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Integration as Service: Implications of Faith-Praxis Integration for Training

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Faith-praxis integration should be given further attention as the integration of applied psychology and Christian theology proceeds. The authors outline a rationale for faith-praxis integration based upon patterns of mental health needs and resources in the U.S. and for a Kingdom mandate. Implications of a faith-praxis perspective for trainers of Christian psychologists are suggested in relation to a program's missions statement, faculty, course work, practical training, research, and relationship to the community. Selected activities of existing Christian psychology training programs are included to illustrate these implications. Ongoing discussion is invited concerning this emerging area of integration.

Throughout the many centuries in which psychology and religion have been "inextricably intertwined" (Vande Kemp, 1996, p. 72), various systems of integrating the two fields have been articulated and attempted. Even in the contemporary integration movement of the 20th Century, characterized by distinctive graduate training programs and specialty journals, there have been twists and turns in the development of integration models and themes (Bouma-Prediger, 1990; Eck, 1996). Most of these integration models have pertained directly or indirectly to the branches of psychology related to human services (e.g., clinical, counseling, community). These varying approaches to integrating applied psychology and Christian theology may be viewed pessimistically as pre-paradigmatic fumblings or, more optimistically, as part of an evolving exploration of the nature of human need and human service. In either case, it is important to patiently work out the various ways in which Christianity and psychology relate and interact.

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It has become clear that integration is not a unidimensional activity in which we are searching for the single true method of combining psychology and Christianity. Rather, there are multiple integration schemes and foci, each with distinctive features and emphases (Bouma-Prediger, 1990; Worthington, 1994). These disparate approaches to integration are derived both by the varying perspectives of integrators and by the fluid needs and demographics of changing cultures and societies. Though the foundational truths about human nature and God's character will not change, approaches to interpreting and applying these truths in a culturally relevant manner will change.

In the 25th Anniversary issue of the *Journal of Psychology and Theology*, Tisdale, Thelander, and Pike (1997) observe that "we have the opportunity to begin a new era in integration" (p. 3). In this new era, Christian psychologists will be wise to consider what Bouma-Prediger (1990) has called "faith-praxis" integration. Faith-praxis integration involves a practical and applied focus on matters of authenticity, human service, and vocation. That is, professional work is seen as Christian calling or ministry. Faith-praxis integration involves a commitment to service and has clear implications for the training of psychologists.

The purpose of this article is to provide a rationale for faith-praxis integration in psychology and to suggest implications of this notion for the process of clinical training. In it, we outline our perspective that increasing our attention to integration as service is not only needed in order to respond to demographic and epidemiological realities in our society, but it is supportable, even compelling, from a theological vantage point. We discuss implications for professional training and highlight a few examples from existing Christian training programs. In so doing, we

hope this article serves to invite others to join in discussions about this emerging area of integration.

Faith-Praxis Integration and the Future of Our Discipline

For those who train psychologists, a set of challenging decisions must be tackled concerning the knowledge to be transmitted, the values developed, the skills that students should be prepared to competently perform, and the types of clients to whom students should be exposed. Along with conventional concerns about providing solid preparation in the core aspects of the discipline, programs training professional psychologists may look for a particular niche to fill or emphasis to provide. In the wake of managed care, discussions of the future of our discipline in recent years have oft been punctuated with the language of the marketplace in which the successful marketing of a commodity (typically psychotherapy) is emphasized (Brickey, 1998; Fraser, 1996; Karon, 1995; Resnick & DeLeon, 1995). In response to perceptions of threatening health care conditions, the discourse has a survivalist ring to it, as besieged professionals batten down the hatches and huddle to plan a defense (see Cummings, 1995; Hersch, 1995). What is being posed or answered in these edgy discussions appears to be the question, "how can psychology position itself to survive?"

Faith-Praxis Integration and an Epidemiological Perspective

Although not unsympathetic to the question of fiscal viability, we wish to raise a very different one. Our question follows directly from a faith-praxis perspective on integration and asks the Christian trainer of psychologists committed to the process of integration to consider "how can psychology position itself to *serve*?" While this question has important theological origins discussed later in this article, it also follows from an examination of existing patterns of mental health needs and resources in the United States. Data describing these patterns come together to provide a sort of epidemiological rationale for "integration as service," which has three basic components: (a) the allocation of resources for existing mental health needs in the U.S. is disproportionate across populations, (b) practitioners are disproportionately homogeneous, and (c) the tools available to practitioners (i.e., assessment and intervention methods) are differentially relevant across populations. These three points are developed in this section.

The Allocation of Mental Health Resources

It has been well documented that the prevalence of cognitive, emotional, behavioral, and social problems in our country far outweighs the people and services available to respond to those needs. Whether documenting broadly defined problems of living or detailing a more circumscribed analysis of diagnosable mental disorders, a wide gap between existing needs and existing resources can be observed (Levine & Perkins, 1996). Examining the contours of this chasm more closely, however, reveals irregular patterns of distribution across the recipients who have been able to access existing mental health resources. The list of groups who are documented as disproportionately underserved currently includes children and adolescents (Kazdin, 1990), rural residents (Murray and Keeler, 1991), older adults (Teri, 1993), some ethnic minority groups (Cheung, 1991), people with low socio-economic status (Hammons, 1993), those with chronic or severe mental illnesses (Hargrove, 1992), and those who are homeless (Rosenberg, Solarz, & Bailey, 1991). Ironically, when members of underserved groups do receive services, they tend to be over-represented in the most restrictive and expensive service delivery settings, such as in-patient psychiatric facilities (Orford, 1992).

Many of the groups identified here are likely to retain their underserved status in the future. Indeed, several are predicted to increase in proportion to the total population. Recent percentages of economically disadvantaged young children in this country, for example, are greater than any time in the last 30 years (Children's Defense Fund, 1994). Likewise, over one-fifth of the U.S. population is projected to be age 65 or older by the year 2020 (APA, 1997), at which time so-called minority groups will constitute a majority of the population (Takanashi & DeLeon, 1994).

Factors contributing to the underserved status of these groups are as numerous and diverse as the groups themselves. The U.S. Surgeon General's (1999) recent report on mental health acknowledged cultural, financial, organizational, and diagnostic influences on the underserved status of racial and ethnic minority groups, for example. Five barriers to outpatient treatment which were specifically high-

lighted include cost, differences in help-seeking behavior across ethnic groups, mistrust of the mental health system based on a history of negative experiences, biases in clinicians' judgments in their work with diverse groups, and the stigma associated with mental illness and treatment.

Some groups may present disproportionately greater needs for services. People living in poor conditions, for example, are exposed to disproportionately high levels of health compromising risk factors. The robust relationship between socio-economic status and both mortality and morbidity has been shown to be a gradient in which death and disease rates rise as socio-economic status decreases, with the effect observable across the entire span of the socio-economic continuum (Adler et al., 1994).

One way of interpreting this sort of finding is to conclude that disproportionately higher levels of health problems pose greater challenges to our ability to meet those higher levels of need with services. While increased vulnerability to various forms of disease and problems in living can be linked to socio-economic status, we want to stress that this sort of relationship has not been demonstrated for status variables associated with all the underserved groups we mention here. Even when such evidence exists, such as with socio-economic status, increased vulnerability alone cannot account for the underserved status of that particular group.

In other ways, however, significant barriers to receiving adequate services are related to variables which define the life circumstances of some of these underserved groups. Communities which are sparsely populated expose residents to a greater risk of needing services that may be not accessible to them because people and services are so widely dispersed. Consequently, residents in small, rural communities may find that they have access to a relatively small number of mental health services which may be limited in scope or may require travel at a distance that is prohibitive.

Barriers to accessing services exist as well for other groups by virtue of their unique attributes. Children, dependent upon adults to identify and respond to their needs, are affected at the individual level when educational or emotional needs are unrecognized or not brought to the attention of professionals. Children, who hold little power as a political constituency, are also affected by public policy decisions which may negatively impact or ignore their concerns. In the case of older adults, some (though, again, not all) will be restricted from obtaining services by ill health or restricted mobility, limited finances or inadequate social supports.

Having mentioned these factors, we want to avoid an analysis of the problem of "under-service" that seeks explanations solely through the examination of attributes of the groups themselves. The problem is a complex one, more appropriately viewed from an ecological rather than a within-group perspective. More germane to our purposes in this paper is a focus on those elements of the problem which we can most directly influence as scholars and trainers of the next generation of psychologists. The last two components of the epidemiological rationale outlined here highlight inherent limitations in the tools and methods of our discipline which are currently available to meet the needs of underserved groups. It is our contention that these limitations help perpetuate the underserved status of groups.

Homogeneity of Practitioners

Despite clear evidence of disproportionate need, the field of psychology has been less than successful in attracting and equipping practitioners and scholars to work effectively with underserved groups. People with chronic mental illnesses, for example, experience a shortage of human resources from our field, despite the fact that treatment of serious mental illness accounts for large proportions of annual spending on mental health (Millet & Schwebel, 1994). In a recent survey of clinical psychology training directors, only 8% of programs were identified that offered a special track focusing on serious mental illness (Johnson, 1993). Earlier studies indicate that graduate students and mental health professionals report a lower preference for work with the seriously mentally ill than any other population (see Hargrove, 1992, for examples).

Age-defined underserved populations have also received disproportionately little attention by our field. Kazdin (1993) provides evidence that children and adolescents in general, and minority youth in particular, have been underrepresented by professionals in both clinical practice and research activities. Similar omissions have occurred at the other end of the developmental spectrum as well. While interest in older adults appears to be on the rise in recent years, federal support for research and training with older adults has waned since the 1970's, and relatively less progress has been made in training psy-

chologists to work effectively with this population (Teri, 1993).

Likewise, psychology as an applied discipline has a continuing need to grapple with significant limitations in our relevance to culturally diverse groups (Hall, 1997). Although APA-accredited psychology programs have made some advances in the areas of minority training, 74% do not require the completion of a course specifically addressing minority issues (e.g., Psychology of the African-American) and 40% do not offer practicum training in locations where minorities are served (Bernal & Castro, 1994). Despite continuing calls to increase the number of psychologists-of-color, the number of African-American candidates who enter and complete psychology graduate programs has remained flat at around 3.5% since 1977 (Kohut & Pion, 1990). Allison, Echemendia, Robinson, and Crawford (1996) argue that psychology must continue to address these concerns with aggressive recruitment and training of ethnic minority psychologists while simultaneously increasing the cultural competence of all psychologists.

A recent study of the perceptions of psychologists toward professional engagement with underserved groups provides additional evidence of the problem we have attracting practitioners to work with underserved client populations (Johnston, 1999). Reports of clinical activity by 268 members of the American Psychological Association who indicated that they specialized in applied work confirmed their low levels of clinical engagement with underserved populations. These practitioners reported significantly less satisfaction and interest in clinical work with underserved groups than with other client populations, perceiving far greater barriers and far fewer rewards involved in working with underserved populations than with other groups.

Assessment and Intervention Methods

Finally, the match between currently available assessment and intervention methods and the current needs and values of underserved groups is often an ill fitting one. An analysis of the evolution of models and methods in psychology shows that the origins of most of our technology and theory are found squarely in the community of adults reflecting the dominant culture. Ivey (1995) argues that traditional counseling and psychotherapy theory are Caucasian, male, eurocentric, and middle-class in origin and practice. Canning, Case, and Johnston's (in press) analysis of Christian psychological scholarship over a recent 6-year period suggests that "Christian psychology" may be at least as guilty of this lack of attention to more diverse populations. The field needs theoretical models that are relevant in addressing the needs and competencies of groups that are underserved. Without such models, our methods are in danger of becoming void and irrelevant. Indeed a variety of evidence showing limited success with diverse client groups would support just such a gloomy prediction. Child psychopathology and its treatment, for example, have suffered from a historic lack of attention and from the practice of "downward extension," a process in which a priori adult constructs and methods are used with children, without adequate appreciation of important developmental distinctions (Ammerman, Last, & Hersen, 1993; Kazdin, 1993). The field of parent education is another case in point. Strategies which have been effective with middle-class parents have not translated well to other populations when it comes to attracting and maintaining participants, as well as achieving, maintaining, and generalizing treatment gains. Pronounced limitations in the acceptability and effectiveness of parent training strategies have been associated with poverty (Duman, 1984), single-parent status (Webster-Stratton, 1985), and minority group status (Holden, Lavigne, & Cameron, 1990). Finally, the acceptability of counseling and therapy modalities in general to clients-of-color may be questioned given evidence of their comparatively early termination from treatment (Sue & Sue, 1990).

The professional response to our limitations in these arenas has traditionally been rather narrow in focus. Suggested solutions have often centered around identifying the most effective inducements to engage difficult populations in evaluations and interventions which are presumed to be in no need of overhaul. It is only recently, and in limited measure, that professional psychology has begun to examine how the very nature of our own tools and methods limits our acceptability and effectiveness with diverse groups.

Taken together, these four observations from the epidemiology and service delivery literature brings into focus the persistent distribution of psychology resources away from those who need it most. The picture is clear: A distressing portion of our citizenry do not receive the mental health services they need. This contemporary reality represents a real-world

context for scholarship and practice to which psychologists with a Christian world view and commitment must respond.

Faith-Praxis Integration and the Kingdom of God

Woven into the heart of any mission to train competent Christian psychologists should be a commitment to serve those populations traditionally considered underserved. For Christian psychologists, this aspect of a training mission is one of significant challenge best perceived as an expression of hope, revealing an earnest commitment to the work of the Kingdom of God. Without this essential identifying marker of faith-praxis integration, coupled with a commitment to other forms of integration, we would offer little that is not available in any competent secular training program. In good conscience, we should question the necessity of establishing another training site in a marketplace already considered saturated by many (Robiner, 1991).

The label "underserved" holds a great deal of political symbolism that might easily detract from a Kingdom perspective. For many, the term functions as a categorical role call of those who have traditionally advocated their victimized status. For others, the mere acknowledgment of the dispossession of these populations is a political statement in and of itself. Thus, discussions about underserved populations often take on an overly guarded and cynical character. This is not surprising; the present socio-historical environment evokes a suspicion of those perceived as social reformers and a frustration toward those who advocate politically correct behavior. This highlights the necessity of viewing faith-praxis integration within the framework of a Kingdom perspective.

Faith-praxis integration must be consistent with a Kingdom mandate. Without such linkage, the work loses its legitimacy as a Christian enterprise. When we speak of a Kingdom mandate, we mean those endeavors that are biblically directed, teleologically focused, Holy Spirit inspired, and surrendered to the Lordship of Christ. Although it would be impractical to engage each of these propositions within the limited scope of this article, we hold that the commitment to the underserved hinges on a perspective of the Kingdom as a teleological anchor. This provides us with a vantage point from which to assert the legitimacy of our undertaking.

As Christians, we are challenged to transcend the "now" for the "not yet," to pursue the work of Christ with an eye toward his full reign. It is our challenge, as it has been with other Christians throughout the ages, to work out this faith in a socio-historic context. The biblical narrative serves to point us backward to the victory of the cross and forward to Christ's full reign. The initiation of the Church offers evidence of Christ's eternal victory, while the promise of the Kingdom signals His imminent rule. Hence, the Kingdom of God offers to us a spiritual and psychological point of reference that is less reactive or subject to the opposing political wills and social resources of our generation. This perspective, however, holds us accountable to work out these transcendent mandates in our socio-historical context.

One such mandate is found in Matthew 25:31-46, in which inheritance of the Kingdom is linked to a response to the disenfranchised and those who dwell on the fringes of society. This text in Matthew suggests that our inheritance in the Kingdom of Christ is contingent on our willingness to respond to the socially wounded. When we ignore those who sit on the outside, the fringe dwellers, we deny Christ and His Kingdom. Hence, if we accept the reality of Christ's Kingdom, we are faced with social and personal responsibility that has eternal consequence (Lk. 19:11-27). Serving the underserved represents a declaration of the presence of Christ's Kingdom, not a politically correct posture.

To assume a perspective of the Kingdom is to assume a posture of faith, one that constrains us to deal with the tension of expressing the eternal in our own time-bound context. With Christ we declare the Kingdom as present, in the now, among us (Lk. 17:21). However, this declaration holds an inherent tension of the "not yet," or that which is still to come in human events. Hence, we are faced with a particularly human dilemma. How do we declare the Kingdom in a period where cynicism is warranted and mistrust is appropriate? How do we declare the Kingdom in a social context where almost all struggle with some experience of alienation? How do we, as Christians, declare the Kingdom in an environment where it is easier to give up and let others respond? Furthermore, how do we as Christian psychologists pursue the Kingdom when it is in tension with our vocational socialization?

As social scientists it is appropriate to question the goals, design, and impact of previous social poli-

cy on populations that have been considered underserved, simply because we have found very few interventions that have had long term effectiveness. However, as Christ's disciples, we must avoid the particular form of fundamentalism that asks us to ignore the social urgencies of our day to focus exclusively on tasks that fundamentalists consider to be more spiritual. Evangelism and discipleship are central to our service to God's Kingdom, but they are not exclusive or devoid of context. Under the anointing of the Spirit, Christ reminds us that the good news must respond to the needs of the poor, the captive, the blind, and the oppressed (Lk. 4:17-21).

Christian psychologists should be cautious and prudent; but, our circumspection should lead to questioning and examination for the purpose of effective engagement, not systematic withdrawal. The Kingdom pulls us forward in human time toward an anticipation of the eternal and with an assurance of God's intention that does not allow us to relinquish hope for those broken in our present. Consequently, there is little validation within the Christian narrative for a self-protective resignation in which we rationalize away our responsibility for being "salt" (Matt. 5:13). On the contrary, in the face of God's Kingdom, we are challenged, first, to love God utterly, and in so doing to love and engage those who have need (Lk. 10:25-37). Christ was concerned essentially with the reign of God and the restoration of humanity. As his disciples, we are compelled to re-examine our practices and our vocation in light of this different purpose, this different teleological end. We must ask how we function as emissaries of God's active love, and how we might work out our commitment as Christ's Church to establish the Kingdom.

Having urged for a Kingdom pursuit, we must caution against assuming this is simply a moral imperative. The summons to a Kingdom pursuit is not the spiritual, psychological, or social salvation of people as a result of extensive human efforts: the salvation of humans by humans. It is also not a form of Christian Humanism in which we trust our goodness to overcome evil. It is, however, recognition and acknowledgment that God is invested in establishing the Kingdom in the earth, utilizing available surrendered human vessels. For those who are disciples of Christ, this mandate supersedes ethical or moral purposes even as its expression is moral and ethical. To think of the Kingdom-building process as quintessentially a human endeavor, and of ourselves as the central players of the drama, is as misguided as withdrawal. If faith-praxis integration is viewed solely as moral crusade, then we become useless to God's work at best, or counterproductive and rebellious at worst. Johnson (1997) in his article, "Christ, the Lord of Psychology," asserts that God must be the central figure: the King with final authority, ordering the events of the Kingdom. Hence, it is for Christ and his Kingdom that we respond in a redemptive way to the lives of those who have become "the least of these" (Matt. 25:34-46) and our neighbors in need (Lk. 10:25-37). We are challenged, via our call to obedience, to assume a position of "co-collaborators" with Christ, declaring and pursuing the presence of the Kingdom of God and the healing of persons (Matt. 4:23-24). Essentially, serving the underserved must be a Kingdom enterprise, not a good Christian deed. It must be a work in line with the teleological goals of the Kingdom. The Kingdom holds us accountable spiritually and socially, but it also provides us a point of reference, an anchor by which to interpret the human condition and therefore human history. Hence, our commitment to service is done as an act of obedience and a statement of faith, for when we serve the underserved, we agree that Christ's Kingdom is in our midst.

Faith-Praxis Integration and Implications for Clinical Training

Responding to this Kingdom mandate and to the epidemiological realities in our country will require us to articulate specific training philosophies and develop relevant methods of practice which are consistent with the sort of mission we outline here. An emphasis on faith-praxis integration does not suggest a practice void of theory. Rather, it calls for a theory significantly informed by practice. As the word "praxis" implies, faith-praxis integration must transcend a rational or scientific worldview and affect the practical work of psychologists. This calls for the provision of services to those especially in need, challenging the systems that lead to the specific need, and assisting clients in developing the necessary skills to challenge those systems. A faith-praxis integration model should encourage the clinician to have an impact on the individua, as well as the systems, and should focus on helping the client change both individual, and system characteristics.

Thus, faith-praxis integration forces us to examine the ways we have traditionally trained profession-

al psychologists. The major models which have guided our training (Boulder and Vail) have largely been an attempt to determine the degree to which competencies in practice and research should be emphasized. The roles and responsibilities of the psychologist in society (advocate, consultant, one who intervenes in the context of systems) have received less attention in clinical programs, being left to our colleagues in other disciplines (community psychology, to name one). Within the context of Christian psychology, counseling and psychotherapy have been the dominant practice and training models. Analyses of the myriad Christian approaches to counseling or therapy have sometimes included the notion of "service" (see Bufford, 1997 for some examples). To date, however, these and other references to service, in our notions of integration or our methods as practitioners, have not appeared to lead to widespread, explicitly stated commitment to underserved groups.

Teaching our students competencies which will enhance services provided to underserved populations continues to be a challenge–one that we have not yet mastered as a discipline, Christian or otherwise. In the following section, we begin a discussion about training implications of our position and offer a few illustrations with examples from existing programs. In it we introduce six aspects of a training program which provide opportunities for the application of a faith-praxis perspective: the missions statement, faculty, course work, practical training, research, and relationship with the community.

Mission Statement

A mission statement is the anchor of any Christian psychology training program. The purpose of such a statement is to identify the values and aspirations which will guide policies, faculty selection, and curriculum decisions, and which are meant to be reflected in the character and activities of graduates. A faith-praxis perspective on integration, then, may first be evident in the content of a training program's mission statement. Given the barriers existing in our current health care system, Christian training programs will not somehow become more effective at turning out competent psychologists to serve these groups without an explicit, intentional commitment to this end. The mission of the authors' own training program includes the following: "to emphasize and model a commitment to professional practice as service, especially to the Body of Christ, the Church, and also to those persons who have been marginalized and wounded by our society on the basis of racial or ethnic identification, age, socioeconomic status, or gender ..." (Wheaton College Graduate School, 1996). While we are in no way claiming to have arrived in this statement, or in our implementation of the aspirations it reflects, we do believe the commitment it articulates is a necessary foundation.

Faculty

The paramount contribution that faculty make to students' training is undisputed, and the nature of training faculty will influence how well students are prepared for service with underserved groups. By virtue of their own identities and life experiences, faculty members provide students with diverse role models with respect to age, gender, ethnicity, socioeconomic status, and regions in which they have lived; the scholarly and practical expertise of faculty are also critical. Without close exposure to faculty who are actively engaged with underserved groups, students can hardly be expected to value such work and may not receive the instruction necessary for developing needed competencies (Allison et al., 1996).

Course Work

Programs can examine whether or not course work follows recommendations in the literature on cultural competence. Psychology training recommendations generally fall into two categories. The first advocates that programs provide a specific course to deal with general diversity concerns, or offer individual courses on a specific population (e.g., Gerontological Psychology, Psychology of the African-American, Psychotherapy with Children and Adolescents). A second approach stresses immersion, or the incorporation of these concerns throughout the curriculum. Here, course material, regardless of subject area, is chosen and examined in such a way that information and perspectives that are relevant to underserved populations are highlighted. Examples of this include emphasizing serious mental illness or developmental disabilities in an assessment seminar, including special consideration to rural contexts in an ethics discussion on avoiding multiple relationships, or assigning a paper on the role of culture in intervention to students in a course on cognitive-behavioral therapies. Both the individu-

al course work and immersion approaches deserve consideration. For example, one study showed that even a one credit course was associated with a more positive, non-racist racial identity on the part of Caucasian students (Neville et al., 1996). Beyond the question of course content is the concern about how learning processes are designed. Some have noted that exposure to pedagogical models which incorporate diverse learning styles may better prepare students for their work with diverse populations (Ponterotto, Alexander, & Grieger, 1995).

Practical Training

Programs must also prioritize exposure to clients within underserved groups for their students. Not surprisingly, practical experience has been linked to the development of cultural competency. Allison et al. (1996) found that the number of therapy cases handled during training was a significant predictor of competence in work with 10 of 13 client groups. Our own training program has invested economic and human resources in the recruitment of desirable sites, and all students are required to spend at least one year in a site where they will have significant engagement with at least one underserved group. A departmentally-sponsored research project enabled staff to track these experiences over time. In a recent reporting period, a mean of 34% of our students' client contacts were with individuals belonging to an underserved group. One-third of our students reported 50% or more of their client contacts with individuals belonging to an underserved group (Canning, Pozzi, & Crisafulli, 1997). Although we have documented evidence of students' practicum activities, we do not know how those activities compare to students at other schools or the impact of our training program on student's activities after graduation. These are both areas for future research and consideration.

Research

Research activities provide additional contexts for students to engage with marginalized groups, increasing their vision and skills. Programs can foster students' research competencies with underserved populations by choosing relevant classroom material and assignments, and exposing them to alternative research models such as participatory action research. Faculty can provide research opportunities pertaining to underserved groups. Examples of these kinds of projects in our department include an evaluation of an intervention for caregivers of older adults, a Rural Psychology special interest group, a longitudinal study investigating factors affecting students' interest in working with underserved populations, and a project that seeks to develop and implement a parenting training program for Latino families. Many of these projects have received funding from within the institution. Beyond providing opportunities for students, departments can and should invest in evaluating their training with respect to the concerns we raise here. Our own program's outcome research on practicum training with underserved groups (described in the section "Practical Training" earlier) is one example of evaluation which can contribute to the effective implementation of our call to serve.

Relationship with the Community

A final, particularly noteworthy illustration of a faith-praxis commitment to training is in the use of community-based sites to provide services and training. A fitting example is The Center for Aging Resources, which is part of the School of Psychology at Fuller Theological Seminary. The center serves as a setting for professional training of graduate psychology students while the community is provided with a broad array of services. Clinical services include in-home and outpatient therapy, evaluation for psychiatric medication, and support groups for isolated elders in residential families and for other older adults on topics such as parenting young relatives or coping with a family member's substance abuse. In addition, the center offers adult day care for clients with dementia, elder abuse prevention workshops, trauma debriefing, peer counseling and consultation about home safety concerns (Center for Aging Resources, 1999). The center's model exemplifies our vision in a number of ways. First, attention is given to a group which has traditionally received inadequate resources. Second, in choosing which services to offer, the center augments traditional clinical methods with a host of other strategies in a manner responsive to the unique qualities and needs of this population. Finally, the center provides a context for psychology students' exposure to older adults, potentially fostering future interest in such work (Johnston, 1999; Mirabi & Weinman, 1985) and providing the sort of experience essential to ethical, competent practice. In combination, the Center

goes beyond providing services (important in and of itself) by contributing to the future supply of qualified practitioners available to older adults.

Concluding Comments

What forms of psychology or service would result from our arguments? The implications we raise and the illustrations we offer here are modest, mostly staying well within the bounds of what is the currently accepted approach to contemporary Christian professional psychology training. Admittedly, we have only scratched the surface of these implications. We believe it is likely that a strong commitment to our Kingdom mandate would stretch the field well beyond current emphases on individualistic, pathology-focused theories of personality and modes of practice, encouraging approaches that are more ecological and competency-focused and methods which are more community-based, collaborative, and preventive in nature. But many methodological and structural questions remain unanswered here. What would more adequate services and mechanisms of delivery for underserved groups look like? What training methods are best suited to these goals? Our chief aim in this article has been to highlight a perspective on integration that has allowed us to explore the implications of that view for training future psychologists. We would like to encourage dialogue about the issues raised in this article among Christian clinical training directors, faculty, supervisors, and trainees within individual training institutions, but also across institutions and within our professional organizations.

In his cogent and inspiring work *Until Justice and Peace Embrace,* Wolterstorff (1983) identifies an important tension with which we wish to end our discussion. Addressing the scholarly community, he speaks of "the difficult and complex task of weighing the need for praxis-oriented theory against the need for non-praxis-oriented theory ..." (p. 172). While acknowledging the valid place of each, he argues that decisions about where to invest our energies be made "... in the light of the deprivations and oppressions to be found in the social order as it stands" (p. 172). The well-documented pattern in which certain groups are disproportionately underserved by the mental health resources in our society appears to us to be one such deprivation in the social order which must factor into our decision-making as trainers of future generations of psychologists. Wolterstorff's appeal "for the integration of Christian commitment and theorizing, by way of the commitment becoming the *governing interest* of the theorizing ... that places itself in the service of the cause of struggling for justice" (p. 164) is one Christian psychologists today would be wise to consider. Whatever the direction this sort of theorizing might take, our mandate seems clear. Facing the irrelevance of our psychological and integrative theories for some groups, we need to prepare individuals who can produce scholarship, provide services, and change social systems in the light of the pressing realities we have outlined in this article. In short, we need to prepare psychologists who will "act justly, love mercy, and walk humbly with (our) God" (Micah 6:8b).

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