A systematic review on chaplains and community-based clergy in three palliative care journals: 1990 - 1999

Kevin J. Flannelly, Andrew J. Weaver, Walter J. Smith and Julia E. Oppenheimer

Am J Hosp Palliat Care 2003; 20; 263
DOI: 10.1177/104990910302000407

A systematic review on chaplains and community-based clergy in three palliative care journals: 1990 – 1999

Kevin J. Flannelly, PhD
Andrew J. Weaver, PhD
Walter J. Smith, SJ, PhD
Julia E. Oppenheimer, BA

Abstract

A systematic review of all articles appearing between 1990 and 1999 in the American Journal of Hospice and Palliative Care*, the* Hospice Journal*, and the* Journal of Palliative Care *was conducted. Articles citing at least one reference were categorized as scholarly, included in the study, and divided into either research or nonresearch categories. Scholarly articles were classified as research if they contained clearly defined methods and results sections, even if these headings were not used. Research and nonresearch articles were subdivided into qualitative and quantitative research and general reviews or program descriptions, respectively. All scholarly articles were read to see if they mentioned clergy, including the terms rabbi, priest, minister, pastor, imam, chaplain, or other religious professionals. Of 838 scholarly articles published between 1990 and 1999 in the three journals, 348 (41.5 percent) were research articles, 417 (49.8 percent) were reviews, and 73 (8.7 percent) were program descriptions. Forty-seven (5.6 percent) of all 838 scholarly articles mentioned clergy or chaplains in some way. Clergy and chaplains were more likely to be an integral part of research articles, whereas mention of them in nonresearch articles tended to be incidental (chi-square = 16.8, $p < .001$). Moreover, quantitative articles were more likely to include clergy as an integral aspect of the article than were qualitative articles (Fischer's exact probability test, $p = .088$). The results are discussed with respect to the mutual roles hospice chaplains and community-based clergy play in providing spiritual care at the end of life.*

Kevin J. Flannelly, PhD, Associate Director of Research, The HealthCare Chaplaincy, New York, New York.

Andrew J. Weaver, PhD, Director of Research, The HealthCare Chaplaincy, New York, New York.

Walter J. Smith, SJ, PhD, President and Chief Executive Officer, The HealthCare Chaplaincy, New York, New York.

Julia E. Oppenheimer, BA, Research Assistant, The HealthCare Chaplaincy, New York, New York.

Key words: hospice, clergy, chaplaincy, pastoral care, end of life

Introduction

Clergy are most often sought for counsel in situations associated with grief and loss, such as personal illness or injury, the death of a spouse or close family member, a change in the health of a family member, or the death of a close friend.[1] In a recent national survey of more than 1,200 adults, 89 percent said if they were facing their death, they would find comfort in "believing in [the] loving presence of God or [a] Higher Power," and 71 percent said they would find comfort in a visit by a member of the clergy.[2] Surveys by the National Institute of Mental Health found that clergy were as likely as mental health specialists to have a person experiencing complicated bereavement or depression see them for assistance.[3]

According to the National Funeral Directors Association, clergy in the US officiate at an estimated 1.5 million memorial and funeral services

annually. Several studies of Christian and Jewish clergy in the United States,[5-7] Canada,[8] and the United Kingdom[9,10] have found that bereavement and death and dying issues are the most common problems congregants bring to clergy. Americans in a crisis involving the death of someone close are almost five times more likely to seek the aid of a clergyperson than all other mental health sources combined (54 percent vs. 11 percent).[11] This means that each year clergy have contact with millions of people who have lost friends and family.

The widespread use of religion and clergy when coping with the stress of loss[12] is not surprising given the importance of religious community to the majority of Americans. Approximately 70 percent of Americans say they are members of a church or synagogue, and about 40 percent attend one of these places of worship at least weekly.[13] In 1998, there were 353,000 Christian and Jewish clergy, including 4,000 rabbis, 49,000 Catholic priests, and 300,000 Protestant ministers, according to the US Department of Labor. Surveys indicate that clergy are among the most trusted professionals in society.[13]

More than 10,000 of these clergy serve as healthcare chaplains working closely with hospital, nursing home, and hospice staff.[14] In a recent survey of 160 hospices in California, 90 percent offered pastoral care services to patients and their families.[15] A study of nursing staff conducted in a large teaching hospital in Canada found that nurses were more likely to make referrals to chaplains when patients were diagnosed as terminally ill or dying than they were for any other presenting problem.[16]

Faith communities can offer both social support and a cognitive framework to address loss and grief. In a group of older men who experienced the death of someone close, membership in a synagogue or church was a good predictor of much lower levels of depression than those with no such affiliation.[17] When 231 patients with end-stage cancer were asked what maintained their quality of life, "their relationship with God" was the most frequent answer among 28 alternatives.[18]

Rabbis, priests, imams, ministers, and other religious professionals are in a unique position of trust in that they can help people connect with support systems available through their faith communities.[1] Undoubtedly, persons in distress go to clergy in such large numbers because, for many individuals, accompanying the distress are questions of meaning and purpose that can be uniquely addressed within communities of faith.

In a long-term study of 124 parents who lost a child to sudden infant death syndrome, McIntosh, Silver, and Wortman[19] found that greater religious participation was related to increased emotional support from others and an increase in the meaning they found in the loss of the child. Religion appears to offer for these parents an effective means to make sense of the loss that can enhance their well-being, lower their distress, and facilitate their recovery from the loss. In a study conducted in Northern California with persons grieving the death of a family member or very close friend, a strong link was found between the ability to make sense of the loss through religious beliefs and practice and positive psychological adjustment.[20]

Given the important role that faith communities and clergy play in caring for those facing death and for their grieving loved ones, the authors undertook a review of the research literature on clergy in three primary palliative care journals. The purpose of this study was to examine the degree to which articles in these journals discussed community-based clergy and chaplains between 1990 and 1999. We hypothesized that nonresearch articles would be more likely than research articles to discuss the role of clergy or chaplains. Since recent research has found an increase in healthcare articles about religion, spirituality, and, to some extent, chaplaincy, we also hypothesized that the number of articles about clergy/chaplains would increase over time.

Methods

The authors visually reviewed all the articles in the *American Journal of Hospice and Palliative Care*, the *Journal of Palliative Care*, and the *Hospice Journal* (now the *Journal of Pain and Palliative Care Pharmacotherapy*) between 1990 and 1999, excluding editorials, commentaries, rejoinders, literary works (e.g., poems), letters to the editor, and regular columns. Articles that cited at least one reference were categorized as scholarly articles. Scholarly articles were divided into either research or nonresearch categories. Articles were classified as research if they contained clearly defined methods and results sections, even if these headings were not used. The research articles were subdivided into qualitative and quantitative research. Articles were classified as quantitative if they presented descriptive or inferential statistics, even if they employed qualitative methodologies, such as ethnography or grounded theory. The nonresearch articles were categorized as either general reviews or reviews organized around the description of specific programs (program descriptions). The researchers read all research and nonresearch articles for mention of clergy, including the terms rabbi, priest, minister, pastor, imam, chaplain, or other religious professionals.

Articles that mentioned chaplains or clergy were coded (incidental or integral) according to their importance or prominence in the articles (e.g., some measurement or description of their role, being part of a survey sample, or merely briefly mentioned). The percentage of each type of article that

Table 1. Mean percentage of research and nonresearch articles that mentioned chaplains or community clergy: 1990 – 1999		
	n	%
Quantitative research	17	6.1
Qualitative research	2	2.8
All research	19	5.5
Program descriptions	13	17.8
General reviews	15	3.6
All nonresearch	28	5.7

dealt with chaplains or community clergy was calculated and analyzed using Pearson's Correlation Coefficient and Analysis of Variance (ANOVA). Frequency data were analyzed by chi-square.

Results

Quantitative findings

We found a total of 838 scholarly articles published between 1990 and 1999 in the three journals we examined. Of these, 348 (41.5 percent) were research articles, 417 (49.8 percent) were reviews, and 73 (8.7 percent) were program descriptions. Of the 348 research studies, 277 were quantitative and 71 were qualitative. Forty-seven (5.6 percent) of the 838 scholarly articles we examined mentioned clergy or chaplains in some way.

Table 1 shows the number and the percentage of research and nonresearch articles that mentioned clergy or chaplains. No significant difference was found between the percentage of research and nonresearch articles that mentioned clergy/chaplains. Among the nonresearch articles, program descriptions mentioned clergy significantly more often than other types of reviews (chi-square = 26.7, $p < .001$). But most of the program descriptions simply mentioned that chaplains were part of the treatment team or gave a brief description of the chaplain's role (77 percent). Since there were only two qualitative articles by our definition, a statistical comparison of qualitative and quantitative research was not undertaken. Correlation analyses found no changes over time in the number of articles that mentioned clergy or chaplains.

Research articles were significantly more likely to mention clergy or chaplains as an integral aspect than were nonresearch articles (chi-square = 16.8, $p < .001$) (Table 2). Quantitative articles were more likely to include clergy or chaplains as an integral aspect of the article than were qualitative articles (Fischer's exact probability test, $p = .088$). Indeed, 12 of the 17 quantitative studies that mentioned clergy or chaplains contained at least one dependent variable that measured some aspect of their role or function.

Descriptive findings

One of the two reviews that focused on clergy/chaplains discussed the need for hospice chaplains to recognize their abilities and limitations when providing spiritual care to people of different faiths.[21] The other review documents the history of the founding of Our Lady's Hospice for the Dying in Dublin by the Irish Sisters of Charity in 1879.[22] The one program description described the creation of a network of clergy who volunteered to serve as "on call" chaplains at hospices in the East Bay area of California. A brief discussion of the training they received is provided, along with an evaluation of the program.[23]

Five of the quantitative studies specifically addressed the need for spiritual care. Three of the five examined differences in the spiritual care provided by chaplains and other hospice staff,[24-26] and one assessed the work satisfaction of hospice directors in relation to their own spirituality and the presence of a chaplain on their hospice team.[27] The fifth study examined chaplains' roles and the challenges they face and measured their daily caseload.[28]

Two quantitative studies looked at outreach programs. The first was a national survey of the various services provided by outreach programs, including chaplain services.[29] The second was a study of the amount of time that chaplains and other staff spent with patients living in hospices or living alone and the cost of providing both kinds of care.[30]

Another national survey asked if clergy were part of the faculty of medical residency programs of nearly 600 accredited programs, and found that clergy were on the faculty of 23 percent of them.[31] A different study described a program in which medical students spent a rotation in hospice that included sessions with a chaplain.[32] Two of the remaining four studies included a single measure of chaplaincy services,[33,34] and the other two were surveys of clergy.[35,36]

Discussion

The majority (58.5 percent) of scholarly articles published between 1990 and 1999 were program descriptions or general reviews. Although general reviews mentioned chaplains or clergy

Table 2. Percentage of articles that mentioned clergy chaplains as an integral or incidental aspect of the article				
Type of article	Integral		Incidental	
	n	%	n	%
Quantitative research	13	76.5	4	23.5
Qualitative research	0	–	2	100
All research	13	68.4	6	31.6
Program descriptions	1	7.7	12	92.3
General reviews	2	13.3	13	86.7
All nonresearch	4	14.3	24	85.7

relatively infrequently (3.7 percent), they were mentioned much more often in program descriptions (11.8 percent), which might be expected.

Contrary to our first hypothesis, no significant difference was found between the percentage of research and nonresearch articles that addressed clergy or chaplains. Still, research articles, especially quantitative articles, were significantly more likely to include clergy or chaplains as an integral aspect of the article than were nonresearch articles. In fact, the majority of quantitative studies that mentioned clergy or chaplains also measured some aspect of their role or function as a dependent variable. We found no support for our second hypothesis that the number of articles about clergy or chaplains would increase over time.

Overall, 5.5 percent of research studies and 6.1 percent of quantitative studies mentioned chaplains or clergy. Among the 277 quantitative studies, 12 (4.3 percent) contained at least one dependent variable relating to clergy or chaplains. By comparison, a systematic review of the psychology literature between 1991 and 1994 found that less than one percent (1 in 600) of the quantitative studies that appeared in eight major journals mentioned clergy or chaplains,[37] and the same was true (0.8 percent) for a review of articles appearing in six marriage and family journals between 1995 and 1999.[38] A comparable review of three oncology nursing journals found that only 1.2 percent contained a dependent variable of clergy or chaplains between 1990 and 1999.[39]

Several articles in the *Hospice Journal* discussed the importance of spirituality and spiritual care in the hospice field. The study by Millison and Dudley[27] indicated that hospice professionals in general are a spiritual group, and that those who were more spiritual experienced greater satisfaction in hospice work. The work satisfaction of the hospice directors who were surveyed was also directly related to having clergy as members of the hospice team. Of the 120 hospice programs these researchers surveyed, 92 percent reported having clergy available to provide a spiritual component of care.[27] In some instances, however, spiritual care was provided by volunteer clergy, a patient's own clergy, or nonclergy church leaders. Although this role was filled less often by nonclergy, many nonclergy hospice professionals reported having assisted patients with spiritual concerns. While clergy typically attended to patients' spiritual needs through traditional religious practices, other staff tended to do so through nonconventional approaches.[25]

A nationwide survey of hospice professionals conducted by Babler[24] also found significant differences between spiritual care provided by social workers, nurses, and spiritual care professionals, incorporating most of the same questions used by Millison and Dudley.[25] As expected, spiritual care professionals provided the highest level of spiritual care. However, nurses also provided substantial spiritual care to patients. Social workers were the least likely to attend to patients' spiritual needs. A later study by Reese and Brown[26] supports Millison and Dudley's findings[25] with respect to hospice chaplains, but suggests that social workers may be more attentive to patients' spiritual needs than their results indicated. Even so, nurses may deal with patients' spiritual needs more often because they have more direct contact with patients. In a study conducted at a general hospital in 1991, researchers found that 88 percent of all patient referrals to chaplains came from nurses, compared to 8 percent from physicians and 4 percent from social workers.[40]

Reese and Brown[26] emphasized the important role clergy play on a hospice team. Their review of visits from staff nurses, social workers, and clergy to home hospice patients found that spirituality was the most frequent theme of discussion during visits and that clergy addressed more spiritual issues than the other two professions. Indeed, four of the top 10 issues discussed with patients involved spirituality, yet the hospice Reese and Brown studied had only one part-time clergyperson on staff.

Sontag's survey of 34 hospice programs in California[28] found that less than half had paid chaplains on their staffs, with most of the other programs relying on volunteers. Chaplains at nearly three-quarters of the facilities had caseloads of more than 40 patients per full-time equivalent (FTE) chaplain. Petersen's survey of 175 hospices throughout the United States[29] yielded some interesting findings. Among hospices without outreach services, more chaplaincy services were provided as their census increased. By contrast, chaplaincy services decreased as the census increased in hospices with outreach services. A recent survey of 370 hospital directors across the United States[41] found that hospitals with no religious affiliation, including university hospitals and psychiatric hospitals, employed roughly 1 to 1.5 chaplain FTEs per 100 patients. Religiously affiliated hospitals, on the other hand, employed close to three chaplain FTEs per 100 patients.[41]

Conclusions and recommendations

In summary, this study found that articles published in three primary palliative care journals in the 1990s mentioned and discussed chaplains and community-based clergy more frequently than has been found in several other professional fields, including nursing, psychology, and marriage and family counseling. The higher number of these articles in the palliative care journals probably reflects the high degree of reliance individuals and families have on religion and clergy in dealing with end-of-life issues and care. The fact that clergy and chaplains were mentioned most often in program descriptions gives some indication of their integral role among hospice staff. Only a few articles described the role of the chaplain in detail. In addition, although research articles were somewhat less likely to discuss chaplains and clergy, when they were included they played a more integral part in the studies. This was especially true among the quantitative studies, where 13 of the 17 studies mentioned chaplains or clergy.

Pastoral or spiritual care has always been viewed as an indispensable component of hospice and other palliative care programs in the United States. This includes provision not only for patient-centered spiritual care, but also bereavement aftercare support to surviving family members. While all hospice team members share responsibility for the integration of care, they do look to religious professionals trained as chaplains to take the lead in the management of the spiritual needs of patients and family members.

Since the majority of end-of-life care supported by organized hospice professionals is delivered at home and not in hospital-based programs, hospice chaplains rely heavily on relationships with other community clergy to support the spiritual care needs of patients and families. Many community clergy are willing to assist, but they may lack specialized training and experience in working with dying persons. As noted earlier, bereavement and death and dying issues are among the most common problems congregants bring to community clergy.[5-10] While some studies have found that community clergy feel they are adequately prepared to address these issues,[5,42] others have found that clergy want more training in this area.[6,9,43] Hospice chaplains can play an important role in providing education, consultation, and peer support to their fellow community-based clergy.

The growth of the clinical pastoral education movement in the United States is ensuring that more seminarians are receiving basic education in the care of the sick and dying. Clergy are also learning more effective ways to collaborate with other healthcare professionals in the total care of patients and families facing life-threatening illness, and are more readily accepted as partners in caring by medical and nursing professionals. Mental health training, like that provided by clinical pastoral education, is extremely important for clergy because they are asked to deal with a host of mental-health problems. Indeed, surveys conducted by the National Institute of Mental Health have found that clergy are more likely than both psychologists and psychiatrists combined to be approached for help by a person who has a mental-health diagnosis.[3] Several studies over the years have enumerated the kinds of mental-health problems that are presented to clergy in pastoral counseling. Anxiety and depression typically are the most common, followed by alcohol and drugs problems.[5,6,43,44] Clergy see people with suicide issues or severe mental illness in pastoral counseling far less often.[5,6,43,44] Unfortunately, clergy say they are not adequately prepared to deal with most mental health problems.[42,45]

Future research needs to include rigorous studies that investigate the positive or negative outcomes of spiritual interventions in end-of-life care. We must define the level of training and experience required of religious professionals and their community clergy collaborators to ensure that competent and compassionate care is given to the sick and dying.

Acknowledgment

This research was funded in part by a grant from the Riklis Family Foundation/ Mona R. Ackerman, PhD.

References

1. Weaver AJ, Revilla LA, Koenig HG: Counseling families across the stages of life: A handbook for pastors and other helping professionals. Nashville, TN: Abingdon Press, 2002.
2. Gallup GH, Bezilla R: *The Religious Life of Young Americans*. Princeton, NJ: Gallup International, 1992.
3. Hohmann AA, Larson DB: Psychiatric factors predicting use of clergy. In EL Worthington, Jr. (ed.), *Psychotherapy and Religious Values.* Grand Rapids, MI: Baker Book House, 1993, pp. 71-84.
4. Walczak K: personal communication, March 1, 2002.
5. Abramczyk LW: The counseling function of pastors: A study in practice and preparation. *J Psychol Theol.* 1981; 9: 257-265.
6. Ingram BL, Lowe DW: Counseling activities and referral practices of rabbis. *J Psychol Judaism.* 1989; 13(3): 133-148.
7. Wood NS: An inquiry into pastoral counseling ministry done by women in the parish setting. *J Pastoral Care*. 50(4): 340-348.
8. Wright PG: The counseling activities and referral practices of Canadian clergy in British Columbia. *J Psychol Theol.* 1984; 12: 294-304.
9. Francis LJ, Robbins M, Kay WK: *Pastoral Care Today: Practice, Problems, and Priorities in Churches Today*. Farnham, Surrey, UK: Waverley Christian Counseling, 2000.
10. Lount M, Hargie ODW: The priest as counselor: An investigation of critical incidents in the pastoral work of Catholic priests. *Couns Psychol Q.* 1997; 10(3): 247-259.
11. Veroff J, Kulka RA, Douvan E: *Mental Health in America: Patterns of Help-Seeking from 1957 to 1976.* New York: Basic Books, 1981.
12. Koenig HG, McCulloch ME, Larson DB: *Handbook on Religion and Health.* Oxford, UK: Oxford University Press, 2001.
13. Gallup GG, Lindsay DM: *Surveying the Religious Landscape: Trends in US Beliefs.* Harrisburg, PA: Morehouse Publishing, 1999.
14. VandeCreek L, Burton L: Professional chaplaincy: Its role and importance in healthcare. *J Pastoral Care.* 2001; 55(1): 81-97.
15. Foliart DE, Clausen M, Siljestrom C: Bereavement practices among California hospices: Results of a statewide survey. *Death Stud.* 2001; 25(5): 461-467.
16. Bryant C: Role clarification: A quality improvement survey of hospital chaplain customers. *J Healthc Qual.* 1993; 15(4): 18-20.
17. Siegel JM, Kuykendall DH: Loss, widowhood, and psychological distress among the elderly. *J Consult Clin Psychol*. 1990; 58(5): 519-524.
18. McMillan SC, Weitzner M: How problematic are various aspects of quality of life in patients with cancer at the end of life? *Oncol Nurs Forum.* 2000; 27(5): 817-823.
19. McIntosh DN, Silver RC, Wortman CB: Religion's role in adjustment to a negative life event: Coping with the loss of a child. *J Pers Soc Psychol.* 1993; 65(4): 812-821.
20. Davis CG, Nolen-Hocksema S, Larson J: Making sense of loss and benefiting from the experience two construals of meaning. *J Pers Soc Psychol*. 1998; 75(2): 561-574.
21. Hall SE: Spiritual diversity: A challenge for hospice chaplains. *Am J Hosp Palliat Care*. 1997; 14(5): 221-223.
22. Kerr D: Mother Mary Aikenhead, the Irish Sisters of Charity, and Our Lady's Hospice for the Dying. *Am J Hosp Palliat Care.* 1993; 10(3): 13-20.
23. Perrino T: Developing a large, volunteer hospice chaplain network. *Hosp J.* 1996; 11(3): 95-101.
24. Babler JE: A comparison of spiritual care provided by social workers, nurses, and spiritual care professionals. *Hosp J.* (1997; 12(4): 15-26.
25. Millison MB, Dudley JR: Providing spiritual support: A job for all hospice professionals. *Hosp J.* 1992; 8(4): 49-66.
26. Reese DJ, Brown DR: Psychosocial and spiritual care in hospice: Differences between nursing, social work, and clergy. *Hosp J.* 1997; 12(1): 29-41.
27. Millison MB, Dudley JR: The importance of spirituality in hospice work: A study of hospice professionals. *Hosp J*. 1990; 6(3): 63-78.
28. Sontag MA: Hospice as providers of total care in one western state. *Hosp J*. 1996; 11(3): 71-94.
29. Petersen S: Beyond hospice care: A survey of community outreach programs. *Am J Hosp Palliat Care*. 1992; 9(1): 15-22.
30. Bly JL, Kissick P: Hospice care for patients living alone: Results of a demonstration program. *Hosp J.* 1994; 9(4): 9-20.
31. Plumb JD, Segraves M: Terminal care in primary care postgraduate medical education programs: A national study. *Am J Hosp Palliat Care.* 1992; 9(3): 32-35.
32. Knight CF, Knight PF, Gellula MH, et al.: Training our future physicians: A hospice rotation for medical students. *Am J Hosp Palliat Care.* 1992; 9(1): 23-28.
33. Bunston T, Elliott M, Rapuch S: A psychosocial summary flow sheet: Facilitating the coordination of care, enhancing the quality of care. *J Palliat Care.* 1993; 9(1): 14-22.
34. Rutman D, Parke B: Palliative care needs of residents, families, and staff in long-term care facilities. *J Palliat Care.* 1992; 8(2): 23-29.
35. Gochman DS, Bonham GS: The social structure of the hospice decision. *Hosp J.* 1990; 6(1): 15-36.
36. Wilker HI, Lowell B: Bereavement services development in a rural setting. *Hosp J.* 1996; 11(4): 25-39.
37. Weaver AJ, Koenig HG, Larson DB: Marriage and family therapists and the clergy: A need for clinical collaboration, training, and research. *J Marital Fam Ther.* 1997; 23(1): 13-25.
38. Weaver AJ, Samford JA, Morgan VJ, et al.: A systematic review of research in six primary marriage and family journals: 1995-1999. *Am J Fam Ther.* 2002; 30: 293-309.
39. Weaver AJ, Flannelly LT, Flannelly KJ, et al.: A 10-year review of research on chaplains and community-based clergy in three primary oncology nursing journals: 1990-1999. *Cancer Nurs.* 2001; 24(5): 335-340.
40. Koenig HG, Bearon LB, Hover M, et al.: Religious perspectives of doctors, nurses, patients, and families. *J Pastoral Care.* 1991; 45(3): 254-267.
41. VandeCreek L, Siegel K, Gorey E, et al.: How many chaplains per 100 inpatients? Benchmarks of health care chaplaincy departments. *J Pastoral Care.* 2001; 55(3): 289-301.
42. Virkler HA: Counseling demands, procedures, and preparation of parish ministers: A descriptive study. *J Psychol Theol*. 1979; 7(4); 271-280.
43. Lowe DW: Counseling activities and referral practices of ministers. *J Pastoral Care*. 1986; 5(1): 22-28.
44. Bell RA, Morris RR, Holzer CE, et al.: The clergy as a mental health resource: Parts I and II. *J Pastoral Care.* 1976; 30(2): 103-115.
45. Mannon JD, Crawford RL: Clergy confidence to counsel and their willingness to refer to mental health professionals. *Fam Ther.* 1996; 23(3): 212-231.