.2	0.8	2.7	0.7	3.1	0.8	8.8[b]	D36–12, D12–Clg
Psychologist presents seminar	3.0	1.0	3.2	0.9	3.0	0.9	2.6	1.0	7.7[b]	D36–Clg
Psychologist provides consultation	3.0	1.0	3.2	1.0	2.8	0.9	2.8	1.0	4.0	
Psychologist leads support group	2.7[a]	0.9	2.8	0.9	2.7	0.8	2.3	1.0	5.6[b]	D36–Clg
Clergy provides consultation	2.3[a]	0.9	2.3	0.9	2.4	0.9	2.0	0.8	3.1	
Psychologist evaluates religious group	2.2	1.0	2.5	1.0	2.0	0.9	2.1	1.0	6.2[b]	D36–12
Psychologist refers to clergy	2.2	0.8	2.4	0.8	2.3	0.7	1.7	0.7	13.6[b]	D36–Clg, D12–Clg
Psychologist having office in church	2.1	1.0	2.4	1.0	1.7	0.8	2.2	1.2	9.2[b]	D36–12, D12–Clg
Clergy presents seminar	2.1	0.9	2.2	0.9	2.2	0.8	2.0	1.0	1.7	
Psychologist evaluates religious program	2.0[a]	0.9	2.1	0.9	1.7	0.8	1.9	0.9	4.8[b]	D36–12
Co-therapy	1.9	0.9	1.9	0.9	1.7	0.8	1.9	1.0	0.9	
Theme 3: Obstacles to collaboration										
Psychologists do not need clergy	3.5	0.8	3.6	0.8	3.4	0.8	3.6	0.8	1.1	
Unaware of available resources	3.5	0.8	3.3	0.9	3.7	0.8	3.5	0.8	3.3	
Differing worldviews	3.4	0.7	3.4	0.7	3.3	0.6	3.6	0.6	1.8	
Concern about advice other will give	3.4	0.8	3.4	0.7	3.4	0.8	3.4	0.8	0.0	
Not enough time	3.4	1.0	3.4	0.9	3.4	0.9	3.3	1.0	0.1	
Lack of trust	3.3	0.8	3.5	0.8	3.0	0.7	3.3	0.9	9.7[b]	D36–12, 12–Clg
Clergy do not need psychologists	3.3	0.8	3.3	0.8	3.4	0.7	3.1	0.8	1.5	
Concern about education of clergy	3.2	0.9	3.1	0.9	3.2	0.9	3.4	0.8	2.4	
Bad experience in past	3.1	0.9	3.2	0.8	3.0	1.1	3.0	0.9	2.0	
Different values on payment	2.8[a]	1.0	2.8	1.0	2.7	0.9	2.9	1.1	0.9	
Concern about education of psychologists	2.7[a]	0.9	2.7	0.8	2.5	0.8	2.8	1.0	2.7	
Theme 4: Ways to enhance collaboration										
Shared beliefs and values	4.2	0.8	4.2	0.7	3.9	0.8	4.5	0.7	12.4[b]	D36–12, D36–Clg, D12–Clg
Other's professional reputation	4.1	0.9	4.0	0.9	4.2	0.8	4.2	0.8	2.1	
Other's psychological awareness	4.0	0.7	4.0	0.6	4.0	0.8	4.1	0.7	0.2	
Recommended by a colleague	3.8[a]	0.9	3.8	0.9	3.9	0.8	3.9	0.8	0.2	
Previously established relationship	3.8	0.9	3.8	0.9	3.9	0.9	3.7	0.8	0.6	
Other's theological awareness	3.8	0.9	3.7	0.9	3.5	0.9	4.2	0.8	8.6[b]	D36–Clg, D12–Clg
Other's professional degrees or credentials	3.4[a]	0.9	3.4	0.8	3.5	1.0	3.5	0.9	0.6	
Other's denominational affiliation	2.4[a]	1.1	2.4	1.0	2.3	1.1	2.7	1.1	2.5	
Other having a university affiliation	2.0[a]	1.0	2.0	1.0	2.0	1.1	2.0	1.0	0.1	
Gender of other person	1.9[a]	1.0	1.9	1.0	1.8	1.0	1.9	1.0	0.3	
Ethnicity of other person	1.8	1.0	1.9	1.0	1.8	1.0	1.8	0.9	0.1	

Note. Post hoc comparisons for between-group differences were only computed if the overall analysis of variance showed significant differences using an alpha of .005. When applicable, post hoc comparisons were done with Scheffé tests and alpha of .05. Profile analyses comparing adjacent means were computed after a repeated measures multivariate analysis of variance showed overall within-group differences, $p < .001$. Div. = Division. D36–Clg = significant difference between Division 36 respondents and clergy respondents using a post hoc Scheffé test, $p < .05$; D12–Clg. = significant difference between Division 12 respondents and clergy respondents using a post hoc Scheffé test, $p < .05$; D36–12 = significant difference between Division 36 respondents and Division 12 respondents using a post hoc Scheffé test, $p < .05$.

[a] The endorsement of this item is significantly lower than the preceding item on the ranked list, $p < .05$. [b] Overall between group differences observed, $p < .005$.

ratings were on the upper end of the scale, suggesting that both clergy and psychologists perceived a variety of activities to be collaborative. Nonetheless, it is striking to note how consistently clergy saw the behaviors described on this questionnaire as less collaborative than did psychologist members of Division 36. Ten of the 12 behaviors were rated as significantly more collaborative by Division 36 respondents than by clergy. Similarly, Division 12 members rated 5 of the 12 items as more collaborative than clergy respondents. These findings may reflect a general response set where psychologists, especially those interested in religious issues, experience greater optimism about collaboration than clergy.

Clergy may perceive psychologist–clergy collaboration less favorably than psychologists because they have experienced fewer benefits than psychologists. If clergy–psychologist relationships tend to be unidirectional—with the psychologist being perceived as the expert who offers services (e.g., therapy, seminars, evaluations) at the request of the clergyperson—then it understandable that clergy question whether this is true collaboration (cf. Tyler, Pargament, & Gatz, 1983). When Kloos et al. (1995) interviewed 18 religious leaders regarding their views of collaboration, most respondents immediately associated collaboration with referring parishioners for therapy or having psychologists lead support groups in their parishes. As the parish leaders were given an expanded vision of collaboration throughout the interview, most expressed increasing interest in collaborating with psychologists. If collaboration is to be bidirectional and mutually beneficial, then psychologists interested in collaborating with clergy need to actively consider ways clergy might contribute to the effective work of professional psychologists.

Psychologists must also continue advocating their expertise to clergy, especially in those areas that clergy may not readily associate with psychological training. Kloos et al. (1995) reported that clergy desire to improve the quality of their work and their communities, and that these desires are the primary motivators propelling clergy to consider collaborating with psychologists. Referring a parishioner for psychotherapy may carry relatively little perceived benefit for clergy, yet the vitality of religious communities can be enhanced through psychologists' skills of program evaluation, suicide prevention (Weaver & Koenig, 1996), education (Weaver, Samford, & Koenig, 1997), and consultation (Pargament et al., 1991). These skills need to be emphasized in developing relationships with clergy.

Theme 2: Frequency of Collaboration

Participants also rated the same 12 behaviors on the extent to which they occur in the professional world, using a scale from 1 (*never*) to 5 (*always*). On the average, none of the respondent groups reported any of the 12 collaborative behaviors as occurring with a high degree of frequency. The highest mean frequency rating for any item and any group of respondents was 3.2 (a rating of 3 corresponded with the descriptor *sometimes*).

Division 36 members reported four behaviors as more frequently occurring than did their Division 12 counterparts (see Table 1). For two of these, clergy also rated the frequency as greater than did Division 12 members. These ratings probably reflect the different experiences of each group. That is, psychologists selected without regard to religious values (Division 12) have less experience with psychologist–clergy collaboration than those in the other two respondent groups, and therefore rate the collaborative behaviors as less frequently occurring.

Group differences were also found between Division 36 members and clergy on three items. Division 36 members rated each of the following behaviors as more frequent than did clergy: a psychologist presenting seminars to a religious congregation, a psychologist leading support groups in a religious congregation, and psychologists referring to clergy. At least for these behaviors, psychologists interested in religious issues apparently perceive more collaboration to be occurring than perceived by clergy. There were no behaviors where clergy ratings exceeded Division 36 ratings. Many Division 36 members may themselves be involved in collaborative work with clergy, and thus perceive a moderate frequency of collaboration to be occurring. In contrast, some clergy may have little or no contact with psychologists, and therefore report lower frequency of collaboration. This is possible because there are many more clergy than psychologists.

As discussed previously (and noted by Meylink & Gorsuch, 1988), referral patterns between clergy and psychologists tend to be unidirectional, with clergy providing more referrals to psychologists than vice versa. Our findings are consistent with this observation, and the discrepancy is apparent to both psychologists and clergy. Moreover, when considering the rate at which psychologists refer to clergy, both groups of psychologist respondents reported a greater frequency than did clergy respondents. It is possible that clergy and psychologists have different views of referral behavior. Clergy often refer parishioners for mental health services, in effect "turning over" the parishioner's treatment to the psychologist. Indeed, sometimes psychologists insist on being the primary provider of mental health services to prevent conflicting treatment approaches. But when psychologists refer clients to clergy, they may be most interested in collaborative care where both the clergy and psychologist are providing services, either conjointly or separately. Meylink (1988) reported an intervention in which she successfully trained psychology graduate students to refer clients for concurrent interventions with clergy, but the intervention had no effect on the students' likelihood of turning over their clients to the clergyperson for primary care. This disparity in what is meant by a referral may contribute to clergy perceiving themselves to be the recipients of referrals less often than psychologists estimate.

Theme 3: Obstacles to Collaboration

Participants rated the prevalence of 11 factors that potentially hinder collaboration. Response options ranged from 1 (*never*) to 5 (*always*). The distribution of mean ratings for obstacles to collaboration is quite restricted, ranging from 2.7 to 3.5 on a 5-point scale. All 11 potential obstacles included on the questionnaire received moderate ratings from all groups, with few within-group paired comparisons reaching significance, and with between-groups differences on only one item (lack of trust). On this one item, Division 12 members rated lack of trust as a less frequent obstacle than did Division 36 members or clergy. Division 12 members may be less aware of problems

of trust between clergy and psychologists than the other respondent groups.

The problem of trust has been noted in previous research on collaboration between psychologists and clergy (Kloos et al., 1995). In general terms, it seems likely that trust problems are related to lack of interaction and to disparate values and beliefs between clergy and psychologists (Newberry & Tyler, 1997), but a more precise understanding of the role of trust in clergy–psychologist collaboration is important. What factors inhibit trust between clergy and psychologists? What might be done to establish greater trust? These are important topics for further investigation.

Theme 4: Ways to Enhance Collaboration

On the last portion of the questionnaire, participants rated factors that might affect their decision to enter into a collaborative relationship, using ratings that ranged from 1 (*extremely unimportant*) to 5 (*extremely important*). Whereas a restricted range of mean ratings was observed for obstacles to collaboration, a wide range was observed among the factors contributing to collaboration. Group means ranged from 1.8 to 4.5 on a 5-point scale, with numerous within-group paired comparisons reaching significance.

Some of the factors contributing to collaboration between clergy and psychologists are common factors that would be expected to enhance the likelihood of various types of collaboration. These include the reputation of the other person, having an established relationship with the other person, and the recommendation of a colleague. Other contributing factors, such as shared beliefs and values, may be specifically related to the territorial similarities between the work of psychologists and clergy.

Shared beliefs and values appear to be more important to clergy when considering collaborative relationships than to psychologists. Previous survey research suggests that conservative clergy and clergy from small congregations are less likely than liberal clergy and clergy from large congregations to refer parishioners to mental health practitioners (Mannon & Crawford, 1996). Those clergy with conservative theological inclinations and those leading small enclave-like congregations may find it especially risky to send parishioners outside the religious community for mental health services. An analogous process appears to affect psychologists considering collaboration. Division 36 members, many of whom presumably hold more devout religious beliefs than other psychologists, reported shared beliefs and values to be more important than did Division 12 members.

In a previous study using a qualitative interview methodology, Kloos et al. (1995) found that religious organizations with an existing relationship to a university were more inclined toward collaborative arrangements with psychologists. In the present study individual respondents reported university affiliation to be relatively unimportant, and no group differences were observed.

Clergy rated the importance of theological awareness more highly than either group of psychologist respondents. It will be interesting to monitor the success of graduates from religiously oriented psychology doctoral programs in establishing effective collaborative relationships with clergy. Though some religiously oriented doctoral training programs in clinical psychology have been operating for many years (e.g., Fuller Theological Seminary, George Fox University, Rosemead School of Psychology), there has been a recent proliferation of new programs (e.g., Asuza Pacific University, Regent University, Seattle Pacific University, Wheaton College). Many of these programs have theological studies requirements as part of the training model. As graduates of religiously oriented training programs increase in numbers, will there be corresponding increases in collaboration between clergy and psychologists?

For psychologists with no formal theological training, an introductory understanding of basic theological principles can be obtained in several ways. Auditing a course at a seminary or other religious institution, perusing a basic theology text (cf. Erickson, 1985), attending worship services on a regular basis, meeting with a spiritual director, discussing epistemological and worldview assumptions with clergy, or reading a book pertaining to the integration of psychology, theology, and spirituality (cf. McMinn, 1996) are all helpful ways to gain insight into the values and beliefs of clergy.

It is important for psychologists to recognize that religious systems are much more than moral codes or methods of seeking life after death. At the heart of all major religions are epistemological values that often conflict with the predominant values of modernity and postmodernity. Whereas psychologists often place great confidence in scientific findings (modernity) or might be offended by any universal truth claims (postmodernity), clergy have often staked their professional lives on the truth claims of sacred texts. These are viewed as timeless truths that transcend particular cultures and intellectual trends, and provide a stable tradition of faith from one generation to the next. Though it may not be necessary for psychologists interested in collaborating with clergy to share these epistemological assumptions, they need to recognize and respect the basic worldview of clergy and parishioners.

Implications and Application

What importance do these findings have to the professional psychologist interested in developing collaborative relationships with clergy? One immediate conclusion is that psychologists face a relative dearth of information about collaborating with clergy. If a psychologist is interested in learning more about collaborating with clergy, how are the requisite skills and knowledge obtained? Our training in graduate school socialized us to go first to the literature to read about emerging areas of practice, and to attend continuing education workshops and seminars. When it comes to collaborating with clergy, the literature is sparse and there are virtually no professional workshops offered on the topic. Moreover, it appears that only a moderate amount of collaboration is occurring. Much more could be done in this regard to the benefit of both professions.

One effective way of learning about clergy–psychologist collaboration is to consider exemplars of effective collaboration. Examples of clergy–psychologist collaboration given by our survey respondents span a range of activities. One psychologist described testing a child for learning disabilities and then (with parental permission) sharing the results of the evaluation with the child's minister for purposes of community support and to

maximize the benefits of religious education within the parish. Another psychologist reported working with a church staff to help define the church's vision and develop policies and procedures for counseling services. A psychologist consulted with a priest about a client having religious delusions. The priest not only consulted with the psychologist, but also involved himself in the treatment—even inviting the client to stay for a time in the monastery. Another wrote about bringing a rabbi into treatment to help an adolescent client understand his father's religion in a healthy way. One clergyman described how pleased he was when a psychologist included church activities in a recovery contract for a man adjusting to a difficult divorce. Other psychologists provided workshops, conflict resolution services, and consultation to clergy and church communities, and assisted in developing peer-counseling programs. One psychologist helped develop a script for a dramatic sketch about dysfunctional families for a religious service. Clergy reported coleading a wellness group with a psychologist, working with psychologists in prison ministries, AIDS care, or hospice care, targeting and tutoring high-risk adolescents, producing a television program on family issues, and collaboratively preparing a marriage preparation program.

Emerging forms of collaboration, as illustrated in some of the previous examples, go beyond traditional referral activities, seeing both professionals as having valuable resources and limitations (Tyler et al., 1983) and involving partnering together on joint projects. A common obstacle to mutually beneficial collaboration has been the discrepancy in the direction of referrals, which tend to be unidirectional, from clergy to psychologists (Meylink & Gorsuch, 1986), and may have little expectation of continued involvement after the referral is made.

Though collaboration has the potential to go beyond simple referral from one professional to another, the importance of mutual referrals should not be dismissed. Because most Americans seek help first from religious communities when faced with mental health challenges, Kloos et al. (1995) described clergy as the "front line" for access into the mental health system. Clergy often function as gatekeepers to the professional practice of psychology (Gorsuch & Meylink, 1988), so there are obvious professional benefits for psychologists who collaborate frequently with clergy. Similarly, psychologists who seriously consider the religious values and perspectives of their clients may often find it necessary to consult with and refer to clergy regarding their clients' coping strategies and support systems (Weaver, Koenig, & Larson, 1997).

If psychologists reading this article were to suddenly become interested in collaborating with clergy and were to develop innovative bidirectional collaborative models, they might still find it difficult to engage clergy in collaborative relationships because the benefits of collaboration are perceived as less significant among clergy than among psychologists (Kloos et al., 1995). A variety of obstacles appear to have a moderate inhibiting effect on collaboration between psychologists and clergy. Among these, perhaps the most immediate need is to explore ways of enhancing trust between clergy and psychologists. To some extent, trust is a function of familiarity and proximity. Weikart, Peggs, and Davies (1982) reported a successful intervention with clergy and family practice physicians where spending time together over breakfast and attending a training course together enhanced familiarity and referrals. Two of us found similar results when we hosted a lunch for local clergy as part of our rural psychology practice (McMinn & Campbell, 1997). Beyond proximity and familiarity, it is also important to explore other ways to enhance trust. For example, does effective collaboration require common beliefs on matters related to creed and doctrine? Does it require common beliefs about using spiritual interventions as part of religiously oriented psychotherapy? If so, which spiritual interventions reflect important shared values and beliefs? The extent to which psychologists and clergy successfully respond to these and related questions will likely affect their potential to work collaboratively in the present and the future.

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