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This article explores the challenges of training clinical psychology doctoral students in the integration of psychology and Christianity. Our training program is based on a competency model that includes the integration of psychology and Christianity as a specific area of clinical competence. Competence in integration is evident in the students' respect and empathy for clients as well as specific knowledge and skills in working from a faith perspective. Training in integration has unique challenges including the variability in practicum supervisors' knowledge and skill in working with religion as an aspect of diversity. Semester evaluations completed by both practicum supervisors and graduate students show that students' competence in integration is often more advanced than the supervisors'. This imbalance can cause discomfort for the supervisor and lead to misunderstanding as students attempt to practice within an integrative framework. The nature of the practicum site often determines how an integrative perspective is incorporated into clinical care. Medical settings and clinics affiliated with faith-based organizations often support both an implicit understanding and explicit use of faith as a protective factor. In contrast, forensic settings and school sites tend to limit explicit discussions of faith. It is recommended that training programs incorporate both implicit and explicit opportunities for the integration of Christianity and psychology and increase supervisors' awareness of integration as an aspect of diversity.

Who hasn't felt some of the heart-pounding anxiety when preparing the self-study or during the site visit by the American Psychological Association, Commission on Accreditation representatives? The extensive preparation requires a review and evaluation of every aspect of the clinical program. Similar to many programs, our self-study required a 200+ page appendix to provide the requested program data. But, in addition to the microanalysis, the self-study also gave us an opportunity to have meaningful discussions with our students about our larger mission and values. In small group meetings we asked our students, "Why did you choose George Fox University?" and talked about how their expectations had or had not been met. The most frequent response to the "Why GFU?" was, 1) the focus on the integration of psychology with Christian thought 2) the mentoring relationships embedded in our research and clinical team models and 3) the opportunities for training in health psychology. Interestingly, there was much more variability in the expectations for the integration curriculum than for the clinical and research mentoring or practicum training. Responses ranged from the opportunity to contrast the theological and psychological conceptualization of grace to how to pray with a client in session.

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Program Distinctives

Perhaps in response to the changing needs and expectations of students, our integration curriculum underwent a major restructuring three years ago. The curriculum no longer includes content-focused courses in Old and New Testament, for example. Instead the integration courses reflect a combination of knowledge and clinical application, utilizing team-teaching with a religious studies scholar and a psychologist co-leading classroom interactions regarding integration. Given that integration is a program distinctive and remains a priority for our students, the integration program will continue to evolve and incorporate both knowledge and clinical skills. The emphasis on mentoring relationships is another distinctive aspect of our program. Mentoring occurs as students participate in "vertical" teams for research and clinical work. The term vertical describes the composition of the team, which includes students from each cohort year as well as the faculty mentor. Clinical and research vertical teams meet weekly or bi-weekly; allowing students from multiple cohorts to work closely with each other. Our program's growing emphasis on health psychology is another relative distinction for Christian doctoral programs in professional psychology. Eight years ago, 15% of our practicum training occurred in medical settings; in

contrast, almost 40% of practicum placements for 2010-11 occurred in medical settings. A large part of this growth has been fueled by students' interest in primary care training.

A final unique aspect of our program is related to our geographical setting. Many cities across the country contain more doctoral training programs in clinical psychology than we have in the entire state of Oregon. Instead, Oregon is home to only three university programs, two of which are in professional psychology. This small number is advantageous to students in that it facilitates a collaborative training voice as we communicate with our regulatory boards, practicum sites, and state associations. The two professional psychology programs often share practicum sites and supervisors, have coordinated a practicum placement process and established cross-program student involvement in the state psychological association. This collaboration may reflect the Oregon culture that is often perceived to be quite relaxed and open, or it may simply reflect the reduced competition that occurs when there are a limited number of programs.

Clinical Training Embedded in Program Objectives

We have used the clinical competency model (Fouad et al., 2009) to embed clinical training across multiple program areas. Competencies reflect the core professional activities of psychologists and include the expected knowledge, skills and attitudes that should be attained at different levels of training (practicum, internship, licensure). The Benchmarks document shown in Fouad et al. (2009) included 15 areas of competence; our program emphasizes 7 of the 15 competencies (Relationship, Intervention, Assessment, Research, Diversity, Consultation and Supervision). Reflecting the mission of our program, we added *Integration* as an 8th area of competence. The 8 competency areas have been mapped across coursework, clinical training, and research activities in the program. For each of the competencies, we have identified specific objectives and goals for each year of training. As part of the clinical competency model, the students are assigned to clinical teams that include a clinical faculty mentor who helps each student to develop an individualized training plan (ITP). The students' ITP identifies specific training goals and methods to demonstrate attainment of their competency goals. For example, a student in his or her second year of training may identify a specific goal in the competency area of assessment (e.g., achieve competency in cognitive assessment). To demonstrate this competency, the student may opt to submit a digital recording from the cognitive assessment course that shows his or her ability to administer the test. In addition to the coursework, the student may also include a work sample of a completed assessment protocol and report that he or she has completed at his or her practicum site and that has been reviewed by the practicum supervisor and presented to the clinical team. An example of competency in integration may include using the ADDRESSING model (Hays, 2001) as part of a diagnostic interview. The ADDRESSING model requires the student to explore the following aspects of diversity during the clinical interview: Age, Disability (visible and invisible), Religion and spirituality, Ethnic identity, Socioeconomic status, Sexual orientation, Indigenous heritage, National identity, and Gender. Demonstrating competency would include use of the model in the interview and incorporation of the relevant data in the report and treatment plan. Thus, the framework of clinical competency encourages students to find meaningful ways to gain knowledge; more importantly, the students gain self-awareness and confidence as they demonstrate the competency to others. Nelson (2007) suggested that not only should graduate students gain knowledge and skills, but also it is important that they "know what they know" as they seek to develop competency across the multiple areas of professional psychology.

Collaboration and Challenges Within the Professional Community

As faculty for a Christian training program in professional psychology, we have experienced both success and failure in our interface with the larger professional community. Success is heartwarming and affirming when practicum supervisors report that our students have a greater sensitivity and respect for clients than is typical for graduate students. In fact, the aggregate scores of practicum supervisor ratings show that *respect for clients* is the category where our students typically receive higher scores than in any other category related to professionalism and foundational competencies. In a recent evaluation of a student, one supervisor from a community mental health facility reported "she shows a respect and empathy for our most vulnerable

patients that provides a healing presence beyond any therapeutic intervention." The aggregate rating demonstrates the high level of respect our students have for their clients and the specific feedback from supervisors often reflects our students' skills in empathy. This positive feedback helps to balance a few of the mistakes made by students when they have attempted to integrate their faith into their clinical work at the practicum sites. Unfortunately, these mistakes have morphed into urban legends that detract from the good clinical work in integration.

Urban legends are stories that may or may not be grounded in truth but have taken on a life of their own in the re-telling. In working with a new forensic site and supervisor, the story of the bible-stuffing student was re-told to me. Apparently one of our practicum students (over 10 years ago) took her Bible into the forensic facility and shared some scripture with a Christian inmate. A guard reported this to the practicum supervisor who then contacted our Director of Clinical Training and followed up with the student. This story has moved between facilities and/or supervisors, and the most recent version described a Fox student who was "stuffing" the New Testament into all inmates' totes of personal belongings. In another illustration, one of our students was working with an adolescent female in a Community Mental Health center who had experienced significant trauma. The adolescent told the practicum student that she used to feel comforted by stories from the Bible that she had learned in Sunday School and that she wished she had a Bible. The next week our student took an extra Bible into the practicum site and asked the supervisor if the agency could anonymously provide a Bible to her client. In the most recent version of this story, I was told that a student attempted to "sneak" a Bible to a non-Christian client in an effort to heal her trauma.

These illustrations highlight the relevance of two recommendations suggested by Worthington et al. (2009): the need for training programs to include competence in dealing with spiritual and religious clients and the need for students to develop skills in managing the resistance to spiritual and religious issues they may encounter in supervisors or clinical settings. Each of these situations could have had a different outcome if the student had been able to work with his or her supervisor to identify ways to respond to the client's spiritual needs within the broader context of clinical care. For the adult in the forensic facility, could the student have been encouraged to explore the client's spiritual background and identify institutional resources including the chaplain, library resources, or the weekly Bible study? For the adolescent girl, how could the experience and memory provided by scripture be activated as a protective factor as she worked through her trauma? How could the practicum student facilitate current access to spiritual or religious resources within the institution that could be used as coping skills or support? If the students in each of these vignettes had been able to explore these issues and develop competency within the context of the practicum site, it is likely that both clients would have an improved outcome, rather than becoming the main character in an urban legend.

We encourage students to know that their practicum supervisors and settings have different levels of acceptance or comfort with spiritual and religious content. Worthington (1988) described a "zone of toleration" (p. 169) that therapists experience for spiritual and religious values that differ from their own values. Worthington suggested that when supervisors or psychologists encounter students and/or clients whose faith experiences are too far outside of their own experiences, they may be limited in their ability to effectively respond to the faith concerns presented in the clinical environment. One supervisor brought this concept to life when we changed one of the clinical evaluation forms completed by the practicum supervisor. The new forms reflected the eight competencies emphasized by our program, including a section on the integration competency. The form included the following description of integration and requested that the practicum supervisors evaluate the skill of the students in demonstrating competency in the area of religious and spiritual integration.

"Integration Competency (e.g., student understands religious faith systems and how they relate to services offered by professional psychologists, respectful of religious and spiritual issues in assessment, intervention, supervision and consultation.)"

This description of integration competence is somewhat more inclusive than what may be comfortable for some readers, as we train our students in both the integration of psychology with Christian thought and the integration of psychology with more inclusive religious and spiritual issues. Supervisors use a 5-point Likert-type Scale (ranging from "Far Below" to "Far

Above the Expected Level") to complete this global assessment of student competency. In addition to the scaled responses, there was a response option for "Not Applicable" for supervisors not comfortable or interested in assessing the integration competency as well as a place for narrative responses.

One week after the new form was sent out, I received a call from one of our supervisors who said that she was offended by the inclusion of the integration competency and requested that it be removed from the assessment form she completed on the two students she supervised. Her concerns led to a broader discussion of integration and she told me that she had heard about our student who wanted to provide the Bible to the adolescent girl (as described in the earlier vignette) and she perceived that we "were trying to push Christianity down the throats of supervisors and clients." Although there are benefits to our relatively small professional community, there are also costs as evident in the re-telling of inaccurate stories that perpetuate misperceptions. During our conversation, I referred back to that situation and explained that an integrative approach would guide the student to respond to the client's spiritual needs regardless of the specific religious identity. An integrative approach would support the use of spiritual disciplines whether the young woman had been a Muslim who had found comfort in the Koran or a Buddhist who found peace in meditation. The different examples seemed to help and by the end of the conversation, the supervisor had a more accurate understanding of the integrative approach to psychotherapy. In reviewing the conversation, I realized that working within a Christian worldview had been outside her "zone of toleration" but when the integrative response was framed within a Hindu or Buddhist worldview, she was able to understand and accept the importance of an integrative response

Supervisors and Students' Competency in Integration

The aggregated data from our student and supervisor evaluations show that both students and supervisors perceive that our students demonstrate significantly greater competency in the integration of faith and psychology than do their practicum supervisors. On a 0-4 rating scale, with 4 being the most favorable rating, the average student rating of practicum supervisors is 2.5 while the average supervisor rating of students is 3.5.

These results present both a challenge and an opportunity for students as they interface with the larger professional community. The challenge is highlighted by Worthington et al. (2009) when the authors caution that without the benefit of specific training as well as a lack of therapist self-awareness, there is an increased risk that interventions may lead to failure in the therapeutic relationship. Yet students may be hesitant to ask their supervisor for guidance in using integration. This hesitancy may, in part, be explained by the research of Schulte, Skinner, and Claiborn (2002) who showed that rather than assessing the client's religious and spiritual orientation as a standard component of supervision, many clinical supervisors were open to the discussion of spirituality if it seem relevant to the case. Given the power differential between supervisors and students, many supervisees may be reluctant to initiate a discussion designed to demonstrate the relevance of spirituality in order to receive supervision. When both supervisors and students perceive that students have greater skill in addressing integration issues, it is even more likely that students will hesitate to bring up spirituality or religiosity. Thus, there are limited options at the practicum site for students to explore and receive training in integration.

Training: Integrative and Non-Integrative Sites

In a recent interview regarding her training at our new Behavioral Health Clinic, a student described the parallel learning process that occurred in her development of competency in integration. She explained that as she became more comfortable and confident in discussing integration with her supervisor, her clients seemed to open up to discussing their spirituality. Although she reports that her intake and interventions have not changed, she wondered if her confidence in working with spiritual issues was unconsciously communicated to the client. The student suggested that her awareness and attention to spirituality may have non-verbally given her client permission to discuss her faith. She noted that this growing awareness has subtly influenced her conceptualization, she explained:

> It is the way I see the clients without even realizing it is integration. It has really helped me to have empathy for one of my clients who struggles with addiction. I can understand the struggle between her hope and desire to stay clean, and the broken part of her

> that relapses and then blames and shames herself. With an integrative approach I can respond with more empathy while reinforcing her value as well as her ability to stay clean, parent her kids, and make rent.

Approximately 25% of our placements occur in explicitly integrative settings. In these placements, integrative training includes both content and process components. Spiritual and religious content is evident in the intake form, the treatment plans, and in the termination protocols. This content may include specific treatment interventions such as meditation, prayer, journaling, and other spiritual disciplines that are consistent with the client's worldview or it may include interventions specific to a client's diagnosis such as attendance at an Alcoholics Anonymous group for a person struggling with alcohol dependence or a social activity at church for someone with social anxiety who wants to begin a desensitization process within a supportive milieu. The process aspects of integration are most evident in the case conceptualization and the empathic response to the client. Students develop an appreciation for the tension between the awareness that humans are created in God's image but remain affected by personal or corporate sin. Understanding the complexity of the redemptive process occurs as students struggle with the pain and hope in their client's story and the ability to process this tension with a supervisor who encourages the student to view this struggle through an integrative lens.

Although not explicitly integrative, our medical sites allow for the integration of spirituality and religion with much greater comfort than other domains of training (community mental health, university, or K-12 schools). This openness may be a function of the Catholic heritage of some of the medical sites, but it also reflects a worldview that understands functioning according to a biopsychosocial framework. Our colleagues in Primary Care understand the protective function of religious communities; they have been exposed to the research that shows that patients who are involved in a community of faith have better health outcomes and greater social support than patients not involved. The Primary Care Provider isn't concerned about proselytizing when he or she encourages the patient to attend church, synagogue, or mosque or to meet with a priest or rabbi to discuss fears or gain support. One provider explained that he thinks mental health is "too skittish" about encouraging people to use the support systems that have kept people functioning for hundreds of years.

Non-integrative practicum sites and supervisors appear to experience our mission in more subtle ways. In reviewing several years of student evaluations from integrative and non-integrative supervisors and sites, one consistent finding is that our students demonstrate significant strength in the relationship competency, which includes an ability to develop rapport and show empathy and respect for the people they serve. Using the 5-point Likert-type scale, our students consistently receive an average rating of 4.6/5 in the evaluation of their skills in the relationship competency. In other ratings of professionalism, our students have frequently "topped out" on the question that asks our supervisors to rate the respect that is shown by our students for the clients with whom they work. The respect is specifically evident when working with clients from diverse backgrounds, and is often described in the narrative section of the evaluation and by supervisors during site visits. As I listen to the different examples and stories, I realize that integration often occurs implicitly as students show that they can conceptualize and care for their clients from an integrative framework without ever saying the word "Jesus".

Integrative Dimensions of Clinical Training

Our program addresses the integrative dimensions of training explicitly through a yearly clinical colloquium, grand rounds presentations, and academic coursework. Additionally, the integration competency is one of the eight competencies that cross our curriculum. Therefore, each student has specific goals and opportunities to demonstrate competency throughout their clinical and academic training. The most explicit part of our integration curriculum occurs in the academic coursework that is dedicated to integration. The integration classes encompass 20 credit hours in our 125-hour curriculum. Following student feedback, a significant revision in our integration curriculum occurred three years ago. In the previous integration curriculum, faculty from the Religion Department taught the integration courses, but our students expressed frustration that the professors and course content didn't actively integrate psychological research and practice. So, one of the primary curriculum revisions was to have

each integration course team-taught by a faculty member from the Religion department and a faculty member from our department. Although this change created some initial havoc with course load and syllabi changes, the student feedback has been positive.

Many of the course syllabi address integration through books, articles, lectures, and assignments. However, within the domain of clinical training, much of the integration learning occurs implicitly via the scheduled mentoring activities. These activities include the weekly clinical mentoring groups that allow for case discussion from an integrative perspective, the development of individualized integration goals within the student's Individualized Training Plan, and the oversight/mentoring relationship that each second-year student has with a fourth-year student. The implicit modeling and opportunity for deep conversations around integration occur naturally in these mentoring contexts. However, we have found that there is a great deal of variability because the specific integration conversations often need to be initiated by the faculty supervisor or mentor. And, while each faculty member would agree that he or she is open and willing to have those conversations, we search for ways to "create space" that will encourage those pivotal discussions in an organic rather than formulaic method. Some of these pivotal conversations include questions of gender roles as well as balancing the multiple priorities of graduate school. Both women and men have expressed appreciation for the conversations that allowed them to explore their roles as Christian men and women, parents, spouses, and clinicians-in-training. One third-year female student said, "The best part of this clinical team was the opportunity to discuss our multiple 'calls' as clinicians, mothers, and wives. And learning how to be good enough as these rolls overlap and push on each other."

These conversations and relationships reflect some of the intangible rewards of working in an integrative training model. As our program seeks ways to facilitate integrative training, it would be helpful to learn how other programs have created opportunities, both explicitly and implicitly, to foster integration. There are limited opportunities to share ideas and strategies that facilitate training in integration across the multiple domains of graduate work. The organic nature of integration suggests that each program is likely to have its own emphasis and style, and it would be helpful to hear how other programs are responding to the changing needs of students.

Rewards and Challenges

At the end of my tenure interview, the chair of the committee asked me, "What is the best part of your job?" I didn't even have to think about my response, I immediately replied that it is the opportunity to participate in the developmental trajectory of our students. The development reflects a transformation from a psychological neophyte to a skilled intern with advanced clinical skills.

Many students enter our program with a poignant mix of eagerness, motivation, and anxiety and they leave our program with a sense of competence and a confirmation of their call to serve others. In addition to acquiring large amounts of knowledge and skills, clinical training requires the student to engage in reflective self-evaluation that contributes to their growth as a person and as a professional. Both students and faculty witness the outcome of this rigorous process as students realize they are developing skills that make a difference in the lives of their clients. Students "sparkle" when they describe their experiences during graduate school. For some students, it is the rush of adrenalin that occurs when they successfully complete a risk assessment in the Emergency Department and the positive feedback they receive from the family and medical staff. Other students may experience a sense of mastery and satisfaction as they use cognitive-behavioral therapy to help an outpatient client work through a depressive episode or in the response a child has to a play therapy intervention. Many students express their sense of satisfaction as they move from unconscious incompetence to conscious competence and realize their ability to facilitate growth in the lives of clients.

In some ways, the growth that occurs in the training of graduate students reflects the dynamic that occurs in the therapeutic relationship. As clinicians or as trainers, we realize that the "self" is an essential tool that facilitates growth. Our engagement and supportive presence facilitates learning as clients or students move toward differentiation and independence. And just as therapy is a time-limited experience that can trigger a life-long process of growth, graduate training facilitates life-long learning as students enter their professional lives.

Yet we know that clinical progress can be variable and that outcome is affected by uncontrollable factors that facilitate or sabotage a client's growth. A similar paradigm exists in clinical training; outcome is affected by factors within and outside the program. The most salient challenges from outside our program include the limited number of internships, the need to demonstrate mastery of an increasing number of clinical competencies, and the ever-changing job market that is dictated by third-party payers. Challenges within our program include the increasing financial burden of graduate training, recruiting and developing students and faculty of color, and the development and maintenance of quality practicum training and supervision. A final challenge includes the need to provide ongoing support and compensation for clinical faculty who are expected to engage in productive research and writing as evidenced by publications, demonstrate excellent teaching as evidenced by teaching evaluations above the university mean, and clinical mentoring and training that moves a student from unconscious incompetence to conscious competence in five years. Thus, the challenge for the Director of Clinical Training is to attend to and balance the needs of multiple stakeholders including the students, practicum sites, and clinical faculty.

New Directions in Clinical Training

Clinical training will need to remain nimble to meet the contemporary needs of society; specifically, we'll need to adapt to a changing demographic and emerging service areas. Diversity includes many variables including but not limited to gender, age, ethnicity, sexual orientation, religion, and socio-economic status. Although we need to increase our efforts to recruit and develop diverse students and faculty, the current professional community of psychologists is not able to mirror the demographic profile of the country. Thus, the need for graduate training and continuing education in diversity remains a priority. Training in diversity must continue to evolve and include both the acquisition of knowledge about diverse groups as well as a respect for the individual differences within groups.

As our markets continue to change, we will need to adapt our skills to fit the emerging areas of clinical service, including primary care and other healthcare settings as well as meet the emerging demand for evidenced-based care. Recent legislation for parity coverage for mental health conditions has provided financial support for treatment, but along with that support comes an increasing expectation for the use of evidenced-based treatments. Although it is important that we adapt our clinical training programs to meet the needs of changing markets and services, it is equally important that we maintain our training in the traditional skills of psychological assessment and specialty mental healthcare.

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