

Pastoral and spiritual care interventions as independent variables in religion/spirituality and health research: a pilot project to operationally specify clergy & chaplain practices

ABSTRACT

The purpose of the pilot project is to develop a methodology for: operationally specifying clergy and chaplain interventions at a level of detail that will enable replication by other clergy and chaplains; developing consensus definitions of the constructs and terminology used in describing pastoral and spiritual care interventions; establishing the infrastructure of procedures for managing the development of an archival knowledge base of the pastoral and spiritual care practices of religious and spiritual care-givers. The methods for developing the initial prototype for this knowledge base are derived from the intervention specification methods of psychotherapists and nurses that are used for clinical trials to establish the efficacy of their practices. The results thus far have included the development of a number of preliminary draft specifications of interventions, and a preliminary template for the uniform representation of the various common aspects of clergy and chaplain interventions, and for the identification of terminological usages and conventions. The availability of fully specified operational descriptions suitable for replication in research studies will help to fill a gap in religion and health research, as well as support the long range goal of evidence-based pastoral and spiritual care.

INTRODUCTION

The purpose of this pilot project is to identify the practical issues that are involved in developing a prototype online web-accessible knowledge base of the various religious and spiritual practices of clergy and chaplains for those who are ill, tailored to the specific needs and problems of the patients, and described in sufficient detail to enable replication by other clergy and chaplains. These reproducible detailed descriptions of pastoral and spiritual care interventions are intended to be useful for the long-term effort to identify evidence-based efficacious chaplaincy practices, and for the clinical and field education of clergy. The availability of fully detailed descriptions of religious and spiritual interventions, specified operationally in a consensus controlled vocabulary, will be helpful for the long-term effort to develop a knowledge base of evidence-based practices for clergy and chaplains and for research on the health outcomes that may be attributed to the religious and spiritual interventions that address the needs and problems of patients.

Research on the influence of religion and spirituality on health outcomes during the past several decades has increased with notable contributions by many researchers, but has been singularly lacking in addressing the potential influence of clergy and chaplain

interventions on patients' religious and spiritual response to the challenges of health recovery. The 2001 landmark review of over 1,200 studies on religion and health found that over two-thirds of those studies showed significant statistical associations between religious activity and better mental health, better physical health, or lower use of health services (Koenig, McCullough & Larson, 2001). But only three studies could be found at that time that explicitly included chaplain or clergy interventions as a mediating influence (*Ibid.*, p. 420-21). In general, the designs of studies of the influence of patients' religion and spirituality on health outcomes have not only not included measures of the potential effects of clergy and chaplain interventions on health outcomes, but also have not included controls for these potential effects.

When clergy and chaplain interventions occur in health care contexts it is reasonable to suggest that they be accounted for or controlled in some way in study designs, whether or not there is a theoretical model of how they may effect the activation of the subjects' religious and spiritual resources and thereby potentially influence health outcomes. Whether these interventions are modeled as variables that may strengthen or modify the influence of the subjects' measured religiosity and/or spirituality on the specific health outcomes measured in the studies, or in some other way to control for their possible effect, it is reasonable to expect that they should be represented in some way.

In addition to the philosophical and pragmatic issues involved in the specification and measurement of religious and spiritual factors (Hall et al., 2008; Hill et al., 2000; Hill & Pargament, 2003; Idler et al., 2003), the difficulty in accounting for the potential influence of clergy and chaplain interventions arises from several other sources: the great variety of such interventions in actual pastoral and spiritual care practice; the absence of operational specifications of these interventions; the absence of a controlled vocabulary for clarifying the constructs and terminology used in describing and distinguishing between these different types of interventions; and the absence of a consensus knowledge base for the field of pastoral and spiritual care. The very few research studies that have explicitly included consideration of the potential influence of clergy or chaplain interventions on health outcomes have not described those interventions with sufficient details to allow replication studies to further verify or refine the reported outcomes. (Florell, 1973; Bliss et al., 1995; Iler et al., 2001; Bay et al., 2008). These studies have provided valuable suggestions for feasible designs for including chaplain and clergy interventions in systematic research studies, but have not illustrated how to develop the detailed operational specification of the interventions that would allow replication studies.

This lack of specification of clergy and chaplain interventions is understandable in view of the fact that relatively few clergy and chaplains have been positioned in institutions where there has been active research on the influence of religion and spirituality on health outcomes. This kind of methodological practice – the detailed operational specification of clergy and chaplain pastoral and spiritual care practices – has not been part of the applied disciplines within religious and spiritual studies up to the present. Systematic research to define clearly and test the efficacy of religious and spiritual interventions has been advocated from the early years of the pastoral care movement, and a number of

exploratory studies have been undertaken (Gleason, 2004). But these studies have lacked the methodological design and control framework for an empirical verification of the efficacy of the approaches advocated. For the purpose of developing evidence of the efficacy of specific clergy and chaplain interventions, the scope and level of detail in the intervention specifications must be that which will enable consistent replication of the interventions by other clergy and chaplains. Very few of the researchers who have studied the potential effects of religion on health outcomes have been providers of direct religious or spiritual care, or have been able to benefit from collaboration with clergy and chaplains in order to assure that the scope and degree of details in the descriptions of the interventions would allow reproducibility by other clergy and chaplains.

In addition, the constructs and terminologies used in the empirical study of religion and spirituality have seldom matched the philosophical and theological assumptions embedded in the pastoral and spiritual care literature of clergy and chaplains. The encyclopedic *Dictionary of Pastoral Care and Counseling* published in 1990 (Hunter, 1990) laid some of the groundwork for a coordinated effort, but the programmatic resources for building on this foundation have not been available thus far.

The pilot project reported in this paper has been undertaken to lay the groundwork for a practical methodology for developing and making accessible the detailed operational specification and unambiguous characterization of the religious and spiritual interventions of clergy and chaplains. This pilot project is designed to identify the practical methodologies that can be used to develop operational descriptions of clergy and chaplain interventions in sufficient detail so that the interventions can be reproduced consistently by other clergy and chaplains, both for their practices and research studies, as well as for clinical education and field training programs for seminarians. The specification methodologies that are developed in this project may help to remedy the lack of empirical research on the influence of clergy and chaplain interventions on health outcomes, as well as support the development of the professional knowledge base for evidence-based chaplaincy.

METHOD

The pilot project is addressing the practical issues involved in the development and application of three interrelated methodologies and processes for:

- 1 - developing and refining a template of the facets required for operationally specifying clergy and chaplain interventions at a level of detail that will enable replication by other clergy and chaplains;
- 2 - the incremental semantic clarification of the constructs and conceptual relationships among the terms used in describing the activities and effects of pastoral and spiritual care interventions, as the basis for developing consensus definitions;
- 3 - establishing the infrastructure of procedures for managing the development of an archival knowledge base of the pastoral and spiritual care practices of religious and spiritual care givers, that will be web accessible.

The initial methodology for the operational descriptions of the pastoral and spiritual care interventions of clergy and chaplains in caring for those who are ill has been derived from the experience of psychotherapists in developing manuals describing their therapeutic interventions for the purposes of clinical research and clinical training, and also from the experience of nurses in developing a descriptive research-based knowledge base on the efficacy of nursing practices. This pilot project is exploring the ways in which these sources of experience in practice specification can guide the evolution of the methodology for developing the knowledge base of detailed operational descriptions of reproducible clergy and chaplain interventions. In developing the detailed descriptions of psychotherapeutic interventions for Phase I testing in clinical trials, the peer review and pilot testing phase can be counted on to reveal many issues that need clarification and standardization for the trials. In a similar manner, the development of preliminary drafts of descriptions of religious and spiritual interventions can be counted on to identify the procedural and content issues that are needed for replication, as well as the conceptual and terminological ambiguities that need clarification.

The editors of the major medical journals have been progressively requiring more information from authors about the details of their clinical research protocols. The progressive elaboration of the CONSORT statement's requirements over the past dozen years has improved the quality of reporting of randomized clinical trials (Plint et al., 2006). The members of the CONSORT Group have continued to extend the scope of the revised statement of 2001 to address the needs of additional categories of clinical trials, such as non pharmacological interventions (Boutron et al., 2008a). The progressive development and refinement of the CONSORT statement now has included general specifications for the description of behavioral interventions used in clinical trials (Boutron et al., 2008b). The editors of the *Annals of Internal Medicine* have raised the bar further by requiring authors to be willing to make available the details of their research protocols, their data sets, and the analytical software used for their findings so that other researchers can, at minimum expense, reproduce the findings reported in the authors' articles. This reproducible research model is intended to achieve research reporting that the public can trust (Laine et al., 2007); the general requirements for the description of behavioral interventions outlined in these efforts offer a framework that is instructive for the pilot project.

A preliminary template of the types of details needed in the descriptions of clergy and chaplain interventions is readily derived from the guidance for planning clinical trials of psychotherapy treatments: the contents of treatment manuals, therapist training materials, and adherence/competence assessments have been outlined (Rounsville et al., 2001; Carroll & Nuro, 2002). The methods for the reflective analysis of clergy and chaplain practices are suggested by the descriptive research studies of nursing care that have focused on the practices of nurses for handling the specific needs and problems of patients (Benner, 1982a; Benner, 1982b). This focus of nursing research over the past two decades was stimulated by the methodological work of Benner and others (Rolfe, 1998). This more detailed description of nursing interventions has paralleled much of the specification and manualization efforts in the field of psychotherapy. The nursing experience in describing practices has also illuminated the importance of a progressive

refinement of care givers' perceptions of patients' needs, and the importance of a shared descriptive vocabulary for specifying caring practices (Benner & Wrubel, 1982a; Benner & Wrubel, 1982b). The nursing experience also has clarified the singular importance of the level and scope of detail in the descriptions of practices (Conn, 2007), and the importance of a description of interventions as the foundation for developing a nursing knowledge base (Lobo, 2005). This experience in the field of nursing suggests the practical contextual issues that can be expected in developing operational descriptions of chaplain and clergy interventions (Benner & Sutphen, 2007).

1 - The Procedures for the Development of Replicable Descriptions of Interventions

The initial scheme for developing the methodology for the description of clergy and chaplains' practices starts with inviting clergy and chaplains to develop draft descriptions of actual interventions that have been conducted with patients in a variety of contexts. Other participating clergy and chaplains will then assist these authors to identify the additional facets and level of detail in the practice descriptions that others would need to know to enable them to replicate the intervention as the author intends. The authors and participating clergy and chaplains will then cooperate in progressively refining and completing these descriptions to the point where they are sufficiently detailed to be reproducible by other clergy or chaplains. The process of refinement and elaboration of these initial draft descriptions into fully operational specifications is accomplished through collaboration and iterative comment by other clergy and chaplains. The details and content elaborated in this progressive refinement of drafts are then to be organized in accordance with a consistent template of facets and aspects. The successive drafts of the descriptions are thereby progressively refined and clarified through several iterations of review and comment until they provide fully-characterized and reproducible operational specifications of the pastoral and spiritual care interventions.

In this pilot project, the initial drafts of intervention descriptions are being developed both by experienced chaplains and by pastoral and spiritual care providers in clinical training, supervised by experienced chaplains. These initial drafts are to be based on actual intervention experiences, which are recorded in some level of detail through recall shortly after the interventions. These initial recorded descriptions of actual interventions, referred to as "verbatim," are then discussed with peers for their comments and suggestions. With this background, the authors develop the first draft of a description of how they ideally would have conducted that visit, or how they would propose to conduct that visit with that patient if they had the opportunity to conduct the intervention over again. The intervention plan and description may then be broadened a bit to be applicable to any patient with similar characteristics and needs. The initial drafts of intervention descriptions are expected to be incomplete and without adequate details for replication or reproducibility. By progressively reworking the drafts through consultations with peers, and reorganizing them to fit the common template for the detailed operational specifications, the drafts will be filled out and refined as reproducible interventions. The fully detailed operational descriptions of the interventions, therefore, will be proposed as the intervention plans for the most efficacious ways in which the authors as chaplains can visualize addressing the specific needs and problems of the patients identified in the original visit encounters, and for other patients with similar characteristics and needs.

2 - The Procedures for the Consensus Vocabulary Development Process

Within this iterative development process, the authors of the drafts will have an opportunity to compare what they mean by the key terms they use with the definitions of those terms, or similar terms, used by the developers of other intervention descriptions. This comparison, along with concept modeling to clarify the relationships between terms, is intended to provide the information for developing consensus definitions of the constructs and terminology used in describing pastoral and spiritual care interventions.

3 - The Procedures for the Development and Management of the Knowledge Base

Establishing the infrastructure of procedures for managing the development of an archival knowledge base of the pastoral and spiritual care practices of religious and spiritual care givers is also intended to be an incremental process. The operational descriptions of proposed ideal chaplain and clergy interventions for specific patient issues and contexts are intended to be introduced into a prototype on-line knowledge base. This knowledge base of chaplain and clergy interventions is intended to be designed to enable clergy and chaplains to find proposed ideal intervention plans through multi-faceted identifiers, including what may be considered to be the central patient issue to be addressed in the intervention. The access and retrieval needs of the users of descriptions in the on-line knowledge base will be identified incrementally as the initial knowledge base prototype grows in size and usage.

The scope of this pilot project is intentionally limited in several ways. The project does not include the testing for efficacy of these descriptions of interventions through replication in practice. The descriptions are intended to be fully capable of being tested in clinical studies, but the testing will be up to researchers and not an activity of the pilot project. The scope of the project is limited to supporting the development of the descriptions to the level of detail that will enable them to be replicated for testing.

The project does not intend to make any recommendations for specific interventions, or to evaluate the usefulness of individual descriptions for pastoral and spiritual care. The selection and use of specific intervention descriptions will be up to the decisions of individual clergy or chaplains, or researchers. The voluntary reporting of experiences with specific interventions, however, will be encouraged.

RESULTS

During the first two years of this pilot project (2006 and 2007) the exercise of developing preliminary draft descriptions of interventions, called Ideal Intervention Papers (IIPs), was introduced into the curriculum of four hospital-based Clinical Pastoral Education (CPE) programs: three intern groups and one resident group. The participating hospital institutions are located in the states of Indiana, Ohio and New York. At St. Vincent Hospital, Indianapolis, eleven chaplain interns under the supervision of chaplain John Gleason completed the description writing exercise, currently identified as the Ideal Intervention Paper (IIP), during the Winter-Spring of 2006 and 2007. Four chaplain residents at Clarian Health, Indianapolis, under the supervision of chaplain Yoke Lye Lim Kwong, completed IIPs and offered their critiques of the exercise during CPE

programs in the summer of 2007. In addition, interns and residents at the Lutheran Hospital of Indiana in Fort Wayne Indiana, at the Children's Hospital Medical Center in Cincinnati Ohio, and at Bellevue Hospital Center in New York City, completed draft descriptions of interventions.

The IIP development exercise started with fairly detailed descriptions, called verbatims, of actual interventions based on the interns' recall of specific patient visits. These verbatim descriptions were then presented for discussion and critique in peer group discussion sessions. After these discussions, the interns developed revised and refined preliminary short manuals describing idealized approaches to conducting the interventions (the Ideal Intervention Papers). These proposed interventions described how ideally the interns would recommend conducting those patient visit interventions if they or someone else were to do those visits over again, or if in the future they or other chaplains encountered patients with closely similar characteristics and needs.

The eleven St. Vincent interns produced IIPs with the following central issue identifiers: fear of surgery, patient and family guardedness, patient need to express spiritual and emotional concerns, infant death, respiratory distress, guilt regarding spouse's death, coding infant, undiagnosed illness, end of life issues, sudden death, and pastoral etiquette (regarding the presence of the family pastor). The four Clarian residents' central issue identifiers were: triangulation (by an uninvited pastor), advocacy for the hospital, end of life issues (twice), extreme pain (twice), amputation issues, and faith as a resource. Each resident's IIP had multiple identifiers.

At the East Central ACPE Region Fall Conference in Cuyahoga Falls Ohio on September 29, 2007 Gleason conducted a workshop entitled, "Verbatim2: A Best Practices Protocol for CPE Students." The purpose was to introduce CPE educators and students to the exercise of developing an Ideal Intervention Paper (IIP), following a protocol that was designed to consolidate the learning experience gained in traditional peer group verbatim presentations and discussions. Several attendees agreed to include the revised IIP protocol in their clinical training curricula in the future.

The protocol and template for the initial development of a description draft has been revised several times during the past two years based on feedback from those who have developed intervention papers and from their supervisors. A revised protocol was tested in a second pilot phase, and preparations for a third revision are underway.

The initial efforts of this project have confirmed the feasibility and potential value of the Ideal Intervention Paper exercise in CPE curricula. This exercise can be adapted and extended as the first step in developing drafts of replicable descriptions of interventions. Given sufficient professional cooperation from the faith communities and organizational members of the associations in the pastoral and spiritual care movement, and provided adequate financial support, this initiative and methodology can provide a practical approach for the development of religious and spiritual intervention specifications for religion and health research as well as for the clinical training of clergy and chaplains, and projects for identifying evidence-based chaplaincy practices.

Copies of the current version of the protocol and guidance are available. In addition, a draft of the contents expected in a fully detailed replicable intervention description has been developed as initial guidance, based on the content lists in the CONSORT (Boutron et al., 2008) and Carroll & Nuro (2002) articles, and is also available from the authors. (See contact information below).

DISCUSSION

The pastoral and spiritual care practices of clergy and chaplains in health care contexts are a specific, consciously applied discipline of support for the religious and spiritual needs of persons who are ill. The religious and spiritual needs of patients are a dimension of human striving that is grounded in certain universal human needs and yearnings pertaining to one's need to find meaning in life; to one's realization of a sense of self apart from, yet in relation to, a group; to one's maintenance of a sense of union with that which may be seen as transcending self (Stoddard & Burns-Haley, 1990). Often this need is expressed in the patient's conscious effort to deepen her or his personal relationship with God (Hill et al., 2002; Hall et al., 2008). The religious and spiritual care practices of clergy and chaplains that provide support for these patients' efforts are quite varied in scope and content, and are expected to be useful to the patient to the extent that they fit the particular needs, culture, and aspirations of the patient.

The pilot project has not adopted any policy or criteria for determining whether or not a proposed description of an intervention is appropriate for the characteristics and needs of patients. No position has been taken on the on-going discussion of whether or to what extent the concepts of religion and spirituality are related or overlap. The spiritual care practices of different chaplains may or may not engage religious forms, depending on the theological viewpoints of those individual chaplains. The pilot project does not judge the appropriateness of individual interventions, or establish criteria for inclusion and exclusion of interventions in the prototype knowledge base. The project seeks to support the development and availability of adequately detailed descriptions of the full range and variety of the interventions that individual clergy and chaplains consider to be useful and effective in meeting some of the specific religious and spiritual needs of patients. The chaplain or clergy member who authors a replicable intervention description is relied on to judge whether the intervention can be useful and appropriate, and therefore should be included in the knowledge base.

It is recognized that the same arguments that have been made for and against the manualization of psychotherapy treatments can be made against the detailed descriptions of the religious and spiritual care interventions clergy and chaplains. Psychotherapy treatment manuals have been considered to be a turning point in psychotherapy research (Luborsky & DeRubeis, 1984) in that they support the internal validity and integrity of the treatment and facilitate training because of their operational specification of treatments (Dobson & Shaw, 1988). But the treatment manuals also have been criticized as limiting therapist flexibility in adapting a treatment to the specific needs of particular patients (Davidson & Lazarus, 1995; APA, 2006).

Whether or not individual interventions actually are replicated by any other chaplain or clergy person besides the author is beyond of the scope of the pilot project. How these descriptions of interventions may be evaluated or used by other clergy and chaplains, or by researchers, is not within the scope of the project. The sole criterion for accepting descriptions of interventions for inclusion in the prototype knowledge base is whether or not the intervention is described in sufficient detail to enable replication by clergy or chaplains other than the author.

The purpose of the pilot project, and the purpose of the prototype archival knowledge base of clergy and chaplain interventions, is not to prescribe what interventions chaplains should use in specific situations; the purpose is to enable clergy and chaplains to have access to full descriptions of the variety of proposed approaches various colleagues consider to be valuable. The knowledge base created by these intervention descriptions will enable clergy and chaplains to review and discuss the various different approaches and interventions that other chaplains and clergy consider appropriate for particular cases and profiles of patients' needs.

There are quite pragmatic institutional factors that have limited the participation of clergy and chaplains in research on the influence of patients' religious and spiritual activities and attributes on health outcomes. This paper is not the appropriate place to review these historical and institutional factors (VandeCreek, 1999; VandeCreek, 2000). What is useful to recognize here is that this pilot project represents a concerted effort to develop inductively the operational specifications of clergy and chaplain interventions that have not been available for consideration by caregivers and researchers up to the present.

In contrast to research in psychotherapy, however, currently there is little expectation that there will be research grant programs for supporting clinical trials of the interventions. Also the career reward of academic promotion is not expected to be a significant source of motivational support for participation in the program, since very few clergy and chaplain caregivers are positioned in academic institutions and programs. There is a need to develop incentives and career rewards for those clergy and chaplains who voluntarily participate in this effort. At present there is no tangible incentive for voluntarily participating in this effort other than professional self-respect and interest in improving the religious and spiritual care of patients. Participation can be time-consuming, since the development of a fully detailed reproducible intervention description usually takes multiple iterations and revisions. The time lines that are relevant for the development of psychotherapy manuals and the associated materials for therapist training and adherence/competence assessments (e.g., Rounsaville et al., 2001: pages 139 ff.) may turn out to be useful approximations for estimating the pace at which the development of individual well-described clergy and chaplain interventions can proceed.

In keeping with research objectives for the scientific study of the influence of religion and spirituality on health outcomes, it is questionable whether research studies should assume that the religious and spiritual support practices of clergy and chaplains have no effect on health outcomes. This assumption probably is not consciously articulated in the design of studies, but appears to be implicit when there is no independent variable or

control for this factor in the design of studies, or when there is no model offered for how to pick up the effect of these interventions through the measurement of the religiosity or spirituality of the patients.

The influence of clergy and chaplain interventions on health outcomes can be considered to be measured by the enhanced religiosity or spirituality of the patient that may result from the interventions. In this approach, the instruments measuring the patient's religiosity or spirituality would pick up whatever influence on health outcomes might be attributable to the clergy or chaplain interventions, but would not differentiate the influence of the clergy and chaplain interventions from other influences. A limitation of the assumptions inherent in this approach arises from the timing of the interventions in relation to when the measures of religiousness or spirituality are conducted, as well as in the assumptions as to how quickly the effect of the intervention may change the measurable religiosity or spirituality of the patient. Assumptions about how the clergy or chaplain interventions may affect the patient's relationships with the individuals providing the patient with social support also may need to be considered more explicitly in study designs that include controls for social and other support factors.

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