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SCIENTIST-PRACTITIONER-ARTIST-BELIEVER: TRAINING CLINICIANS TO BE RESPONSIBLE SCIENTISTS, ETHICAL PRACTITIONERS, AND CREATIVE AND FAITHFUL PEOPLE

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Abstract: The Scientist-Practitioner model is among the most common and respected training models for clinicians in the world. Research on the efficacy of psychological treatments has also indicated the importance of the real and creative relationship between the client and therapist, a relationship in which the psychologist is called upon to be not only a good scientist and ethical practitioner, but also a creative collaborator with the client. Many clinicians also endorse a religious or spiritual perspective which calls us to meaningfully integrate our faith, science, and practice in service to the client, the church, and the community. This paper will explore the important relationships among these roles as a psychologist, and suggest ways in which training programs may support the development of trainees as scientists, practitioners, artists, and people of faith.

Key Words: Scientist-Practitioner model, Psychological treatments, Clinical training, Religious perspective, Integration.

Resumen: El modelo científico-práctico es el más común y respetado de los modelos de entrenamiento en el mundo. La investigación en cuanto a tratamientos psicológicos ha indicado también la importancia de la relación, real y creativa, entre el cliente y el terapeuta, una relación en la cual el psicólogo está llamado a ser, no solo un científico bueno con ética, sino también un colaborador creativo con el cliente. Muchos psicólogos clínicos también apoyan una perspectiva religiosa o espiritual, la cual nos pide una integración significativa de nuestra fe, ciencia y práctica al servicio del cliente, la iglesia y la comunidad. Este ensayo explorará la importante relación entre los roles del psicólogo y sugiere caminos en los cuales los programas de entrenamiento pueden apoyar el desarrollo de los que están siendo entrenados como científicos, practicantes, artistas y personas de fe.

Palabras clave: Modelo científico- práctico, Tratamientos psicológicos, Entrenamiento clínico, Perspectiva religiosa, Integración.

This is a paper about integration, about wholeness: the integration of disciplines, the integration of the tangible and the intangible, and the integration of multiple perspectives in the life and practice of the clinician.

The author must first acknowledge that these comments have been shaped by and applied in a North American context. Further, the author's own theoretical orientation as a clinician (integrative) and pedagogical style (collaborative) have significantly shaped the reflections herein. Those who live and work in other parts of the world and who embrace other approaches are encouraged to draw upon the strengths of their own cultural, theoretical and pedagogical traditions in the application of this material.

The Scientist-Practitioner Model

The Scientist-Practitioner model, often called the Boulder Model, is among the most commonly endorsed training models for clinicians in the world (O'Sullivan & Quevillon, 1992). In this model, the psychologist acts as a scientist who develops and tests hypotheses, engages in research relevant to practice, and applies research findings to both assessment of and intervention with clients. Programs using this model endeavor to offer research-based training and encourage trainees in their ongoing application of scientific findings to work with clients. The benefits of the Scientist-Practitioner model, including the placement of clinical training in the realm of science and observable phenomena, are numerous and widely acknowledged. The recent emphasis on the study and use of empirically supported treatments is among the best examples of the relevance of the Scientist-Practitioner model.

While this model places emphasis on observable and measurable phenomena that lend themselves more or less easily to exploration using the scientific method, it is limited in its ability to prepare clinicians to address less tangible elements of human experience, including many forms of artistry and religious/spiritual experience. It is important that the strengths of the Scientist-Practitioner model are retained, while exploring the importance of these less easily measurable dimensions of experience. This exploration is important if the emerging clinician, and those who endeavor to train emerging clinicians, value an emphasis on the development of the whole person. This emphasis on the whole person is a perspective that is not only valued among mental health practitioners, but one that is also embraced by the Roman Catholic Church and many other religious traditions.

The Clinician as Artist

As clinicians, we are artists in many ways. Many argue that effective psychotherapy is both

a science and an art. That is, excellent and effective therapy is grounded in science, while retaining openness to creative and spontaneous experiences between therapist and client(s). There are technical elements of psychotherapy that can be taught to trainees (as in manualized treatments), and also less tangible elements that are as distinctive and unique as the clinicians who use them.

As artists, clinicians are engaged in the creative process, which includes the "capacity to produce work that is both novel and useful" (Carr, 2004, p. 150). According to Csikszenmentmihalyi (1999), creativity involves a dynamic interaction among three systems: the person, the domain, and the field. Thus, creativity in the clinical work of psychologists may be conceptualized as the product of a dynamic interplay among the clinician (and his or her unique characteristics, talents, traits, and motivations), the client, the domain of psychotherapy (which includes the guiding psychotherapy models, techniques, and practices), and the field of psychology (which includes peers engaged in similar work).

Clinicians, as whole people, are also artists to the extent that we apply creativity beyond the practice of psychotherapy. Bjorck (2007) asserts that "as a discipline, psychology lends itself well to creative personalities" (p.57). This includes many forms of artistic expression (painting, drawing, dance, music, sculpture), both with clients and in the clinician's life outside of work. The cultivation of creativity, according to Bjorck, may also be an act of worship: "After all, the Creator fashioned all women and men in His image (Genesis 1:26-27), which implies that we are creative too by our very nature!" At the same time, many Christians have come to "think, or at least fear, that creative dreams are egotistical, something that God wouldn't approve of for us" (Cameron, 2007, p.16).

In training programs, many trainees come to the conclusion that creativity is beyond the scope of clinical practice, and that the only responsible practice is that which has already been developed and scientifically supported by someone else. Thus, for many trainees, creative impulses may be experienced as threatening, either to one's theology or to one's emerging identity as a psychologist embracing the Scientist-Practitioner paradigm. Perhaps the most effective corrective to this perspective comes in the modeling of faculty members and clinical supervisors who are engaged in their own creative explorations, both in psychology and in their personal lives. It may also be helpful for trainees to understand that creative pursuits are an important element of therapist self-care, and may increase the practitioner's resiliency and effectiveness, particularly when responding to trauma (Gregerson, 2007).

The Clinician as Believer

Surveys of American psychologists have shown that mental health practitioners in the United States tend to be far less religious than the communities they serve in terms of religious affiliation,

attendance, beliefs and values (Delaney, Miller & Bisono, 2007). Similar relationships have been found in other English-speaking countries (Australia and the United Kingdom). Psychologists also appear to have lower rates of religious affiliation, belief in a personal God, and religious attendance than academics in other fields (Delaney, Miller & Bisono, 2007). At the same time, many religious psychologists persist in the field, teaching and practicing in both secular and religious environments, and many non-religious psychologists endorse the value of religious and spiritual activities for clients, even when they don't engage in them personally.

Just as clinicians do not spring fully-formed from graduate training programs, believers do not spring forth in wholeness from the church. Each person's spiritual development as a believer may be understood in light of a predictable developmental trajectory (e.g. Fowler, 1981; Tate & Parker, 2007) and the individual's unique experiences. Thus, at any stage in the clinician's career, she or he may demonstrate differing levels of religious belief, practice, and integration of clinical theory and skills.

The psychologist is also invariably impacted spiritually by the experiences she or he has in the clinical setting: "Therapists are profoundly impacted by the suffering and evil with which they sit. We become like that which we habitually reflect" (Langberg, 2006, p.258). Sitting with others in their suffering shapes the clinician in important ways, as the psychologist is challenged to explore his or her images and understanding of God, the nature of humankind, the nature of suffering, and his or her own identity as a believer (Langberg, 2006; Cooper, 1992). For this reason, several writers have suggested that Christian psychologists continue to practice spiritual disciplines (such as worship, study, and prayer) so that integration between belief and practice increases and the spiritual health of the practitioner is supported. The benefits of this integration go beyond a sense of meaning and well-being on the part of the therapist; positive relationships have been found between religious integration and clinical empathy (Muse, Greer, Estadt & Cheston, 1994), particularly among those for whom religion involves a sense of a personal relationship with God.

The benefits of this integration of faith and practice are also not limited to the experience of the clinician. Clients report that religion and spirituality play a significant role in both treatment and a sense of recovery from psychological distress (e.g. Bussema & Bussema, 2007). Experiencing distress and receiving treatment may be strengthening to the faith of many, when seen in the context of a spiritual journey (Mayers, Leavey, Vallianatou & Barker, 2007).

Religious integration thus presents an opportunity for growth in the emerging clinician, his or her trainers/supervisors, and the clients they serve.

Challenges to Integration

While integration of faith and practice presents many opportunities to emerging clinicians and those who train them, those who seek integration often experience obstacles at the cultural, professional, institutional, interpersonal, and intrapersonal levels.

Cultural

The relationships among religion, public life and professional practice vary significantly by culture. In some cultural contexts, established religion, such as that of the Roman Catholic Church, colors most aspects of public and private life (Rizzuto, 2004). In other cultural contexts, faith and reason are seen as being at odds, or as spheres so separate that discourse between them is seen as challenging at best and fruitless at worst. While the United States remains a highly religious country (Delaney, Miller & Bisono, 2007), it is also a highly secularized culture, with many Americans compartmentalizing their faith and professional lives.

Professional

The clinician-in-training is soon confronted with professional obstacles to the integration of faith and practice. Among the most salient of these is the historical antipathy of many influential psychologists towards religion (e.g. Freud's labeling of religious belief as an extension of unresolved oedipal issues, Ellis' labeling of many religious beliefs as "irrational"). The tendency in many theoretical traditions has been to see the faithful believer as pathological, naïve, or as one evading personal freedom and responsibility. The greater the differences between a client's religious beliefs and the dominant ideas of the culture, the more likely the client will be to be pathologized by the clinician (O'Connor & Vandenberg, 2005).

In the twentieth century, forces within psychology also conspired to increasingly limit the scope of psychology: "Psychology was reduced first to the study of mind, and then of behavior, with more recent focus on the neural substrates of behavior. Having first lost its soul and then its mind, psychology gradually returned to the study of cognition and, more recently, is showing signs of renewed interest in spirituality and religion as well" (Delaney, Miller & Bisono, 2007, p.538). Some psychologists continue to compartmentalize faith and science, assuming that issues of faith lie beyond the scope of scientific inquiry.

Additional professional obstacles to integration include a lack of training, lack of supervision or peer support for integrative work, limited models or paradigms for integration, ethical concerns about imposing the therapist's beliefs on clients or violating professional boundaries with clients, and attempts to compartmentalize clients' distress (e.g. "Is this a religious problem or a psychological

problem?").

However, the field has become increasingly open to exploration of religious and spiritual topics. Recent research has suggested not only high levels of religiousness among Americans, but increasing openness to integration of spiritual and religious material in psychotherapy among clinicians (Young, Wiggins-Frame & Cashwell, 2007). However, psychologists often report that they do not feel personally competent to counsel clients about religious or spiritual issues, due to a lack of professional training or supervised experience in these areas (Delaney, Miller & Bisono, 2007). Clinicians may, however, draw upon a swiftly growing body of scientific material exploring the relationships among religious variables and human functioning (Spilka, Hood, Hunsberger & Gorsuch, 2003), and the use of explicitly religious intervention strategies by therapists in sessions with clients (McMinn & Campbell, 2007).

Institutional

Integration efforts by faculty and the students they train are not only influenced by cultural and professional factors; institutional dynamics may also have a significant impact on integration efforts. The openness of the leadership and administration of the university, support for interdisciplinary study, and the historical relationship of the psychology department to other departments on campus may help or hinder integration efforts. The institution's response to Ex Corde Ecclesiae (Pope John Paul II, 1990), the relationships between faculty in psychology and those in theology and philosophy departments, and the on-campus relationships among faculty and clergy may also play significant roles in the type and amount of integration of psychology and faith that is encouraged among faculty and students. A tension exists on many campuses, particularly religious campuses, about what will constitute orthodoxy. Thus, exploration of the relationships between faith and psychology may raise questions of whose version of Christianity (or even of Catholicism) will be addressed.

Interpersonal

At the interpersonal level, integration is impacted by relationships among faculty members (both within psychology departments and across campuses), and in relationships between faculty and students. For those students who express an interest in integration work, the modeling of integration by faculty and clinical supervisors is of critical importance (see Aten, Boyer & Tucker, 2007; Campbell, 2007; Jones, 2007; Tan, 2007). Those supervisors and faculty who take into account both the emerging clinician's developmental trajectory as a therapist and religious and spiritual development may be particularly effective in fostering integration (see Ripley, Jackson, Tatum &

Davis, 2007). That is, students in preliminary stages of clinical and spiritual development may be particularly dependent on instruction from teachers and supervisors, whereas more advanced students will both seek out integrative experiences and bring their own perspectives to bear on integration issues.

Intrapersonal

Perhaps the most significant obstacle to integration lies within the individual. In a recent study of American psychologists (Delaney, Miller & Bisono, 2007), almost half of respondents indicated that religion is not an important part of their lives. Further, although the majority (91%) indicated that they believed in God at some point in their lives, a quarter of respondents indicated that they no longer held such a belief.

Internalized prejudices about religion may also serve as an obstacle for integration, as most of those who teach psychology were trained in psychological theories and approaches that are hostile to religion. Individuals may also compartmentalize faith and scientific or clinical pursuits to help manage anxiety about integration or perceived inadequacies in our own faith development. The task of integration of faith and the science of psychology in teaching, research, and practice involves risks, both professional (when faced by unsupportive or hostile colleagues or students) and personal (as one is faced with difficulties in one's own spiritual or religious life). Many may choose to keep faith and psychology separate to reduce both anxiety and complexity.

Opportunities for Integration

While obstacles to integration abound, opportunities are also plentiful. Aten and Hernandez (2004) suggested eight domains in which supervisors can help emerging clinicians work more effectively with religious clients and religious or spiritual issues. These domains included: Intervention skills, assessment approaches and techniques, individual and cultural differences, interpersonal assessment, theoretical orientation, problem conceptualization, selecting treatment goals and plans, and professional ethics. All of these dimensions are relevant as faculty members seek to support the clinical and spiritual growth of emerging clinicians. In each of these domains, faculty members and clinical supervisors may work with trainees to develop both implicit and explicit integration strategies.

Theoretical orientation

The theoretical orientation of the therapist plays a significant role in the conceptualization of the nature of the personality, understandings of health and distress, and the selection and

implementation of therapeutic strategies. Theories espoused by psychologists contain assumptions about the nature of the person, and the relative importance of free-will and determinism in human action.

Faculty members may encourage students/trainees to explore existing models of personality and psychotherapy and to critique them based on a Christian perspective (see Jones & Butman, 1991; McMinn & Campbell, 2007). Further, students may be exposed to the growing body of literature addressing the integration of Christian thought and specific theoretical approaches such as Psychoanalysis (Rizzuto, 2004; Strawn, 2007), Psychodynamic Therapy (Terrell, 2007), Cognitive-Behavioral Therapy (Tan, 2007), Multimodal Therapy (Bjorck, 2007), and Postmodern approaches (Blanton, 2008). Students may also be introduced to explicitly Christian models of personality and human behavior (e.g. Puffer, 2007; Dean, 1985). In these exercises, students are challenged to address the ways in which Christian models of persons differ from (or fit) with models of personality and pathology found in the psychological literature (and how psychological teachings fit with a Christian understanding of persons).

Problem Conceptualization

In what ways do our theological perspectives shape our conceptualization of the client and his or her concerns? How does this impact our understanding of what will aid the client? Faculty members may encourage students/trainees to explore these questions, both in theoretical assignments and in direct work with clients. This may involve theological models of distress (e.g. Beck, 2007), as well as psychological ones (e.g. Capps, 2007). One recent example of this approach occurred on the author's campus when an undergraduate student (Ana Lopez) explored the psychological concept of self-injury in light of Pope John Paul II's encyclical Veritatis Splendor (1993). The student discovered that many of the psychological models of self-injury assumed unconscious processes. In contrast, one assumption of John Paul II was that human action is primarily conscious in nature. The student grappled with the tension between these approaches, weighing her perspectives as both an observant Catholic and a psychological trainee.

Intervention Skills

Faculty and supervisors may encourage emerging clinicians to explore and experiment with explicitly religious interventions in sessions with clients, particularly those religious interventions for which scientific data are available. Students may be guided to the literature exploring clients' perceptions of the appropriateness and helpfulness of explicit religious interventions in therapy (Martinez, Smith & Barlow, 2007). This may involve interventions in the context of specific

psychological approaches (e.g. Bjorck, 2007; Tan, 2007), inclusion of more traditional religious practices and spiritual disciplines in therapy such as confession, prayer, and forgiveness (Dyslin, 2008; Weld & Eriksen, 2007: Cheong & DiBlasio, 2007), incorporation of principles from spiritual direction (Barrette, 2002; Evans, 2005), and referral to clergy (Bilich, Bonfiglio & Carlson, 2000).

Professional Ethics

One of the most significant areas of concern among clinicians considering integration work lies in the field of ethics. Plante (2007) suggested four common pitfalls experienced by those attempting to integrate psychology and religion. First, we are vulnerable to blurred boundaries and dual relationships. Faculty and supervisors can help students/trainees explore appropriate boundaries among the roles of psychologists and believers, mental health professionals and clergy. Students may benefit from consideration of their roles as health professionals, citizens in a liberal society, and individuals who hold specific personal religious beliefs and values (Pesut & Thorne, 2007).

Second, Plante (2007) asserts that we are vulnerable to spiritual and religious bias, particularly because we know so much about our own tradition and often so little about other faith traditions. Faculty may introduce students to examples and readings from multiple faith traditions to encourage students to broaden their understandings of what is normative in religious traditions other than their own.

Third, we are vulnerable to the assumption that being a member of a faith tradition makes us an expert in the tradition. Faculty and supervisors can encourage emerging therapists to identify areas of strength where they may responsibly practice integration, and areas in which they are obliged to seek out supervision, consultation with psychological and religious experts, or make referrals.

Fourth, we must address destructive religious beliefs and behaviors no matter what religious context they exist in, while also offering respect to traditions other than our own. This may involve engaging students in case study and role-play exercises where they are challenged to identify healthy and dangerous behaviors and to devise culturally-sensitive and religiously-relevant interventions.

In Conclusion

If we hope to nurture wholeness and integration in emerging clinicians, we must be creative and integrative ourselves. We don't need to build the house for them, but we can introduce them to the tools important in integrative work. That is, as faculty members, supervisors, and clinicians, we can model integration in our teaching, research, supervision, and clinical work. We can support students/trainees in their efforts to understand and navigate cultural, professional, institutional, interpersonal, and intrapersonal obstacles to integration, and we can introduce trainees to specific

models and examples of integration in clinical work

References

Aten, J.D., Boyer, M.C. & Tucker, B.T. (2007). Christian integration in clinical supervision: A conceptual framework. *Journal of Psychology and Christianity, 26*(4), 313-320.

Aten, J.D. & Hernandez, B.C. (2004). Addressing religion in clinical supervision: A model. *Psychotherapy: Theory, Research, Practice, Training, 41*, 152-160.

Barrette, G. (2002). Spiritual direction in the Roman Catholic tradition. *Journal of Psychology and Theology, 30*(4), 290-302.

Beck, R. (2007). The winter experience of faith: Empirical, theological, and theoretical perspectives. *Journal of Psychology and Christianity, 26*(1), 68-78.

Bilich, M., Bonfiglio, S. & Carlson, S. (2000). *Shared grace: Therapists and clergy working together*. Binghampton, NY: The Haworth Pastoral Press.

Blanton, P.G. (2008). Integrating postmodern and Christian contemplative thought: Building a theoretical framework. *Journal of Psychology and Christianity, 27*(1), 73-84.

Bjorck, J.P. (2007). Autobiographical Reflections on Psychology and the Artistic Spirit. *Journal of Psychology and Christianity, 26*(1), 57-60.

Bjorck, J.P. (2007). A Christian application of Multimodal Therapy. *Journal of Psychology and Christianity, 26*(2), 140-150.

Bussema, E.F. & Bussema, K.E. (2007). Gilead revisited: Faith and recovery. *Psychiatric Rehabilitation Journal, 30*(4), 301-305.

Cameron, J. (2007). *The complete artist's way: Creativity as a spiritual practice*. New York: Jeremy P. Tarcher/Penguin.

Campbell, C.D. (2007). Integrating Christianity across the supervisory process. *Journal of Psychology and Christianity, 26*(4), 321-327.

Capps, D. (2007). Augustine's Confessions: The story of a divided self and the process of its unification. *Pastoral Psychology, 55*, 551-569.

Carr, A. (2004). *Positive psychology: The science of happiness and human strengths*. New York: Routledge.

Cheong, R.K. & DiBlasio, F.A. (2007). Christ-like love and forgiveness: A Biblical foundation for counseling practice. Journal of Psychology and Christianity, 26(1), 14-25.

Cooper, H. (1992). The therapist and the suffering servant. *Cross Currents*, 437-443.

Csikszentmihalyi, M. (1999). Implications of a systems perspective for the study of creativity. In R. Sternberg (ed.), *Handbook of Creativity* (pp.313-335). Cambridge:

Cambridge University Press.

Dean, M.J. (1985). Paradox and promise: A theological and psychological view of humankind. *The Journal of Pastoral Care*, XXXIX(2), 127-139.

Delaney, H. D., Miller, W. R. & Bisono, A. M. (2007). Religiosity and spirituality among psychologists: A survey of clinician members of the American Psychological Association. *Professional Psychology: Research and Practice, 38*(5), 538-546.

Dyslin, C.W. (2008). The power of powerlessness: The role of spiritual surrender and interpersonal confession in the treatment of addictions. *Journal of Psychology and Christianity, 27*(1), 41-55.

Evans, B.A. (2005). Ancient and classic pastoral counsel: Approaches to anxiety, doubt and guilt. *Journal of Psychology and Christianity, 24*(1), 80-88.

Fowler, J.W. (1981). *Stages of faith: The psychology of human development and the quest for meaning*. San Francisco: HarperSanFrancisco.

Gregerson, M.B.J. (2007). Creativity enhances practitioners' resiliency and effectiveness after a hometown disaster. *Professional Psychology: Research and Practice, 38(*6), 596-602.

Jones, J.W. (2007). Training supervisors to integrate psychology and Christianity. *Journal of Psychology and Christianity, 26*(4), 336-341.

Jones, S.L. & Butman, R.E. (1991). *Modern psychotherapies: A comprehensive Christian appraisal*. Downer's Grove, IL: IVP Academic.

Langberg, D. (2006). The spiritual life of the therapist: We become what we habitually reflect. *Journal of Psychology and Christianity, 25*(3), 258-266.

Martinez, J.S., Smith, T.B. & Barlow, S.H. (2007). Spiritual interventions in psychotherapy: Evaluations by highly religious clients. *Journal of Clinical Psychology, 63*(10), 943-960.

Mayers, C., Leavey, G., Vallianatou, C & Barker, C. (2007). How clients with religious or spiritual beliefs experience psychological help-seeking and therapy: A qualitative study. *Clinical Psychology and Psychotherapy, 14*, 317-327.

McMinn, M.R. & Campbell, C.D. (2007). *Integrative psychotherapy: Toward a comprehensive Christian approach.* Downer's Grove, IL: IVP Academic.

Muse, J. S., Greer, J. M., Estadt, B.K. & Cheston, S. (1994). Are religiously integrated therapists more empathic? *The Journal of Pastoral Care, 48(*1), 14-23.

O'Connor, S. & Vandenberg, B. (2005). Psychosis or faith? Clinicians' assessment of religious beliefs. *Journal of Consulting and Clinical Psychology, 73*(4), 610-616.

O'Sullivan, J.J. & Quevillon, R.P. (1992). 40 years later: Is the Boulder Model still alive? *American Psychologist, 47*(1), 67-70.

Pesut, B. & Thorne, S. (2007). From private to public: Negotiating professional and personal identities in spiritual care. *Journal of Advanced Nursing, 58*(4), 396-403.

Plante, T. G. (2007). Integrating spirituality in psychotherapy: Ethical issues and principles to consider. *Journal of Clinical Psychology, 63*(9), 891-902.

Pope John Paul II (1990). *Ex Corde Ecclesiae: On Catholic Universities*. Rome: Vatican.

Pope John Paul II (1993). *Veritatis splendor*. Rome: Vatican.

Puffer, K. A. (2007). Essential Biblical assumptions about human nature: A modest proposal. *Journal of Psychology and Christianity, 26*(2), 45-56.

Ripley, J. S., Jackson, L.D., Tatum, R.L., & Davis, E. B. (2007). A developmental model of supervisee religious and spiritual development. *Journal of Psychology and Christianity, 26*(4), 298-306.

Rizzuto, A.M. (2004). Roman Catholic background and psychoanalysis. *Psychoanalytic Psychology, 21*(3), 436-441.

Spilka, B., Hood, R.W., Jr., Hunsberger, B. & Gorsuch, R. (2003). *The psychology of religion: An empirical approach*. New York: The Guilford Press.

Strawn, B. D. (2007). Slouching toward integration: Psychoanalysis and religion in dialogue. *Journal of Psychology and Theology, 35*(1), 3-13.

Tan, S.Y. (2007). Use of prayer and scripture in Cognitive-Behavioral Therapy. *Journal of Psychology and Christianity, 26*(2), 101-111.

Tan, S.Y. (2007). Using spiritual disciplines in clinical supervision. *Journal of Psychology and Christianity, 26*(4), 328-335.

Tate, Y. B. & Parker, S. (2007). Using Erikson's developmental theory to understand and nurture spiritual development in Christians. *Journal of Psychology and Christianity, 26*(3), 218-226.

Terrell, C.J. (2007). A discussion of intentional incarnational integration in relational psychodynamic psychotherapy. *Journal of Psychology and Christianity, 26*(2), 159-165.

Weld, C. & Eriksen, K. (2007). Christian clients' preferences regarding prayer as a counseling intervention. *Journal of Psychology and Theology, 35*(4), 328-341.

Young, J. S., Wiggins-Frame, M. & Cashwell, C. S. (2007). Spirituality and counselor competence: A national survey of American Counseling Association members. *Journal of Counseling & Development, 85*, 47-52.

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