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Special Issue
Innovations in Christian Mental Health Care and Training

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CONTENTS

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Introduction to the Special Issue: Philip, the Ethiopian, and Us: Casting a Vision for Christians in the Mental Health Professions

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This special issue of the *Journal of Psychology and Christianity* is a collection of diverse views regarding adaptability. The phrase, which is common in evolutionary theory, is essential for Christians in the mental health field and members of the Christian Association for Psychological Studies to consider. As an introduction to the six articles and discussant that follow, we argue that the escalating numbers of people in need of mental health services, the rising healthcare costs to provide those services, and the insufficient number of trained providers to care for those in need call for a new vision in mental health delivery. Evident in each of the articles, the Christian Church, in its full array of theological perspectives, is uniquely positioned to influence the professional mental health cultures, provide unique channels of care to people in need in the U.S. and worldwide, and recreate the understanding of human wellness. The authors of these articles encourage the reader to "Go big and think large" as we exist in culture and bear witness to the Creator as defined in the Christian tradition.

"How can I understand, unless someone explains it to me?" (*New International Version Bible*, 1984, Acts 8:31). Consider the Ethiopian and his search for truth as he contemplated ideas that existed outside of his direct awareness and control. As an East African Ethiopian, he likely was distinct racially from others as he passed through the Middle Eastern geography. His religious culture did not permit him to understand the Jewish tradition, but it intrigued him. And the descriptive phrase of "eunuch" suggests a sexual difference between him and the broader culture. He was an outsider in multiple dimensions. Consider also the role that Philip played as one who could stand between social systems, the Ethiopian's religious tradition and culture on one side and the writings of Isaiah and the emerging Christian paradigm on the other. He could connect a person with a process. He stood in the middle. As Christian mental health professionals, academics, and students, we, like Philip, stand between systems.

Consider our work. Our cultures. Our churches. These are the social systems through which many readers of the *Journal of Psychology and Christianity* create change, alleviate suffering, promote justice, and, ultimately, participate in the sacred calling of reconciliation as God's ambassadors, as described in 2 Corinthians 5. We provide a unique perspective on the connection between person and process because of our commitment to both the faith tradition and discipline. We, as a community of Christian mental health providers, professors, and students, explain the Christian understanding of the eternal to people imbedded in social systems. As those systems change, so must our ability to adapt and adopt change to remain effective towards our calling. This edition of the *Journal of Psychology and Christianity* addresses how this holy calling might be applied to changes in our social systems, how the need for your expertise is changing, and how we might prepare for effective mental health care in the future.

This holy calling, or vocation according to Martin Luther, is what we do between baptism

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and the final resurrection as agents of Christ's redemption in a fallen creation (Kolden, 1983). Vocation, then, is a way of being that goes beyond occupation and requires grappling with the complexities of grading students' papers while simultaneously asking, "Who is my neighbor?" Or for the clinician, it is "How do I assist a client in meeting treatment goals and also function as a change agent for the broader socio-cultural contexts in which the client lives?" Perhaps to play on Luther's notion of the two kingdoms, we suggest that vocation for those in the mental health professions is to live in the dialectic—earth and heaven, secular and sacred, statistical significance and faith, God and the devil.

In Jesus, it is of course that we see the narrative and the objective touch and find expression together. The Gospel writers tell us that Jesus entered humanity by being born of a virgin, a story told a thousand times over that could never be proven in a lab, yet was verified by people of varying social and ethnic strata (i.e., shepherds and the Magi).

We are not prophets, prognosticators, or soothsayers. This edition is not a Christianized version of Alvin Toffler's *Future Shock* or Thomas Friedman's *The World is Flat*. Rather, the authors of the articles in this volume speak of what our roles, activities, and attentions may require of us in the coming years based on data and experience. As we have conversed with the authors regarding the development of their manuscripts, the phrase "Going big, thinking large" has been frequently repeated. The authors have addressed how we as Christian mental health professionals might expand our influence, affect our culture, and address crucial needs in society, our professions, and our religious institutions. Indeed, those who read this journal, those who participate in the community of scholars, and providers of Christian mental health are indeed "thinkers" and "doers." Academic journals exist to inspire great doing because of serious and meaningful thinking. Emerging from this edition are ways that we all might think and act as mental health professionals, given the mission to be "ambassadors of reconciliation."

It is time to think and do. Circumstances in societies worldwide call for innovation in mental health services. Consider a problem that was presented at a Christian Association for Psychological Studies (CAPS) plenary address in 2018. Data were presented regarding the continued rise in virtually every diagnostic category within DSM-5 over the past 50 years. This rise continues despite advancements in medicine and in the veracity of our empirically-based clinical treatments. The problem was summarized by Higgins (2017), who wrote,

> The most discouraging assessment came in 2013 from an in-depth analysis by the U.S. Burden of Disease Collaborators. Hundreds of investigators gathered data on 291 diseases and injuries between 1990 and 2010. Combining premature death and disability to calculate the burden of each disease, they found that the toll of mental disorders had grown in the past two decades, even as other serious conditions became more manageable. (pp. 20-21)

In other words, we are getting better at reducing the effects of many of our most serious health issues, but conditions such as depression, anxiety, suicide, addictions, and childhood behavioral disorders continue to rise and, in some cases, are rising at alarming rates. Because of this, the need for care, support, guidance, and therapy has never been greater.

As evidence, consider the information from the National Institute of Mental Health (NIMH) regarding the prevalence of any mental illness reported in 2016 and again in 2019 (NIMH, 2021). They reported that the prevalence of any mental illness, which is the phrase used to describe any adult who can be given a DSM-5 diagnosis, has increased 2.3 million people in just three years. Given the traumatization occurring during the COVID-19 pandemic and the years following, it is extremely likely mental illness frequency will increase at a steeper rate than we have seen to date. These data do not include "non-clinical" mental health related issues, such as marital conflict, career malaise, or personal development. Of great concern should be the 18 to 25 demographic. Their "any mental illness" (AMI) increased 7.3% in just three years. That increase will probably result in additional age-related increases over the next 50 years as that group ages and current children enter the adult demographic (Mental Illness, 2021). These data raise serious concern regarding the provision of sufficient mental health care in the next 20 years and beyond.

The increase in frequency and prevalence translates to increased cost and an increased demand for mental health providers. Diehlman et al. (2016) published a report based on 2013 data that estimated the amount paid for mental health services was nearly $188 billion and increasing at a rate of 3.7% per year. In 2021 dollars, assuming their rate of growth, the amount is around $250 billion. This is the calculated amount for actual dollars spent, not including the unmet need for services that are not provided.

All this suggests that we are spending billions of dollars on mental healthcare and need billions more. There are millions of people in need, and millions more have needs that remain unaddressed. We are training hundreds of thousands of mental health professionals and must train hundreds of thousands more. The data suggest that we are losing ground. Systems need to change. Creative solutions are needed.

But maybe there is another component to be added to this system, which we as Christian mental health providers, educators, and students have unique expertise. Enter the church and include the sacred. The inclusion of an augmented path of support exists in the professional literature in the community psychology models of care. The psychologist Ken Pargament has dedicated his career to integrating mental health science-driven practices with that which is seen as sacred, both religious and spiritual. Let us assume that his conclusions are true, that

> a number of studies have shown that people who draw on their spiritual resources in coping with stressful situations experience better health and well-being, even after controlling for the effects of a variety of psychological and social explanatory variables such as social support, secular coping, health practices and personality. (Pargament, 2007, p. 28)

If this is true, we can also assume that the church has something magnificent to offer the culture, as do we as the ones who stand in solidarity with the church and possess the expertise of the mental health profession. Pargament is not merely suggesting that the church has a place in psychology, but the factors intrinsic to religious and spiritual systems are central to human well-being.

Therefore, we are not to think "small," as in "Maybe we can be validated by the secular mental health culture." Indeed, Christian mental health professions have access to a massive subculture, the Church. The church and culture, like the Ethiopian on the road to Africa, asks, "Can someone please help me understand this problem?" The understanding of the Scriptures, theology, and mission, along with the understanding of mental health and effective intervention, places us in a unique position to address a substantial part of our mental health crisis. We can propose and lead change. The change allows us to infuse the Christian motivation for the care of others at every level of service. It should not serve as a separatist model in which we Christians care for our own out of a xenophobic reaction to secularism. Rather, we are called to engage the world in the science of human care and theology of the Creator's redemptive and reconciliative mission. Towards this end, we present the work of scholars who are committed to these ideals.

The first article by Campbell and Hathaway (2021) calls us towards engagement in our professional disciplines. These authors have dedicated their careers towards faithful service in the American Psychology Association at the highest levels. Their call is for us to follow in their example.

As Campbell and Hathaway (2021) call us to participate in the professional organizations of mental health, specifically addressing psychology, Hull and Romig (2021) speak to Christian leader training sites accredited by CACREP and within the counseling profession. Their concern is to help the counseling profession engage the profession through ACA and its divisions to impact mental health in ways consistent with a Christian worldview. "Identifying with the greater counseling profession affords occasions for CCEP faculty and students to be involved in accreditation councils, licensure boards, counseling associations, credentialing boards, specialized counseling tasks forces, and legislative or advocacy projects. Garnering positions of influence within the counseling profession will ensure integrative perspectives, values, and approaches to counseling and training are voiced and, when necessary, defended in the face of shifting philosophical approaches to counseling and ethical practice" (p. 24).

Davis and Baraka draw from decades of experience in applying counseling and psychology to member care and international missions. They argue that models of intervention developed by mission organizations could be used as templates for church and local communities to render mental health care. Their conclusion is where we all might begin: "Implementing mental health care as a standard component of missionary care has paid off with increased wellness and resilience for missionaries. This same vision could be applied to the local church and parachurch organizations in the US." (Davis & Baraka, 2021, p. 37).

Fort and Watson address the issue of racial justice. They address ways we think and act, looking boldly through our Christian lens towards our efforts at integration. They "propose Christian integrative approach to systemic change can provide something more when we incorporate Christian virtue as our motivation and aim. With Spirit-infused courage, justice, humility, and ultimate hope in Christ's kingdom to come, we can move forward boldly with actions that empower others to take a seat at the integrative table and dismantle barriers that inhibit a more inclusive integrative dialogue" (Fort & Watson, 2021, p. 47).

Two articles propose how we can take our craft to the church. First, Grcevich and Grcevich have focused their work on the unique issues that families with special needs children need to address. The church has received valued guidance from their organization, Key Ministries, which consults with churches in caring for families so as to make participation in community worship possible. Here they "propose a mental health inclusion model for use in churches of all sizes and denominations. The model facilitates recognition of common barriers to church engagement and assimilation and application of inclusion strategies across ministry activities and environments offered to all" (Grcevich & Grcevich, 2021, p. 55).

Similarly, Kansiewicz and Smith (2021) addressed mental health ministry applied to the church. They conducted a mixed-methods analysis of low-cost therapy housed within church contexts. To summarize their findings, they conclude that participants wanted to attend therapy within the church community, participants wanted their clinicians to be trained and licensed, and that the church could provide such services at a lower cost than through the general mental health service providers.

Finally, Wang (2021) responds to this journal's contributions by asking the ever-important question, "So now what?" Christian thought and interaction with the behavioral sciences has developed and matured. The axiomatic next step in this faith-profession development, Wang asserts, is to engage the teaching of Jesus that guides us in a posture of love. Informed by ongoing biblical guidance and christians' historical responses like Dietrich Bonhoeffer, Wang challenges Christian mental health professionals to stand in the moral gap found in both the secular and sacred contexts.

This collection of thought intends to move us all towards innovation and courage. We are the beneficiaries of others who dedicated careers towards creating Christian mental health. We have arrived. We are here with psychology and counseling training programs and thousands of practicing clinicians. Our future is found in demonstrating that the practice of mental health care can be advanced because of the unique contributions that we make to the field. As the need for mental health services increases, we find ourselves in situations similar to many periods of world history. For example, historians have suggested that the terrible Antonine Plague of the 2nd century, "which might have killed off a quarter of the Roman Empire, led to the spread of Christianity, as Christians cared for the sick and offered a spiritual model whereby plagues were not the work of angry and capricious deities but the product of a broken Creation in revolt against a loving God" (Stone, 2020, para. 4).

As with our reference to Phillip serving the Ethiopian he met on the road, we have a lot of explaining to do.

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Shaping the Playing Field: Integrated Professional Service Roles

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This manuscript describes a rationale for Christian mental health professionals to become active leaders in professional organizations. Drawing on our experience over several decades engaging in these roles, and providing a biblical rationale, we call for more Christians to engage secular organizations as a way of integrating their faith with their professional organizations or academic disciplines.

The purpose of this paper is to encourage our students and colleagues to "go big" and to "think large" about their role as influencers. We think that mental health professionals are trained, prepared, and expected to have influential roles in the lives of people. That is what we do in the clinic and in the university office—we influence others. However, we have encountered many who think that their influence is rather small—perhaps just the counselees in front of them or the students in their class or the parishioners in their church. That is true, but our sphere of influence can actually be much larger. It could and, we would argue, should include professional organizations that often make the rules and guidelines for our professions. We can have seats at those tables, too, and be key influencers in local, state, and national organizations.

To discuss this vision contextually, we want to describe some of the history of integration and some of our experiences in this area. We hope to provide a meaningful vision for our sphere of influence.

A Legacy of Faith Influence in Mental Health Care

The integration of Christian faith in the mental health professions has both a long and short history. The long history is that Christianity has had a profound impact on the formation of mental health strategies. Biblical writers clearly addressed suffering and mental anguish and followers of Christ have had much to say about both surviving and thriving in the human condition. Early mental health practitioners, such as William Tuke (Kibrea & Metchalfe, 2016) and Dorthea Dix (Viney & Zorich, 1982) were clearly motivated by their faith. Likewise, early academics addressed the issues of religion and faith in psychology (James, 1902). So, for centuries Christianity has played a role in shaping the mental health professions.

The short history pertains primarily to the education and training in faith-based programs. Following Yarhouse and Fisher (2002), we will confine our discussion to the development of religious-distinctive training programs. Doctoral training programs in psychology were not friendly toward faith perspectives in the mid-20th century, and this muted, and at times open, hostility led to the creation of the first doctoral program in clinical psychology that was accredited by the American Psychological Association. A history of this can be found in Maloney (1995), and further elaboration of religious-distinctive training programs can be found in Campbell (2011, 2014). Today there are several doctoral and masters training programs in mental health professions (psychology, professional counseling, marriage and family therapy, and social work) in faith affirming or religious institutions. Accreditation battles have waged in these professional arenas around various issues including academic freedom and diversity.

The early focus in integration was on training models (Carter & Narramore, 1979; Johnson, 2010). The issues addressed in these early works were primarily theoretical with attempts

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to show the various ways the discipline of psychology could relate to the discipline of theology. Other integration issues were more practically oriented, such as Tan's (1996) emphasis on implicit vs. explicit integration and McMinn and Campbell's (2007) emphasis on domains of integration. Similarly, professional organizations developed to address both theoretical and practical issues: The Christian Association for Psychological Studies and the American Association of Christian Counseling are examples of these organizations, each offering continuing education programs. In addition to training programs, various academic and professional journals have arisen that have facilitated the communication of faith integration in mental health. One such publication is the *Journal of Psychology and Christianity*.

Training Profession Shapers

Although there has been much good work in several areas of the integration enterprise, one area that has been neglected is a specific focus on developing leaders to shape the mental health professions. We call this activity shaping the playing field, much like sports teams advocate for changes to the rules of the playing field. As integrative mental health professionals we have neglected explicit training and advocacy in this area. Religious-distinctive training programs, professional journals, and organizations have prepared professionals for clinical work, ministry, academic positions, and research, but corporately we have not prepared Christian professionals to contribute to the profession in service roles. Both authors of this article have significant experience in working in and with secular professional bodies in service roles and we hope to encourage many Christian professionals in the mental health field to take up this mantle and shape the professional field of the future.

Professional Role Formation

There are now dozens of Christian higher education programs committed to integrated training that hold specialty accreditation in mental health fields such as health service psychology, marriage and family, social work, or professional counseling. There is considerable diversity across these programs in how they instantiate their training vision. Some are housed in academic institutions that require adherence to statements of faith and codes of conduct for student admission and faculty employment. Others require faith adherence by faculty and informed consent by students to be taught from this faith perspective even if the students do not personally embrace the creed of the institution. Some of the integrative programs have emphasized integrating around certain areas of practice such as marriage, family and couples counseling, or health psychology. Yet all such programs that hold specialty accreditation, such as accreditation by the American Psychological Association (APA), Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE), Council for Accreditation of Counseling & Related Educational Programs (CACREP), or Council on Social Work Education (CSWE), are simultaneously committed to preparing graduates who can function with integrity in their roles as professionals once training has been completed.

The notion of being a *professional* has evolved substantially in recent centuries (Bayles, 1981; Martin et al., 2017). Bayles (1981) has argued that by the 20th century, a growing distinction between *professional* and *non-professional* vocations emerged and various efforts to identify the characteristics that made a form of life professional were offered. For instance, Bayles saw the contemporary professional as a vocational form that requires a relatively greater emphasis on intellectual abilities and *roles* or activities aimed at meeting important needs.

> *The APA Dictionary of Psychology* (2015) defines a role as a coherent set of behaviors expected of an individual in a specific position within a group or social setting. Since the term is derived from the dramaturgical concept of role (the dialogue and actions assigned to each performer in a play), ROLE THEORY suggests that individuals' actions are regulated by the part they play in the social setting rather than by their personal predilections or inclinations. (n.p.)

In the context of professional training, programs are intended to inculcate students with the ability for graduates to adopt and instantiate professional *roles*.

Accreditors often call attention to the expected function of accredited training programs as pathways for *socialization into professional*

roles. It is expected that a program will have a sufficient number of faculty who are suitably qualified to function as role models for students of the professional identity that a program is aiming to instill. Accreditors expect programs to admit and retain a sufficient number of students with the conducive prior preparation, aptitudes, and career goals to facilitate a community in which a shared professional vision is fostered. Such professional formation involves many facets of development, from acquiring competencies and a requisite knowledge base to adopting professional attitudes, virtues, and habits that characterize a profession. Since the development of the first professional ethics codes in the 19th century, a defining part of professional identity formation has been training those in professions to conform to specific and delineated practice standards outlined in ethical standards and other forms of professional guidance (Baker, 1999).

Christian integrative programs have focused substantial effort on meeting these professional socialization aspects expected of accredited training programs in the mental health professions. There is a focused literature on professional ethics from a Christian perspective that has emerged from this effort (Sanders, 2013). APA working groups have also generated guidance for how to navigate ethical challenges or tensions that may sometimes arise from one's professional role expectations and one's faith standards (Hathaway, 2011). This highlights an issue that Hathaway and Yarhouse (2021) have referred to as *role integration.*

Role Integration

Role integration refers to "the effort to live out in integrity role expectations and patterns that arise from a psychological vocation in a particular context in a way that is simultaneously faithful to one's Christian identity" (Hathaway & Yarhouse, 2021, n.p.). The challenge of professional role integration arises when Christians, committed to be faithful disciples of Christ, attempt to adopt established roles within a secular profession. When secular professional and Christian forms of life offer parallel guidance on how one functions in some practice context, one's Christian faith and professional formation may be cross-reinforcing. Early modern medical schools, for instance, often adopted Christianized forms of the Hippocratic oath. To become a physician was to enter a vocational calling that was frequently understood and affirmed in Christian terms (Gregory, 2001). In a similar vein, integrative training programs often find congruence with the Christian spirituality in common aspects of mental health professional preparation, such as the cultivation of empathy, prohibitions against exploitation of clients, fostering well-being, and other aspects of caregiving congenial to the Christian pastoral traditions and virtues.

Yet there is an awareness that tensions sometimes arise between one's professional path and one's Christian faith. Hathaway and Yarhouse (2021) noted various forms of role conflict that may occur when one's Christian faith and professional identity do not fit together well. Since ancient times, Christians have sought to navigate conflicts between being a disciple of Christ and various vocational or professional paths. For instance, a divergence of opinion arose over whether Roman soldiers who became Christians should leave their military service or remain soldiers. While some, such as Tertullian, asserted that the way of Christ is incompatible with serving in the Roman military, others, such as Augustine, argued that a faithfully Christian path was possible for Christian soldiers. He offered guidance about the shape such a path might take for a Christian who was a Roman general (Smith, 2017).

Integrative training programs have focused much effort on helping their graduates anticipate areas of challenge and to effectively function simultaneously both as faithful Christian disciples and in mental health professional roles. Discussions in these programs are common and nuanced regarding when professionals may or may not appropriately share their faith. For instance, integrative training programs frequently offer both Christian and professional rationales to clarify why the Christian mental health professional should not engage in proselytization *in their professional role*. Ways of managing value conflicts around moral divides that may arise with clients over things such as divergent sexual ethics, abortion, or end of life matters often arise in ethics classes, practicum, and other discussions between faculty and students.

Our perception is that integrative training programs have been quite astute in helping attentive students find suitable ways to faithfully navigate these role integration issues. While there are sometimes no easy or comfortable answers about some role integration challenges, we believe that most Christian mental health professionals trained in integrative programs navigate their professional roles with the same skill and congruence as others who enter the field. In a study of Christians who were trained in integrative versus secular training programs, Sorenson and Hales (2002) found some evidence that those trained in the integrative programs found less conflictual ways to inculcate professional roles. They speculated that this may be due to Christians in secular programs tending to discount the guidance of their trainers when faith-profession conflicts arise because they judged the trainers to not be credible sources of guidance on such matters.

Despite the level of sophistication achieved by the integrative training programs in helping students prepare for multiple areas of role integration, such programs have understandably emphasized shaping students to fit into the professions as Christians. Hathaway (2016b) has described this as a primarily reactive form of integrative professional role socialization. The secular mental health professions first set the rules of the game, and then Christian training programs seek to find ways to prepare their graduates to play the game within those rules and boundaries. But professions are constituted by the professionals that inhabit them. When Christians enter the professions, they do not become second-class professionals by virtue of their effort to be faith integrative in their profession. As members of the profession, they are entitled to raise their voice and exercise their influence regarding the way the profession is shaped. Doing this effectively requires advocacy skills, knowledge of how to enter profession shaping roles, and career space to invest time and effort needed for such a proactive engagement of the profession. While advocacy for client well-being with various systems is sometimes cultivated as a clinical tool, particularly in community psychology or social work programs, the ability to advocate *within* a profession for the shaping and direction of that profession is not a common area of preparation (Scales & Kelly, 2016).

The Need for Profession Shapers

Both current authors now have decades of experience in mental health training programs aimed at Christian integration. We are both aware of many graduates and faculty members associated with such programs who have emerged as leaders and influencers in various niches of the mental health fields. Yet our perception is that there is a relatively lower emphasis on *intentional* preparation of graduates for roles as profession shapers, even though there are multiple types of profession-shaping roles available to members of the mental health professions. Perhaps at the most implicit and non-strategic level, modeling for peers, trainees, and various other publics is a particular way of being a professional and can shape a profession. If winsome and contagious, such modeling may draw others to emulate a professional's approach or manner of being in the profession. Christian themes of being an *ambassador for Christ* or doing our work "as unto the Lord" might encourage this sort of implicit, example-based influence to shape the professions. Advocating for change in the profession is an explicit example of influence. Ratts and Hutchins (2009) described the need for developing competency in social justice advocacy. Although we have chosen more implicit routes of influence over our careers, explicit routes could be developed as well.

While finding much value in a winsome exemplar of implicit influence, we would suggest that such strategies are likely to be slow and limited in their ability to shape large swaths of the professional landscape. How else do mental health professionals shape their profession? All contemporary mental health professions, but especially psychology, have committed to scientifically informed practice. At the broadest level, the recent evidence-based practice movement has explicitly impacted all of the mental health professions. Some Christian contributors to the integrative enterprise have been able to impact the field through spiritually oriented evidenced-based practice (Worthington et al., 2013). The influential work done by Worthington and his associates in Christian approaches to couples counseling illustrates an integrative research program that bore such fruit. A key challenge in attempting to influence the field through the promulgation and dissemination of

integrative evidence-based practice approaches may arise due to resource limitations facing many integrative training programs. Such programs are typically housed in faith-based higher education institutions that are not structured to be the sort of research institutions that can fund substantial clinical science projects.

Yet there is another profession-shaping route that we suspect is often cultivated as a career path for graduates of integrative training programs. There are various professional service roles open to members of the mental health professions that influence their strategic priorities, professional policies, organizational practices, and regulatory landscape. Examples include serving in membership elected positions in the governance of organizations like the American Psychological Association (APA), functioning in an appointed role on work groups or task forces, or serving on committees and advisory councils. In addition to those profession shaping roles in professional associations, regulatory bodies such as state licensing boards heavily shape the mental health professions.

While faculty at several of these integrative training programs have functioned in professional service roles, we do not believe it has been common to inculcate a mindset of such professional service or leadership in their graduates. Yet because the Christian training programs represent only a small minority of training programs and professions like psychology are atypically irreligious compared to the general population, the possibility that biased decision making may create unnecessary and harmful role conflicts for people of faith who enter these professions is a real one (Hathaway, 2016a). We recommend that integrative training programs intentionally foster an awareness of the need for their graduates to be involved and proactive members of their professions and help to shape them in beneficial ways. Potential examples of such beneficial impact include promoting higher levels of competence in working with spiritual issues (Park et al., 2018), promoting viewpoint diversity within the mental health professions from perspectives underrepresented in those professions relative to the general population (Hathaway & Yarhouse, 2021), or more effectively harnessing the vast potential resources of religious organizations for social justice advocacy (Todd & Allen, 2011).

Before moving on we would like to highlight an increasingly critical area for Christians to engage in profession shaping. Along a central aspect of social work, there is now a growing trend among the other mental health professions to adopt advocacy and social justice activities in their professional priorities, training culture, and scope of practice (Hathaway & Yarhouse, 2021). Biblical thought provides a good Christian foundation for this concern for social justice. Yet it must be admitted that over the course of the 20th century, social justice ideology evolved in ways that foster tension for many Christians (Paradise, 2014; Williams, 2020). It is vital that Christians reaffirm the biblical command to "seek justice" and to contend for the marginalized and oppressed in our professions (viz., Isaiah 1:17; Micah 6:8). As the secular mental health professions increase their emphasis on social justice concerns, it will be essential for Christians to be able to effectively champion justice in biblically faithful and discerning ways. Given the momentum around such ideological trends, it will be no small task for Christians to find a way to assume a social justice mantle that is fully aligned with a biblical worldview and is professionally compelling. This is perhaps one of the greatest profession shaping challenges facing Christians at the present moment.

Christ and Professional Culture

Neibuhr's (1951) influential text, *Christ and Culture*, contrasted different ways that Christians have sought to relate to their cultures throughout the ages. Some tended to be rejecting towards culture. Others attempted to assimilate with their culture, while still others sought to somehow combine their Christian faith and culture in a paradox or synthesis. Neibuhr appeared to prefer a final posture of attempting to *redeem, convert, or transform* culture in light of Christ. While Christians in the mental health professions have provided examples of each type of approach, those Christians who enter the professions have made explicit decisions to function congruent with prescribed standards and regulatory expectations. Consequently, for a licensed Christian mental health professional to adopt a rejecting posture towards the profession would be a form of dishonesty: One would be promising to abide by professional standards by virtue of accepting voluntary credentialing

as a member of the profession, but then subsequently deciding to ignore this promise. If Christians find tension with some aspect of their professional culture, what posture should they take towards their profession as they endeavor to change it to allow for more congruent role integration?

One option that some Christians may consider is to attempt a Christian conquest of the secular mental health professions. While this has not been a prominent feature of the integrative training programs, it has sometimes been evident in how Christians have responded to various mental health trends. For instance, when the American Counseling Association (ACA) revised its ethical code to prohibit values-based referrals, the state of Tennessee passed a law prohibiting the licensing board from taking any adverse action against a counselor who referred a client out based on a conflict with the counselor's deeply held principles (Almasy, 2016). While any Tennessee counselor who is a member of the American Counseling Association is still subject to ethical oversight by the ACA, no action can be taken against their licensure in Tennessee as result of this law for engaging in value-based referral. It should be noted that this action arose through a state political process and was imposed on the licensing board, rather than from in the counseling profession itself in Tennessee.

While Hathaway (2014) has stated that the values-based referral standard in the ACA code is problematic, he has also argued that this sort of externally imposed fix is deeply alienating within the profession and likely to invite the sort of backlash that has been evident (Almasy, 2016). A different sort of outcome occurred in the American Psychological Association (APA). The Board of Educational Affairs (BEA) at APA appointed a working group to deal with training issues arising from conscience clause proposals that addressed similar conflicts between clinician personal beliefs/values and some of the clinical situations they may be asked to make the focus of treatment by clients. Hathaway was part of this working group that consisted of psychologists with varied interests and backgrounds. Through a careful process of dialogue and engagement, the group strove to produce a win-win type of guidance document that would respect the sometimes competing interests impacting the document. The process was repeated with a follow-up APA working group that addressed the issue of value-based referrals. While APA policy did not prohibit value-based referrals, as did the ACA ethics code revision, the BEA/Board of Professional Affairs working group offered recommendations that attempted to resolve the same competing interests (APA, 2020).

In a similar vein, Hathaway served on the faith-based entities subcommittee for the U.S Department of Education's Rule Making Regulatory process in 2019. The subcommittee was constituted by a varied group of members who often expressed competing concerns about accommodation of religious missions in federal education regulations. While arguing for a robust protection of the religious liberties of faith-based institutions, Hathaway also noted during the sessions that professionally accredited training programs must ensure that individuals are protected from harm by individuals entering these professions. He sought to influence the recommendations of the subcommittee in a way that allowed the competing interests to be all beneficially balanced without sacrificing religious liberty if possible.

How do these subsequent examples contrast with the case of the Tennessee law protecting value-based referrals for counselors? It may be that they reflect a different way of relating to culture in advocating for Christian concern. Hathaway's strategy aligns with what some have called the way of the exile (Bible Project, 2020; Griffith, 2015). As we have moved into an increasingly post-Christian cultural moment, calls to emulate the *way of the exile* are becoming more common. Jeremiah prophesied to the people of Judah that were taken into captivity in Babylon. He advised them to "seek the peace and prosperity of the city to which I have carried you into exile. Pray to the Lord for it, because if it prospers, you too will prosper" (*New International Version Bible*, 2011, Jeremiah 29:7). By seeking the well-being for all involved, they, too, would prosper. Similarly, for those of us who are exiles in the secular mental health professions, seeking outcomes that promote the well-being of all to the greatest extent possible positions us to more strategically preserve space for authentic Christian roles in the professions. Thus, if nothing else, self-interest should motivate us

to seek win-win solutions to professional policies that impact Christians.

Yet Christians have a greater mandate to seek such outcomes than mere self-interest. Perhaps a good place to start with a rationale for engaging our professions is that the professional societies or organizations are made up of people, and it is the people in the organizations, both Christian and non-Christian, that we love. As bearers of the image of God (Genesis 1:27), we realize that God created all people in his image and cares deeply about them. It is because of the image of God and the way that God cares for all his creation that we also love and respect all persons. Why should we not also care about our colleagues and the decisions they make regarding the care for others?

In the last days of Jesus's earthly ministry, he met with his disciples in a personal setting to address some important issues. It appears in the text (John 13-17) that he was preparing them for the work that they were embarking upon. In that Upper Room Discourse, Jesus described that his disciples are in this world but not of it. In various texts we are told that God loves the world (John 3:16), but not the things of this world (I John 2:15), and further that we are not to be conformed to the things of this world (Romans 12:2). By application, we can apply this to our professional lives—that we can love our profession and the people in it without everything that our profession represents or promotes. Returning to Niebuhr's (1951) *Christ and Culture* approaches, Christians can seek to transform culture, which is often interpreted as integrating the truths of Christianity and the truths of psychology at a theoretical level and as facilitating healthy transformative change at the personal and social level.

Similar to the "in but not of" metaphor Jesus described, the Apostle Paul described Christians as ambassadors in this world (2 Corinthians 5:20). As ambassadors, we are not of the land or country, but we love the land and the people of the land. Again, another application could be that we love our fellow professionals and the profession itself (the land), while still finding our home with our Creator. Of course, living in two worlds naturally creates tension that is part of serving God while serving our professions.

Fostering Profession Shaping Competencies

As alluded to earlier in this manuscript both of us have had many professional service roles throughout our careers, and our desire is to share some of the lessons learned from our experiences. Our hope is that we can encourage other early and mid-career professionals to engage the mental health professions in a way that will be a positive influence for health (implicit integration) and for Christ (explicit integration). Here are some lessons Clark has learned in his years of service:

1. Forming positive relationships is a top priority; this is not so that colleagues will love you but so that colleagues will see that you care for and love them. As the old adage says: "People don't care that you know until they know that you care." Always value the other and the relationship you can have with your colleagues.
2. Lead with grace. Marital researcher and therapist, John Gottman, describes the importance of a "soft startup" in marital interactions, which is designed to keep the couple communicating, rather than escalating in conflict (Lisitsa, 2013). Similarly, I have found that people nearly always respond well to grace. No one likes to be put down or to be humiliated or to have their ideas discounted. Grace extends a positive and redemptive response to another, and people sense the goodness of this.
3. Listen well. Look for what another is really saying and try to understand the emotional state from which the content comes. Do not just hear the words, but feel the feelings so that your colleague genuinely feels heard.
4. Similarly, communicate that you can learn much from another, and that you do not know or have all the truth. Sometimes I think Christians dismiss others with their own arrogance of knowledge. We have much to learn about the human experience, suffering, and spirituality by assuming a stance of openness, rather than closed arrogance.

Through these mechanisms, I have found a seat at many tables—ones that I never dreamed would be open to me. I would like to think that I have earned a right to be heard in this way. I

can also say that I can point to times when I was able to influence significant professional decisions in ways that were consistent with my understanding of faithful devotion to Christ.

Bill would echo these recommendations and also highlight some of the social aspects of moving into professional shaping roles.

5. Express interest and be willing to serve: While I had some professional service roles that were more local as a military psychologist, my first professional service role in a national association occurred by asking a mentor who held a national office if there were opportunities to serve. It just so happened that they were looking for a program chair for the APA division's programing at the annual convention and I moved into the position. For many students, developing professional service skills in leadership or committee positions at one's graduate institution, local psychological associations, or state associations can be precursors to later national or international service.
6. Earn your keep: The program chair role, along with many other professional service roles, are volunteer positions that nonetheless have real responsibilities and work attached to them. Doing these positions well is important if one is to seek or be selected for other service opportunities.
7. Bring others along: If we want to have an impact on the profession, we need to not only seek positions of influence for ourselves, but we also need to use our connections to facilitate others entering into to professional service roles.

Intentional Training for Integrated Professional Service Roles

Thus, to become influencers within our professions, it is important to put this on the radar of our students and early career professionals. It is vital that opportunities for service are provided to students and they are encouraged to pursue these opportunities. At times, students may be reticent to apply or reach out in response to an opportunity, but opportunities rarely just come directly to you and it is important that students take an active role in pursuing the professional opportunities that are there.

One of the easiest ways to do this as a professor is to write papers with students and submit them to professional conferences. Then, take the students with you to the conference and introduce them to others that you know. In this way, students learn how to respond and connect with professionals in the larger associations. Another way is to encourage students to get involved in professional student organizations or early career professionals to join other organizations for professionals at the same point in their career development. Students should be encouraged to look for advertisements and openings on boards and committees so that they can see these as professional opportunities to shape the professional playing field.

Role modeling professional service is likely an important part of encouraging students in integrative programs to seek such service opportunities. But more is needed than students just being aware that faculty members are sometimes gone for weeks at a time to go to meetings. Sharing stories, when appropriate, of the live issues being encountered *fresh from the professional service field* may help create a vision for this role. When Bill was flying back from an internship interview as a doctoral student, he crossed paths with a faculty member from his graduate department. The faculty member was a prominent industrial-organizational psychologist who was also then a member of APA's council of representatives. He was returning from a council meeting in which it was evident that a group of science-oriented psychologists were likely going to form a separate organization. The faculty member had spent years arguing for the importance of the integration of science and practice and bemoaned this development. He recalled the developments with passion and pathos. Bill recalled being fascinated as a graduate student feeling that he had a window on the future of our field into which he was now venturing. A few years later the American Psychological Society was formed (now called the Association for Psychological Science).

Another important skill for helping our students move into profession shaping roles is fostering integrative complexity in their problem solving and thinking. If our analogy of the way of the exile in professional contexts is correct, our students will need to be able to effectively function as Christians in a post-Christian environment. There are two dangers to be avoided. One is mere assimilation. If profes-

sional service means that the students simply accept whatever is common on any topic being promulgated by the professional community, then they will be salt that has lost its savor. On the other hand, if they merely function as counterpoints stridently objecting to anything that does not fit comfortably into their pre-existing Christian schema, they will be like salt poured into an open wound. Both extremes are likely to have little lasting influence on the profession. It may not always be possible to find a win-win solution or a compromise that is not lethal from the standpoint of either professional or Christian integrity. But a Christian mental health professional should strive, in the power of the Spirit, to seek the well-being of those in whose land they reside while in exile. This requires humility, cognitive flexibility, a discerning commitment to the essentials, and the ability to see what is not. Can we foster that kind of thinking in our students?

Our hope has been to communicate in this article the importance of seizing opportunities to shape the professional playing field. For several reasons, this is the time to engage the mental health professions from a Christian perspective: (a) There are several mental health professions in which Christians are currently involved (often as practitioners), and additional professions may be on the horizon, such as the current movement to create masters level practitioners within APA; (b) Religion, broadly defined, has been a more acceptable topic within mental health professions over the last two decades, as it has been seen as an important aspect of multicultural diversity; (c) There is room now for younger professionals to follow in some of the paths we have addressed in this manuscript.

Engaging the professions in this way has been a rewarding aspect of our careers. It is also a lot of work, usually with no pay, and sometimes not even expense reimbursement. Hopefully, we have provided some rationales that show the value of this work and ideas of how this can be done. We would be remiss if we did not also describe the stress that such work can place on us as individuals. We have described the tension that is inherent in living in a different land as an ambassador or as an exile from one's homeland. But there is also some personal suffering that comes with this work. There are times when each of us has been falsely accused of things we have not done, or things have been said about us because of our affiliations with Christian institutions. Our hope and prayer is that any suffering we have endured has been for the cause of Christ and not for our own glory (1 Peter 3).

We conclude by returning to the theme of *going big* and *thinking large* about profession shaping. We have given examples and suggestions that are informed by our own journey as Christian integrators and educators in psychology. Our experiences have occurred in a cultural setting with secular mental health professions that have been well established for over half a century. Yet there are still many cultures where this is not the case. There are also many parts of the world where religion, Christian and otherwise, is the central form of life that people rely on to navigate their daily existence. Christians have an opportunity in those contexts to shape mental health professions more richly informed by perspectives of faith from the ground up. But this will only occur if Christians follow a spirit-led initiative to do so. Going big and thinking large literally could mean creating entire mental health professions in some countries that are naturally aligned with the religious faith of those populations. If the global mental health professions grow in such religion-friendly terms, then the playing field will be indelibly impacted in ways highly conducive to a *faithful* psychology for Christian practitioners.

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The Changing Landscape of Christian Counselor Education: Threats and Opportunities to Effective Integration

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Christian Counselor Education Programs (CCEPs) are under increasing pressure to develop curriculum that meets professional counseling licensure requirements and specialized accreditation standards while pursuing the effective integration of Christian faith and psychological science. This article will discuss potential threats related to program viability, effective integration, spiritual formation, and ethical decision-making facing CCEPs in the current professional counseling milieu. In addition, this article will outline opportunities for continued integrative and advocacy efforts around Christian counseling training and practice.

There is mounting pressure on graduate-level counselor education programs at Christian institutions to deliver a theologically informed, clinically relevant, spiritually formative training experience that meets the demands of specialized program accreditation and diverse state requirements for professional counseling licensure. Counselor education programs must now disclose whether their curriculum meets the educational requirements for their graduates to achieve counseling licensure in each state across the United States (National Council for State Authorization Reciprocity Agreements [NC-SARA], n.d.). State licensing boards are increasingly supportive of legislation where specialized accreditation, specifically through the Council for Accreditation of Counseling and Related Programs (CACREP), sets the educational standard for entry-level licensure in professional counseling for that state. Currently, 23 states require licensure applicants to hold a degree from a counseling program accredited by CACREP or equivalent (American Counseling Association [ACA], 2016). Five states have endorsed licensure requirements where only graduates from a CACREP-accredited counseling program are eligible for counseling licensure in that state (ACA, 2016). This has led to recent recommendations for licensure portability agreements that would enhance licensure reciprocity between states and, thus, increase public access to counseling services nation-wide (ACA, 2016; The National Portability Taskforce, 2019). Compliance with these licensure endorsements or portability proposals include possessing a graduate degree from a CACREP accredited counseling program.

The counseling profession continues to move ever closer to a unified license or pathway to professional practice in the United States. There is growing agreement within the counseling profession around the specific protective factors necessary to vet qualified counseling practitioners. One such process, reflecting the collective agreement of four significant counseling associations, including the American Association of State Counseling Boards (AASCB), the Association for Counselor Education and Supervision (ACES), the American Mental Health Counseling Association (AMHCA), and the National Board for Certified Counselors (NBCC), has already published recommendations of a national licensure endorsement process where licensure portability is contingent upon the counselor possessing a graduate degree from a CACREP-accredited program (The National Portability Taskforce, 2019). While there is no formal licensure portability process currently in place in the U.S., the inevitability of such an initiative to be approved in the near future is great. Christian counselor education

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programs (CCEPs) must consider the relevant costs and benefits to seeking, achieving, and maintaining CACREP accreditation for their degree programs, including how these endeavors influence the integration of psychology/counseling and Christianity.

A growing number of Christian counselor education programs (CCEP) seem committed to the pursuit of specialized program accreditation through CACREP. Religiously affiliated counseling programs with CACREP accreditation almost doubled from 44 accredited programs in 2012 to 76 accredited programs in 2017 (CACREP, 2013, 2018). CACREP accreditation requires counseling programs to commit to rigorous annual program assessment across standards related to the institution, unit or department, faculty, clinical training, and curricula (CACREP, n.d.). Institutional commitment to the pursuit of CACREP accreditation often comes at significant financial and human resource expense and may result in decisions to forgo this pursuit despite the benefits inherent to obtaining an affirmative accreditation decision. Christian institutions and CCEPs have the added responsibility of discerning whether specialized accreditation through CACREP impedes a religiously oriented education, or worse, opposes it. These decisions become additionally complicated when attempting to assimilate specialized accreditation standards with a CCEP's mission, theological commitments, spiritual formation objectives, and conduct codes.

The integration of psychology/counseling with a Christian worldview and theological training may be the essential factor that sets a CCEP apart from non-religious programs. Many CCEPs have rich histories steeped in theological and spiritual formation traditions that guide both counseling curriculum and clinical practice (Garzon & Hall, 2012). The commitment to the effective integration of psychology/counseling and Christianity is a serious enterprise that requires much time and energy (Carter & Narramore, 1979; Entwistle, 2015). The plethora of diverse approaches to integration (Entwistle, 2015) combined with relatively little research on pedagogical strategies for effective integration (Garzon & Hall , 2012; Garzon et al., 2014) complicates how CCEPs identify faculty competent to teach integrative courses while also meeting CACREP (2016) standards related to core faculty. As noted by Ripley (2012), the survival of integration may hinge upon training and employing the "best and brightest" faculty to deliver and develop integrative learning environments in the future (p. 151). Prioritizing integrative approaches to counselor training and assessing its effectiveness in producing competent integrationist counselors is complicated, costly, and requires the commitment of CCEPs and the institutions wherein they reside. The remainder of this article will outline some perceived threats and opportunities in specialized accreditation, integration, and formation for CCEPs to consider in this rapidly changing educational landscape.

Threats

Financial Resources

Professional educational programs seeking and maintaining specialized accreditation within their discipline generally require significant university resources to meet the specific quality-assurance demands of the profession. The financial and human resource burden that CCEPs face in developing an integrative curriculum that matches specialized accreditation and licensure standards is significant, especially when compared to non-professional, non-accredited programs. In understanding the cost-benefit ratio of pursuing CACREP accreditation, CCEPs must determine the financial cost of meeting certain faculty ratio standards set by CACREP (2016), including whether the unit has enough appropriately credentialed counselor education faculty. Some Christian institutions will simply be unwilling or unable to hire the requisite counselor education faculty needed to meet or maintain CACREP ratios due to budgetary restrictions. While some administrators may see specialized accreditation as an effective recruiting tool that provides credibility among those skeptical about the quality of counseling training offered by faith-based programs, others may focus on the financial bottom line. However, non-CACREP accredited CCEPs risk reduced enrollments and the associated losses in revenue as more states approve counseling licensure regulations contingent on graduating from a CACREP program. Under these financial conditions, CCEPS will face mounting fiscal scrutiny in their attempts to develop an accredited, marketable, and fiscally solvent counseling

degree that provides an integrative and formative training experience.

Faculty Resources

CCEPs committed to pursuing CACREP accreditation while maintaining high integration standards across their counseling degree put workload pressure on their faculty. CACREP requires faculty to demonstrate content coverage of hundreds of CACREP standards across their curriculum. This means a single course could house multiple standards that need to be addressed somewhere in the course material. Determining when, where, and how to cover CACREP standards across an entire counseling degree and within specific courses is a significant task. The commitment to achieve and maintain CACREP accreditation (which changes its standards every seven years) may overwhelm faculty resources and, thus, strain efforts toward effectively pursuing integration and spiritual formation objectives in an individual course or anywhere in the curriculum. Preliminary data suggest that less than a quarter of all CACREP accredited counselor education programs have a course in their curriculum specifically addressing spirituality and spiritual competencies (Young et al., 2002), calling into question whether or not CCEPs are reducing integrative coursework and formative activities in their curriculum, or eliminating these specialized courses and credit hours altogether to comply with minimum credit hour standards for counseling degrees set by CACREP. Effectively integrating Christianity and psychology/counseling even minimally across fewer credit hours and/or courses already inundated with CACREP standards will continue to present unique challenges for CCEP faculty.

CACREP accreditation additionally requires CCEP faculty to continuously evaluate student learning, as well as engage in program level assessment, taxing them beyond the traditional margins of their faculty responsibilities. Substantial effort by faculty to compile, aggregate, and assess key student performance indicators is necessary to determine overall program efficacy. As many CCEP faculty can attest, CACREP program assessment, student remediation, and gatekeeping duties often preclude faculty from pursuing robust integration agendas. Beyond the workload related specifically to CACREP accreditation, CCEP faculty are already overwhelmed trying to maintain clinical licensure, skills, and practices on top of the required teaching loads, faculty development, research agendas, and service expectations at their universities. The unique clinical supervision and student remediation work performed by CCEP faculty often goes unrecognized at institutions where administrators do not comprehend the additional duties required of faculty in clinically oriented programs, further stretching counselor educators beyond their limitations. The threat to integration will remain unless Christian universities provide CCEP faculty with the requisite administrative resources, teaching load reductions, and other compensatory mechanisms to support faculty in meeting the accreditation, clinical, and remedial demands inherent to their role. In addition, CCEP faculty must necessarily become vigilant in protecting and prioritizing integration-focused curriculum development and student learning outcomes over other commitments or risk forfeiture of integration altogether in their counseling program. Without significant institutional backing, it is hard to imagine how Christian counselor educators can maintain or even further the integrative discipline beyond its current standing, let alone why they would choose to work at a Christian university.

Training

Developing faculty knowledgeable and skilled in teaching, modeling, and supervising from an integrative perspective who also meet CACREP standards and are savvy to specialized accreditation processes may be a key determinant in the future of integration across CCEPs. However, the lack of Christian CACREP-accredited doctoral programs in Counselor Education and Supervision (CES) may threaten this prospect. CCEPs with or seeking program accreditation through CACREP must ensure that their faculty meet core counselor education standards, particularly I.W. and I.X. (CACREP, 2016). These two standards require that faculty have CES degrees "preferably from a CACREP-accredited program" (Section 1.W) and a well-developed counselor identity (CACREP, 2016, Section 1.X). In addition, CACREP-accredited CCEPs must employ a minimum of three such core faculty (CACREP, 2016, Section I.R) while maintaining adequate

core faculty ratios across annual credit hours delivered (CACREP, 2016, Section I.S) and relative to student full-time equivalents (CACREP, 2016, Section I.T). In order for CCEPs to meet these faculty-related CACREP standards they must mine the small, but growing, population of graduates from Christian CES programs for faculty with relevant integration education, clinical training, and abilities. CACREP-accredited doctoral programs in CES housed at a private Christian institution account for less than 5% of total CACREP CES programs (CACREP, n.d). The dearth of Christian CES programs accredited by CACREP increases the pressure on CCEPs to hire faculty who meet CACREP requirements and have adequate training in teaching or supervising from a Christian integrative perspective. This phenomenon calls into question exactly how the next generation of CCEP faculty will adequately deliver integrative and formative counselor education.

Establishing new CACREP-accredited CES doctoral programs at Christian institutions may produce a larger pool of faculty candidates for CCEPs to hire from. However, with only emerging pedagogical guidance on integration in counselor education doctoral programs (Loosemore & Fidler, 2019) there is little assurance that Christian CES doctoral programs are producing graduates competent to teach and supervise from an integrationist perspective. Furthermore, criteria for determining the effective practice of integrative teaching, supervising, and remediation seems to be an area yet unearthed within the literature. While we laud Loosemore and Fidler for producing a relevant CES doctoral course template on Christian integration, evaluating learning outcomes and utilizing core assignments for integrative competency remains an enigmatic enterprise. Comprehensive and evidence-based integration competencies, standards, and evaluations are imperative for validating well-meaning course/curriculum designs and producing faculty who can articulate cogent philosophies on Christian andragogy, supervision, counseling, remediation, and advocacy. While an argument could be made that the integration of psychology/counseling and Christianity has survived to date without any specific integrative standards in place, it is concerning that the future of integration at CCEPs may rest in the hands of counselor educators who have not been rigorously appraised through the lens of a common, minimum set of integration competencies. How can our profession ensure CCEP graduates can effectively address faith issues in counseling, given there are no standards or competencies, let alone ascribe to a religious worldview?

Ethical Decision Making

CCEPs may further question how their programs train students to handle delicate values, issues, and conflicts resulting from differences between client and counselor worldviews. CCEPs must train students to work effectively and ethically with clients from diverse worldviews, which requires understanding worldviews outside of orthodox Christianity (Scott, 2019). A student in a CCEP must not only understand their own worldview and that of their client(s), but how core beliefs and worldviews intersect and influence counseling treatment (Association for Spiritual, Ethical, and Religious Values in Counseling [ASERVIC], 2009; Sanders, 2013; Scott, 2019; Tjeltveit, 1999). The current ethical standard for handling values conflicts mandates that the counselor bracket their personal values and work within those of the client (Lindy, 2014; Martz & Kaplan, n.d.). Imposing values on the client and referring the client due to a values conflict are prohibited, creating a dilemma for some students in a CCEP who believe this could be a violation of their strongly held values and core beliefs. There is a perception in the counseling field that students with strong moral beliefs, particularly on matters related to sexual ethics and behavior, will be at heightened risk of doing harm by imposing values on clients or referring clients to other practitioners because of a conflict of values (Smith & Okech, 2016). Further, it has been suggested that counselors holding to strong values are at heightened risk of failing to show unconditional positive regard (Elliott, 2011). Refusing to support such clients or referring them to a counselor whose values are more closely aligned with those of the client is considered a form of imposing values and/or practicing unethical discrimination (Hermann & Herlihy, 2006; Shiles, 2009).

Faculty in CCEPs must help students find ways to navigate values conflicts while maintaining their integrity and demonstrating veracity in their relationship with clients (Scott, 2019). These same faculty will likely face addi-

tional scrutiny from non-religious sectors of the counseling profession, where doubts about how CCEPs are ethically and legally addressing values conflicts have already surfaced (Smith & Okech, 2016). CCEP faculty and students face mounting pressures to openly endorse values and behaviors antithetical to historically held doctrines of the Christian faith or to take theological positions favored by leaders in the professional organization (Meyers, 2018), even though such positions are debated within Christian faith communities. Failure to advocate for culturally normative positions could bring charges of unethical behavior against faculty (Meyers, 2018; Smith & Okech, 2016). Ultimately, these matters could even influence decisions on whether to approve or renew a CCEP program's accreditation (Human Rights Campaign, 2020; Smith & Okech, 2016).

Failure to train students on effective integration may lead to counseling practices that confuse Christian clients who might expect the counselor to openly address issues of faith as part of the counseling process. Ambiguous positions on integration may alienate pastors and other referral sources within Christian faith communities who may be suspicious that counselors could lead clients astray on matters of spiritual formation, core doctrinal teachings, or righteous and holy living. Faculty in CCEPs must find a way to balance responsibilities owed to the profession and those owed to the church. The question of "what should the Christian faith community expect of graduates of CCEP programs" seems reasonable from the perspective of clients and other stakeholders.

Opportunities

Teaching Spiritual and Religious Competencies

Training culturally competent counselors is an important outcome expected for CACREP programs (CACREP, n.d.). Multicultural competencies require clinicians to understand and work effectively with clients from diverse cultures, including those with deeply-held spiritual and religious worldviews (Farook, 2018). Evidence suggests counselors generally rate themselves as needing training and guidance to understand spiritual and religious matters as part of the client's culture and identity (Barto, 2018; Young et al., 2007). A well-designed CCEP curriculum should teach and assess ASERVIC's (2009) spiritual competencies as they relate to their program outcomes. Focus on these spiritual competencies across program curricula may further assist CCEP faculty in increasing or better attending to integration practices in their approach to teaching and supervision.

Graduates of CCEP can learn skills for helping clients thoughtfully reflect on their worldview, core beliefs (including in the area of morality), and values, given how these larger dimensions of the client's identity have ramifications on how clients experience life. Addressing existential/spiritual issues related to clarifying one's identity, sense of purpose, and meaning in life is often an important element of counseling for many clients. Further, helping clients identify and evaluate ways to enhance their well-being in ways that lead to greater human flourishing often include conversations on worldview. Some counselors may be hesitant to engage clients at this level of discussion for fear of not respecting client autonomy by virtue of imposing values. The ability to engage in thoughtful, caring, and honest dialog is an important skill for counselors, particularly when a disagreement exists between the client and counselor on a fundamental core belief or value. Broaching and dialoging can be done in a way that is sensitive to the person of the client and respectful of client autonomy, while allowing the counselor to maintain fidelity to their own identity (Day-Vines et al., 2007). Worldview and values conflicts between the counselor and client will undoubtedly occur. Rather than ignoring those issues or attempting to bracket counselor values, well trained, sensitive counselors can learn to engage clients in respectful and caring dialog about values, including value differences they may experience (Doherty, 1995; 2001). The addition of social justice advocacy to counselor competencies has complicated how faculty in CCEPs address sexual ethics specifically and worldview issues more generally. As the greater counseling profession increasingly supports advocacy efforts for causes that may conflict with deeply held religious beliefs, including such matters as polyamory (Tweedy, 2011; Williams & Prior, 2015) and atheism (Bishop, 2018), CCEP faculty and graduates have real opportunities to demonstrate both commitment to their

faith and compassionate care for those holding divergent beliefs or lifestyles.

Impacting the Counseling Profession At-Large

CCEPs who have or are pursuing CACREP accreditation must demonstrate a unified counselor identity across their unit while delineating how each faculty member identifies with the counseling profession (CACREP, n.d.). While CCEP faculty may gravitate towards identifying with or involvement in specific Christian counseling associations or organizations, this often reduces faculty influence to a small Christian bubble. Identifying with the greater counseling profession affords occasions for CCEP faculty and students to be involved in accreditation councils, licensure boards, counseling associations, credentialing boards, specialized counseling tasks forces, and legislative or advocacy projects. Garnering positions of influence within the counseling profession will ensure integrative perspectives, values, and approaches to counseling and training are voiced and, when necessary, defended in the face of shifting philosophical approaches to counseling and ethical practice. Christian institutions would do well to support CCEP faculty in pursuing such endeavors as a missional approach to preserving integration for current and future counselors. Such support would also help provide effective, faith-based counseling to clients of faith who could benefit from working with a spiritual or religiously-oriented counselor.

Another potential area of opportunity would be CCEPs uniting in advocating for more focus on spirituality and religion on licensure examinations and across educational/course requirements for licensure. Currently there are no state licensing boards in the U.S. who require a specific course on spiritual/religious issues (ACA, 2016), nor do professional counseling licensing exams identify spiritual/religious issues as a major testing domain. The National Counseling Exam (NCE), required by the majority of U.S. states for counseling licensure, consists of six major domains with more than 170 knowledge, skill, and task content categories (NBCC, 2019). Less than 2% of these content areas mention spiritual/religious issues or values and are restricted to only two of the exam's major domains. With a large majority of the American population affiliating with a religious or spiritual faith (Pew Research Center, 2015), CCEPs can advocate that all professional counselors be competent to address the worldviews of their clients. CCEPs dedicated to infusing the ACA-endorsed Spiritual Competencies (ASERVIC, 2009) across their curriculum and training objectives need to be far more vocal in advocating that these same competencies be assessed by preparatory examinations and licensing standards. It is further recommended that members of Christian Association for Psychological Studies (CAPS) and the American Association of Christian Counselors (AACC) unite to develop aggressive agendas to influence the national and regional licensing boards towards increased attention on spiritual/religious issues and values in the licensure pathway.

Pursuant to these same advocacy efforts, CCEPs need to begin developing a set of integrative educational and curricular standards for counseling programs. These standards could be applied, like specialized accreditation standards, to faith-based programs committed to developing integrative or spiritually competent counselors. Christian counselor educators and counselors who have served on licensing boards or been involved in specialized accreditation could begin preliminary discussions around identifying key stakeholders and outlining practical "next steps" in such a process. Important consideration must be given to developing a standards creation and revision process, best practice guidelines for program accreditation and assessment, and affiliated endorsements or credentials that could be tied to these standards. This effort could be coordinated by CAPS, AACC, or ASERVIC with the goal of one or all of these groups recognizing or endorsing these integrative standards as the minimum requirement for integrative training or an affiliated counseling credential.

Informing the Process of Ethical Decision Making

To effectively train counselors, faculty in CCEPs will need to have a sophisticated understanding of worldviews (Tjeltveit, 1999), research in moral psychology (Haidt et al., 2003; Haidt, 2012), and perhaps most importantly, ethics and moral philosophy (Tjeltveit, 1999; Urofsky & Engels, 2003). Counseling codes of

ethics are embedded with assumptions that are not always openly stated and comprised of general principles with loosely defined terminology, allowing for sufficient latitude in interpreting ethical principles in ways that could place spiritual and religious clinicians and faculty at risk. For example, the lack of definitional clarity around what constitutes imposing values onto clients in the ACA Code of Ethics (2014) is problematic. Tjeltviet (1999) opined that matters of ethics and values in therapy warrant rigorous intellectual inquiry, but it is questionable whether such processes are occurring in ethics coursework for counselors or at broader levels of the profession. Consequently, students are expected to uncritically accept the most elemental aspects of the ethics code and the standards built upon those elements. The principles are taken for granted as being prima fascia or self-evident, but their meaning and application may simply reflect the socially constructed opinions of those in power at the time the code was developed (Pederson 2002). While respecting client autonomy is foundational to the counseling ethics code, what assumptions are embedded in privileging this principle and what ethical theory justifies privileging this principle over the others? Medical ethicists have critiqued the shift from respecting the person of the client to respecting the autonomy of the client (Saad, 2017), but few, if any, similar critiques have taken place in the counseling profession. Similar questions need to be raised regarding the meaning and application of the harm principle (Smith, 2010). CCEP faculty and graduates can champion future ethical code construction and interpretation that go beyond secular humanistic perspectives and account for diverse spiritual and religious worldviews.

Opportunities to Inform the Profession

Christian counselors and counselor educators can facilitate more well-informed and sophisticated understandings of how worldview influences the counseling process for the broader profession. Researching, presenting, publishing, and advocacy efforts focused on spiritual and religious aspects of human well-being should be prioritized both within and outside of Christian counseling contexts. With the introduction of social justice advocacy as an obligation for professional counselors, robust discussions of how justice is defined, particularly within the Christian faith, warrants substantial discussion. Ethical decision-making processes and defining what constitutes unethical actions necessitates a clarification of definitions of the elemental ethical principles that inform the ethical codes before applying to specific practices. For example, the ethical principle "first, do no harm" has been foundational to counseling ethics codes for decades, but how exactly is harm defined and who defines it? What exactly is ethical practice for a counselor when a client is engaging in self-harm? When does a counselor's actions rise to the level of unethical practice and potential disciplinary intervention? Are leaders within the profession knowledgeable enough of the philosophical and religious complexities underpinning ethical decision making to provide competent guidance to trainees? Knowledgeable faculty, if not leadership, in CCEPs can provide meaningful input to clarify such complex matters.

Another highly salient topic relates to respecting client autonomy, perhaps considered to be the most important of the ethical principles found in the preamble to the ACA ethics code. Some important questions that warrant robust discussion include that of "what does autonomy assume about the human person?" Curricula in CCEP programs can teach students to have a robust understanding of biblical anthropology and how it compares with anthropologies embedded in other worldviews, as well as within counseling theories. To what extent is the counselor morally complicit in client decisions to engage in legally allowed behaviors that harm self or others (a question rarely asked other than in clear "duty to warn/protect" scenarios)? In general, it appears the profession simply assumes no moral complicity exists so long as the client makes autonomous decisions which are respected by the counselor. Counselors working within a Christian worldview may find such disavowal of responsibility inconsistent with biblical teaching and wish to learn ways to speak with clients openly about behavioral choices that, in the opinion of the counselor, lead to self-harm or harm to others. Robust debates on these types of questions have been and continue to take place in health care fields but are strangely lacking in the counseling field.

A foundational understanding of ethical theory and moral philosophy is required for such discussions, and faculty in CCEP programs with such knowledge could provide substantial help to both their students and the profession.

Protecting the Christian Practitioner

Faculty in accredited programs carry gatekeeping responsibilities related to counselor competency. This responsibility becomes particularly difficult when it comes to assessing, shaping, and remediating counselor dispositions. For CCEPs, this poses additional challenges when related to counselor ethics and ethical decision-making, particularly in the area of sexual ethics. Faculty in CCEP programs that attempt to adhere to historical, biblically orthodox sexual ethics risk facing accusations that they are allowing, if not teaching, trainees to adopt discriminatory practices based on sexual ethics that will differ from those of current and future counseling clients and what seems to be the dominant view of sexual ethics within the counseling profession. Presently, there seems to be little tolerance within the profession for what Tjeltveit (1999) called the "moral stranger." For example, opinions have been offered that programs embedded in institutions adhering to such values foster discrimination and injustice and should not be accredited (Human Rights Campaign, 2020; Smith & Okech, 2016). It has even been stated that counselors, and faculty by implication, that hold to strong values judged to be discriminatory probably do not belong in the profession (Elliot, 2011). Faculty in CCEPs need to be prepared to address such allegations and equip trainees to not only practice in nondiscriminatory ways, but be prepared to ethically handle dilemmas related to sexual ethics and other potential values conflicts related to contested moral issues. Faculty and trainees need to learn how to handle such dilemmas in ethical ways, but without compromising their integrity on deeply held moral beliefs. There will exist a need for institutional support enabling CCEP faculty to pursue involvement and service activities within professional associations and in advocacy efforts (on behalf of faith-based programs).

Faculty roles in CCEPs may require advocating for counselors facing accusations of unethical practice, particularly related to matters of sexual ethics. Monitoring decisions made by state licensing boards and advocating for alumni and other counselors facing such allegations may become necessary tasks for faculty. Proactive work with licensing boards, including the possibility of service on such boards, will likely be required of some faculty at CCEPs so as to reduce the possibility of boards adopting and imposing biased interpretations of ethical standards that increase the likelihood of Christians facing accusations of unethical practice, particularly on matters related to sexual ethics. Administrators at CCEPs need to understand the importance of such activities to reduce the risks posed to their own programs by such actions and provide sufficient time within workloads for engaging in such service activities.

Conclusion

The mounting pressure on CCEPs to pursue and maintain specialized accreditation through CACREP while meeting diverse state counseling licensure requirements is significant. CCEPs committed to Christian integration and spiritual formation within this professional milieu will face unique financial, administrative, departmental, and faculty challenges in comparison to non-accredited, non-professional (clinical) programs at their institutions. Without a continued, concerted, and immutable commitment of CCEPs and Christian institutions of higher education to Christian integration we risk developing future counselors and counselor educators unable to competently or ethically integrate spiritual and religious values in counseling. Despite the relevant threats to Christian integration within CCEPs, there remain robust opportunities to preserve and even enhance the integration of Christianity and counseling/psychology in the broader counseling profession. We hope this article raises the appropriate awareness around the potential difficulties CCEPs are facing related to their Christian commitments, but most important we hope this article encourages Christian institutions, faculty, and counselors to bravely prioritize integration as the sine qua non of faith-based training and counseling for years to come.

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What Mental Health Professionals Can Learn from Missionary Member Care: Ways of Thinking, Doing, and Being

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The field of member care has contributed to the development of resources for missionary personnel and has assisted with the preparation and retention of cross-cultural workers. While member care historically drew from Western psychological models of care, member care models developed within the past 20 years have resulted in distinct ways of thinking, ways of doing, and ways of being that reflect the unique characteristics, cultures, and preferences embodied in missionary personnel. This article provides a summary of the development of missionary member care and explores future member care paradigms that professional mental health care practitioners might consider instructive.

Missionary member care has at its core the provision of support and service to missionary personnel. In essence, member care seeks to apply biblical principles of loving one another through providing international and interdisciplinary support for mission personnel and their work (O'Donnell, 2015). O'Donnell's (1997) seminal article provided the most often used definition of the term member care:

> [Member care is] the ongoing investment of resources by mission agencies, churches, and other mission organizations for the nurture and development of missionary personnel. It focuses on everyone in missions (missionaries, support staff, children and families) and does so over the course of the missionary life cycle, from recruitment through retirement. (p. 4)

During its early development from the 1950s-1980s, missionary member care was heavily influenced by Western mental health practices and models of care, largely because of the predominance of North American mental health professionals interested in missionary care (Powell & Wickstrom, 2002). But mission personnel on the field quickly learned that a more multi-disciplinary and contextualized approach than was common in Western psychology was needed given the distinctive cultural milieu and facets of life overseas (O'Donnell, 2002). These unique cross-cultural situations required new ways of thinking, new ways of doing, and new ways of being.

Member Care History

The practice of structured and targeted care systems for missionaries originated in the 1950s with the inception of Missionary Training International in 1953 and the Narramore Christian Foundation in 1958 (Koteskey, 2013). The 1960s brought a greater focus on supporting cross-cultural workers in overseas missionary service by providing preparation for language study, field orientation, and furloughs (Odman, 1964) and assisting sending agencies in identifying factors that contributed to an individual's fit for missionary service (Hubble, 1969). At this time, the term "member care" was not yet in use, although the concept of "missionary care" was beginning to take hold, and by the late 1980s the two terms would be synonymous (Koteskey, 2013). Of importance, many of the foundations of member care began within the field of psychology (O'Donnell, 2015) and drew on literature

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describing missionary characteristics (Webster, 1955; Sargent, 1960) and common emotional difficulties among mission personnel (Stringham, 1970; Williams, 1973). In addition, the field of missionary care pioneered some of the earliest efforts at integrating theology and psychology (Koteskey, 2013; Narramore, 1973), with efforts to ensure the emotional well-being of first-term missionaries (Piepgrass, 1972).

The member care movement expanded rapidly during the 1980s through the inception of Mental Health and Missions, an annual conference founded by John Powell and David Wickstrom, in collaboration with Missionary Training International (Gardner, 2002; O'Donnell, 1997, 2015). Subsequently, the 1990s introduced a growing body of literature on member care, a term that had been operationally defined by O'Donnell and O'Donnell (1992) in *Missionary Care: Counting the Cost for World Evangelization*. Later publications of O'Donnell's (2002) classic text on Doing *Member Care Well* and Powell and Bowers' (2002) volume on *Enhancing Missionary Vitality* introduced standards for care and best practices. Member care had developed a platform for voices from around the field, resulting in a global voice.

In reviewing the history of member care, it is important to recognize factors that account for underrepresentation in academic literature. Many member care experts are first and foremost on-field practitioners, providing care and actively working to serve their missions community and context. In some cases, the practitioner role and non-academic nature of member care work lend little time for empirical research and the types of scholarly publications that are commonly eschewed as authoritative among English-speaking academics. Thus, contributing voices outside the English-speaking, Western world are frequently overlooked in the peer-reviewed literature. Additionally, security concerns for members working in countries where missionaries are not welcomed may also contribute to the scarcity of academic literature within the field of member care.

Contributions to the Literature

Nonetheless, there is an ever-expanding body of literature on topics related to missionary member care. To date, the literature has primarily focused on the history and development of the field and has highlighted contributions to cross-cultural living and service (Crawford & Wang, 2016; Hall & Schram, 1999; Powell & Bowers, 2002). For example, guidelines for pre-field assessments for international workers, alternative treatment approaches, re-entry to the home country, and trauma and burnout are recurring themes in the member care literature. Much of the empirical literature stems from dissertations that focus on third culture kids (TCKs) and re-entry and missionary retention (Crawford, & Wang, 2016; Davis et al., 2010; Davis et al., 2013). Additionally, research continues to grow on what impacts "resilience" among missionary personnel (Schaefer & Schaefer, 2012; Thom et al., 2019; Davis et al., 2020). Yet there is scant literature exploring or evaluating member care models or current trends in member care, including what Crawford and Wang (2016) identified as gaps in the literature pertaining to clinical outcomes, longitudinal studies, the impact of technological advances and telehealth approaches, and studies to equip mental health professionals to work with diverse mission personnel.

One consistent theme in the field of member care regards the openness to embrace new paradigms and consider future directions (Crawford & Wang, 2016; O'Donnell, 1997; Powell & Bowers, 2002) largely because circumstances on the mission field require innovative approaches to care without the resources available in the professional mental health disciplines. Perhaps member care, with its nimble and pioneering approach to missionary care, can help inform and inspire professional mental health care directions. In particular, the member care movement embraces ways of thinking, ways of doing, and ways of being that may provide useful instruction to mental health professionals.

Learning from Missionary Member Care: Ways of Thinking, Doing, and Being

Ways of Thinking

Two decades ago, as the member care movement began to expand, Kelly O'Donnell and Dave Pollock proposed a new way of thinking about missionary member care by suggesting a Member Care Model for Best Practice (O'Donnell, 2002; see Figure 1). This model sought to address the multiple and overlapping contours of care needed when providing care to mis-

sionaries. The model suggests a flow of care that includes five permeable spheres visualized as concentric circles. In this model, the most central sphere of care is deemed *Master Care*, indicating that all care begins with one's relationship to Christ. The circles of care then proceed outward to include *Mutual Care/Self Care* (ways of caring for self and others); *Sender Care* (ways that mission agencies and churches care for their personnel from recruitment through retirement); *Specialist Care* (the explicit care of pastors, mental health professionals, physicians, etc.); and *Network Care* (connecting to others and consulting, strategizing, etc.). It is a holistic, flexible framework that O'Donnell suggested was "a grid to guide and a guide to goad" (O'Donnell, 2002, p. 16).

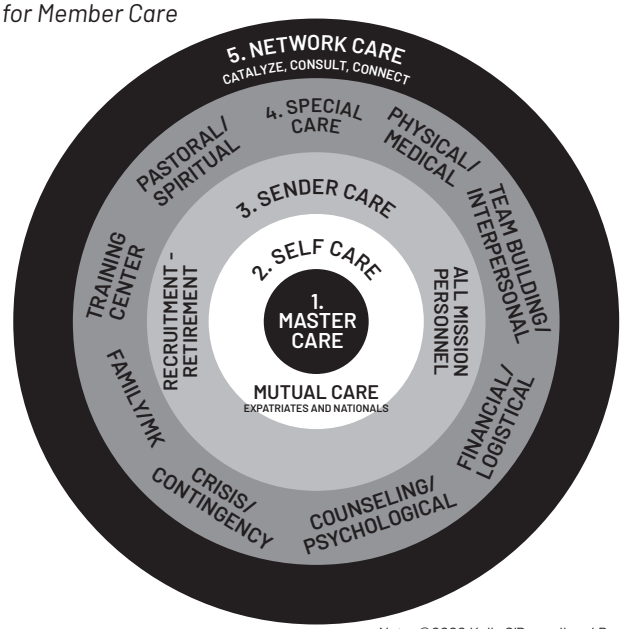
In essence, this member care model suggested that a permeable back-and-forth flow of care among missionaries, their team, their senders, specialist caregivers, and the broader network allows the best care for missionaries (Pollock, 2002). Without overlapping care from sending agencies and the greater network, care by provided by mental health professionals alone may not be adequate. This concept of inter-disciplinary care has long been embraced by the mental health profession as contributing to successful outcomes (Mulvale et al., 2008; Schultz et al., 2014; Stamm, 2003).

What may be novel thinking for mental health professionals, however, is the central importance of both *Mutual Care* and *Master Care* as starting points when addressing the care needs of individuals. Missionary member care begins with the care that community members provide for each other and with an understanding of the individual's relationship to Christ. The importance of both social support and spiritual support as key components of adjustment is supported in the professional mental health literature (Myers et al., 2011; Wolf et al., 2014). An intriguing paradigm conceptualization within member care, however, considers *Master Care* and *Mutual Care* as intrinsic and overlapping with *Specialist Care*. Many North American mental health care models begin with assessment and diagnosis by a specialist and then seek structures including community and spiritual resources as adjunctive care. Yet in many cultures, *Specialist Care* is considered a luxury, a Western ideal, or an unattainable resource (O'Donnell, 2011).

Given the centrality of *Master Care* and *Mutual Care* in this model, member care places a strong emphasis on training lay-level counselors

Figure 1

A Best Practice Model for Member Care



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through on-field workshops and seminars related to mental health care, spiritual formation and direction, peer-to-peer debriefing, and conflict resolution. For example, the Narramore Christian Foundation offers a bi-annual Counseling and Member Care Seminar in locations such as Thailand, Turkey, and Greece to train cross-cultural member care providers. Each two-week, intensive seminar is limited to 40 participants and provides practical training in basic counseling skills and understanding key psychological issues, such as anxiety and depression, suffering and trauma, shame, grief and loss, gender identity, conflict resolution, and sexuality. The training provides a foundation for cross-cultural member care workers to be equipped to provide care to others in situations where specialist mental health care may be limited, inaccessible, or undesirable.

Perhaps there is a place for Western mental health professionals to implement a care model that centralizes and even prioritizes the importance of *Master Care* and *Mutual Care* as the first means of caring for others. This idea gained relevance during the COVID-19 pandemic, when travel and resources became quickly limited and communities needed to find new ways to provide mental health support to those in their midst. While the mental health professions diligently adapted to modify service options for existing clients and to provide continuing education regarding telehealth to providers, the missionary member care movement advanced extraordinarily. For example, the Global Member Care Network (GMCN; Global Member Care Network, 2020), sponsored by the Mission Commission of the World Evangelical Alliance, had a well-functioning platform already in place when the pandemic of 2020 created a need for new ways of thinking about how to provide member care services. Within a few weeks of global shutdowns, GMCN offered support to member care providers through email correspondence, 10-minute YouTube videos, reflective worksheets, and access to a vibrant Facebook community (H. Hoffmann, personal communication, November 24, 2020). The advance of member care education that occurred due to the pandemic was described by Harry Hoffmann, who is coordinator of GMCN, as "a breakthrough," (personal communication, November 24, 2020). During the first few weeks of the pandemic, nearly 6,000 member care providers signed up for a free online course entitled "Member Care Foundations" (Hoffmann, 2020) and offered by GMCN, which provided immediate access to a confidential forum for consultation regarding missionary clients, powerful sharing of new ideas, and perhaps most importantly care and support for the member care providers in the community—*Mutual Care* at its best.

Of crucial importance, the member care model as posited by O'Donnell (2002) is culturally sensitive and applicable across diverse contexts, largely because the model creates a permeable back-and-forth flow that is broad enough to be used by both large and small organizations and widely applicable to member care contexts across diverse nationalities (O'Donnell, 2015). Within the past two decades since this model was first introduced to a mostly Caucasian, Western missionary member care community, member care has rapidly expanded to include a strongly contextualized focus that is attractive to diverse providers in North and South Asia, across Africa, and throughout Latin America (Schulz & Howley, 2013). A seminal text entitled *Doing Member Care Well: Perspectives and Practices from Around the World* (O'Donnell, 2002) dedicates nearly half of the text to counseling and member care perspectives penned by diverse authors and representing cultures worldwide.

To further illustrate member care's commitment to diversity, when GMCN offered a free course entitled Member Care Foundations at the outset of the 2020 pandemic, the participants included member care providers representing Rwandan, Ugandan, Indonesian, Chilean, and Colombian ethnicities, among others. The synergy that exploded as a result of prioritizing diverse and global perspectives on member care was described by participants as "powerful" and "simply outstanding" (H. Hoffmann, personal communication, November 24, 2020). May this serve as a potent prototype for mental health professionals and educators committed to including diverse voices in training the next generation of mental health care professionals. Perhaps educators might borrow from the member care way of thinking to offer free online courses that incorporate both professors and students who represent global perspectives on mental health care.

Ways of Doing

From the outset, missionary member care providers needed flexible ways of providing care to constituents, simply because Western models could not be easily applied to an overseas context or the needed resources were not readily available. A noted strength of cross-cultural workers, in general, is their ability to be flexible and creative when typical ways of doing are unavailable (Powell & Bowers, 2002; Schaefer & Schaefer, 2012). Thus, missionary member care incorporated creative approaches, such as integrated care and counseling teams who traveled to remote locations where cross-cultural missionaries live to provide services for several days or a week; regional care facilities that provide on-field psychiatric assessment, clinical mental health services, pastoral counseling, spiritual direction, and educational consultation from one location; and the implementation of internet-based virtual counseling, psychiatry, and debriefing long before the 2020 pandemic made telemental health a common practice (GodSpeed Resources Connection, 2020; Schwandt & Moriarty, 2008).

Short-term Member Care Approaches

An early method of providing member care involved caregivers who traveled to remote locations to provide short-term counseling, psychiatric assessment, prayer, spiritual guidance, team conflict resolution, educational consultation for children, and so on. While organizations such as Barnabas International, Narramore Christian Foundation, and Mobile Member Care Team began utilizing itinerant caregivers decades ago, the idea is now mainstream in providing care to cross-cultural missionaries. Long-term experience suggests that "the ministry of presence" (P. Bradford, personal communication, November 25, 2020) in which missionaries have an opportunity to build ongoing relationships in face-to-face interactions with care providers who travel at regular intervals provides the most helpful model. Carr (2002) noted that itinerant caregivers must be mindful to engage with cultural sensitivity and recognize the importance of working with mission administrators to plan the visit.

Counseling Centers

What began as itinerant travel to offer mental health services to missionaries burgeoned in 1990 to become a counseling center in Nairobi, Kenya (Brown & Brown, 2002). Tumaini Counseling Centre was the first multi-disciplinary counseling center that exclusively served Christian missionaries and remained the only on-field missionary care center for several decades. Currently, Tumaini offers services in four different languages. Their providers, which include psychologists, psychiatrists, professional counselors, social workers, education specialists, and a family physician, offer a robust set of services to missionary families who travel to the center (Tumaini Counseling Centres, 2020). The idea of offering care on-field to missionaries, rather than having them return to their home country, represented a paradigm shift in member care. Subsequently, multi-disciplinary counseling centers for cross-cultural workers have opened in Chiang Mai, Thailand (Cornerstone Counseling Foundation, 2020; The Well International, 2020); Antalya, Turkey (Olive Tree Counseling, 2020); and Málaga, Spain (SentWell, 2020), with other locations being planned (T. Hibma, personal communication, November 24, 2020). Hoffmann (personal communication, November 24, 2020) reported that there are approximately 30 member care center initiatives all over the world intending to open soon, offering a mix of therapeutic services and preventative trainings.

One of the unique offerings of these regional counseling centers is the provision of short-term intensive services. The authors, both of whom worked in member care roles cross-culturally for more than a decade, recall regular instances when clients would travel from a nearby country for one to three weeks to obtain various services, such as intensive individual or family counseling, psychiatric assessment, trauma care, educational assessment, spiritual and pastoral care, and so on. For practitioners trained in the West, this model has many drawbacks and may introduce ethical concerns to be addressed. However, in the past two decades as the member care movement has developed, much has been written to address ethics and standards of practice (Crawford & Wang, 2016; Hall & Sweatman, 2002; O'Donnell, 2006; Pow-

ell & Bowers, 2002). Carr (2002) suggested that mental health professionals who undertake working overseas with cross-cultural workers need to be mindful of obtaining supervision and working within an accountability structure that includes other professionals. Brown and Brown (2002) noted that complex situations, such as personality disorders, significant unresolved early trauma, or some eating disorders, are not able to be managed on the field and, instead, require the cross-culture worker to return to the home country for treatment.

The benefits of on-field counseling, however, seem to outweigh the risks when member care services are offered with attention to competence and ethical standards. Brown and Brown (2002) noted that on-field counseling is more cost-effective in regards to both time and finances, is less disruptive to the family unit, requires less time away from the primary mission assignment, and is a more attractive option to many cross-cultural workers. For example, when missionaries are able to receive on-field counseling, they avoid the travel expense of returning to their passport country, the disruption to their children's schooling, and the impact on their ministry team when they depart. Granted, some situations require missionaries to leave their ministry location and return home for long-term counseling; however, many common difficulties may be successfully managed with short-term, intensive counseling while remaining in the ministry location.

What is noteworthy is the surprising success of this short-term intensive model, where clients travel to the counseling center location for one to three weeks and engage in multiple sessions, returning every three to four months for regular, intensive work over a longer period of time. While the examples are anecdotal, since the field of member care lacks significant empirical research, it should be noted that newer cross-cultural workers beginning their tenure of service frequently inquire about the availability of member care and counseling services as they make decisions regarding field of service. Mission agency administrators have indicated that the on-field model provides fewer disruptions to the missionary's family, team, and overall work-life balance. Cross-cultural workers who have received on-field counseling propose that their family is stronger and more able to continue the work of their calling.

Creative Adaptations

Yet on-field member care is changing as the world adapts to a new normal. The Mobile Member Care Team that provided itinerant services to missionaries in West Africa disbanded in 2017 and, instead, maintains an active and robust website of resources known as the Mobile Member Care Toolbox (2020). The Tumaini Counseling Centres in Kenya and Uganda are reforming, as their staff has become more transitional and they have invited mental health professionals to join the Centres for shorter periods. Additionally, although missionary member care accepted and incorporated telehealth as a creative platform long before it was widely utilized by mental health professionals (Crawford & Wang, 2016; Reguiero et al., 2016; Rosik & Brown, 2002; Schwandt & Moriarty, 2008), the COVID-19 pandemic propelled member care providers to implement telehealth modalities for multi-day or week-long retreats that had not previously been conducted solely online. For example, Narramore Christian Foundation flexed to offer a one-week virtual retreat for children of missionaries who were returning to the U.S. to attend college (Narramore Christian Foundation, 2020). Missionary Training International also shifted its annual Mental Health and Missions conference to a shortened online format, rather than canceling or postponing the event (Missionary Training International, 2020). While it is unknown whether this trend toward online retreats will continue, what seems apparent is that core characteristics like flexibility, creativity, and the ability to adapt quickly to stressful changes—all of which are key traits of seasoned missionary personnel—enabled the field of member care to thrive during the COVID-19 pandemic. Websites that were already providing free resources, such as the one maintained by Member Care Associates (Member Care Associates, 2020), were poised and ready. One online member care organization, GodSpeed Resources Connection, quipped on its website, "Quarantined? We are built for this—literally!" (GodSpeed Resources Connection, 2020). There may be an embedded lesson for mental health professionals. Perhaps we would be wise to consider how creativity and greater openness

to change, within the bounds of competent and ethical practice, might allow for more adaptive and culturally responsive mental health care.

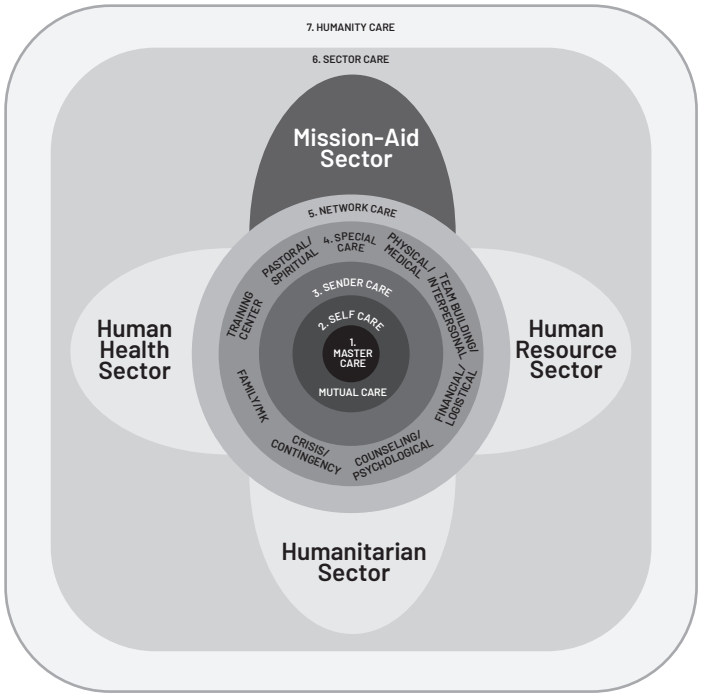
Ways of Being

A core way of being for member care involves embracing diversity in leadership and implementing contextualized, culture-specific perspectives on care. For example, the GMCN website (Global Member Care Network, 2020) highlights member care leaders and perspectives from countries such as India, Brazil, Indonesia, Korea, Malaysia, several African nations. and several European countries. Indeed, one might notice that care representatives from North America are in the minority in the GMCN. In essence, missionary member care adopts an attitude of learning from diverse approaches to member care. For example, Member Care Latin America is emerging with care centers in Colombia, Peru, and Ecuador. In Nigeria, a member care model adapted and contextualized to meet the needs of Nigerian missionaries is being implemented among over 800 Nigerian missionaries (H. Hoffmann, personal communication, November 24, 2020). In Málaga, Spain, a therapeutic retreat center is being developed to provide culturally appropriate member care resources for Ibero-American missionaries serving in North Africa and the Middle East (T. Hibma, personal communication, November 24, 2020). May this embracing of diversity at the highest levels of member care leadership provide a model for Christian mental health professionals in the West who wholeheartedly agree with the usefulness of diverse perspectives but often struggle to implement diversity in leadership.

As previously highlighted, another core way of being in the member care movement involves embracing creativity, flexibility, and openness to change. Perhaps it is this openness to change that has allowed member care to lead the way in truly embracing diverse perspectives in member care models and creating a diverse leadership within the global movement. Perhaps, too, it is the flexible thinking so indicative of mission personnel that allowed for the integration of psychology and theology in the practical, forward-thinking way that was evident in

Figure 2

Global Member Care Model Updated to Include the Missio Dei



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missionary member care from the 1950s, even before a strong integration perspective existed in Christian mental health practice.

The Way Forward

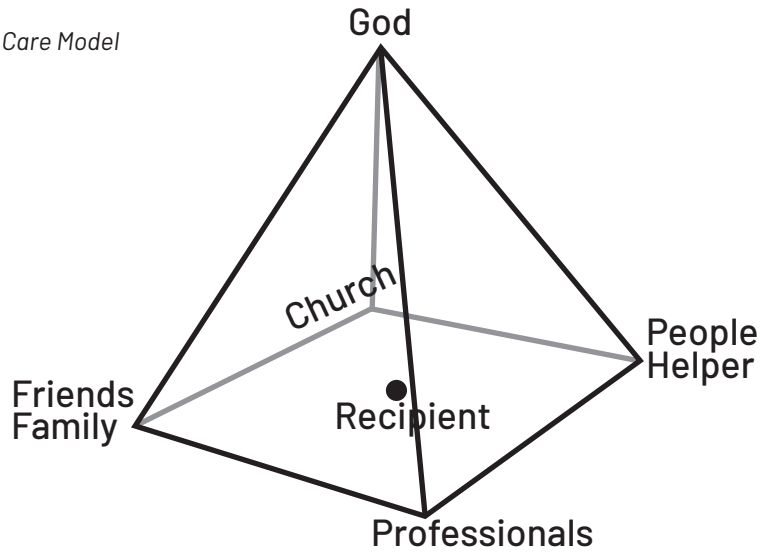
As we look to the future, we might surmise that the same creative, flexible thinking that allowed important paradigm shifts to occur in the way that member care is conceptualized might also serve to direct future endeavors. While gains have been made in contextualizing member care materials for diverse populations, more effort is needed to provide and disseminate those resources globally (P. Bradford, personal communication, November 25, 2020). One way this might occur is through the burgeoning availability of online Master Classes made available for little or no fee. Because of the remarkable success of the vast GMCN online network, perhaps smaller groups of contextualized trainings could be held online, targeting member care needs in a specific cultural population. Hoffmann, who coordinates GMCN, suggested that the future of member care training may lie in "content marketing" (Hoffmann, personal communication, November 24, 2020), which relies on offering valuable and relevant content to attract and train a clearly defined audience.

As times change and member care adapts to new global realities, new models of member care are being developed and applied globally. In 2016, O'Donnell and Lewis-O'Donnell updated the original Best Practices Model for Member Care (O'Donnell, 2002) to include multi-sector care for all humanity as part of the *missio Dei* (O'Donnell & Lewis-O'Donnell, 2016, p. 304; see Figure 2). This model expands the original vision of missionary member care beyond mission-aid workers to include sectors encompassing international business, human health, humanitarian, and human resources. As with the original model, the updated model continues to highlight holistic care and personal development for those working in demanding contexts (O'Donnell, 2011).

In addition, the Pyramid of Care Model (Hoffmann, 2020; see Figure 3) is rapidly gaining acceptance among member care training organizations as a collaborative way of thinking about providing holistic care to missionaries. The pyramid shape incorporates the many groups of people who impact the missionary worker and, in essence, is a model that encourages both inter-agency and interdisciplinary collaboration. While interdisciplinary collaboration has been a hallmark of missionary member care for some time, inter-agency collaborations are a newer part of the landscape. Tim Hibma, who directs the Narramore Christian Foundation, remarked that a growing edge for member care must be to encourage more robust collaboration among

Figure 3

The Pyramid of Care Model



Note. Reprinted with permission from Pyramid of Care Online Course (Hoffmann, 2020).

mission organizations (personal communication, November 24, 2020). While these collaborations are certainly occurring, more barriers could be traversed as we envision new partnerships. This growing desire for partnerships among agencies was also highlighted by Perry Bradford, a leader in missionary care, who noted that the pandemic brought about more openness to collaboration, and that this openness must remain if we are to accomplish the task of global missions (personal communication, November 25, 2020).

Indeed, openness is a hallmark of the missionary member care movement. This openness has allowed the movement to embrace new ways of thinking, new ways of doing, and new ways of being, thereby providing more robust care to the global community of missionaries. May this inclination for embracing adaptive models of care sink deep into the field of professional mental health so that we might humbly consider lessons to be learned from missionary member care.

Implications for the Church and Mental Health Professionals

The missionary member care movement has provided a model that is instructive for both the church and Christian mental health professionals. As detailed in this article, many mission organizations have an intentional member care program to support mental health wellness among their members, a focus that is vital to keeping missionaries thriving overseas. It seems that the church in the U.S. has not yet caught this vision for integrating a mental health component into church offerings. Missions is leading the way by making mental health a priority for their members. Churches can do the same—commit to take mental health seriously and implement new ways of thinking, being, and doing to support mental health wellness for their members.

Mental health professionals are well poised to use their influence in the church to do what missionary member care has long been doing for its members: mental health care that is adaptable to its context, its members, and their needs. Implementing mental health care as a standard component of missionary care has paid off with increased wellness and resilience for missionaries. This same vision could be applied to the local church and parachurch organizations in the US. The time to consider a paradigm shift is now.

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Journeying Toward a More Inclusive Integrative Endeavor: Fostering Integrative Leadership Through an Intentional Focus on Intersectionality, Mutuality and Empowerment

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A more inclusive integrative endeavor is essential for Christian psychology, counseling, and marriage and family therapy to remain attuned and responsive to the needs of the entire church and the concerns of society at large today. In this article, we draw from personal experience and scholarly research to advocate for strategies and practices that empower underrepresented voices in the integration enterprise to take their place at the table. Specific "top down" and "bottom up" strategies are provided to address structural and systemic barriers to inclusive integration. An eschatological vision of the great banquet table as described in Revelation 19 is proposed as the hope and aim of the 21st century integrative endeavor that incorporates the diversity of expertise necessary to advance the liberating realities of the Divine kingdom.

Introduction

As we look ahead to the future of integrative scholarship and practice, the changes in our profession, and the cataclysmic shifts taking place in our society, the need for more inclusive voices around the integrative table beckons us to attend to more holistic aspects of the integrative endeavor. In this article, we will describe structures, practices, and processes that invite and empower leadership and scholarly contributions to the integrative endeavor from voices that have been traditionally underrepresented in academia in general and integration scholarship in particular. Throughout this article, we will emphasize the value of adopting a lens that promotes attending to the realities of intersectionality, intentional empowerment, and engaging in mutually meaningful dialogue on this journey toward inclusive integration. We proffer that the aforementioned components are essential ingredients that foster professional development and leadership opportunities necessary for a more holistic understanding of integration.

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We offer these reflections on the future of a more inclusive integrative endeavor from the unique vantage point of many intersecting aspects of our own social identities (i.e., gender, race, and faith traditions), our professional engagements (as practitioners, professors, and scholars), and our leadership roles (as Director of Integrative Dialogue and Dean of the School of Psychology, Counseling & Family Therapy at Wheaton College, respectively). It is our hope that, in sharing portions of our intersecting personal and professional journeys, the conceptual and relational markers that impact our integrative leadership will empower others to reflect on their own journeys and (continue to) make conscientious choices to empower underrepresented integrators to "take a seat at the table." We are convinced that a posture of humble, yet convicted, intentionality in this process will pave the way for a more holistic, relevant, and impactful form of engagement for all scholars and practitioners who desire to embody a posture of inclusivity in our work as integrators.

A Brief Historical Perspective on the Integration Endeavor: Omissions and Blind Spots

The integration of psychology and theology is a burgeoning subfield with a rich history within the disciplines of psychology, counseling, and

marriage and family therapy (MFT). Particularly within the field of psychology, this history evidences a small but mighty contingency of scholars and practitioners invested in a more holistic understanding of human flourishing. Early integrators coupled their deep appreciation for the conceptual frameworks that psychological theories provided with a deep understanding of biblical and theological truths from within the Christian tradition. Contributions from Christian philosophers to the integration endeavor were also invaluable for the critique of values and worldview assumptions underlying the science of psychology.

Early integrators' understandings of biblical truths were grounded in a high degree of formal and informal training in Christian formation and biblical and theological studies. Additionally, many early integrative scholars were invested in their own spiritual practices. Such formal training and engagement in personal and communal spiritual practices laid the foundation for the nascent subdiscipline that we now think of as "integration" that followed in their train. As a result, early integrators could, and did, draw on these deep theological traditions as they reflected on psychological experiences. Such theological training and immersion in individual and corporate spiritual practices gave birth to a series of systemic shifts in the field of integration that have created the infrastructure and professional capital that have allowed articles such as this one to be published.

More specifically, a strong belief in the value of ongoing interdisciplinary dialogue between the guilds of psychology and theology paved the way for the emergence of seven doctoral programs in the United States (each accredited by the American Psychological Association [APA]) that specialize in the integration of psychology and Christian theology. Moreover, scores of master's level counseling programs (each accredited by the Council for Accreditation of Counseling and Related Educational Programs [CACREP]), as well as MFT programs (accredited by the Commission on Accreditation for Marriage and Family Therapy Education [COAMFTE]) that also emphasize shared integrative value. As these institutions were conceived, they each established a strong community of students and scholars interested and committed to the integrative endeavor and—subsequently—gave birth to an entirely new generation of theoretical perspectives, clinical conceptualizations, and scholarly products. Thus, the systemic nature of this emphasis in integration is seen in the array of integrative infrastructures that emerged—examples of many which are included below:

1. Doctoral programs in clinical and counseling psychology (e.g., Fuller Theological Seminary's School of Psychology [1964]; Biola University's Rosemead School of Psychology [1968]).
2. Master's programs in counseling and marriage and family therapy that are regionally accredited and housed within Christian higher education institutions (e.g., Fuller Theological Seminary's Master of Science in Marriage & Family Therapy [established in the 1970s in the School of Theology and then migrating to the School of Psychology & Family Therapy, where it would gain formal accreditation in the 1980s]; Wheaton College's Master of Arts in Clinical Psychology [established in the 1980s, then transitioned to accredited programs in Clinical Mental Health Counseling and MFT in 2016]; and Denver Seminary's Master's in Clinical Mental Health Counseling [accredited by CACREP in 1997]).
3. National and international conferences on the integration of faith and psychological science (e.g., Christian Association for Psychological Studies [CAPS] in 1956; The American Christian Counselors Association [ACCA] in 1986).
4. Scholarly communities of Christians within various sub-disciplines (e.g., The Society for the Exploration of Psychoanalytic Therapies and Theology [SEPTT] in 2007).
5. Peer-reviewed journals that focused on integration were added to the scholarly and professional communities (e.g., *Journal of Psychology and Theology* [1974], *Journal of Psychology and Christianity* [1982]).
6. Innumerable integrative textbooks, handbooks, and self-help materials that are accessible to lay audiences (e.g., CAPS book series from InterVarsity Press).
7. Successful advocacy for the importance of religion and spirituality (R/S) in both research and applied clinical practice, including the development of R/S compe-

tencies (e.g., American Counseling Association's [ACA] Association for Spiritual, Ethical and Religious Values in Counseling [ASERVIC], American Psychological Association's [APA] Society for the Psychology of Religion and Spirituality [Division 36]).

The aforementioned list is far from exhaustive. There are many, many more exemplary institutions, programs, and scholarly communities that have been established contributors to the integrative dialogue and more that continue to enter the scene. But each of the aforementioned examples demonstrate the role that systems play in sustaining the longevity of the marriage between the disciplines of psychology and theology. Now, as we settle into the world of integration in the 21st century, it is our charge to continue to build upon the foundation that these systems have laid. Yet, as we acknowledge the wisdom and insights that have laid the firm parts of this foundation, we must also acknowledge the blind spots and costly omissions that accompany this integrative inheritance as well.

Upon closer inspection, it also becomes apparent that the contours of the early years of the integrative enterprise were reflective of the vast majority of its early constituents: Christian men (along with some noteworthy women) who were committed to the truths of the gospel and a deep value for the holistic health of the human person—in mind, body, and spirit. Many of the early integrators were White, middle-aged men with a high degree of education and a strong affiliation with various strains of the evangelical and fundamentalists traditions. Men such as J. Harold Evans, the founding editor of the *Journal of Psychology and Christianity*, and Clyde Narramore and his nephew Bruce Narramore, who would become the founding administrators of the Rosemead School of Psychology, were instrumental in the establishment of scholarly communities that believed that mental, emotional, and relational needs could be met by combining the research of psychological literature with the wisdom of our sacred texts of Scripture.

Though often less well-known, early female scholars such as Hendrika Vande Kemp (one of Fuller Seminary's first female faculty), Mary Stewart Van Leeuwen (Professor of Psychology & Philosophy at Eastern University), and Frances J. White (a professor at Wheaton College) paved the way for a more inclusive understanding of integration in their teaching and writing. Drawing upon their research in philosophy and psychology, these women paved a way for interdisciplinary engagement and a critical approach to psychology, all the while attending to the significance of a distinctively female contribution to the field. Such women blazed a trail as early female figures in the field of Christian higher education that, up to that point, had made very little room for the voices of female scholars, clergy, or mental health practitioners. As practitioner-scholar-educators, we are exceptionally grateful for the path that they paved for us.

If we continue this exploration into the past, one does not need to dig very deeply into the integration literature to discover that the perspectives of ethnic and racial minority scholars and clinicians within the United States (and abroad) have been sparse. And the voices of female academics and practitioners from all ethnic backgrounds—though extant in pockets of the field's history, as noted above—have been quite limited, compared to their White male counterparts. For a host of reasons, the emergence of more representative voices has been elongated, and space for representative integrative leadership from historically marginalized perspectives has been especially protracted. This is a painfully powerful observation.

Allowing the gravity of this reality to sink in brings us to an important juncture: a more inclusive integrative endeavor is essential for Christian psychology, counseling, and MFT to remain attuned and responsive to the needs of the entire church and concerns of society at large. The distinctive sense of vocation that marks all integrative scholarship, education, and practice is grounded in the Christian call to bear witness to the redemptive work of Christ in the world and the restorative work of the Spirit in every sphere of life—whether this is done implicitly or explicitly.

As integrative professionals, our primary task is to embody, unveil, and usher in the riches of the Kingdom of God into our work spaces. However, this mission cannot be accomplished if we are not listening to the Kingdom perspectives that come from a full representation of the Body of Christ at work within all corners of the field of mental health and the psychological sciences. Our ability to listen to what, and how, the Spirit is speaking within an inclusive pro-

fessional community will empower us to attend to the work of the Spirit in the lives of those we teach and serve and in the research and scholarship that we produce. For the future of integrative scholarship to have a sense of meaning and place that is seen and valued by all corners of the church—and for it to reestablish a sense of cultural awareness within a rapidly diversifying profession—underrepresented voices must not only be heard, but also empowered.

Setting the Table: Envisioning a Holistic Integrative Endeavor Inclusive of Missing Voices

The cultural shifts that are taking place in our nation and world belie the necessity of attending to the needs and values of our current context. While such attunement is not offered merely for the sake of "relevancy," as psychologists and mental health professionals it would behoove us to be well-acquainted with the language, mores, and cultural expectations of our changing society so that we are equipped to both understand and serve our communities faithfully. This psychological attention to the sociopolitical landscape is as paramount for integrators as sensitivity to the holistic needs of a parishioner is for a clergy member. Neither psychological nor pastoral care can be offered effectively if one is naïve regarding the milieu in which they have been called to serve. Attending to the changes in our environment becomes a perquisite to effective and culturally appropriate research and practice.

In that vein, it is noteworthy that the U.S. Census Bureau projects that a series of noteworthy demographic shifts are on the horizon here in the United States of America (Vespa et al., 2020). The U.S. Census Bureau projects the following: (a) the percentage of adults over the age of 65 will double between the years 2010 and 2060; (b) the country's racial make-up will shift from 1 in 8 individuals who identified with cultures of non-European ancestry in 1950 to 1 in 3 by 2060; and (c) the fastest-growing demographic in the U.S. currently comprises biracial or multiethnic individuals. It is projected that U.S. residents with a multiethnic heritage will increase by 200% by the year 2060 (Vespa et al., 2020). These changes in age and ethnic/racial background are remarkable to watch and require discernment to know how to respond to them with attention and care.

As we reflect on the significance of changes in ethnic and racial culture, it is also important to note that the impact of other demographic factors, such as those pertaining to gender identity or sexual orientation, are still largely undercounted (U.S. Census Bureau, 2020). This is due, in part, to the fact that—historically—questions regarding gender identity and sexual orientation have not been adequately assessed through the census process. Our lack of understanding regarding the experiences and perspectives of all facets of our community leaves us ill-equipped to teach, research, or practice with appropriate skill or adequate care within our beautifully and painfully complex set of social systems. Many things need to change.

As we pause to process all of this information, we acknowledge that many will perceive the shifting demographics and accompanying changes in cultural values as a signal of a country detaching from its roots. While in some ways this may be the case, a broad view of these changes also welcomes the observer to recall the values of the early Christians, who migrated to these inhabited lands to make room for the variegated perspectives and diverse experiences of all immigrants who would come to consider this land "home." From this vantage point, attending to the current perspectives, needs, and desires of our changing demographic is an opportunity for us to provide space for the cultural roots of our oft overlooked neighbors to be planted in the soil that is also their home.

Moreover, all of the demographic changes taking place in the U.S. (and around the globe) reflect an invitation to integrative scholars, clinicians, and educators to listen more carefully—and more intentionally—to the growing number of voices of those who have historically been on the periphery of our teaching, writing, and clinical practice. Our careful and prayerful listening must be accompanied by reflective and intentional action, as well. Whatever action we take, moving forward will necessarily require more consistent engagement with the voices of those who have too often been overlooked in society and in the church. It is our firm conviction that making space for underrepresented voices to gather around the table and share their experiences and perspectives will enable

all of us to understand the season of human history that we live in more fully, and will empower us to journey with our neighbors with greater wisdom and care.

Why Move Toward a More Inclusive Integration?

Despite all of these overtures toward openness and the admonition to adopt a posture of inclusivity, a burning question likely remains unanswered for many: Why? Why would we make room for the voices of others whose experiences are so different from those of our "founding fathers?" Arguably, answering this question is essential for any movement forward.

In response to this question, we proffer that the invitation towards an inclusive conversation is grounded in the biblical call for justice. The Christian virtue of justice involves seeing the "others'" inherent value as created by God in His own image and loved by Him for eternity. Conversations surrounding justice in recent times has left the church struggling to remember that justice is, in fact, one of the Divine attributes (a distinctive characteristic of God's very being) and one of the most prominent Divine expectations for the people of God. Clarified and reiterated in both the Old and New Testament (Amos 5:24, Hosea 12:6, Micah 6:8, Luke 11:42), the Christian call to live lives, and create systems, that foster justice is—consequently—a core expectation of integrators as well.

It follows, then, that internal postures and external practices of exclusion and discrimination are inconsistent with the Christian ethic of justice. As Christians involved in the integrative endeavor, we are called to a courageous response to the fear of "the other" that often manifests in the church and larger culture. Justice includes treating others as an end in themselves, rather than exploiting and misusing people as a means to an end (Waddams, 1964). The virtues of justice and courage, then, are integral to a genuinely inclusive integrative endeavor.

From a more personal perspective, the journey towards a more inclusive integration for each of us began with the establishment of a firm foundation built upon the visionary and courageous work of early integrative scholars who advocated for a "place at the table" for Christian perspectives in psychology, counseling, and family therapy within their broader guilds. As noted earlier, these mothers and fathers of integration provided a robust philosophical, scientific, and moral apologetic for conducting the science of psychology from a theistic worldview. Their courageous engagement with members of their guild from a distinctively Christian perspective made space for the validity of spiritual and religious dialogue within such professional settings. For this advocacy we are grateful. As we think about the impact of the past on our present experiences, reflecting on our personal journeys into the field of integration reveals the development of values and convictions that continue to shape our hopes for a more holistic and inclusive integration endeavor.

My (C.J.F.) journey into the world of integration began as a high school student who stumbled upon the book Boundaries: *When to Say Yes, When to Say No to Take Control of Your Life* on the shelves of my parents' home library. As I poured over its pages, I discovered that Henry Cloud and John Townsend (1992) had taken the realities of interpersonal challenges and provided recommendations for relational restoration that were grounded in the truths of Scripture and psychological research. I was enamored. Such early exposure to the intersection of faith and psychological perspectives laid the groundwork for my major in psychology and minor in biblical and theological studies in college. Exploring the world of "abnormal psychology" proved to be especially transformative when my professor highlighted the parallels that existed between the gospel writers' depiction of a man possessed by a demon in Mark 5 and the DSM's identification of similar symptomology as a mental health disorder. He challenged us to think critically about what we saw, and I did. My eagerness to explore these concepts further prompted me to read the textbooks for my Biblical Exegesis and Hermeneutics course with even more care and interest, as I was beginning to see that the themes that we were unpacking in those classes had direct implications for what I was trying to understand in my psychology textbooks.

As I prepared for graduation, I knew that my undergraduate degree had whetted my appetite for even deeper and more nuanced understanding, and I decided to pursue my graduate studies at Fuller Theological Seminary so that I

could continue to delve more deeply into both disciplines simultaneously. As a graduate student, I found that my twin loves for these disciplines was catapulted even further! I learned to ask psychological questions in my courses on systematic theology and theological questions in my courses on psychological interventions. The papers that I wrote in these classes laid the foundation for the small volume that I would write as my dissertation on the ways that the history of church doctrines on affect have impacted our understanding of emotional well-being in the church today.

Reflecting on these pivotal experiences, I am keenly aware that the opportunity to explore these ideas was facilitated by the incredible professors who read my work and offered substantive and encouraging feedback on my writing at both the undergraduate and graduate levels. Undoubtedly, the privilege that I had to be shaped by women and men who are deeply committed to integration in every sphere of their professional (and personal) lives empowered me to do the same. Now, as a professor who teaches classes explicitly focused on integration in my courses at Wheaton College and in my guest lectures for graduate programs around the country, I am keenly aware of the call to steward these opportunities to empower the next generation of integrators.

As an early career integrative scholar, I am also mindful of the value of intergenerational relationships as I continue on my vocational journey. As a result, I am intentional to initiate, maintain, and strengthen relationships with integrative scholars whom have gone before me, even as I set aside regular time in my schedule to mentor those who are coming after me. This intentional approach to professional and personal relationships provides the chance to embrace the differences in perspective that come from varying experiences, expertise, and personal backgrounds when approaching a collaborative enterprise. When these differences are intentionally acknowledged, the transformative value of intersectionality in research, professional presentations, and teaching can be seen so much more clearly (Fort, 2018).

My (T.S.W.) journey towards the integration of psychology and Christian faith began as an undergraduate student at a state university double majoring in psychology and religious studies. Attempting to bring the two disciplines together for my thesis was a lonely pilgrimage with very few guides to show me the way. Imagine my joy in coming to Wheaton College for a Master's in Clinical Psychology to study under the tutelage of wise and influential integration scholars, such as Stan Jones, Rich Butman, Fran White, and Bob Roberts. This initial introduction to the integration literature felt much like sitting down at a banquet table to a rich feast of intellectually nourishing, faith informed thought and provided impetus for further graduate studies and eventual entry into the Christian academy as a faculty member. However, my early introduction to the integrative endeavor also left me with a desire for something more and raised questions (and potential doubts) about how my perspectives from intersecting identities as a woman, a first-generation college graduate, and a daughter of an anabaptist upbringing could be part of the conversation. I wondered, "Is there a place at the table for me?" "Are there models and mentors to show me the way?"

These questions fueled an early career curiosity about the intersection of gender and integration scholarship. I was fortunate to find a wise mentor in Cynthia Neal Kimball, who invited three early career women in the department to join her in the qualitative study of women's experiences in the Christian academy—a project made possible by internal funding from the institution. I remember little of our research discoveries, but I clearly recall that the process of collaborative research with a group of female colleagues in Christian academia was life changing. In the process of learning to conduct research on missing voices, I found my own.

Through mentoring, collaborative research, and institutional support of exploratory scholarship, I was able to form a research team of my own to initiate a project examining gender differences in the integration literature. Our content analysis of published scholarship by gender and type of integration found that women authors were more likely to publish clinical and faith-praxis integration articles, an applied approach to integration that was underrepresented in the literature at the time of our study (Watson et al., 2001). This line of research underscored a strong desire to pursue an inclusive integration endeavor and began to grow a strengthening conviction that missing voices

at the table would lead to an imbalanced, diminished, and potentially irrelevant integration endeavor that would fall short of Kingdom impact. The inclusive integration challenge grows as we consider the importance of incorporating intersecting identities and unique perspectives of men and women from multiple racial and ethnic groups, who have also voiced the need for diverse cultural perspectives on the integration endeavor.

Piecing it All Together: Personal Experience and Scholarly Research in Conversation

In light of this cursory review of our personal journeys, it is appropriate to ask how our experiences square with academic scholarship. A review of the literature reveals what is already quite evident at first blush: The voices of women and faculty of color are underrepresented in academia. Griffin (2020) noted that the hiring and retention of ethnically diverse and female faculty is far below what is needed to provide representation of the general population, not to mention the student populations, at most institutions. In psychology, the experiences of female psychologists in academia have improved in recent years, particularly in the rates of women achieving academic positions, receiving research grants, and holding leadership positions in the field. However, stark inequities remain when comparing women's financial compensation and the arc of their professional advancement to senior ranks to the upward mobility of their male counterparts (Gruber et al., 2020). While women represent a high percentage of faculty in academia at early career stages, our ranks diminish as we look at the gender balance among tenured professors and senior scholars of influence. This gender disparity results in fewer models and mentors for early career female psychologists who are looking for those who have forged a path ahead. The barriers that having a limited number of female mentors can create, particularly in the field of integrative scholarship, is a reality that both of us have experienced first-hand.

Women in academia with intersecting identities experience additional challenges. Lisa Bowleg (2012), a social psychologist, defined intersectionality theory as

> a theoretical framework that posits that multiple social categories (e.g., race, ethnicity, gender, sexual orientation, socioeconomic status) intersect at the micro level of individual experience to reflect multiple interlocking systems of privilege and oppression at the macro, social-structural level (e.g., racism, sexism, heterosexism). (p.1267)

In other words, the word "intersectionality" is another way of affirming the reality that every aspect of our social location impacts our experiences on both an individual and a systemic level. Griffin (2020) aptly described the challenge in this way:

> Women of color experience additional forms of marginalization as compared to white women because of their exposure to racism; and women of color are oppressed in ways different from men of color because of their encounters with sexism. A person's positionality based on their identities cannot be quantified with easy math; rather, having multiple minoritized identities amplifies marginalization as individuals experience different forms of identity-based oppression at the same time. (p. 283)

While acknowledging the exponential impact of these intersecting identities is complex and may even be perceived as costly, failing to do so leaves us detached from the reality. Thus, the lens of intersectionality is critical for us as we journey forward towards implementing supports and removing barriers to an inclusive integration endeavor (Fort, 2018).

Empowering Others to Take Their Place at the Table: Strategies and Practices to Promote Sustainable Systemic Change

Acknowledging that removing barriers is essential to an inclusive integrative endeavor then prompts us to ask, "What then do we do to change the future of the integrative endeavor?" We propose that a commitment to intentionally empowering missing voices is an essential strategy for ensuring that the necessary people are gathered around the table for inclusive integration conversations. However, as stated previously, before we can move forward we must recognize the very real structural and systemic barriers that pose a threat to inclusive integration and work actively to remove them. Toward this end, it is our belief that an inclusive integrative endeavor will incorporate both top-down and bottom-up approaches to equity.

A top-down approach to implementing sus-

tainable systemic change involves using our positions of privilege and power to amplify the voices of others—particularly professionals from groups that historically have been underrepresented in academia. This can be done in a host of ways, including intentional citation of the quality work of ethnic minority colleagues, extending invitations for keynote addresses and/or named lectures, and designating internal grant funding for historically underrepresented faculty. A bottom-up approach involves listening to and learning from the wisdom and experiences of underrepresented groups and recognizing that these perspectives are vital for the integration endeavor to remain attuned to the contemporary needs of the church and society.

Too often, the rationale for avoiding such intentional measures is grounded in the fear of undue preferential treatment for underrepresented colleagues to the exclusion of other qualified colleagues who might also benefit from such opportunities. However, this line of reasoning fails to accept the poignant reality that many faculty, clinicians, researchers, and scholars from historically marginalized communities are far less likely to benefit from the systems that are already in place when compared to their majority culture counterparts (Whittaker et al., 2015). As a result, the traditional systems that are *assumed to be* equitable at face value (e.g., in distribution of funding, extension of invitations for speaking or publishing opportunities, etc.) are plagued with blind spots that lead to the neglect of these scholars or the wholesale dismissal of their work. When colleagues wonder why faculty of color or female colleagues may publish less than their counter parts, we must acknowledge the institutional and structural barriers to such professional flourishing.

In order to move forward, we will propose strategies for sustainable systemic change that can foster the development of leadership from underrepresented voices in the integration endeavor. While articulating a comprehensive strategy for addressing systemic racism and sexism in academia is beyond the scope of this article, we will identify key strategies and practices to address systemic barriers to the recruitment, retention, and flourishing of faculty from underrepresented groups. Notably, we propose that a Christian integrative approach to systemic change can provide something more when we incorporate Christian virtue as our motivation and aim. With Spirit-infused courage, justice, humility, and ultimate hope in Christ's kingdom to come, we can move forward boldly with actions that empower others to take a seat at the integrative table and dismantle barriers that inhibit a more inclusive integrative dialogue. As we reflect on the challenges in our own professional journeys, it is imperative that we use these insights, and any power/authority that we have, to name and address the barriers for the sake of the generations coming after us.

Empowering Future Scholars Through Intentional Mentoring

Griffin (2020) has reminded us that the graduate students of today are the professors, clinical supervisors, and organizational directors of tomorrow. One practice that both authors have incorporated in our roles as supervisors and faculty members is to seek out opportunities to encourage undergraduate and master's level students from underrepresented groups to consider an advanced degree and our master's and doctoral level students to consider a career in academia. More often than not, we have found that the power of a respected faculty member's recommendation has propelled students forward into vocational opportunities that they had not realized they were qualified to pursue.

In addition, we can empower students by providing them with opportunities to teach (i.e., teaching assistant [TA] positions that include opportunities to lecture, not just grade assignments), provide peer supervision to younger clinicians in their training programs, and take the lead on research projects in which they have shown a vested interest. Personally and professionally, as we take stock of our own privileged access to resources as educators, research advisors, and clinical supervisors we are able to acknowledge the power that we have to create a safe space for our students, supervisees, and mentees to explore their God-given giftedness to contribute to the field in magnificent ways that neither we, nor they, could have even imagined.

These examples of personal and individual changes can also be paralleled by organizational changes as well. The Christian Association for Psychological Studies' (CAPS) recent decision to initiate the McNeil Scholars program (https://caps.net/mcneil-scholars) is an excellent exam-

ple of an organization finding a way to empower scholars and practitioners at a systemic level. This new initiative is a mentoring program that builds towards an inclusive integration of the future. The aim of the program is to provide graduate students from historically underrepresented communities with a two-year commitment from a professional mentor who specializes in integration and is eager to journey with the student in their professional pursuits. We trust that other organizations will be able to think of creative ways to engage members of historically recognized and marginalized communities in our efforts towards inclusion and full participation.

Recruitment and Hiring Practices

Intentionality in the hiring process can also provide key opportunities to invite missing voices to take their place at the professional table. One of the most successful strategies I (T.S.W.) have found in the recruitment process is to personally reach out to colleagues and alumni from a wide range of backgrounds to keep them updated on open faculty positions and invite their involvement in the inquiry and application process. These small but consistent points of contact have the power to convey the sincerity of commitment not only of an individual administrator, but also of an institution invested in hiring representative faculty.

Similarly, as an ethnic minority scholar and clinician, one of the most effective strategies that I (C.J.F.) have seen for mitigating the gap in access to professional opportunities has been in the intentional creation of networks of allies. I have been delighted to be connected with faculty of color around the nation who are careful to extend opportunities to each other. Moreover, these groups of colleagues have been strategic in our efforts to include promising students who do not yet have the social capital to gain access to privileged information about various professional opportunities. The regularity with which such opportunities are exchanged between faculty at various institutions increases the probability that qualified applicants will become strong candidates and exemplary recipients of a host of awards, honors, and opportunities that are well deserved. In contrast to the encouraging opportunities mentioned above, it is also worth noting the woefully inaccurate (and deeply painful) rhetoric that I (C.J.F.) have heard in a number of Christian settings—rhetoric grounded in the false belief that historically underrepresented applicants are not considered for various positions because there "simply are not enough qualified applicants to consider." More often than many would like to admit, however, the reality is that the networks of prestigious professional communities are more insular than they even know, and this insularity is itself a systemic inhibitor for equitable access to a wide array of opportunities. Shifting the narrative that we tell is imperative. Genuine change cannot take place otherwise.

As social scientists, educators, and mental health care providers, we benefit from paying careful attention to our own susceptibility to such cognitive distortions and flawed heuristics as the *fundamental attribution error* (used to explain away disparities in our recruitment processes) and the impact of the *recency effect* (which impacts perceptions of the number of ethnically diverse and well qualified scholars who might make up our applicant pools) in our search for new hires. When our circles are homogenous, in any sense of the word, our perceptions of qualified and available candidates will be inherently skewed. Moreover, as integrators, acknowledging the pull of these implicit biases allows us to verbalize the psychological processes that can make it difficult to live lives marked by the virtues of courage, justice, and humility that are intended to be the hallmarks of the people of God. Only after we acknowledge the impediments to faithful Christian practices may we journey towards repentance and transformation.

So, practically, what does all of this mean? As we consider practical solutions, Griffin (2020) has admonished academic institutions to look beneath the surface of institutional hiring and retention practices to identify systemic barriers. Towards this end, she writes,

> Institutions must acknowledge how administrators, faculty, policies, and structures create and maintain (un)welcoming campus environments. Institutional leaders must understand and address how sexism and racism are embedded in academic structures, systems, departments, colleges, and programs in a comprehensive way to truly understand why they have failed to or have made minimal progress towards increasing the number of women and men of color on their faculties. (pp. 279-289)

This admonition is as true for Christian colleges and universities as for our non-religious counterparts (Longman, 2017). Our efforts towards systemic institutional change are essential not only for the sustainability of our efforts, but in order to demonstrate integrity in our commitment to practice *all* of what we preach. Towards that end, it is important to assert that "increasing the numbers" is only as valuable as the increasing opportunity to learn from, and journey with, those who offer perspectives outside of mainstream of psychology in general or integration specifically. A simple change in "optics" reflects a commitment to political correctness and does not serve as a testament to a robust understanding of the diversity of experiences that is reflective of the Divine Kingdom.

Faculty Retention and Support

Despite our best intentions, we must acknowledge that inviting faculty from underrepresented groups to take a seat at the table is a necessary but insufficient step towards inclusion. Institutions must also *invest* in faculty retention initiatives and sustainable supportive policies. Suggested strategies include assessing the campus diversity climate, instituting a diversity plan, cluster hiring of diverse faculty, providing multicultural resources, and robust mentoring programs (Romero, 2017). Advocating for funding for scholarship and professional development can also be an important strategy for empowerment. For example, in the School of Psychology, Counseling & Family Therapy at Wheaton College, we provide annual membership for faculty from underrepresented groups with the National Center for Faculty Diversity and Development (NCFDD)—a well-established and respected professional community that also facilitates a popular Faculty Success Program to encourage successful scholarship practices for those in the academy.

Institutional support for engagement in communities outside of one's institution affirm the value of robust infrastructures that empower faculty to attend to their own professional needs. For faculty who come from communally-oriented cultures, the pull to meet the needs of other underrepresented members of the community (be it colleagues, students, administrators, or clients) is felt. Engagement in programs such as NCFDD reminds underrepresented faculty that the admirable desire to be a resource to others must be complimented by the consistent reminder that self-care in the form of attending to personal and professional needs may be one of the most sustainable ways that they can be a resource for those around them.

From a personal standpoint as a female faculty of color, I (C.J.F.) can testify to the fact that seeing my academic dean (T.S.W.) demonstrate her commitment to my scholarly success by actively pursuing funds to support my continued development was key. I am always watching for trustworthy signifiers that institutional discussions surrounding recruitment and retention of underrepresented faculty is not merely rhetorical strategy. Under Terri's leadership, it has been a joy to discover such congruence between her personal beliefs and professional investments. She models a way of life that is exemplary.

Collaboration

Collaborative scholarship opportunities can also be a basis for faculty empowerment and the promotion of self-efficacy and collective efficacy. The concept of "collective agency" draws on ideas from both psychology and sociology, and it proposes that "perceived *collective* efficacy will influence what people choose to do as a group, how much effort they put into it, and their staying power when group efforts fail to produce results" (Bandura, 1982, as quoted in Hipp, 2016). For our purposes, a group might refer to an academic department or program in a university or group psychotherapy practice; it can be any gathering of colleagues with some sense of collective identity. In any case, the power of *our* shared perception of our goals, *our* sense of agency, and our commitment to change will shape *our* ability to reach *our* desired ends.

As we think about the value of fostering a shared sense of identity, we also propose that inclusive integration is fostered through intentional collaborations. For example, collaborative scholarship—such as the co-creation of this article—invites missing voices to bring much needed perspectives and priorities to the integration literature. This practice involves recognizing the limitations of our own voices and seeking out thought partners who will enrich, challenge, and modify our cherished notions of integration. Invitations for collaboration can be

especially empowering for early career faculty from underrepresented groups in academia; these invitations communicate "your voice matters" more powerfully than one might imagine.

A critically important professional marker for me (T.S.W.) was the invitation by two of my respected mentors to revise several chapters for a second edition of their integration text. This was a daunting task, as it involved updating and revising their original work. Looking back, I believe this collaborative scholarship project was a personal and professional turning point as my mentors' actions were an invitation to join the conversation as a trusted peer. This experience modeled for me the essential importance of collaborative scholarship as professional empowerment.

Instilling Courage

Courage is an essential virtue for the practice of intentional empowerment of others. Thomas Aquinas identified four sub-virtues that demonstrate courage: magnanimity (the confidence to develop our God-given gifts), magnificence (the willingness to use these gifts to take on great tasks for God), patience (also defined as long-suffering), and perseverance (constancy and fortitude) (Kaczor & Sherman, 2009). Courage involves recognizing and using our own gifts in God's service through the power of the Holy Spirit and encouraging others by naming and calling out the use of their God-given gifts. Instilling courage is an important responsibility of Christian leaders, mentors, and clinical supervisors (Watson, 2018). In reflecting on our own professional journeys, we have both been able to identify pivotal professional moments when colleagues and mentors were used by God to instill in us the courage to take our places at the table and contribute to the integration conversation. We also take great joy in creating opportunities for others to boldly use their gifts in ways they have not yet imagined.

A professional example of this type of empowerment for me (C.J.F.) came when an editor at a major publishing house invited me to provide a series of blind reviews for forthcoming books written by integrative professionals whom I respected. The editor's email invitation acknowledged his awareness that I would be providing feedback to scholars more senior than I. He was firm in his assertion that my perspective as a more recent contributor to the integration literature would provide valuable editorial insights that he believed would enhance the quality of these publications. The publisher's awareness of my own scholarly trajectory, and his familiarity with the work of my senior colleagues, allowed me to internalize the affirmation that was coupled with this invitation. This direct invitation was an explicit affirmation of my professional voice.

Moreover, as an African American scholar, the publisher's acknowledgement of my intellectual and professional capabilities was essential for me to take in his feedback. In a day and age where asking a Black woman to join a panel, a committee, a leadership team, or a board of directors is considered "politically correct"—invitations that are often extended in a perfunctory way—clarifying that the invitation is not merely extended for the sake of tokenism becomes especially important.

Leadership Development: Risks and Opportunities

Over the course of our careers, we both have felt the strong pull to step into spaces and roles of influence in order to extend the representation and influence of voices that are often underrepresented from various aspect of our intersecting identities (gender, race, ethnicity, age, socioeconomic status [SES], denominational background, relational status, and professional identity). While these opportunities for engagement in leadership are welcomed occasions to remove barriers to inclusive integration, they also pose a professional risk—particularly to our voices as scholars. Women in psychology hold a disproportionate number of middle management academic positions and are more likely to be offered and accept professional roles, which can negatively impact time devoted to research and scholarship activities. In fact, Gruber et al. (2020) noted, "Women are more often offered and accept service roles that do not provide a pathway to power" (p. 16).

As noted above, faculty from underrepresented groups are often faced with a disproportionate amount of "invisible labor," including requests for committee work and a wide range of institutional service. The increased advising load carried by faculty of color is magnified by the fact that faculty of color are often hired one

by one, rather than in pairs or as a cohort. These faculty are often sought out by students of color and majority students alike, and the increased time spent in both formal and informal modes of faculty advising can be very weighty. Accounting for these trends can lead to structural academic change, such as when administrators watch for these patterns and facilitate conversations with faculty to creatively restructure teaching loads, research expectations, and adequate advising release time.

For early career faculty, mentors and supervisors can play a key role in helping faculty sift through requests for institutional and professional service, empowering them to choose wisely and say "no" frequently. In my own experience (C.J.F.), Terri has been a wonderful example of this type of leadership. As a first-year faculty member, Terri invited me to meet with her one-on-one on a regular basis in order to serve as a resource for me as I navigated my first year in the academy. These consistent meetings provided predictable space to process unexpected challenges, navigate expected road bumps, and build a collegial rapport that could not be fashioned any other way. Moreover, as a pre-tenured faculty member, I was mindful of the significance of Terri's words even before I was formally hired: she often reiterated her desire and commitment to be a practical resource for me. Each time I have faced a new professional challenge, it has been a gift to watch Terri confirm her commitment to be a resource in every way that she can.

And I (T.S.W.), in turn, have learned a tremendous amount from Christin's astute observations, leadership gifts, and intellectual/theological acumen. (In fact, I am absolutely convinced that I am the one that benefits the most from our times together!) Both the similarities and differences in our intersecting identities related to gender, age, race, ethnicity, faith background, and leadership roles have added richness and nuance to our collaborations as we listen to and learn from each other.

Systemic Change Through Mutually Meaningful Dialogue

Thus far, the recommendations that we have offered have focused on ways that those in power can acknowledge their positions of influence and actively use them to empower others. However, sustainable systemic change also involves attunement to the needs of our underrepresented colleagues, students, and clients; a "bottom up" approach to change. Through fostering mutuality and meaningful dialogue, we invite those who may not yet have positions of power to speak truth about their lived experiences. Sustainable systemic change must involve boldly naming the attitudes, practices, and structures that maintain barriers and disempower faculty, clinicians, and researchers from underrepresented groups from taking their place at the table. ACA's (2018) advocacy competencies are an excellent guide for empowerment strategies to join with students and colleagues to advocate for systemic change in academic spaces to address social, cultural, and economic barriers to inclusion of underrepresented voices.

In order to have a worthwhile conversation, adopting a posture of "cultural humility" is an essential virtue (Tervalon & Murray-Garcia, 1998). Adopting this posture enables us to recognize our systemic and personal blind spots and how much we need to learn from the perspectives and experiences of others. In my leadership role (T.S.W.), I have engaged in conversations where a courageous colleague reveals their experiences of a microaggression or a microinvalidation in their interaction with me. In these moments, I have often found myself seeking forgiveness for my blind spots. While I may not always feel like I have power, it is important for me to muster all the courage I can to recognize instances of negative impact of my position of power and privilege on others, in a humble and non-defensive manner. This posture has led to rich opportunities for listening and learning that have transformed my view of self, others, and the world.

Underrepresented voices are uniquely attuned to critical needs and issues in church and society that require a fresh voice and courageous willingness to pursue change. Gruber et al. (2020) highlighted the important contributions of women in psychology to address societal problems, such as sexual harassment, inequities in salaries related to gender, and gender bias. Edwards (2020) asserted that those marginalized groups who have been most impacted by societal and structural injustice are perhaps best equipped with the vision and skills to promote real change. He wrote,

> History has demonstrated that oppressed people best understand what justice can look like…Suffering has the ability to push the faithful on to greater faithfulness. While the heat of oppression forces some people to melt, it causes others to harden. Amazingly those who have endured injustice often possess great faith, which produces spiritual depth, providing motivation and insights for all who follow behind these godly people. We must tap into the spiritual power of those who know oppression. (p. 161)

It is essential that the integrative endeavors of the future are attuned to the leadership voices of colleagues from underrepresented groups. We have so much to offer that is so often unseen and underutilized. The necessity of this transformation cannot be underestimated. Attending to this call to listen, and respond, to the voices of those who are historically overlooked within the subdiscipline of integration is not only important for those who are underrepresented, but it is of great value for the field of integration's longevity as well. Failing to do so makes it far too likely that forthcoming generations will deem integration a thing of the past—an altogether irrelevant idea that was beneficial for the past but bears little significance for the present and no lasting purpose for the future.

This is a dire assessment. Yet, the opportunity to shape the future remains before us. It need not end in this way.

The Great Banquet Table: A Bold Eschatological Vision of Inclusive Integration as Transformative for the Church and Society

While the Christian academy is lagging behind many of its secular counterparts when it comes to embracing inclusive practices, the Christian imagination makes room for something more. Our shared vision of the ultimate inclusive table, *the great banquet* described in Revelation 19, provides a hopeful vision for inclusive integration marked by a diversity of expressions. As believers, our knowledge of the spiritual reality that we are all invited to the same eschatological table ought to propel us forward! Moreover, our practical embodiment of this vision of the Kingdom can become one way that we see the fulfillment of the prayer that our Lord taught the disciples to pray: "Your Kingdom come, your will be done, *on earth as it is in heaven*" (*New International Version*, 2011, Matthew 6:10).

Christian hope is a gift from God that allows us to live in the angst of the "already but not yet" of Christ's kingdom work. Through hope, we can persevere in the face of adversity and opposition to inclusion and equity. N. T. Wright (2008) reminded us of this with the following:

> But what we can and must do in the present, if we are obedient to the gospel, if we are following Jesus, and if we are indwelt, energized and directed by the Spirit, is to build for the kingdom…Every act of love, gratitude, and kindness…all of this will find its way, through the resurrecting power of God, into the new creation that God will one day make. (pp. 327-328)

This ability to "build for the Kingdom" is only made possible when we catch a vision for what this grand and glorious upside-down Kingdom is like (Kraybill, 2011).

Our hope for the future of the integrative endeavor rests in our belief that integrative scholars, researchers, educators, and practitioners will lean into the Divine call to "be imitators of God" (*New International Version*, 2011, Ephesians 5:1) not only in our personal lives, but in our professional endeavors as well. As imitators, we have the great privilege and responsibility of embodying the virtues that are befitting of those who belong to this Divine Kingdom. As such, we "clothe [ourselves]…in humility" (*New International Version*, 2011, Colossians 3:12). This humility prompts us to acknowledge the limitations inherent in our own finite perspectives and perceive the wisdom that can only be found in community. What is more, this humility is coupled with the call for justice. Micah's portrayal of the Divine clarion call to ancient Israel rings true for the people of God today: "He has shown you, O mortal, what is good. And what does the LORD require of you? To act justly and to love mercy and to walk humbly with your God" (*New International Version*, 2011, Micah 6:8).

These verses provide a plumb line against which we can measure our growth in this journey towards sanctification—and the journey towards a more inclusive integration. This admonition is applicable to those in every vocation, but perhaps it is especially apropos for us as integrators. As those who make it our quest to draw connections between the texts of Scripture, the traditions of our Christian faith, and the findings

of psychological research, it is incumbent upon us to discern how we will implement this Divine call in each of our spheres of influence.

As authors, we proffer that an intentional turn towards an inclusive integrative endeavor will empower each of us to bear witness to the liberating realities of the Divine Kingdom more fully. Our decision to make room for the voices of those who are too often unheard can be coupled with a commitment not only to listen, but to act on what we hear. These communal commitments will equip us to see how—together—we can begin to get a glimpse of what it means for this Divine Kingdom to come "on earth as it is in heaven" (*New International Version*, 2011, Matthew 6:10).

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Why Church Attendance is Difficult for Children with Common Mental Health Conditions and Their Families

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Children and adolescents with mental health conditions are less likely to attend religious services than unaffected youth. Depression is associated with a 73% reduction in the likelihood of attending a worship service, while the presence of disruptive behavior disorders, anxiety disorders, or attention-deficit/hyperactivity disorder are associated with 55%, 45%, and 19% reductions, respectively. In this paper, we hypothesize lower rates of church attendance resulting from functional limitations associated with mental health conditions that make entry into a church difficult. Children and youth with mental disorders experience more difficulty meeting common expectations for social interaction and self-control in worship services, small groups, Christian education, service activities, and other church functions. Given the heritability of these conditions, their parents often experience similar challenges engaging in ministry activities. We propose a mental health inclusion model for use in churches of all sizes and denominations. The model facilitates recognition of common barriers to church engagement and assimilation and application of inclusion strategies across ministry activities and environments offered to all.

Little data are available examining the impact of mental illness upon church attendance, despite mental illness representing the most common cause of disability worldwide among youth ages 10-24 (Gore et al., 2011). The preponderance of research on mental health and religion examines religion and religious participation as a psychological and social resource for coping with stress (Koenig, 2009).

Religiosity has been associated with reduced risk of depression and is robustly associated with more rapid remission of depression in patients with serious mental illness and reduced risk of suicide (Koenig et al., 2012; Koenig, 2007). In a study of over 100,000 U.S. healthcare professionals, attendance at religious services at least once per week was associated with a 68% lower hazard of death from despair (i.e., alcohol, drugs, suicide) among women and a 33% lower hazard among men compared with participants who never attend (Chen et al., 2020).

There is similar outcome data for anxiety disorders. Religious interventions decreased symptoms more rapidly than secular interventions in randomized studies of participants with anxiety disorders (Koenig et al., 2012).

The presumption throughout the literature is that participation in worship services and other religious activities promotes positive mental health outcomes. An alternative hypothesis is that persons with more severe manifestations of mental illness experience greater difficulty participating in church or other religious activities. The ability to engage in church activities self-selects individuals with less functional impairment from their mental health conditions.

A random sample of 1,714 adults were interviewed about health and religiosity in the third wave of the Baylor Religion Survey (Dougherty et al., 2011). Worriers—people who self-identified as feeling worried, tense, or anxious for ten days or more in the preceding month (17% of the U.S. population)—were less likely to have attended a religious service in the past year (67% vs. 75%), attend religious services on a weekly basis (17% vs. 37%), read the Bible on a weekly

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basis (13% vs. 29%), or consider themselves religious (19% vs. 39%) compared to non-worriers. Adults who experienced sadness or depression for ten or more days (11% of participants) during the preceding month were less likely to have attended a religious service in the past year (61% vs. 78%), attend services weekly (15% vs. 36%), read the Bible weekly (13% vs. 28%), describe themselves as "very religious" (20% vs. 37%) and more likely to identify as religiously non-affiliated (23% vs. 10%) compared to participants free of depressive symptoms.

Whitehead (2018) examined the impact of physical health, mental health, and developmental disabilities upon church attendance using data generated from nearly 100,000 phone interviews conducted in each of three waves (2003, 2007, 2010-2011) of the National Survey of Children's Health (NSCH). Families of children with no chronic health condition were less likely to report never attending church services compared to the overall sample. The percent increase in odds of children with chronic health conditions never attending church was 84.1% for children with autism spectrum disorders, 72.7% for children with depression, 54.6% for children with oppositional defiant disorder or conduct disorder, 44.7% for children with anxiety disorders, and 19.3% for children with attention-deficit/hyperactivity disorder (ADHD). Conditions not impacting church attendance included asthma, diabetes, Tourette Syndrome, epilepsy, hearing or vision problems, intellectual disabilities, and cerebral palsy.

According to the U.S. Centers for Disease Control (2020), 9.4% of children aged 2-17 years (approximately 6.1 million) have received an ADHD diagnosis, 7.4% of children aged 3-17 years (approximately 4.5 million) have a diagnosed behavior problem, 7.1% of children aged 3-17 years (approximately 4.4 million) have a diagnosed anxiety disorder, and 3.2% of children aged 3-17 years (approximately 1.9 million) have a depression diagnosis. Comorbidity is common, in that children with ADHD display elevated rates of depression, nearly three in four children with depression also have anxiety, and almost one in two children with ADHD also have behavior problems. For children with anxiety, over one in three also have behavior problems and approximately one in three also have depression.

These data suggest that an inclusion strategy for families of children with common mental health conditions is needed. ADHD is five times more common than autism and eight times more common than intellectual disabilities (Zablotsky et al., 2019). Given the prevalence of anxiety, depression, and disruptive behavior disorders, mental illness is the most common disability impacting church attendance and engagement in children and youth.

Multiple factors contribute to the absence of programs and strategies for inclusion of children, adults, and families impacted by mental illness. One is the "hidden" nature of many mental health conditions. Children and adults with these conditions who come to church often seek to avoid calling attention to themselves and reject any special treatment or supports that might single them out as "different." Stigma regarding mental illness prevalent in multiple strains of American Christianity causes many to keep their struggles to themselves (Peteet, 2019). Mental health-related disability may be reflected in some, but not all, day-to-day activities. A person with a mental health condition associated with sensory processing differences may have no difficulty sitting through a Bible study or sermon but experience profound distress in a worship service with especially loud music.

Impacts of Church Culture on Attendance and Engagement

We now present a model for mental health inclusion in churches, grounded in a recognition of how functional limitations associated with mental health conditions often clash with "church culture"—defined here as expectations for how attendees will act and respond when gathered for worship, Christian education, missional service, social activities, and other functions of the local church.

Carter (2007) developed a framework for conceptualizing impediments to church attendance and engagement for individuals with intellectual or developmental disabilities, categorizing barriers as architectural, attitudinal, communication, programmatic, or liturgical. His framework offers a useful starting point for considering the barriers to church attendance for all with mental health disorders.

This framework has worked well for guiding inclusion strategies for children and adults with

physical disabilities. Thousands of churches have taken steps to make their facilities more accessible—providing elevators, restrooms, wheelchair ramps, amplification equipment, or interpreters for persons with hearing impairments. Some churches provide nurses to assist attendees with significant medical needs. Excellent ministries have emerged for serving children and adults with "special needs" offering a modified Christian education curriculum, "buddies" for children or teens who require individualized attention, and special events, such as respite events for parents or proms as outreach to adults in assisted living facilities.

Established models of disability ministry designed to serve children with physical, intellectual, and developmental disabilities are not working for those with common mental health conditions. Disability ministry in the late 20th and early 21st centuries has largely served persons who unequivocally bear no personal responsibility for their conditions, exemplified by the man with congenital blindness miraculously healed by Jesus in John 9. Church leaders recognize the diminished capacity for moral agency among children and adults with more profound intellectual or developmental disabilities. Mental illness forces us to consider the individual's ability to make moral judgments grounded in biblical teaching and their capacity to refrain from actions and behaviors identified as sinful in Scripture. The extent to which mental illness mitigates a child's ability to control their own behavior or reflects upon the quality of parenting they receive is far more ambiguous.

Several hypotheses have been proposed for why children and adults with mental illness have been poorly served by existing disability ministry models.

- The term "mental illness" is used to describe a very broad range of conditions affecting cognition, perception, mood, emotions, and behavior. The support needs of a child with social anxiety are radically different than those associated with oppositional defiant disorder or a teen with early-onset schizophrenia. Recognition of these distinctions within the church is rare.
- Mental health disabilities can be difficult to recognize. Symptoms are often episodic. A child or adult with a mood disorder may function well for months or years until signs of depression or mania emerge. Families are often reluctant to disclose a child's mental health condition to church staff and volunteers. Many adolescents will avoid any ministry or support that draws attention to their differences.
- Mental illness is stigmatized in many churches in ways other disabilities are not.
- Functional impairment from mental illness is often situation specific. The aspiring valedictorian may be overwhelmed by the social demands of youth group, or the star quarterback may be unable to sit through a chapel service because of vulnerability to panic attacks inside crowded or confined spaces.

Grcevich (2018) introduced a framework for church-based mental health inclusion building upon the established practice in disability ministry of identifying impediments to church attendance and engagement, taking into account the heterogeneity of functional impairment associated with common mental health conditions; the extent to which impairment is present some of, but not all, the time in some, but not all, situations; and the reluctance of affected individuals to self-identify to pastors, church staff, and volunteers. It identifies seven barriers to church attendance for children and adults with mental health conditions and their families: stigma, anxiety, executive functioning, social communication, sensory processing, social isolation, and past experiences of church, along with a set of inclusion strategies for overcoming existing barriers sufficiently flexible for use in churches of all sizes and denominational traditions.

Stigma

LifeWay Research (2013) conducted a telephone study of 1,001 U.S. adults in which 55% of non-churchgoers *disagreed* with the statement: "If I had a mental health issue, I believe most churches would welcome me." One explanation may be outsiders suspect the presence of ongoing mental illness will be interpreted by churchgoers as evidence of a lack of faith or diligence in religious practice. Evangelicals or fundamentalists were more likely than other Americans (48% vs. 27%) to endorse the statement that people with serious mental illnesses like depression, bipolar disorder, and schizophrenia can overcome their conditions through Bible study and prayer alone.

Historically, churches have been on the forefront of caring for persons with conditions now understood as mental illness. The church became increasingly disconnected from mental health care throughout the twentieth century as influential theories arose to conceptualize and guide treatment grounded in principles in conflict with traditional church teachings.

Freud's theoretical framework for psychoanalysis viewed guilt as pathological and rejected the concept of guilt as a warning from the conscience of the need to recognize and deal with sin. The psychodynamic psychotherapies derived from Freud's work attribute behavior to instinctive urges or drives—a stark contrast to centuries of Christian teaching that views human behavior as actions resulting from humankind's exercise of their God-given freedom to choose right from wrong, for which the individual bears personal responsibility.

Two foundational assumptions of behaviorism are that nature is the only reality and reality can only be measured through our senses. From a Christian perspective, behaviorism is fatally flawed because its practitioners neglect to consider spiritual dimensions of human existence that cannot be readily quantified and measured. Pure behaviorism is antithetical to the construct of free will and biblical teaching on the importance of the soul.

Humanistic therapies emerged in the mid-20th century in response to the determinism inherent in psychoanalytic and behavioral theory. Self-fulfillment and self-actualization are the goals of humanistic treatment conducted under the assumption the individual is responsible for their own happiness and accountable to only themselves. Adherents of humanism struggle to acknowledge there is a God to whom individuals are accountable. The emphasis on subjective experience and rejection of moral absolutes is incompatible with two thousand years of Christian teaching.

Powlison (1996) detailed how the growing cultural influence of secular therapies triggered an anti-psychiatry movement among conservative Protestants. Many influential pastors and church leaders concluded it was impossible for Christians to be helped by therapies grounded in understandings of humanity incompatible with biblical truths. Psychotherapy constituted a threat to the faith of believers. Nouthetic counseling emerged as an alternative treatment approach grounded in the ideas that everything necessary to counsel people for emotional or behavioral problems that are not unequivocally organic can be found in Scripture; the Bible is sufficient for counseling; the underlying cause of mental illness is sin; and mental health practitioners dissuade people from taking responsibility for their emotions and behavior (Adams, 1986). Criticism of secular approaches to mental health led to criticism of individual Christians seeking secular mental health services. Highly respected church leaders within the reformed and evangelical traditions continue to express suspicion of medical and psychological approaches to mental health diagnosis and treatment.

John Piper (2009) described five-year-olds with self-control difficulties as "unregenerate" and attributed their behavior to parents who fail to "restrain the egocentric impulses of their children and confirm in them every impulse toward courtesy and kindness and respect." John MacArthur (1996) described parents who give permission for their children to take medicine for issues with self-control as doing so "when they will not do it God's way" and implied that parents who do so are choosing to turn their children into "drug addicts." Such attitudes help to explain the perception among many parents that "people in the church think they can tell when a disability ends and bad parenting begins" (Grcevich, 2018, p. 151).

Anxiety

Children and adults with an identified anxiety disorder experience excessive and persistent anxiety or fear inappropriate for their level of maturity that significantly interferes with tasks of daily living, including participation at church. Anxiety disorders represent the most common mental health condition in adolescents and adults and the second most common condition in children (National Institute of Mental Health, 2017).

While many factors contribute to the development of anxiety disorders, a key finding from neuroimaging studies is a relationship between abnormal limbic system activity (the brain area responsible for modulating emotions) and a propensity for overestimating risk in new or unfamiliar situations. Abnormal connections between the limbic system and prefrontal cortex (an area of the brain responsible for higher

order thinking and self-control) have been associated with anxiety disorders in children (Blackford & Pine, 2012).

Anxiety represents a significant barrier to church attendance for children in large part because it represents a barrier to church attendance for their parents or caregivers. A parental history of anxiety (especially maternal history) contributes to a twofold to sevenfold increase in the risk for anxiety in their offspring (Low et al., 2012). Consider the range of challenges adults and children with anxiety disorders may experience in visiting or assimilating into a new church.

- They may fear being dressed differently than everyone else or becoming the center of attention.
- A child may worry they will not know or recognize anyone else in their Sunday school class.
- A parent may presume the adults they encounter on an initial visit—greeters, the children's or student ministry director, their child's Sunday school teacher, ushers, other worshipers, the pastor in a smaller church—are harshly scrutinizing them.
- A child with separation anxiety may become demonstrably emotional at a church where parents are discouraged from bringing children into the adult worship service.
- An adult might experience great discomfort from expectations for self-disclosure in the presence of relative strangers in churches where small group participation is encouraged.
- A child or adult with obsessive-compulsive disorder (OCD) may go to great lengths to avoid physical contact with other worshipers, objects, or furniture because of contamination fears. Sermons or Sunday school teaching may trigger obsessive fears of losing their salvation.
- A child or adult with agoraphobia may avoid church if they are not assured of seating near an exit at worship services where they can leave without drawing undue attention to themselves.
- A teen or adult may be less likely to register for church activities if a phone call to an unfamiliar person is a necessary step in the registration process.
- A child or teen with separation anxiety may feel overwhelmed by the prospect of participating in overnight retreats and mission trips.
- A child or adult with performance anxiety may avoid joining a church if a public profession of faith or baptism is required.
- A parent of a child with anxiety may never return to church if arbitrary rules or decisions cause their child to be separated from someone they depend on for companionship—if they cannot attend Sunday school with a family member or friend in a different grade or age group.

A useful exercise for pastors and ministry leaders is to consider how they would redesign their church's worship services, Christian education, outreach, and fellowship activities if 100% of their attendees experience one or more anxiety disorders.

Executive Functioning

Executive functioning refers to the cognitive abilities involved in modulating other abilities and behaviors. Executive functions represent the means through which children and adults acquire language, make plans, establish priorities, manage time, delay gratification, and exercise conscious control over thoughts, words, and actions.

Executive functioning difficulties are a core feature of ADHD and very common among persons with autism spectrum disorders (Barkley, 1997). Executive functioning is often compromised in children and youth with mood disorders, anxiety disorders, and fetal exposure to alcohol, drugs, and other toxins. Additionally, executive functioning is adversely affected by stress hormones and neural pathways activated in response to adverse childhood experiences, including trauma and abuse (Fisher et al., 2011). This capacity is often greatly compromised in children, teens, and adults with intellectual or developmental disabilities and represents an area of overlap between mental health ministry and special needs ministry.

Scripture places a high value on self-control. The capacity to control one's words and actions are evidence of God's work within us and a key marker of spiritual maturity.

Hathaway and Barkley (2003) hypothesized that persons with ADHD face greater difficulties in religious socialization, religious focus, internalization and integration of faith, stability of spiritual growth, and religious alienation. Their capacity for self-control is often highly dependent on their level of interest in the task at hand

and characteristics of the environments in which they find themselves.

Common challenges to church participation among children and youth with executive functioning weaknesses include the following:

- The process of preparing a child with severe executive functioning deficits for and transporting them to church may leave parents or caregivers exhausted.
- Parents choose to not bring their child to church out of concern for their inability to keep impulsive or aggressive behavior in check.
- They may experience more difficulty sitting, standing, or kneeling for an extended time during worship services designed for adults, especially when they become bored.
- They may experience embarrassment or frustration if expected to memorize Scripture or prayers.
- Some parents are instructed to avoid use of prescription medication on weekends essential to their child's ability to maintain focus and impulse control.
- Excessive stimulation from children's or student ministry worship activities may negatively impact the ability of some youth to maintain self-control.

All too often the very people who should be turning to the church for help experience embarrassment and shame. The inadequacy of the church's understanding of mental illness is demonstrated by each failure to respond compassionately when children and adults struggle to fulfill expectations for self-discipline and emotional control.

Sensory Processing

Sensory processing disorder (SPD) is not currently recognized as a stand-alone medical condition, but sensory processing difficulties are frequently associated with common mental health conditions. The link between sensory processing and mental illness is sufficiently strong to merit inclusion in the National Institute of Mental Health's (NIMH) Research Domain Criteria (RDoC) framework for identifying the root causes of mental illness (Harrison et al., 2019; NIMH, 2019). Five percent or more of children and teens in the United States experience significant functional impairment because of abnormal sensory processing (Ahn et al., 2004).

Persons with sensory processing differences often become overwhelmed because of difficulty integrating too much or too little incoming information from their senses—sight, smell, touch, hearing, and taste. Children and teens with *hypersensitivity* often have marked aversion to noise, light, touch, and taste. They may be extremely picky about the feel of clothes against their skin, pull away from others in response to touch, experience pain in the presence of loud noise, or become nauseous around persons wearing strong fragrances. They may be accident-prone and often avoid gross motor activities involving strength, balance, or coordination. Youth with hyposensitivity are often sensory seekers. They love tight hugs, physical contact, amusement park rides, trampolines, climbing, jumping, and splashing. They may also have a hard time sitting still and keeping their hands to themselves at a worship service or church activity. Some may experience hypersensitivity and hyposensitivity simultaneously.

Families of children and youth with sensory processing differences face multiple potential pitfalls when attending a worship service. Areas near entrances and exits are often crowded. Ambient noise levels and multiple conversations taking place at once produce distress. Physical proximity often results in lots of bumping and touching. Children with an exaggerated "fight or flight" response may attempt to run away or experience severe emotional outbursts.

Worship services frequently produce sensory overload. While high-energy worship experiences with loud music and bright lights may be engaging for persons with sensory hyposensitivity and capture the attention of children and adults otherwise preoccupied with electronic devices, persons with high sensitivity to sensory stimulation often avoid this type of service. Extended periods of standing or kneeling in some Christian traditions may result in excessive discomfort. Handshakes or hugs are unpleasant, as is physical contact during prayer. Seating is often experienced as uncomfortable. Expectations for appropriate dress may preclude some children from attending church who insist upon wearing athletic wear or soft, casual clothing. Children or adults with sensory processing differences may struggle to tolerate the scent of perfume or cologne worn by multiple worshipers seated nearby.

Special church events often produce unique sensory challenges. Church festivals and Va-

cation Bible School experiences often combine high levels of physical activity and sensory stimulation. Children and adults with hypersensitivity may avoid weekend retreats at outdoor campsites and mission trips where the comforts of home are not readily available.

Social Communication

Social communication deficits are common among persons with a broad range of mental health and developmental disabilities. In addition to representing one of the two defining features of autism spectrum disorders in the DSM-5, social communication is often a major source of functional impairment among children and adults with psychotic disorders, ADHD, anxiety disorders, and pragmatic language disorders (American Psychiatric Association, 2013).

Desire for community is reported in a Gallup survey to be one of the top reasons given for attending church (Newport, 2007). Studies have identified friendliness of members and fellowship as key reasons for choosing a church and maintaining a high level of involvement at church (Rainer, 2008). Children and adults who struggle with social communication often desire authentic friendships in which they can be known, understood, and valued. They want to belong to a larger community where they can be recognized for their gifts and talents. Many desperately want to belong to a church.

An adult or child who struggles to make or keep friends is less likely to know someone who would invite them to church. Attending a worship service as a passive observer comes with the prospect of multiple social interactions and potential for embarrassment. One of the most powerful turnoffs to attending church for middle or high school students with social skill deficits is the experience of encountering peers who have bullied them at school or through social media.

Participation in Bible studies or small groups where deeper connections are formed is difficult for someone who does not follow social convention regarding appearance or dress or struggles to follow common rules of social behavior, such as knowing when to speak or how to take turns while speaking. Many small groups take place in homes where youth less familiar with social conventions are more likely to feel out of place.

Social Isolation

Families of a child or teen with a mental illness are less likely than other families to experience the social interactions that bring them into contact with people who might invite them to church. Multiple factors contribute to their relative social isolation.

Having a child with a mental health condition limits available options for childcare. Parents often have less ability to socialize outside of their homes because children who struggle with self-control, anxiety, and emotional regulation cannot be left with teenage babysitters. Even when childcare is available, out of pocket expenses for mental health care often significantly impact discretionary income.

Children with a broad range of disabilities, including mental health conditions, are less likely to attend private Christian schools where they would be more likely to connect with other families actively engaged at church (Sutton, 2015).

Children with mental illness are less likely to be part of the youth sports culture that facilitates connection between families with common interests. Motor coordination disorder occurs more frequently in children and youth with mental health disorders or developmental disabilities than in the general population (Dewey et al., 2002). Children who are unable to attend a church-affiliated school because of their educational support needs are more likely to lack the athletic skills necessary to thrive in competitive team sports.

Children with common mental health concerns are less likely to have friends to invite them to take part in church-related activities for the reasons described above. Teens with depression often isolate themselves from peers and withdraw from extracurricular activities. A boy with ADHD who frequently interrupts peers while they are speaking, lacks the patience to follow the rules of a game, or struggles to control his temper is less likely to be invited for playdates, birthday parties, and special events. Boys and girls who do not get invited to birthday parties may not be invited to Vacation Bible School.

In a culture where increasing numbers of non-Christians come to church in response to personal invitations, the absence of a substantial social network reduces the likelihood of being invited to church (Nieuwhof, 2019).

Family Experiences of Church

A key determinant of a child's church attendance is their parents' pattern of church attendance and engagement while growing up. A study examining religious service attendance and affiliation among young adults noted the likelihood of an adolescent becoming a weekly church attender in young adulthood is 3.2% if they attend church less than once a month as a teen (Uecker et al., 2016). This statistic highlights the need for effective inclusion strategies for youth with mental health conditions and other disabilities. It also points to the need for an inclusion strategy for parents who experience symptoms of mental illness.

The multigenerational expression of mental illness suggests many children and teens with no experience of church have parents whose church experience was disrupted by their own mental health concerns. Serious mental illness (SMI) is highly heritable. Roughly one in three children of parents with schizophrenia, bipolar disorder, or major depression will develop a serious mental illness—and not necessarily the same mental illness as their parent (Rasic et al., 2013). A parental history of anxiety (especially maternal history) contributes to a twofold to sevenfold increase in the risk for anxiety in their offspring (Low et al., 2012).

Parental interactions with pastors, church staff, and volunteers when a child or teen experiences mental health-related challenges represent an additional factor impacting family engagement at church. When a child of a parent grounded in the faith has a negative church experience resulting from disability, the family will often seek another church better prepared to support their child's needs. Parents without a strong faith foundation may be less likely to search for a more supportive congregation and need much reassurance before exploring church again.

Discussion: Seven Action Steps for the Church and the Mental Health Professional

Churches engaged in mental health ministry have typically focused on providing counseling and support to individuals who are already part of a church. Lacking are effective models for building connections and relationships with individuals and families not currently attending church. What would a successful inclusion strategy look like for a church seeking to minimize barriers to church attendance and engagement for children and teens with mental health concerns and their families?

- Mental health inclusion would be conceptualized as a mindset, not a program. The goal is to include children and adults with common mental health conditions into worship services, Christian education, small groups, and other activities in the church.
- Mental health ministry is, by definition, family ministry. An effective mental health inclusion strategy addresses the needs of everyone in the family, especially the most vulnerable children.
- A good inclusion strategy benefits everyone in the church without requiring anyone with mental health support needs to self-identify. Removing barriers to attendance and engagement should enhance everyone's experience of church.
- Responsibility for mental health ministry is owned by the people of the church who are supported by staff in their personal ministry.
- No church will develop a strategy to include everyone with mental illness, but every church can implement a strategy to welcome more children and adults with mental illness.

The following planning model for mental health inclusion features seven broad strategies designed to identify and address barriers to church attendance and engagement throughout each ministry department. The strategies include following:

1. *Establish a church-wide mental health inclusion team*. The team is composed of leaders with the necessary authority, responsibility, experience, knowledge, gifts, and talents to implement effective outreach and inclusion across all the church's ministries. Senior leadership does not always need to be part of the team so long as they unequivocally endorse the process. Mental health professionals and advocates attending the church, along with occupational therapists, architects, interior designers, social service professionals, and respected members with firsthand experience of mental illness may contribute valuable insights to the team.
2. *Create welcoming ministry environments*. Consider the physical spaces in which

ministry takes place. Do the spaces where most teaching occurs promote information retention and learning for all attendees, including those with mental health concerns? Are there unnecessary distractions? How might someone with sensory processing differences experience those spaces? Is the signage throughout the buildings sufficiently clear for attendees who struggle to remember multistep directions? Does the décor in spaces occupied by children and youth help promote self-control?

3. *Prioritize inclusion in activities most essential to spiritual growth*. The typical church emphasizes some activities and practices more than others in the discipleship process. Churches with dynamic and effective teaching pastors may prioritize worship service attendance. For these churches, inclusion efforts might focus on the experience of adults and children during weekend worship times. Churches where small group participation is encouraged might focus on their process for connecting visitors to groups and offer extra training to group leaders. If involvement in community service or missions is encouraged, the team might identify volunteer opportunities for children and adults less comfortable with social interaction.
4. *Develop a mental health communication plan*. A key component of an effective inclusion strategy involves establishing a church culture in which all attendees are given explicit permission for mental health to be a topic of conversation. In the LifeWay study (2014), the top request of churches from family members of adults with serious mental illness was for pastors to talk about mental health from the pulpit. Churches might consider incorporating mental health-related concerns into pastoral prayers or offering sermons addressing mental-health related topics. Social media platforms are useful tools in combatting negative community perceptions about churches and mental health. Online church services represent a means for congregations to introduce themselves and build connections with families in surrounding communities impacted by mental illness.
5. *Offer practical help in response to heartfelt needs*. Most churches have ministries to provide meals when a family member is in the hospital. Would families from the church receive meals if a child is hospitalized for a psychiatric emergency instead of a medical emergency? Churches can maintain current lists of mental health professionals and treatment facilities to share with attendees in need. They can also help by providing affordable counseling services or peer support or making benevolence funds available for short-term mental health needs, such as one-time consultations or prescription refills. Respite events for families of children with intellectual and developmental disabilities can be redesigned to welcome children with primary mental health disorders and their siblings.
6. *Provide mental health education and support*. For many churches, initiation of an inclusion strategy is the result of education offered to pastors, church leaders, and key volunteers about the needs of families impacted by mental illness. Establishment of mental health support groups is a great starting point for an inclusion strategy and powerful signal to church members and the surrounding community that persons with mental health issues are welcome. Such groups help introduce the church to people who would never otherwise attend a weekend worship service and promote relationships between attendees and members of the community not connected to a church.
7. *Release the people of your church into the community to invite friends and neighbors with mental health concerns*. The most effective mental health inclusion strategy is often the presence of a trusted friend to come alongside someone with anxiety, sensory processing differences, or social communication challenges to help them recognize and avoid potential pitfalls for however long it takes the visitor to acclimate to the church. Staff can celebrate and encourage acts of service and outreach through sharing stories during worship services and on social media platforms.

A mental health-friendly church is characterized by a demonstrable inclusion planning process, mental health education for pastors, church staff, and volunteers, implementation of a mental health communication strategy, provision of tangible assistance to affected individuals and families, and establishment of mental health education and support groups (Grcevich, 2019). Mental health-friendly churches are addressing inclusion in innovative ways:

- One church confronted stigma through presenting a sermon series on biblical teaching regarding anxiety. The same church featured video of a worship band member discussing the impact of his panic attacks and depression on his spiritual life during weekend services and hosted a town meeting in which a psychologist and long-time member of the church joined a pastor on staff and a local pediatrician to address misperceptions about mental illness. The livestream of the town meeting was made available through the church's Facebook page.
- The senior pastor of another church opened worship services with prayer for attendees with depression after the church hosted a training for several hundred volunteers on mental health inclusion. The same church reserves aisle seats next to exits for attendees with panic disorder and produced a video featuring an usher who came to church for the first time once such seating was made available.
- One church appointed a mental health liaison to help acclimate first time visitors with anxiety to the church and interface with ministry leaders when they need additional support.
- A church attended by many families involved with adoption and foster care ministry noticed a reduction in aggressive behavior during children's ministry activities after reducing the intensity of lighting and repainting their space in more subdued colors.
- A church's founding pastor filmed a video for their social media platforms explicitly extending a welcome to families in the community affected by mental illness in which he shared the struggles his father experienced as a pastor with depression.
- One church opened a mental health resource center staffed during worship services by a member of their inclusion team that features a prominently located booth with free resources from the National Alliance on Mental Illness (NAMI), as well as other educational resources personally vetted by members of the team. The church also makes space available to a local community mental health agency to provide services onsite.
- Hundreds of churches throughout the U.S. have launched Christian-based mental health support groups affiliated with Fresh Hope or the Mental Health Grace Alliance.
- Church members are being trained as "hope coaches"—individuals trained to come alongside attendees going through a difficult situation or a crisis, walking with them, listening, helping them process their pain, fear, and frustrations, and speaking a faith-filled hope into their situations based upon Romans 8:28 (Fresh Hope, 2020).

Conclusion

Families raising children with common mental health conditions such as depression, anxiety disorders, disruptive behavior disorders, and ADHD are far less likely than unaffected families to attend church services regularly and represent a large, underserved people group. Attributes associated with common mental health conditions cause children and families to struggle to meet cultural expectations within the church for social interaction, social communication, and self-control and impact their experience of the physical environments where most ministry takes place. Effective outreach and inclusion with families impacted by chronic mental health conditions is made possible through inclusion strategies designed to help church leaders identify potential obstacles to attendance and engagement in all ministry departments and minimize or eliminate the impact of these obstacles.

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Implicit and Explicit Impacts of a Church-Based Counseling Program: A Mixed Method Study

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The current study evaluated the implicit and explicit impacts of a church-based counseling model known as Church Therapy, in which licensed counselors and supervised Master's-level counseling students provide low-cost clinical mental health counseling on-site in church office space. Using both quantitative and qualitative methods, this study evaluated attitudes toward professional counseling and views about mental illness as well as direct impacts of the Church Therapy program. Approximately 73% of the quantitative sample agreed that they would only seek counseling from a Christian professional and 62% preferred to find professional counseling within their churches. Case study themes reflected a desire for familiarity and shared faith with a counselor, and the findings highlighted the impact of congregational culture on views about counseling and mental illness.

There is an ongoing conversation about the church's role in responding to mental health needs within their congregations and communities (Donlon, 2016; Omokha, 2020). While pastors and clergy provide important and significant levels of care to their congregations, they are not trained to provide professional mental health counseling (Abraham, 2014; Hedman, 2014). Negative help-seeking attitudes and stigma around mental illness at times prevent active churchgoers from obtaining treatment for mental illness outside the church (Crosby & Bossley, 2012; Royal & Thompson, 2012; Stanford & McAlister, 2008). A variety of approaches have been used to seek to fill this gap and connect mental health professionals with churches (Csiernik et al., 2020; Rogers & Stanford, 2015; Wong et al., 2018). The current study evaluated the implicit and explicit impacts of a church-based counseling model known as Church Therapy, in which licensed counselors and supervised master's-level counseling students partnered with pastors to provide low-cost clinical mental health counseling on-site in church office space.

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Help-Seeking Among Evangelical Protestants

There has been a call for the church to support both individuals with mental illness and their families (LifeWay Research, n.d.; Rogers et al., 2012). For at least the past three decades researchers have been highlighting the role of the Black church in providing social support to its congregants, often taking the role of a large extended family and mental health care provider (Caldwell et al., 1992; Campbell & Winchester, 2020). However, there is a growing body of research regarding the mental health and help-seeking attitudes of White evangelical Protestants as well. According to the Pew Research Center's Religious Landscape Study (n.d.), approximately 25.4% of Americans identify as Protestant evangelicals. Seventy-six percent of these are white. Crosby and Smith (2017) asserted that among Protestant evangelicals, the church often provides the primary social support system for church-going families and should be considered as such by mental health professionals.

Research on help-seeking attitudes suggests that many demographic, cultural, and religious factors play a role in a person's willingness to seek professional mental health counseling (Adams et al., 2018; Crosby & Bossley, 2012; DiVitre & Pan, 2020). According to Royal and Thompson (2012), "Protestant Christians generally find it fairly difficult to seek out psychological counseling" (p. 202). Their study found that Protestant Christians believed that counseling should be a last resort and they questioned the

value and efficacy of therapy. Active churchgoers tend to seek help from their pastors and within their churches (Kirk, 2018; Openshaw & Harr, 2009; Stanford & McAlister, 2008).

Stigma within Church Congregations

According to Corrigan (2000), public and self-stigma develop based on people's attributions of the causes of mental illness. Amongst Protestant evangelical Christians such attributions are often spiritual in nature, including a belief that mental illness is caused by or synonymous with demonic possession and a belief that "moral weakness" or sin is a cause of mental illness (Wesselmann & Graziano, 2010, p. 429). These beliefs can be perpetuated by friends, family, and fellow congregants, which can have a significant impact on help-seeking attitudes (Corrigan et al., 2014).

Specific studies have confirmed that evangelical Protestant congregations have generally high levels of stigma. Stanford and McAlister (2008) found that 41% of individuals with mental illness had their diagnoses "dismissed" by members of their congregation (p. 151). Adams et al. (2018) found a predictive relationship between religious fundamentalism and negative attitudes towards mental illness. Another study found an inverse correlation between mental illness stigma and help-seeking attitudes amongst African-American churchgoers (Neely-Fairbanks et al., 2018).

Trends in Church Counseling Programs

The church has an ongoing role to provide spiritual care and support to those with persistent mental illness, and this will remain an important role for mental health professionals to recognize and value (Abraham, 2014; Openshaw & Harr, 2009). There are a variety of programs that have attempted to meet the mental health needs within church congregations. While lay counseling ministries are common, there is limited data on the effectiveness of these services and the level of training of lay counselors varies (Garzon & Tilley, 2009). Peer counseling for mental illness has been utilized in some churches, with the Living Grace Groups curriculum showing promise in improving mental health outcomes (Rogers & Stanford, 2015).

In addition to lay and peer counseling, some have suggested that churches can offer programming to reduce the stigma of mental illness, provide preventative services, and fill gaps in the current mental health care system (Campbell & Winchester, 2020; Costello et al., 2020). Others have encouraged models that promote collaboration between clergy and mental health professionals in the form of mutual referral or relationship-building networks (Csiernik et al., 2020; Hedman, 2014; Rogers et al., 2013; Wong et al., 2018). There are limited data on specific church-based clinical mental health programs or partnerships. There is a call in the literature for further study on specific collaborative programs between churches and mental health professionals (Hedman, 2014; Neely-Fairbanks et al., 2018; Wong et al., 2018).

The Church Therapy Model

The purpose of the current study was to evaluate both the implicit (congregation-wide) and explicit (client) impacts of a church-based counseling program called Church Therapy. In this program, one professionally licensed mental health counselor and two supervised master's-level counseling students provide clinical outpatient therapy services to congregants in two churches under the umbrella of a non-profit. The Church Therapy model borrows from concepts found in wraparound models of care, where mental health services are embedded into schools, primary care practices, police stations, and places of employment.

The goal of the Church Therapy model is to decrease barriers to mental health treatment by providing low cost, confidential, accessible services in a location already familiar to congregants. The model also aims to reduce stigma throughout the whole congregation through direct psychoeducation and indirect familiarization with the idea of mental health counseling. This model was designed to be replicable in other church settings where there is access to professionally licensed Christian counselors and/or Christian graduate counseling programs.

Research Questions

This mixed-methods study evaluated the implicit and explicit impacts of the Church Therapy program using a quantitative survey and a qualitative case study. The university Human Subjects Review Committee approved both parts of this study. We considered the following research questions: (a) Does the presence of the Church Therapy counseling model in a church

decrease the congregation's stigma of mental illness? (b) Does the presence of the Church Therapy counseling model in a church improve the congregation's attitudes toward professional counseling? (c) Are there differences in stigma levels or attitudes toward professional counseling based on demographic factors? (d) What are the most significant explicit impacts of the Church Therapy counseling program on its clients?

Part 1: Quantitative Survey

Method

Participant Recruitment

Participants for this study represented a random sample of four congregations located in a state in the Northeast United States. Two churches selected for the study were purposefully chosen based upon their participation in the Church Therapy program. Two additional churches were chosen based upon their similar size, denomination, and demographics as compared to the churches with the counseling program. The participants received an invitation to participate in the survey via email blasts and social media invitations directly from the pastors of the churches using a pre-written script. The survey was conducted via SurveyMonkey (https://surveymonkey.com).

Instrumentation

The outcome variables of attitudes toward counseling and mental illness stigma were measured using the Attitudes Toward Seeking Professional Counseling scale (ATSPC; adapted version of the 10-item Attitudes Toward Seeking Professional Psychological Help scale) and 40-item Community Attitudes Toward Mental Illness (CAMI) scale.

The Attitudes Toward Seeking Professional Psychological Help Short Form (ATSPPH-SF) contains ten items that assess help-seeking attitudes and views about professional psychological services. This scale has been used widely throughout the literature and has shown strong validity and reliability across its use in research (Fischer & Farina, 1995). Simpson (2006) provided a rationale for changing the terms "psychologist" and "psychotherapy" to "licensed counselor" and "counseling" due to her population's familiarity with counseling over psychology. The same is true in the Protestant evangelical circles where "professional counseling" is used more frequently than "psychological help." Thus, the present study imitated Simpson's (2006) adjustments to the scale, and we refer to our adapted scale as the Attitudes Toward Seeking Professional Counseling (ATSPC) scale. A scale reliability analysis for the current study sample showed strong reliability of the 10-item ATSPC ($\alpha = .82$). There were no individual items that would have significantly altered the reliability statistics if removed.

The 40-item CAMI scale was developed by Taylor and Dear (1981) and originally divided into four subscales. Subsequent research has used variations of this scale to score subscales separately or create a total score for all the subscales combined. Based on studies that used a total score for all 40-items, the authors adjusted reverse scoring procedures so that a higher total score on all combined subscales reflected more positive attitudes and lower stigma (Abi Doumit et al., 2019). A scale reliability analysis for the current study sample showed strong reliability on the CAMI ($\alpha = .92$). There were no individual items that would have significantly altered the reliability statistics if removed.

We included three additional "yes/no" or "agree/disagree" items in our survey to obtain additional descriptive statistics and grouping categories beyond basic demographic questions. They were the following: (a) "Have you ever participated in individual mental health counseling (either at your church or elsewhere)?" (b) "I would only seek professional counseling with someone who integrated a Christian worldview into their practice," and (c) "I would prefer to seek professional counseling provided at my church over going to counseling somewhere else."

Procedures

This study used a multivariate analysis of variance to determine differences in scores on the ATSPC and CAMI scales based on several grouping categories. The presence of the Church Therapy program was one fixed factor. Exploratory ANOVAs determined which demographic factors may have significance in order to limit the inclusion of independent variables. A four-way MANOVA was used for the final analysis.

Ethical Considerations

All data for this study were stored on password protected devices and was scrubbed of

any identifying information prior to storage. No identifying data were obtained in the quantitative survey. Survey participants checked a box of agreement with the informed consent page. The Samaritans' Helpline number was provided with the survey in case of any distress.

Results

Data Screening

Responses were screened for missing data and univariate and multivariate outliers. Of the 142 complete surveys collected, five were eliminated due to low church attendance (less than twice per month). Two others were removed as univariate outliers, and an additional case was removed as it was the only case not stating a gender preference ($n = 134$).

Descriptive Analysis

There were 71 participants (53%) from churches that had the Church Therapy program and 64 (47%) from the control group churches. Demographics are displayed in Table 1. For the entire sample, the mean score on the ATSPC scale was 23.85 out of a possible maximum score of 30 ($SD = 5.08$, $SE = .44$). On the CAMI scale, the overall mean score was 154.66 where the maximum score would be 200 ($SD = 17.62$, $SE = 1.52$). Descriptive data and Pearson's r correlation for the dependent variables are displayed in Table 2. Results of the three additional survey questions regarding past counseling and treatment preferences are displayed in Figure 1. MANOVA was determined to be an appropriate test as there was a moderate and significant correlation between the CAMI and the ATSPC scores (Pearson's $r = .42$, $p < .001$). Chi-square analyses showed no significant correlations between rates of past counseling involvement or treatment preferences between the Church Therapy program church participants and the control group church participants.

MANOVA Results

Assumptions testing for MANOVA showed univariate and multivariate normality for both the CAMI and ATSPC for both the Church Therapy group and the control group. There were no evident concerns with linearity, multicollinearity, or homogeneity of covariance matrices. Exploratory ANOVAs determined which demographic variables would join the "Presence of Church Therapy program" variable as fixed factors in the MANOVA, with raw total scores on the CAMI and ATSPC scales as dependent variables. Race could not accurately be compared due to

Table 1

Demographics

Item	*Freq.*	%	*Item*	*Freq.*	%
Gender			*Education Level*		
Male	44	32.8	High School	25	18.7
Female	90	67.2	Community/Bible college	22	16.4
Age Group			Bachelor's	40	29.9
Under 45	66	49.3	Doctorage	8	6.0
45 and Older	68	50.7	*Annual Household Income*		
Race			$0-29,999	14	10.5
White	91	67.9	$30,000-$49,000	17	12.7
Black/Af.Am.	13	9.7	$50,000-$74,999	22	16.4
Hisp/Latino	19	14.2	$75,000-99,000	23	17.2
Asian/Asian-Am.	10	7.5	$100,000-$150,000	22	16.4
Other	1	0.7	Over $150,000	36	26.9
Totals	134	100%		134	100%

Table 2

Descriptive Statistics and Correlations for Dependent Variables

Dependant Variable	Mean	*SD*	*SE*	Min.	Max.	Correlation Between Variables
Community Attitudes Toward the Mentally Ill (CAMI)	154.66	16.62	1.52	103	200	.42 $p < .001$
Attitudes Toward Seeking Professional Counseling (ATSPC)	23.83	5.09	.44	9	30	

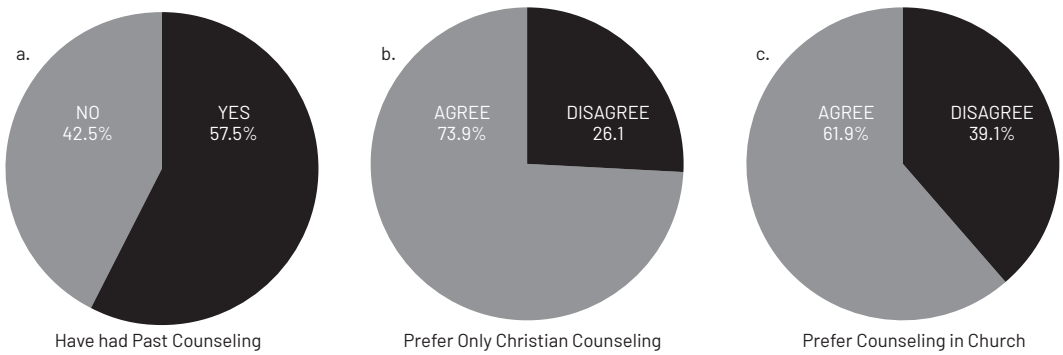
n = 134

unequal cell sizes. No significant differences were found for education level, household income, or age. Age was then split into two categories (Under 45 and 45 or over) to form similarly sized groups. This comparison yielded a *p* value that was closer to significance ($p = .054$) and warranted inclusion in the main analysis to determine if there was significance when crossed with other variables. In the initial exploratory ANOVAs, gender and experience in past counseling also showed significant differences on the ATSPC scale.

To minimize the chance for error, a final four-way MANOVA was run with gender, age group, past participation in counseling, and presence of Church Therapy program as fixed factors. The CAMI and ATSPC total raw scores were dependent variables. Q-Q plots and histograms showed normal distribution of CAMI and ATSPC scores for all groups within the fixed factors. A significant overall difference was found only on the variable of past counseling ($F(2,134) = 7.98$, $p = .001$; Wilks' $\lambda = .88$, partial $\eta^2 = .12$). Tests of between-subjects effects showed significant differences on the ATSPC scale for gender ($F(1,134) = 4.86$, $p = .029$; SS = 103.69, partial $\eta^2 = .04$) and past counseling ($F(1,134) = 15.74$, $p < .001$; $SS = 335.95$, partial $\eta^2 = .12$). Additionally, when crossing past counseling with age group, a significant difference was found on the CAMI scores ($F(1,134) = 5.54$, $p = .02$; SS = 1631.58, partial $\eta^2 = .05$). Those who were older and had not participated in individual counseling had higher stigma and less favorable attitudes toward seeking professional counseling than those who were younger with past counseling experience.

Figure 1

Past Counseling Experience and Treatment Preferences



Part 2: Qualitative Case Study

Method

Participant Recruitment

The researchers used purposeful sampling for the case study to highlight the impact of the Church Therapy program. Clients had received counseling in the program for at least six months and represented diversity in age, gender, ethnicity, and presenting problems.

Semi-Structured Interview

The semi-structured interview questions sought to understand factors contributing to participation in the Church Therapy program, the process of seeking services with the program, and any positive and/or negative feelings about the Church Therapy program. Participants were also asked to discuss previous counseling experiences, views on mental illness and stigma around help-seeking, and their views on the impacts of Church Therapy on themselves and within their congregations. Interviews were audio recorded and transcribed for analysis.

Procedures

Based on the example of Hill et al. (2005), the transcript analysis process involved open-ended questions with reflection and checking throughout the interview to ensure that the participant's statements were properly understood. Three raters—the two authors and one additional assistant—independently reviewed the transcript content that was loaded into a spreadsheet in content blocks (one idea, statement, or response per cell). The three raters each independently summarized the statement and then wrote keywords or themes that captured the essence of what was described. The three raters next compared their independent analyses, calculated frequencies of 2- and 3-rater agreement, and identified the most commonly used keywords. The authors then created a final master spreadsheet that was reviewed by an outside auditor to ensure that the content of the transcripts matched the identified keywords and themes. The auditor's feedback was incorporated into the final analysis of themes.

Ethical Considerations

All data for this study were stored on password protected devices and scrubbed of any identifying information prior to storage. No identifying data were retained in the transcripts, and interview participants signed a written informed consent document. Because the authors have served as counselors in the Church Therapy program, each participant was interviewed by the author that had not been their counselor and was not previously known to them to avoid a dual relationship or compromise of the data.

Results

There were five participants in this qualitative case study. Three were female and two were male. Two had participated in couples therapy, and three had participated in individual counseling. There were three Caucasian participants, one African participant, and one Asian-American participant.

Transcript analysis yielded 100 unique content blocks. All three raters had agreement on 53 of these content blocks. An additional 44 blocks had inter-rater agreement between two of the raters. Only three blocks did not have any initial inter-rater agreement. All content blocks were discussed and labeled. The auditor's feedback showed overall agreement with the rater's themes and provided additional shape to the depth of some themes.

Four primary themes were identified as prominent across all participants. These themes illustrate the explicit impacts of the Church Therapy program on its clients and also demonstrate underlying implicit impacts within the congregations that have the program. The order of presentation of themes reflects the frequency of its occurrence in the analysis, from greatest to least.

Theme 1: Familiarity

The first theme captured a sense of familiarity that the participants had with the Church Therapy program as part of their church experience. Sub-themes within the familiarity included having shared values and faith, experiencing feelings of trust and safety, maintenance of confidentiality, and developing a strong therapeutic alliance. There was an overall expression of feeling safe within the church. Participants described the ways in which familiarity helped them feel comfortable with counseling:

> Location is huge—being within the church itself and the familiarity of [the Church Therapy program] was important to me.
>
> I think it was an element of trust having the

> Church Therapy program associated with the church and people that we knew were committed to that same mission. And since faith is a factor, having that kind of similar theological understanding and knowing that there is a unified kind of view for those recommendations.
>
> I was more comfortable knowing that [the Church Therapy program] is housed in the church. So I'm sure that everything that they're doing will follow biblical teachings.
>
> So it was just more about…this is someone that my pastor trusts to begin with to recommend them to me. So it was a trust factor for me.

Theme 2: Help-Seeking Attitudes

A second theme highlighted overall help-seeking attitudes, including concepts like stigma, negative views or fears about counseling, cultural factors that influence help-seeking attitudes, past counseling experiences, and removal of barriers to care in the Church Therapy program. Overall, the participants experienced more positive experiences in seeking help at the church than they had if they had gone to past counseling. In particular, those that had experienced secular counseling shared that they would not seek secular counseling again. Cultural and gender factors played a role in help-seeking, with general agreement that men are more reticent to seek help. All of the participants reported improvement in help-seeking attitudes after participation in the Church Therapy program. They cited ease of access, location, low cost, and familiarity as central factors in their decision to seek help. One participant had never had any prior counseling and four had negative past experiences in secular counseling. There was overall agreement that they would likely not have gotten mental health treatment if they had not had access to the Church Therapy program. For some, there was a sense of urgency when they needed counseling and their success in obtaining counseling was largely related to the ease of access to the service.

The following responses answer the question, "If there was not a church-based counseling service, would you have sought mental health treatment or counseling elsewhere at that time in your life? Why or why not?":

> I think I would have spoken with the pastors and sought informal counseling, but no professional counseling services.
>
> If I didn't have [the Church Therapy program], maybe I would be forced to talk to a family member or one of my spiritual leaders, or my mentors. I don't think that I would go to a secular therapist…It would be a family member, a pastor, a spiritual leader, a mentor, before I go to that.

The following answers from participants capture additional aspects to help-seeking attitudes, including the desire for integration within the church and an unwillingness to seek counseling outside the church:

> Beforehand I was a little bit skeptical about why I would need counseling…The Church Therapy model helped me to kind of see both angles of that—a clinical and a licensed perspective, but also from a faith standpoint. Having that kind of unification helps me to be able to wrestle and to work through deeply held beliefs I had about counseling in a unique way.
>
> "If [Church Therapy] didn't exist, I don't think many people would go forward with [counseling].
>
> If [my pastor] was saying, "You should go to this place down the street, I really recommend it." I probably wouldn't have gone.

Theme 3: Congregational Culture and Impact

A third major theme was the culture of the broader congregation and implicit impacts of the Church Therapy program on that culture. All the participants had heard about the program from their pastor, some directly in a private meeting and some from a broader church announcement. Some had additionally heard more about the program from fellow congregants. These elements of familiarity that were previously discussed reflect the power of the pastor and congregational impact on help-seeking and views about mental illness.

Several participants shared about ways they felt the presence of the Church Therapy program decreased stigma and improved help-seeking attitudes. Participants also identified the importance of the connection between spiritual and emotional well-being. On the whole, they stated that they appreciated the integration of counseling into the church setting and believed it was important. The participants expressed the following about church culture and the impact of the church on their views about counseling and mental health:

> I think that having a ministry like that within the church will help a lot of people who are probably like me, and also increase awareness in our communities. There's a lot of people that are dealing with…mental health challenges, but there's so much stigma associated with it that they don't even come out and talk about it.
>
> Sometimes there can be a kind of bias against mental illness within the church culture and… having [the Church Therapy] program contributed to a feeling of…like this is a real issue and helping understand it.
>
> And there might be even a stigma just because of lack of education, and having a program like this embedded [in the church] might help with education. But also helping people who have mental illness maybe feel more comfortable talking about those issues in the church where they might normally feel like, do they know if they're going to be treated seriously?
>
> I hear my pastor talking about mental health and even my pastor's wife brings that up and talks about it.

Theme 4: Personal Growth in Counseling

A final prominent theme was personal growth in counseling. All the participants described positive experiences in the Church Therapy program and felt that their presenting problems had been addressed well. The participants described personal reduction of self-stigma, and some were able to identify new language they had received in counseling to understand themselves and their problems better. Some of the specific tools they gained were increased coping skills, psychoeducation about mental illness symptoms, and an appreciation for the importance of attending to mental health. Participants stated the following:

> I was growing…while working with [counselor name], with my mental health. And then I was growing in church as a Christian…they were kind of both growing together to better my life at the same time.
>
> I don't want to feel like I have to hold all this stuff onto myself, but I don't have to, I'm able to move to the step, to the direction that God has and not feeling like, Oh, I'm alone in this situation because I'm not. I have other people who've been through it or understand where I'm coming from.
>
> It makes me realize that there's more to life than just having these situations that we face on a daily basis that we don't have to do it on our own. That there's somebody there that's going to walk with us, right beside us, besides our faith as well.
>
> I definitely feel like it's been very positive and very beneficial for me.

Discussion

Implications

The combined findings of the quantitative survey and qualitative case study provide unique insights into the Church Therapy program and its impact, as well as shed light on the help-seeking attitudes of evangelical Protestants. The percentage of survey participants who had previously received professional counseling (58%) was much higher than expected and exceeds typical rates cited in the literature, usually around 40%. It was clear from both the survey and case study that the participants had a strong preference for distinctively Christian counseling and a majority of them wanted to find professional counseling within their church. Those who participated in the case study also expressed their positive feelings about the familiarity and safety of seeking counseling within their church rather than in the community. Future research could assess a larger population of evangelical Protestants, but our findings align with and add to the literature about the help-seeking patterns of this subpopulation.

These findings provide important implications for the role the church can play in increasing help-seeking and reducing stigma. In these churches where overall positive attitudes toward counseling and low rates of stigma were found, we saw higher than average rates of participation in counseling. This finding suggests that a church's culture around mental health can have a potentially direct and positive impact on the help-seeking patterns and stigma levels of its congregants. Pastors and clinicians can work together to facilitate open dialogue and targeting programs that seek to improve these outcomes and shift the culture around mental health topics.

While we did not find significant differences on attitudes toward professional counseling or mental illness stigma between the Church Therapy program group and the control group, the overall mean scores on the two instruments

reflected generally positive attitudes and low stigma. It is possible that because we chose churches that were in the same denominational network and were of similar size and location, the overall positive views about counseling and mental illness across that network made the Church Therapy program work well. In fact, upon ending the data collection period, one of the pastors of the control group churches reached out to the first author about possible inclusion in the Church Therapy program. Thus, the presence of the Church Therapy program may be more of a reflection of existing positive attitudes rather than the cause.

The significant relationship between past counseling experience and positive attitudes toward counseling is a logical finding, but it begs the question, "Did positive attitudes toward counseling contribute to a high rate of participation in counseling, or did participation in counseling improve attitudes about counseling?" Further research is needed to determine the direction of that relationship. It was also unsurprising to find that women had more positive attitudes about counseling than men and younger participants with experience in counseling had lower stigma than those who were older and had not had prior counseling. These findings align with overall research on the impact of gender and age on help-seeking attitudes.

Limitations

There were a variety of limitations to this study. The use of the CAMI scale may not have yielded more nuanced views about mental illness as it was an older scale with statements that might be considered extreme in today's culture, particularly in the Northeast. Another scale such as the Beliefs Toward Mental Illness scale (Royal & Thompson, 2012) has not been as well researched but may have presented a more palatable set of questions to assess more subtle levels of stigma.

Additionally, a larger sample size may have yielded a broader set of comparisons. The survey participants may not represent a true random sample within the churches, as those who have an interest in mental health or counseling may have been more likely to click on the survey than those who do not have positive views. Due to the COVID pandemic, we were only able to distribute our surveys through electronic means. This method may have limited those who are not as comfortable with technology, in addition to limiting our ability to sample randomly in person.

Future Research

Further research is needed to continue to enhance our understanding of evangelical Protestant help-seeking attitudes, views about mental illness, and engagement with professional counseling. In addition to replicating the quantitative survey from this study within other denominations and regions, more research is needed on church-based counseling models. Such studies could focus on treatment outcomes, congregational dynamics, and other approaches to innovative care within churches. A pretest/posttest study could examine the effectiveness of various individual and group interventions on attitudes toward counseling and/or mental illness. Finally, a longitudinal study on the Church Therapy model could assess its impact over time to determine more specifically whether or not its presence within a church impacts attitudes over time.

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Where Do We Go From Here? A Call to the Christian Mental Health Community to Leverage the Resources of Science and Faith for Social Action and Community Renewal

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In the wake of a global pandemic, social, political, and racial unrest, and unprecedented human suffering, both nationally and abroad, our communities are in urgent need of renewal—biological renewal, social renewal, political renewal, and spiritual renewal. Prilleltensky (1997) argued that knowledge should be a tool of social action. If this is indeed the case, should not the wealth of knowledge created by, and available to, Christian mental health professionals be leveraged to benefit society and directly facilitate community renewal? Unfortunately, many of the issues facing society cannot be adequately addressed through counseling and psychotherapy alone (Bulhan, 1985); because of this, Christian mental health professionals must also consider expanding the scope of our work and professional responsibility beyond individual interventions (Vera & Speight, 2003). Accordingly, this paper explores how recent advancements in research on positive psychology and the psychology of religion and spirituality provide a fertile context for faith communities and scientific communities to collaborate together towards the shared vision of community renewal—a vision of community renewal that is grounded in Christian character and formation as well as empirical science.

As our country and our world has grappled with the financial, emotional, social, political, racial, and (speaking now as a pastor, I would also add) spiritual unrest of this past year, all of us have been engaged in our own unique journey into the wilderness of grief (Berinato, 2020)—over the loss of loved ones, of gainful employment, of relational presence and social connectedness, of hopes and dreams that we once had prior to this era of lockdowns, social distancing, and canceled plans. To be in grief is to occupy a liminal space—a space in perpetual tension between past and present, between what once was and what might be in the future. Even Christ Himself is intimately familiar with what it is like to occupy a liminal space (c.f. Matt. 26:36-46). Moreover, from the standpoint of our Christian faith, this is a familiar space for Christians to occupy because our present existence as the children of God here on earth similarly leads us into this familiar tension between the past and the future. The Advent season is a symbol, an analogy of the entire Christian life—we remember the birth of Christ and the Incarnation, while we also look forward to His Second Coming, when the Kingdom of God will be fully consummated and the world as we know it will pass away. And yet, this year perhaps more than any other year in recent history, as we are still in the midst of a global pandemic, we are holding this constant tension that the *world as we once knew it* has indeed already passed, all the while remaining unsure of what or when the world to come will finally arrive. And so, we now live within a liminal space between the "what was" and the "next."

In fact, this special issue of the *Journal of Psychology and Christianity* edited by James Sells and Mark Newmeyer can be understood a special issue on liminality—as it applies to the entire field of Christian mental health. Moreover, from the many esteemed colleagues who have not only contributed to this special issue, but also made significant and unique contributions to our field, we receive different glimpses, different perspectives on how we might understand and hold this tension between the "what

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was" in Christian mental health and the "next." The collective call of these authors is for us to honor the strong foundation laid before us (i.e., the "what was") by pursuing the "next" of Christian mental health with courage, confidence, and innovation: "Going big, thinking large."

So what, then, does it mean for Christian mental health to go big and think large? The resounding theme established in this special issue is that of expanding the scope and vision of our work as Christian mental health professionals to, in the words of Sells and Newmeyer (2021), "affect our culture and address crucial needs in society, our professions, and our religious institutions." (p. 4) I could not agree more, and my fellow colleagues offer several directions in which we can accomplish this. Campbell and Hathaway (2021), along with Hull and Romig (2021), speak of the importance of continued engagement and advocacy work in our professional disciplines so that training curriculum and accreditation standards are flexible and robust, taking into account the importance of spiritual and religious competencies in the practice of mental health care. Davis and Baraka (2021), along with Kansiewicz and Smith (2021), speak of the importance and feasibility of engaging and mobilizing the local church to meet the vast mental health needs of our local communities—following innovative models of care established by missionary member care organizations as well as low-cost on-site church-based clinical mental health delivery models. Innovative models of church and community engagement will be especially vital as we recover from the multifold deleterious effects of the COVID-19 pandemic on community mental health, especially in light of the fact that the pandemic has disproportionately impacted vulnerable populations such as individuals with special needs, racial minorities, and those in a lower socioeconomic status (SES) who often cannot afford therapy (Kuhfeld et al., 2020; Panchel et al., 2020).

In addition to the COVID-19 pandemic, we are also in the midst of a national reckoning with our racial pandemic, with the latter bearing direct consequences to both the physical and mental health of our communities (Laurencin & Walker, 2020). Sandra L. Shullman, president of the American Psychological Association (APA), explained:

> We are living in a racism pandemic, which is taking a heavy psychological toll on our African American citizens. The health consequences are dire. Racism is associated with a host of psychological consequences, including depression, anxiety and other serious, sometimes debilitating conditions, including post-traumatic stress disorder and substance use disorders. Moreover, the stress caused by racism can contribute to the development of cardiovascular and other physical diseases. (APA, 2020)

And notably, racism exacerbated by the COVID-19 pandemic has targeted other communities of color as well, including Asian-Americans (Cheng & Conca-Cheng, 2020). Together, these trends underscore the importance of Fort and Watson's (2021) vision of a future Christian mental health field that is inclusive, incorporating the voices and perspectives of Christian professionals of various backgrounds and experiences into the next generation of theory and work on integration. They rightly argue that to achieve this end, we need to intentionally address systematic and implicit factors within Christian academia that stifle non-majority voices. Grcevich and Grcevich (2021) take this a step further by encouraging us to critically examine and address systematic and implicit factors within entire church cultures that similarly stifle inclusion—especially on the part of children and families with mental disorders. Their work elucidating these factors (e.g., overt and covert forms of stigma within church life, social isolation) along with practical recommendations (e.g., the establishment of a church-wide mental health inclusion team) is an excellent example of the type of systems-level advocacy and intervention work that awaits us in the future as Christian mental health professionals.

As a field, Christian mental health has come a long way since the days when we were struggling to establish ourselves both in the eyes of non-religious professional organizations as well as with local churches and church leaders. Early work in our field was rightly focused on training models (e.g., Carter & Narramore, 1979; Johnson, 2010; Tan, 1996; McMinn & Campbell, 2007), giving us a common language and foundational frameworks of understanding and articulating how the discipline of psychology could interact

with the Christian faith and how this emerging integrative discipline could be applied to the practice of mental health care. Understandably, much of the focus of this early work has been primarily theoretical in nature and/or primarily contextualized within the space of individual psychotherapy. In fact, reading these works personally earlier in life (e.g., Eric Johnson and Stanton Jones' (2000) *Psychology & Christianity: Four Views*) provided me with rich foundational knowledge that was pivotal in shaping my own journey into this field.

Notably, Prilleltensky (1997) posited that knowledge should be a tool of social action. Furthermore, if this is indeed the case, should not the wealth of knowledge created by and available to Christian mental health professionals be leveraged to benefit society and directly facilitate community renewal? My firm conviction is that the answer to this question is a resounding "yes." Moreover, I would argue that this is the case even more so for us who have given our faith in Christ. During a different era of unprecedented social unrest, Dietrich Bonhoeffer (1997) concluded,

> The church is only the church when it exists for others…The church must share in the secular problems of ordinary human life, not dominating, but helping and serving. It must tell men of every calling what it means to live in Christ, to exist for others (p. 382).

Unfortunately, many of the issues facing our society today (and arguably, the churches in our society just as much) cannot be adequately addressed through counseling and psychotherapy alone (Bulhan, 1985). Because of this, Christian mental health professionals must also consider expanding the scope of our work and professional responsibility beyond just individual interventions (Vera & Speight, 2003). In addition to the many pertinent suggestions and directions offered by my co-contributors to this special issue on how we might do this, I would like to close this paper by adding one more possibility.

With the multifold financial, social, political, and racial problems that have gripped our communities this past year, I believe that an even more fundamental problem has been made evident: in addition to the coronavirus pandemic and the racial pandemic, we are also facing a moral character epidemic. As our country has been undergoing a dramatic increase in partisan social and political polarization (a tendency impacting the full political spectrum), research has found that individuals are harboring increasingly negative sentiment towards those who hold different views than us (Abramowitz & Webster, 2016), people are increasingly unwilling to listen to or consider perspectives different than their own (Stround, 2008), and people are going so far as to increasingly reject social interaction with people with different views as well (Iyengar et al., 2012). This phenomenon of animosity against people outside of one's affiliated group, against people who may hold different views than oneself, is what political scientists call affective polarization (Iyengar et al., 2019). While I do not have the space to synthesize the literature on the origins and causes of affective polarization, research has found that affective polarization has profound effects on our relational functioning. Political preference has been found to increasingly shape who we find physically attractive (Nicholson et al., 2016), the selection of long-term romantic partners (Huber & Malhotra, 2017), whom we choose to be friends with (Chopik & Motyl, 2016), and even our choice of a place of residence (Mummolo & Nall, 2017).

What, then, are the implications of these sociological trends on Christians, and in particular, on Christian mental health professionals? An appropriate place to start would be the greatest commandments. Jesus explained,

> 'And you shall love the Lord your God with all your heart and with all your soul and with all your mind and with all your strength.' The second is this: 'You shall love your neighbor as yourself.' There is no commandment greater than these. (*English Standard Version Bible*, 2001, Mark 12:30-31)

Concerning the second commandment and within the context of our increasingly socially polarized society, a fair question one might ask would be, "And who is my neighbor?" This question was posited to Jesus elsewhere in Luke 10:29-37, which prompted Jesus to respond with the parable of the good Samaritan—a parable with profound relevance to our current context today. Returning back to Bonhoeffer's assertion that the church is only the church when it exists for others, certainly, the others that Bonhoeffer had in mind here are not just those who look like us, think like us, agree with us, and

affiliate in the same groups as us. Katherine Kelaidis (2020) explained that death and suffering (such as what we have observed during this global pandemic) tests the moral health of individuals and societies. As such, a people who are not morally strong, when they become afraid, quickly slip into lawlessness and sacrilege (Kelaidis, 2020). Quoting Thucydides, who spoke of his account of the Great Plague that decimated Athens in 430 BC, she continued, "For the violence of the calamity was such that men, not knowing where to turn, grew reckless of all law, human and divine…Men who had hitherto concealed what they took pleasure in, now grew bolder."

Friends, we are in the midst of a reckoning from a moral and character deficit in our communities and the church here in America is implicated in this reckoning. From the perspective of our faith, the reason why this matters is because deficits and failure in moral character (regardless of the extent to which they are cultivated by socio-political factors and/or global pandemics) are ultimately reflective of deficits and failure in Christian formation and discipleship. Jesus explained

> No good tree bears bad fruit, nor does a bad tree bear good fruit. Each tree is recognized by its own fruit. People do not pick figs from thornbushes, or grapes from briers. A good man brings good things out of the good stored up in his heart, and an evil man brings evil things out of the evil stored up in his heart. For the mouth speaks what the heart is full of. (*English Standard Version Bible*, 2001, Luke 6:43-45)

When I reflect on this reckoning of moral character that is facing society, that is facing the church, I cannot think of a more pertinent group than those of us in Christian mental health to stand in the gap.

With the proliferation of recent scholarship on positive psychology and virtue (much of which being produced by people of faith), we have a context and opportunity—as an entire field—to pursue robust theoretical, applied, and empirical research and practice within our profession while also speaking to matters of utmost importance to Christian formation and discipleship and addressing some of the most pressing needs that our society is facing today. I oversee a large research grant funded by the John Templeton Foundation investigating the formation of character and spiritual life among ecumenical Christian religious leaders, and one of our foundational topics of investigation concerns how one might define, observe, or assess spiritual maturity from a biblical perspective, a theological perspective, from the perspective of historical spiritual traditions, and even from an empirical perspective (c.f. Porter et al., 2019). As part of this work, I have had the privilege of interviewing a group of spiritual directors and human formation advisors at the Mount Angel Seminary and Abbey in St. Benedict, OR. When I asked this group the question, "What do you consider to be observable indicators that an individual embodies the substance of spiritual maturity compared to someone who is merely trying to look the part," I received responses like the following. Spiritually mature individuals are people of freedom—acting and choosing the course and direction of their life in freedom—not reluctantly or out of pure duty or out of fear or manipulation. The spiritually mature are people of communion, with deep relational capacities not only with God but also with one's neighbor. The spiritually mature demonstrate affective maturity—they are aware of internal emotional states and are equipped to cope with these internal states. The spiritually mature are interculturally competent—particularly as it relates to one's treatment of the poor, underprivileged, and those different from them. The spiritually mature are well-integrated people—there is a consistency of character that remains regardless of context. Lastly, the spiritually mature are those who have learned to navigate and not succumb to their will to power, to their will to seek recognition and privileges, to their will to dominate and manipulate others. To think of spiritual maturity in this way—inclusive of not only right doctrine and religious practice, but also of embodied characteristics such as freedom, affective maturity, self-knowledge and self-awareness, intercultural competence, and a well-integrated personality, is both refreshing and timely. As a community of Christian mental health professionals, I cannot think of a better body of individuals who are better equipped to speak into this, to engage and equip communities in thinking about and cultivating these dispositions, and to contribute to making the world a better place in the name of Jesus as a result.

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