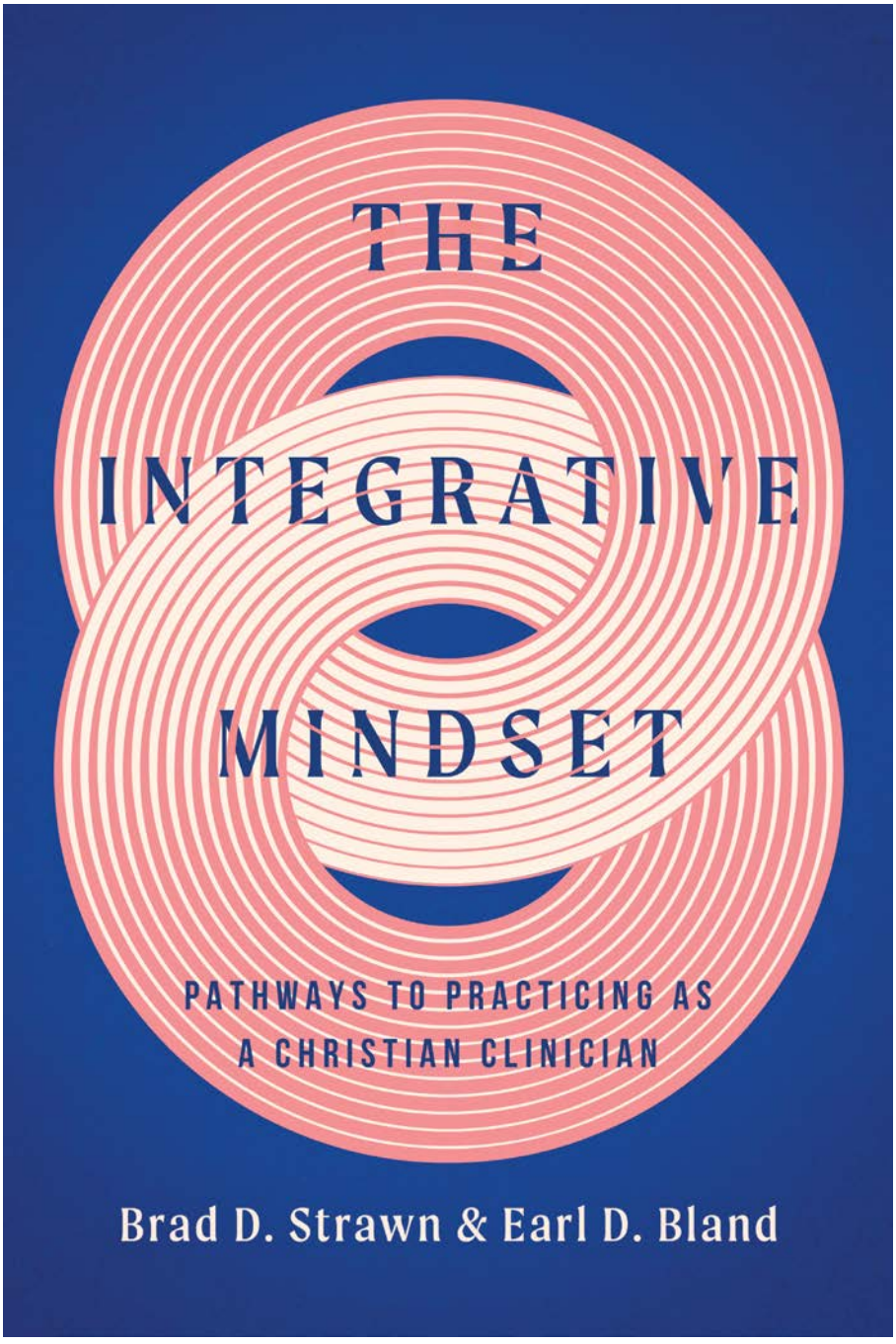

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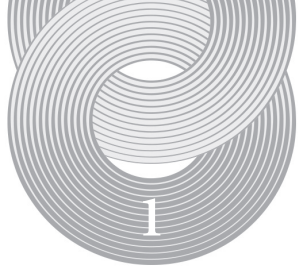


EMERGENCE MATTERS

ILLUMINATING THE INTEGRATIVE MOMENT

It's the first session with a brand-new client. Paperwork has been filled out, introductions have been made, you and the client have both sat down on comfortable furniture, and now you've invited the client to explain what has brought them to see you today. But instead of answering your question, they turn and ask, "You're religious, right?"

What do you say? Why is the client asking this? What *exactly* are they asking? Is this a trap, a defense, an attack, a plea for attachment and solidarity, or something else entirely? How do you incorporate this into therapeutic work? Is talking about religion even okay in therapy? What if the client wants to say more about their faith or is interested in yours? What if they want to talk about what their faith has to do with their psychological issues? Is this a moment of integration of psychology and theology, and if so, what do you do?

Over the years we have had the privilege of conducting and supervising therapy with countless clients who professed religious faith. So, over the years we have heard lots of stories. We have worked with deeply religious clients who said they were afraid to come to therapy because they were told by their Christian friends and pastors that psychology was dangerous and should be avoided.

We've heard these same believers say that instead of coming to counseling they were told that they should have more faith and pray harder. Yet somehow, when all their religious resources disappointed them, they found their way to our offices. On the other end of the spectrum, we have had religious clients come to us saying that if we even mentioned God or the Bible, they would find another therapist. We've even had nonreligious clients say that they had come to see us because even though they were not religious, they thought that maybe there was something spiritual in the world that they might benefit from thinking more about.

We have also had the honor of training students of faith to become psychologists or counselors who were authentically intent in their desire to bring together religion/spirituality with their psychological knowledge. From these students we have also heard stories. Students have told us that they love psychology and love their faith, but they just can't get their mind around how to put these two into meaningful conversation, especially in practical ways they can apply in their clinical work. We have had students wonder whether they are truly integrating their faith into their practice if they are not talking about God or Scripture or engaging in some practice of faith. We have had students (and peers) who were so afraid of integrating faith poorly that they consciously (and unconsciously) avoided the subject altogether, even when the client practically brought it up. We've had students who prayed with a client as soon as the client asked for it and others who adamantly refused, saying, "I'm a psychologist, not a pastor." We've even had students who, while not afraid to ask clients about their personal sex life, finances, or their culture, were terrified to bring up the issue of religion or spirituality, saying, "It's just so personal."

In general, we find that the idea of integration is attractive and desired by our students and colleagues, but the actual embodiment

of an integrative clinical posture has been somewhat illusive. We especially find this with our students from various non-White cultures, who often remark that the writing, research, and theorizing around the integration of psychology and theology is primarily White, patriarchal, and of a Reformed theological persuasion.

So, while *integration*, a term we will define below, has been around for at least fifty years, there is still much confusion about what it is, how to define it, and, for the focus of this book, how to engage it in clinical practice. Our desire is to make the clinical experience of integration more accessible and applicable to everyday work with clients. We specifically want to address the gap so many Christian therapists and counselors encounter when they attempt to bridge the theory or idea of integration and the real-world clinical relationships.

We begin by drawing a parallel with a phrase that our good friend and early integrator John Carter was fond of saying. John would often say that Christians were interested in "thinking Christian thoughts," but they should be more concerned with "thinking Christianly." We believe too that many Christian therapists are interested in "integrative thoughts" (e.g., models, formulas, manuals), but we want to challenge integrators to "think integratively." Semantically, an adverb always modifies another word and usually answers a question such as "How?" If one is thinking Christianly, *Christianly* is modifying the verb *thinking*, and therefore we can expect that there is some *process* to how one is thinking. In *thinking integratively*, *integratively* modifies *thinking* and also suggests a process or a how. Importantly, when we say *thinking* in this context, we are not referring to an abstract intellectual process, although clearly that is an element of what we are considering. Rather, because all thinking is embodied, we recognize that thinking is a deeply affective experience. Consequently,

integrative practice involves the total you—thoughts, feelings, emotional states, and bodily sensations. This book is our attempt to offer a process of *how* to think integratively, or perhaps how to *be* integrative, and why it matters. This process will include five domains (the *matters* that make integration matter): hermeneutics, tradition, ethics, self-development, and resilience. But first let us return to integration itself.

A BRIEF HISTORY OF INTEGRATION TOLD IN FIVE WAVES

While there is an entire literature on interdisciplinary work, some of which we will touch on in later chapters, our focus is on the integration of psychology and theology. In 1953 psychologist Fritz Kunkel first used the term *integration* to describe interdisciplinary activity between psychology and theology. While Kunkel was a major pioneer in the fledgling integration movement, the pastoral psychology movement grabbed hold of the phrase and begin to popularize it (Vande Kemp, 1996). Over time, integration has come to mean many things.

Since the fifties the term *integration* has been used in diverse ways, including (but not limited to) the integration of psychology and Christianity, psychology and religion, psychology and theology (faith and practice, belief and life), psychology and Christian faith, psychology and spirituality, and even psychotherapy and spirituality (Strawn, 2016).

For much of its history, the project to find a satisfactory outcome to the meeting of modern psychology and Christianity has been consumed with developing models of engagement that provide a scaffold or framework for the actual work of integration. This endeavor has produced a remarkable number of diverse and thought-provoking books and journal articles, so much so that some have labeled integration a distinct field of study within the field of

clinical psychology (Vande Kemp, 1996). At the risk of gross oversimplification, perhaps we can think broadly of five waves of discourse that characterize this historical conversation—the apologetic wave, the modeling wave, the applied/empirical validation wave, the spiritual formation wave, and the clinical integrative wave (Bland & Strawn, 2024; Strawn, et al., 2018).

Wave one: Apologetic. In the early days of integration, specifically in Christian evangelical and mainline circles, the conversations generally consisted of justifications regarding why such a dialogue might be useful and even compatible with Christian faith. Because the discipline of psychology largely developed within non-Christian institutions and universities, more conservative and evangelical expressions of Christianity were wary of the development of healing methods that addressed people's thoughts, motivations, and behavior—their *hearts*, if you will—absent a clear reference to the beliefs and practices of Christianity. Many were suspicious of and even hostile to the supposed godlessness of psychoanalysis, behaviorism, or existential/humanistic theories. In response to the gap, early work conducted by faculty at Fuller School of Psychology and Rosemead School of Psychology argued persuasively that psychology and Christian faith didn't have to be strange bedfellows but could be allies in both understanding human nature and partnering in the healing and restoration of human difficulties. Although the apologetic wave was largely aimed at Christians, both lay and academic, there were some justifications of religion and spirituality to the secular world of psychological science as well.

Wave two: Modeling. While wave one was largely successful in the broadly Christian world, by the mid- to late 1980s and into the mid-1990s, this discussion expanded beyond defending a conversation between psychology and Christianity to one of providing

various models of *how* this might be accomplished. Early thinkers such as Paul Clement, Newt Malony, and Richard Gorsuch (Malony & Vande Kemp, 1995), as well as John Carter and Bruce Narramore (1979), among others, developed models of integration. While these were all helpful, they were primarily models with a *view from a distance* in that they were conceptual models rather than imminently and immediately practical models that demonstrated process and methodology. They were *what* models rather than *how* (i.e., process) models. The models increased in complexity as people such as Stan Jones (1986), David Entwistle (2021), Harold Faw (1998), and others expanded the modeling wave, which possibly reached its peak with the publication of *Psychology and Christianity: Four Views* (Johnson & Jones, 2000), later revised to five views (Johnson, 2010). In an interesting, somewhat dis-integrating twist, these authors relegated integration to a viewpoint (i.e., the "integrates view") while offering other viewpoints (i.e., parallels view, Christian psychology view, transformational view, biblical counseling view) on the intersection of psychology and Christianity. In differentiating their models, contributing authors argued for their distinct viewpoints.

Today it is safe to say that there is no unifying model of the integration of psychology and Christian theology. This may again be due to the various domains at work when one is integrating. In a recent work, Malcolm Jeeves and Thomas Ludwig (2018) advocate dropping the term *integration*, suggesting that it is a problematic attempt to make the two disciplines of psychological science and Christian faith say the same thing—what they call *concordism*. Another recent work suggests that integration must be domain specific (Hathaway & Yarhouse, 2021), suggesting that integration looks and acts differently depending on the domain in which one is operating (e.g., theoretical, applied, role). While some may have

become leery of the term *integration*, preferring to reinvent new terminology altogether, we still believe it is a useful word and will discuss our particular meaning below.

Wave three: Applied/empirical. While the project to integrate Christianity and psychology is relatively young, the discipline of the *psychology of religion* has been around for some time.[1] One only needs to think of William James's (1994) *The Varieties of Religious Experience*, first presented as the Gifford Lectures in 1901 and 1902. More recently, this third wave has produced an enormous body of research on religious coping, virtue formation (e.g., humility, patience, gratitude), and human development (Balswick et al., 2016), to name just a few areas. In the psychology of religion, the empirical methodology of psychology is used to study religious phenomena or constructs. For example, one might study the efficacy of prayer or religious concepts such as humility or generosity as contributors to the overall mental health of individuals. Conversely, research also shows how some expressions of religiosity may correlate with prejudice, something we would probably deem as largely harmful to human psychological and social health. More recently, we have seen this area of empirical investigation speak more specifically to how one can promote or use religious and spiritual practices to achieve specific mental health outcomes that are congruent with Christian ethics and virtues within the clinical setting (Knabb et al., 2020; Worthington et al., 2013).

While this kind of basic research is often fascinating and formative for future work in the field, too often it strips religious phenomena from the theological contexts that give them meaning and

[1]We use the term *integrate* here specifically referring to the dialogue between psychology and Christianity, while also acknowledging that the practice of interdisciplinary integration has a long intellectual history and that our current conversation is a dimension of this tradition.

purpose. The inherent risk in this reductive tilt is the possibility of rendering research findings as thin descriptions of historically, culturally, and theologically rich concepts that only achieve full animation within the embodied communal practices from which they emerge. So, the psychology of religion and the empirical wave, as an integration endeavor, must carefully situate the constructs of study within their theological particularities for true and meaningful findings to emerge. Alvin Dueck and Kevin Reimer (2009) specifically warn against the implicit dangers of professional psychology co-opting indigenous religio-cultural practices into the rubrics of Western psychology, which then proport to *legitimize* them through the colonializing power structures of scientific or empirical research.

Wave four: Spiritual integrative. In our earlier work (Strawn et al. 2018), we had identified four waves of integration (apologetic, modeling, applied/empirical, and clinical), but now we acknowledge an additional wave (and placed it as our new fourth wave)—what we have come to call the spiritual integrative wave (Bland & Strawn, 2024). We will describe the fifth wave later, but for now, the fourth wave is characterized by the application of research findings and clinical theory to the process of spiritual formation within persons. While spiritual formation has a long history within various church traditions, it has only been recently that this historically religious practice has engaged the professional world of psychology. This has led to a robust and fruitful conversation, which at times has created some blurring of lines but mostly has provided the opportunity for new ways of discussing the intersection between psychology and the church. William James's *Varieties of Religious Experience* may be one of the earliest examples. Other areas of research include growth in moral and/or spiritual maturity (Benner, 2011; Carpenter, 2020; Collicutt, 2015; Crisp et

al., 2019; Hall & Hall, 2021), wisdom (McLaughlin & McMinn, 2022), and even cognitive neuroscience and the church (Brown & Strawn, 2012; Strawn & Brown, 2020).

WHAT IS MISSING?

In this complex and vibrant landscape of integration, we may find ourselves more confused than we would have hoped. We are more informed about the theoretical and philosophical concerns of integration. We have specific models that can scaffold our approach, and we are even equipped with various "Christian" techniques in our clinical tool belt. Yet, for several reasons, as integrative clinicians deeply immersed in training and practice, we find ourselves (and our students) dissatisfied.

To clarify our position, we believe the first-wave integrationists have thoroughly justified the integration project. Even though some writers (Jeeves & Ludwig, 2018; Johnson, 2010) may chafe at the moniker *integration*, they do not argue that psychology and Christianity should remain isolated—some level of constructive dialogue is the well-accepted norm.[2] But this wave was always a launch program meant to encourage future generations; it was not intended to be the last word.

Next, while the modeling wave was a tremendous step forward in expanding the options for how we might think about an integrative dialogue, we find it limiting in two ways. First, although models of integration are important when talking about the big ideas critical to understanding Christianity and psychology, they are often far removed from the clinical dialogue. Experience-distant concepts found in theory building and theology often do not

[2]We do not naively ignore the fact that there are still some theological and cultural traditions where the apologetic wave is still necessary; however, this is not the central focus of this book. We are thankful for those thinkers, writers, and clinicians who are doing work to make ongoing inroads in these particular cultural and theological areas.

translate well into clear actions in the complex and dynamic practice of psychotherapy.

Second, models, inasmuch as they illuminate a path for thinking, are constrained by the assumptions of the model. Clinical material is seen through the lens of a given perspective, but rarely is the engagement reciprocal, where clinical material is allowed to shape or even influence the construction of the integrative view.[3] Moreover, these models typically assume a singular Christian worldview absent any reference to how specific Christian traditions or the social location of counselor and client may shape an integrative model and its application to the clinical environment (Strawn et al., 2014).

In a growing body of literature, researchers have attempted to develop empirically validated clinical interventions to increase religious virtues such as forgiveness, humility, gratitude, and love. With the development of positive psychology, what used to be a niche preoccupation of Christian psychologists at primarily Christian institutions is now a broad and dynamic area of intellectual and professional inquiry. Some have even called for the establishment of special competencies for those interested in clinical work that involves religious and spiritual concerns (Hathaway, 2011). Due to many shifts in both evangelical Christian culture and the discipline of psychology, we are currently witnessing an upsurge in the number of books and articles attempting to practically discuss how clinicians might apply their faith in a clinical setting or deal with specifically religious clients. For example, there are publications that explore spirituality-oriented interventions within clinical practice and evidenced-based practices that incorporate a

[3]Warren Brown's (2004) resonance model of integration may be an exception. While it is not a clinical model, one of its domains of knowledge—that is, experience—could be conceived of as clinical experience, and each domain is allowed to affect the integrative task.

spiritual or spiritually sensitive orientation. There are also integrative approaches to couple and marital work as well as group interventions and addiction programs. Adjunctive techniques such as spiritual journaling, Christian approaches to mindfulness, and spiritual formation processes in therapy also currently exist. What's more, exclusively Christian publishing groups are no longer the only ones producing work in this area. The American Psychological Association and other publishers are expanding the dimensions of this engagement (Aten et al., 2011; Sandage & Strawn, 2022).

While we are excited about the level of scientific rigor currently being applied to the validation of treatments sympathetic to the integration of Christian faith and psychology, as well as the prolific research on Christian virtues, we are left with a landscape similar to the Wild West. Absent a normative coherence apart from a general allegiance to Christian sensibilities and the thin ethic of modern scientific psychology, clinicians, especially students in training, face a clinical labyrinth when approaching the topic of clinical integrative practice. The complicated maze of clinical ideas and approaches is often confusing and at times tortuous, leaving many to tune a deaf ear and resort to intuition, expedient pragmatics, and collegial advice when attempting to use specific clinical approaches or techniques that might be considered integrative.

However, even if the term *integration* has become problematic for some and completely dismissed by others (Jeeves & Ludwig, 2018), we continue to find it useful. We use the term *integration* to describe an overarching project in which there are numerous methodologies/viewpoints or models. We offer this as a *hermeneutic of hospitality* that allows for different emphases, approaches, methodologies, and foci, including but not limited to particular issues of diversity. For example, we would recognize all five views in Eric Johnson's (2010) *Psychology and Christianity: Five Views* as

methodologies of integration. We would conceptualize non-tradition-specific forms of spiritually integrated therapy also as integration (e.g., Pargament, 2011; Pargament & Exline, 2022; Griffith & Griffith, 2002; Sperry, 2012). And in certain ways we would also conceptualize the research done in the psychology of religion as a form of integration, while recognizing its limitations in terms of theological contextualization.

WHAT WE MEAN BY *INTEGRATION*

As mentioned above, the term *integration* has suffered in part due to the elastic way it has been used. As noted, it has been used to describe everything from the psychological science of studying Christian constructs to the integration of psychotherapy theory and spiritual formation. It has been stretched to the breaking point. No one term can bear that much weight or cover such diverse terrain. Out of frustration, as we indicated earlier, some have advocated giving it up. Rather than disposing of the term, however, we argue for greater specificity in its use. We think integration will benefit by articulating which psychology (which subdiscipline in psychology) and which theology (which theological tradition) are in dialogue. Integration cannot mean the same thing or look the same way when conducting empirical studies on religion as it does when working clinically with faith issues.[4] *There can be no grand unified theory of integration*. We argue that clinical integrative practice must be more specific, more process oriented, and more contextualized. Even with all the necessary specificity and complexity, integration *matters*, and in this book we will offer specific areas of reflection that matter to the overall process of clinical integration.

[4]In this sense we share some affinity with Hathaway and Yarhouse (2021) and their idea of domain-specific integration.

Before elucidating our contextual process model of clinical integration, we must first clarify our conceptual view of *integrative thinking*. We are guided by three process models of integration: Warren Brown's (2004) resonance model, Alvin Dueck's (2002) cultural linguistic model, and Steven Sandage and Jeannine Brown's (2018) relational model. As noted above, there is a difference between models that describe *what* integration is and models that describe *how* or the *process* of integration. These three models are dialogical in nature, engaging with numerous conversation partners that are all in play simultaneously: theology, psychotherapy (theories and empirical work), and client and therapist/counselor.[5]

Brown's (2004) resonance model, which emerges from a Wesleyan theological perspective and uses, with modifications, the Wesleyan quadrilateral, is particularly helpful when thinking conceptually about the integration of multiple epistemologies. Brown suggests that integration is ultimately an attempt to illuminate truth, and in doing so one should use five domains of knowledge: science, reason, experience, Scripture, and tradition. (1) Science is the domain of empiricism, and here the integrator uses both traditional academic research methods and the canon of empirical findings. (2) Reason is the domain of philosophy and logic. (3) Experience is both our direct personal experiences and the experientially accumulated wisdom of a community (e.g., Proverbs or accepted clinical wisdom). (4) Scripture is the holy texts of a given faith and its particular hermeneutic for interpretating those texts. Finally, (5) tradition is the historical accumulated wisdom, practices, and held knowledge of a given theological community.

[5]We'd also like to acknowledge Neff and McMinn's (2020) important work on embodying integration. We experience high levels of resonance between our approach and their emphasis on the dialogical nature of learning integration.

Brown (2004) suggests that when these sources of knowledge find synchrony with one another, truth becomes clearer. When there is ongoing confusion, desynchrony is implied. Integrators must return to the individual domains to fine-tune their interpretation until synchrony is achieved. Brown notes that not all domains have equal input on all truth claims. For example, the Bible has little to say about neuroscience, while neuroscience has little to say about morality. This model is respectful, as each domain retains its own integrity; it is not collapsed or reduced into any of the others, and the interactive impact of the process creates opportunities for fine-tuning or reinterpretation in each domain. Brown's model allows us to put our clinical theory and science into dialogue with Scripture, theological tradition, reason, and experience in a manner in which these are not incompatible but cooperative. This model is collaborative, as synchrony does not equate to sameness or the absence of tension, mystery, or uncertainty. It also doesn't mean the absence of conflict or times of confusion in the process of clinical work. Rather, synchrony allows for a complex engagement of information from multiple dimensions of experience, which allows for flexibility and responsiveness to the uniqueness of each clinical situation.

Second, our integrative approach engages Dueck's (2002; Dueck & Reimer, 2009) cultural linguistic model of integration, which is a culturally informed model. Dueck suggests that the disciplines of theology and psychology be conceptualized as cultural languages. As with any language or culture, each has its own semantics, syntax, norms, customs, practices, and even jokes. To become a proficient integrator is to become bilingual as well as a kind of cultural anthropologist. The goal is not to make one new, hybrid language, or to force one culture to submit to the other, but to engage in a dialogical process in which both may be truly affected.

This requires the integrator to embrace code-switching (adjusting one's behavior to fit the context of the other). Like Brown's model, Dueck's upholds the integrity of each discipline while pressing the integrator to look deeply into context in the same manner as one doing crosscultural investigations. For Dueck, there is neither solely one psychology nor one Christianity.

Finally, this leads us to Sandage and Brown's (2018) relational model of integration. These authors first remind us that disciplines don't integrate; people do. For this reason, they base their model on a differentiated relational framework. In order for effective integration to occur, integrators high in self-differentiation are clear about their own selves, their disciplines, and the limitations of both.[6] Integrative work, which they conceptualize as interdisciplinary work, naturally raises anxiety as psychologists and theologians will recognize the limits of their respective knowledge in their own and the other discipline, and may feel anxious and even ashamed for what they don't know. A self-differentiated integrator will hold on to herself in the midst of this anxiety, respecting the other, not collapsing categories, not overreaching with their discipline, and avoiding defensiveness when challenged. They liken this to intercultural competence and humility, in which one faces differentness without anxiety or defensiveness. In other words, integration requires a secure sense of self.

At first glance it may feel confusing to engage multiple models when conceptualizing integration, but we believe this speaks to the complexity of the task. Brown's (2004) model provides a heuristic

[6]Sandage and Brown (2018) define differentiation of self as the capacity to integrate one's personal thoughts and feelings, and manage intimacy and autonomy in interpersonal relationships. Because integration is a relational process involving persons operating from places of difference (i.e., disciplines), conflict is inevitable. Integrators with high levels of self-differentiation will neither deny difference nor make it the main focus. The self-differentiated integrator will be able to manage the anxiety of these conflicts related to difference through balancing thinking and feeling as well as intimacy and autonomy.

of how the five domains might interact (i.e., integrate) when searching for truth. The approach clarifies that our interpretations of these domains inevitably and necessarily interact. While each domain maintains its own methodology and expertise, it is through the reciprocal influence of the domains where the pursuit of truth occurs.

Dueck's cultural model reminds us of the uniqueness of each discipline and, most importantly to us, to avoid the colonialism in which one discipline usurps the other, engaging in a kind of cultural violence. It also reminds us that disciplined disciplinary competence is the goal.

Finally, Sandage and Brown's (2018) model pushes us to consider ourselves in the integrative process. While other authors have pointed out the importance of the person of the integrator, usually this is related to one's spiritual maturity (Coe & Hall, 2010). Sandage and Brown advocate a psychological model of self-differentiation of the integrator. Integration will be greatly hampered (conceptually and clinically) if the integrator is overly anxious or defensive. She must work to develop a secure sense of self, which includes ownership of her expertise and of her limitations and social location. Self-differentiated integrators will be equipped to manage their anxiety and defensiveness rather than collapsing into either-or thinking, pathologizing those who are different, and shutting down what might be ultimately a constructive conflict.

Again, we believe that these three models are process models of integration directly bearing on clinical integrative practice. They don't just tell us *what* integration does or looks like but actually make suggestions for how to go about it in the clinical room. Integration, even clinical integration, will not be able to fully escape some form of model work. Yet we hope to demonstrate a way of thinking that incorporates how-to aspects, deeply respects

both disciplines, sees the personhood of the integrator and client as paramount, and gives enough freedom to engage in all the various intersectional complexities at work in the room (e.g., culture, race, nationality, different religious backgrounds, gender, sexual orientation).

WAVE FIVE: CLINICAL INTEGRATION

With all the above in place, the focus of this book is on what we refer to as *clinical integrative practice*, by which we simply mean all that occurs *in* the clinical encounter when religious faith is considered. This rather large pseudo-definition is purposefully broad for reasons we hope will become clear. It is broad because we don't want to prescribe integration or reduce it. In this sense we follow thinkers such as Siang-Yang Tan (1996), who suggests that integration can be implicit or explicit. For Tan, in implicit integration, the therapist's religious commitments inform their work in offline ways. For example, a clinician may pray silently for clients during or in between sessions, but faith, holy texts, and so on are not discussed overtly. In explicit integration, the therapist and client overtly discuss religion, faith practices, and important resources from their faith tradition, which may be helpful or may have been hurtful. We agree with Tan that explicit and implicit forms are not mutually exclusive. Therapy may move back and forth between explicit and implicit integration following the lead of the client, the clinical process of the session, and/or personal preferences of the counselor.

However, we would expand Tan's discussion by suggesting that implicit integration processes also operate unconsciously, beyond unspoken or unreported ways the therapist or counselor thinks about the client during or between sessions. We will talk more about this in the proceeding chapters, but we believe the implicit/

unconscious way integration influences our clinical work is a powerful, often unacknowledged process that may take time to enter awareness, for both therapist and client. For instance, why do therapists or counselors find themselves praying (e.g., silently in session or between sessions) for some clients and not others? If a therapist is praying for the client, does the client have a right to know? Why would this be a secret? Why do spiritual themes or ideas come to mind at one point in a session or treatment and not earlier, later, or not at all? Clearly, we can see that the process of spiritual or religious material entering the conscious deliberation of the therapy participants is multidetermined and complex.

In contrast, we are *not* advocating that integration is a kind of biblical counseling (Adams, 1970; Powlison, 2010), where the Bible (as much as we value it) is the main or only source of knowledge and intervention. Neither are we advocating for a kind of therapy in which religious resources *must* be used, invoked, or even discussed. There are many settings where religious therapists practice that do not allow for explicit integration, but as we hinted at previously, we adamantly believe that this does not mean integration is not going on.[7] As Christians in the Wesleyan tradition, we believe that God's Spirit is always at work in the world, wooing creation to God's self in both secular and religious settings.

OUR APPROACH

So, let us put our cards on the table. We advocate for integrative clinical practice not as a classic *what* model, an outcome, or even a process but as an *emergent* property. *In other words, integration emerges out of the nonlinear complex dynamic system that is the*

[7]We believe, as many now do, that religion must be understood as inextricably entangled with culture. In this sense it would be unethical to not allow the discussion of religion in therapy in the same way that it would be unethical to ignore culture, gender, or sexual orientation.

specific configuration of a unique therapist and client dyad. That is, something uniquely integrative (i.e., religious, spiritual) occurs within and because of the particularities of the client-therapist relationship and cannot be prescribed or reduced to something as simple as an intervention. This means that a therapist or counselor *can't* predict what integration is or what it will look like before it is experienced within the integrative moment. Neither can a therapist decide a priori what is a satisfactory integrative outcome.

What integrative clinicians *can* do is place themselves in the complex therapeutic environment in which integration may emerge. *We believe clinicians can develop sensibilities that are receptive to integrative moments.*[8] In this sense we find great affinity with Kenneth Pargament's (2011) spiritually integrated therapy (SIT). Pargament is clear that SIT is not a model of therapy but a way of being with a client such that spirituality may be included in the work. His approach, like ours, can be used with many different types of therapy models and theoretical orientations. It primarily calls for a certain kind of openness and, as we noted above, a dynamic system. In addition, we see the clinician's theory as constructive in the integrative process. For example, those who subscribe to a more cognitive-behavioral model will experience integrative moments of a different quality from those who lean toward a more psychoanalytic or systems perspective.

What do we mean by a *nonlinear complex dynamic system* and a *complex-enough environment*? Complex dynamic systems theory is a way to understand how exceedingly complex capacities (such as human development, mind, personality, relationality, spirituality,

[8]Our use of the term *integrative moment* is an allusion to, and in the spirit of, the work of developmental psychologist/psychoanalyst Daniel Stern (2004), who suggested the critical value of present moments in clinical work, as well as the Boston Change Process Study Group (2010), who highlighted the idea of moments of meeting as critical to therapeutic action, progress, and change.

or in our case integration) can emerge from the myriad ongoing interactions of highly complex systems (Thelen & Smith, 1994). Brains, ant colonies, economics, biological organisms, and human societies are all good examples of nonlinear dynamic systems from which new properties emerge. We conceptualize integration in the clinical practice setting emerging not from a specific way of doing something (e.g., a model), nor from invoking God's name and spirituality into the room (this would be like saying that thinking emerges from a single neuron). We believe integration emerges through the complex relationship of client and therapist intertwined in numerous and varied interactions (in both conscious and unconscious embodied ways). Even clearly explicit attempts by a therapist to invoke spiritual practices or conversations in a session cannot be fully scripted but may emerge from the way the client responds to the therapist's initiation.

Complex dynamic systems theory explains how new capacities emerge. Complex systems are self-organizing and context dependent. They are sensitive to ongoing feedback from internal and external input, allowing them to reorganize when faced with new experiences that threaten the equilibrium of the system (in dynamic systems theory these are called "catastrophes" or perturbations). For example, human persons are complex dynamic systems capable of self-organizing, which means they too can reorganize in the face of new input (this reorganization is a potential, not a given). However, because complex systems self-organize in dynamic ways, different components of the system act, create, and influence other components of the system to experience different states such as symmetry, confusion, stability, reorganization, and the like. For example, in human development we now know that infants are not passive respondents to the parent's care but actively cocreate, albeit with less sophisticated means, the caretaking

environment as parent and infant teach each other and shape the nature of the relationship. The form of this relationship cannot be predicted ahead of time except in broad categories that say little about the specific characteristics of a given parent-child relationship. Change in complex systems is discontinuous, context dependent, jerky, and unpredictable (Weisel-Barth, 2006). Just like a parent-infant or any other human engagement, therapy relationships are created in the meeting of client and therapist. The developmental trajectory of this relationship and what emerges from this relationship are bounded by various contextual factors but are not predictable in specific ways.

Our above assumption that clinical integrative moments emerge and cannot be predicted, scripted, or modeled out may feel discouraging and even overwhelming. If you are a student at an integrative psychology, marriage and family, or counseling program, you have spent money and time and chosen your school, we suspect, to help you integrate. If you are a clinician who has bought this book, you were expecting some answers or at least some help. We encourage you not to despair. Not only do we believe that this way of experiencing clinical work will lead to more meaningful client-specific integrative moments, but we also believe there are practical ways to assist with this. This brings us back to complex systems. The degree to which emerging integrative moments come to fruition and affect the treatment in meaningful ways will depend on creating a *complex-enough* system. How do we develop, as noted above, the sensibilities for this kind of emergence to occur and to be noted by the therapeutic dyad?

Analogy from spiritual development. Here we draw on an analogy from the realm of spirituality. It is commonly accepted that one can't create or force spiritual experiences to occur. Rather, a spiritual seeker places oneself in a context in which spirituality

might naturally emerge. This is often accomplished by placing oneself in a particular type of *setting* (e.g., church or retreat setting, place of solitude) and engaging in particular types of exercises or *practices* (again, these may be communal or solitary, but their aim is to be attuned to the moving of the Spirit). All of this is undergirded by a particular type of *mindset* (i.e., a belief that the above is facilitative of spirituality, a general openness).[9] These *settings*, *practices*, and *mindset*, cooperating with the Spirit of God and the complexity of the human person, allow for the possibility for something spiritual to emerge.

We contend that psychotherapy or counseling, with its attendant *setting*, *practices*, and therapist *mindset*, may (or may not) create a *complex-enough environment* for the emergence of something spiritual and integrative to occur. When it comes to the practice of psychotherapy and counseling, we believe the first two necessary elements, setting and practices, are already in place. The third element, mindset, we believe needs some further elaboration. We contend that five domains of knowledge may inform the therapist's mindset and keep him *thinking integratively*.[10] This is the development of a certain type of integrative sensibility. This is thinking integratively. This mindset, in tandem with the setting and practices of therapy/counseling, allows for maximum dynamic complexity, which is essential to the emergent integrative experience. We will have much more to say about these five domains below (each domain will have its own chapter), but for the

[9]It is important to note, as we will throughout the book, that we believe that all of life, cognition, affect, behavior, and even spirituality are embodied experiences. We think, feel, behave, and are spiritual in and through our bodies. Even God's Spirit is mediated to the human through our bodies. We disavow any kind of disembodied spirituality.

[10]Originally this book was to be titled *Thinking Integratively*, but we felt that this would mislead the reader that what we were suggesting was a cognitive endeavor. Rather, when we say *thinking*, we mean a completely embodied experience (including feelings and emotions), in line with the philosophers of mind who write about embodied cognition.

time being let us simply list them: hermeneutics, tradition, ethics, self-development, and resilience.

An emergent model of integration? An emergent model that is nonlinear and highly complex demonstrates that predictions, regularity, and control in therapy/counseling are illusory. We suspect that as the reader travels through this emergent *model*, they may experience a certain level of anxiety. Part of this comes from the very reason we italicize the word *model*. Models of integration tend to evoke a more static image than we intend. As mentioned above, a dynamic system is a self-organizing system. Like in human development, it may continue to evolve and move to (hopefully) higher levels of complexity and organization. When the client at the beginning of this chapter asks, "You're religious, right?" he sets in motion a process that affects the therapist and client in conscious and unconscious reciprocal ways, within the complexity of the setting and practice of the therapy. For example, as a particular integrative moment emerges from the complexity that is therapy, this new experience will have a causal impact on the therapeutic dynamic and subsequently an opportunity for continued reorganization in a kind of ongoing reciprocal feedback loop. While we believe this movement or dynamic is a much more accurate description of human persons and therapy, it can be anxiety provoking for those clinicians looking for answers on *what to do* and/or signs that they have achieved integration.

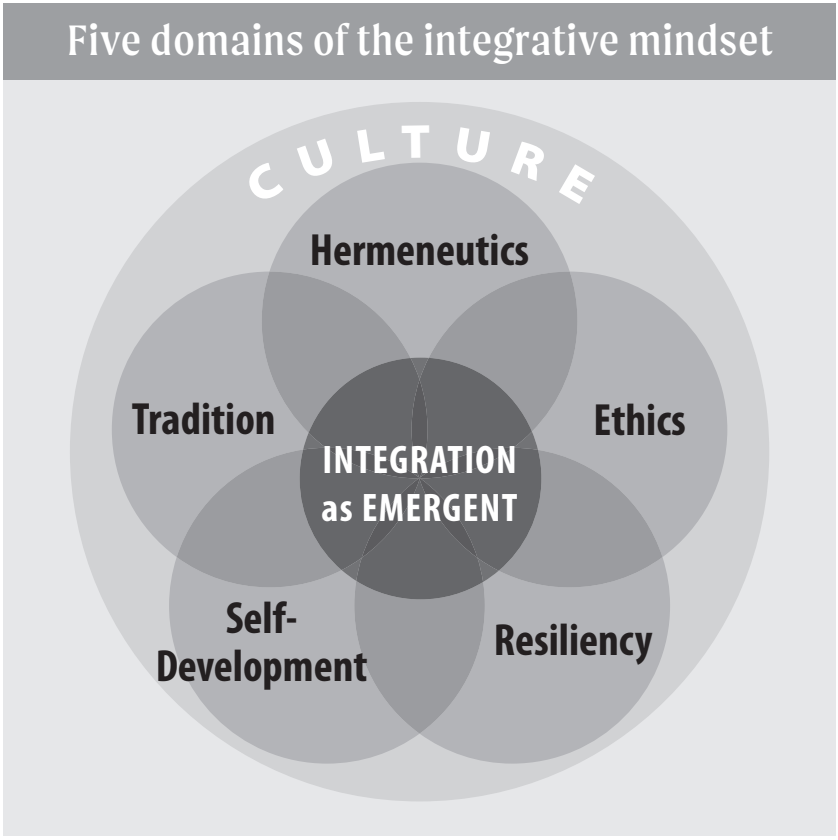
Imagine this example: You are seeing a client who has always believed that God's sovereignty means that God has complete foreknowledge of all things and subsequently has preordained all things that happen. While the client might not phrase her beliefs in quite this way, one might hear phrases such as, "All things happen for a reason" or "God is in control." When the client is

faced with a personal tragedy, in complex dynamical systems language a *catastrophe*, she may either reorganize and begin to understand God's interaction in the world differently, or she may cling tightly to her familiar way of believing. If something new emerges for the client, such as, "Perhaps God doesn't cause tragedies in the world or prevent them," this new emergent idea may begin to affect other modes of inquiry, such as, "How do I understand the Bible?" and "What is the role of prayer?" The therapist and the client cannot predict ahead of time what particular integrative issues will emerge or how they will be organized consciously and unconsciously by both therapist and client.

But let us be clear: we are also *not* saying that it is the therapist's job to try to force emergence. In the above scenario, the client *may* choose to continue to believe that God has ordained all things beforehand. The therapist's job, as always, is to respect the client's particularity, which stems from their history, social location, and theological tradition. If the client chooses to continue to believe that God controls everything, it would be the therapist's responsibility to help her explore how she can or cannot accommodate the new experience (i.e., catastrophe) into her current belief system without considerable internal conflict. We will say much more about this in the coming chapters, but this is a good example of where the therapist's knowledge of their own and their client's hermeneutical way (chapter two) of seeing the world, as well as their tradition (chapter three) and ethics (chapter four), are essential in working sensitively and respectfully with clients.

These five domains (hermeneutics, tradition, ethics, self-development, resilience), which form the *mindset* of the complex dynamic system, are also useful when working with individuals who claim nominal faith, a different faith from the therapist, or no faith at all. Remember, emergence implies that one cannot decide

a priori what integration will mean or look like, or where it may end up. We have both had experiences of working with clients from different faith traditions from our own who deepened in their own tradition, or working with individuals from our own faith traditions who changed or left their faith, and even individuals with little or no faith but whose needle was moved ever so slightly toward a greater faith or spirituality. From our perspective, *all* of these are emergent integrative moments.



Why does this matter? We said at the outset that we hope that this book speaks to practicing clinicians and graduate students interested in the integration of clinical/counseling psychology and

religious faith. We need to reiterate that we believe there are also potentially negative consequences for ignoring our proposed project. To graduate students, understandably desperate to find *the* model of clinical integration, there is a danger that you will be tempted to find a one-size-fits-all model and apply it in ways that miss the intersectional aspects of your clients (differences around religion, gender, culture, sexual orientation, etc.). While it may be hard to imagine, this is a kind of imposing or therapeutic coercion, leading not only to misunderstanding your clients but in fact doing violence to them (Dueck and Reimer, 2009).

An additional danger for those of you who are licensed and practicing is the supervisory influence you may have on fledgling clinicians. If we believe in the supervisory concept of *parallel process*, where what happens in the therapy setting can be unknowingly recreated in the supervisor setting (Sarnat, 2019), we must also believe that it can move in the opposite direction as well (from supervision to therapy). Awareness of these five domains may help a supervisor interested in encouraging integrative capacities in their supervisees to recognize and cultivate emerging integrative moments in the treatment. Ignoring the five domains may create an unsound integrative situation in supervision that plays itself out in untenable ways in the supervisee's work with his client, leading to enactments, stalemates, and premature terminations.

CONCLUSION

In this chapter we have attempted to describe our *integrative clinical perspective* as a process of developing clinical integrative sensibilities within a complex dynamic system made up of the therapeutic setting, practices, and therapist mindset. This system further interfaces with the particularity and complexity of the unique therapist-client dyad, creating a complex-enough setting

for integration to emerge. Because dynamic systems are self-organizing, what emerges cannot be predicted from the sum of the parts, reduced to a priori goals, or predicted or prescribed ahead of time. While this can be anxiety provoking, from it may emerge something holy and wholly unexpected, delightful, and even life transforming. Important in our process is the assumption that the Spirit of God is constantly and pervasively operative in our attempts to form a healing clinical relationship.

We also assume that any thinking about the integrative process and experience, whether in the form of theories, justifications, or empirical research, is susceptible to the effects of sin in a fallen world. Consequently, even in our best efforts, how we think about integration clinically is prone to error and distortion. Sincerity of belief and personal conviction are not foolproof guarantees that our integrative efforts will actually align with what God is desiring in the process of our work with clients. We say this in order to infuse a modicum of humility and wondrous expectancy into our pursuit of integrative moments rather than certitude or reliance on the power and privilege of our training and knowledge. Negative integration is a possibility; in other words, discussions and uses of spiritual or religious processes in treatment are not necessarily virtuous or enhancing of therapeutic action, growth, and progress. In clinical integrative practice disintegration is an ever-present possibility; it is important to remember that good and bad can emerge from a dynamic system.

Now we turn our attention to the five essential domains in making up the mindset of the clinical integrative practitioner. Integration matters, and these are the matters that form the mindset that may create the space for integration to emerge. We hope that as you the reader take in these matters, you will be not only better prepared to work with the client's question at the beginning of the chapter but also excited to do so.

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