

# Reflective Practice and Faith Integration: An Example from Psychology That Can Be Applied Across Disciplines

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*Although faith integration has been part of Christian ministry and pastoral counseling, it has not been included as much in clinical research, training, and practice in psychology, secular counseling, or most health professions. Reasons for exclusion include secular ethics and licensing criteria, but Christian faith can inform research and professional practice—even in secular contexts. Previous authors have discussed the integration of faith with medical practice: in some settings, using providential intervention; and in eldercare, using religious coping. This article extends that work to consider faith integration with reflective practice. Sacrifice of one's own perspective to peer inside the worldview of another, for the sake of healing, not only provides pragmatic improvements to care, but also correlates with God's commandments to love one another. Relevant techniques of reflective practice increase the quality of care given by all healthcare professionals. Many faith-integration techniques presented in this article can be applied to disciplines across the arts, sciences, and humanities.*

**Keywords:** reflective practice, psychology, faith integration, adult hydrocephalus, case study

## A Faith Divide: Pastoral Counseling versus Psychology and Secular Counseling

Historically, pastoral counseling and Christian ministry have included the integration of faith in training and practice.<sup>1</sup> Psychology, secular counseling, and healthcare professions have not. Clergy and pastoral counselors have many tools for infusing their work with lessons from scripture and theology.<sup>2</sup> Among the supports for their work was the American Association of Pastoral Counselors (AAPC), which provided continuing education and resources; AAPC merged with the Association for Clinical Pastoral Education in 2019, to pool their efforts in supporting faith integration in pastoral care/counseling.<sup>3</sup> The same cannot be said for secular counseling and psychology or for the healthcare profes-

sions, which have maintained boundaries between a professional's faith journey and disclosure about it in therapeutic and research environments. For example, codes of ethics in secular counseling and psychology generally prohibit practitioners from discussing personal values and views, such as faith, with their clients.<sup>4</sup> While there is an organization to support Christian faith integration in psychology

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and counseling, less than 1.5% of all licensed psychologists in the United States belong to it.<sup>5</sup>

Secular medicine and health care are similar to psychology. Medical ethics advise against sharing one's faith in medical practice, but a small proportion of medical professionals do belong to organizations with a Christian mission in medical care.<sup>6</sup> Moreover, a few Christian scholars have indicated opportunities and needs for training physicians to integrate faith into their work within faith-based health networks,<sup>7</sup> and others have emphasized the importance of collaborations between stakeholders in client care (secular collaborations, which could be expanded to include faith-integration).<sup>8</sup> Overall, in psychology, secular counseling, and health care (henceforth referred to as "clinical practice and research settings"), there is a "faith divide" between religiously affiliated contexts and secular care settings in terms of the integration of faith, but we propose that Christian clinicians and researchers *can* integrate faith without violating their professions' codes of conduct, even in secular environments.

For professionals who are active Christians, Christ must be at the center of everything—whether work or leisure. Yet, in secular research and practice, one may struggle to integrate faith while observing the practice ethics of her or his profession. How can one fully integrate faith into work with clients and research participants? Previous writers have integrated faith with medical practice, providential intervention,<sup>9</sup> and religious coping in dementia care.<sup>10</sup> The present authors propose reflective practice as a means by which Christian values and secular expertise can be considered together in ways that increase self-awareness, heighten understanding of others, and improve care. An illustrative case follows to indicate how faith can be integrated, even in secular research and practice. Before we describe that exemplary case of reflective practice, we will briefly recount prior contributions to faith integration in our field (psychology).

### Previous Work on Faith Integration in Psychology and Related Fields

Integration of faith and psychology is not a new concept, as previous authors have identified avenues for it to occur. Heather Looy expanded upon the connection between science and a faith-derived

worldview,<sup>11</sup> but identified a barrier between clinician and client when she stated:

Science and scientists are given great authority and power in modern Western culture ... the culture of psychology convinces its students that these worldview beliefs are objective, verifiable truths. Yet as long as psychologists claim that they can discover fully objective truths about human behavior, they risk failing to notice the limits and distortions of their knowledge and close their minds to other potentially fruitful ways of coming to self-understanding. The refusal to acknowledge that everyone has a "view from somewhere" also creates difficulties for Christians who engage psychological science expressly from a Christian worldview.<sup>12</sup>

The authority in clinical practice and research settings, in combination with a Christian worldview, can be misused. A clinician could intentionally or mistakenly let a sense of power and/or expertise interfere with client progress. The potential consequences of such integration are explored by D. Russell Bishop in his article "Integrating Psychology and Christianity: A Biographical Sketch of Mary Stewart Van Leeuwen."<sup>13</sup> Bishop described Van Leeuwen as critically integrating Christian values into evolving issues of the discipline, and the issues that she evaluated were "at the heart of psychology."<sup>14</sup> The connection between knowing right and doing right was a balance portrayed by Van Leeuwen (that is, following the processes delineated by Kirk E. Farnsworth<sup>15</sup>), and Bishop noted this as "a valuable strategy for other Christian professionals no matter what their discipline may be."<sup>16</sup>

David Myers, in his article "Yin and Yang in Psychological Research and Christian Belief," stated that the clinician should give a form of grace, where the client can feel accepted and free from the requirements for any achievements or prestige.<sup>17</sup> This grace is Christ-like because it imitates the grace Jesus showed by selflessly giving his life, without requiring anything from us. A clinician's intent, in a fashion that emulates Christ's, necessitates a person-centered approach. One's focus should be on Christ's will as she or he works to be the Lord's instrument in helping provide care for the client. Being Christ-focused and person-centered at the same time may seem contradictory; the current authors address this in the section about "Rigor and Authenticity," below.

As noted above, pioneers in the integration of behavioral science and faith have identified the influence of one on the other. Walter Hearn stated that psychology must be the “handmaiden of Christianity.”<sup>18</sup> The integral connection between the two manifests as a shared orientation toward clients, those at the mercy of the clinician. Psychology researchers and practitioners alike must make themselves subject to the will of God and his mercy in order to be humbled and serve clients more completely; for example, in 2 Corinthians 10,<sup>19</sup> one finds a combination of authority that comes from working to make every thought captive to God’s perfect wisdom (verse 5) with humility (verse 13) that is appropriate to the specific work that God has set before a person. Furthermore, the letter is person-centered; that is, it is tailored to the needs of the readers in Corinth. In order to make reflective practice subject to Christ, the practitioner or researcher must seek God’s will in humility while considering the confines of the work that God has set before her or him, along with the needs of the client (that is, as in the example in 2 Corinthians, above).

Lauren Seifert and Melinda Baker explored this approach in religious coping with persons with Alzheimer’s disease, in which stakeholder relationships with the practitioner or caregiver are paramount to the success of interventions.<sup>20</sup> They noted key verses in scripture to prescribe behaviors toward clients, with a person-centered approach: Luke 10:25–37 and Matthew 25:34–40 (NIV, below) exemplify the grace given by God:

Then the King will say to those on his right, “Come, you who are blessed by my Father; take your inheritance, the kingdom prepared for you since the creation of the world. For I was hungry and you gave me something to eat, I was thirsty and you gave me something to drink, I was a stranger and you invited me in, I needed clothes and you clothed me, I was sick and you looked after me, I was in prison and you came to visit me.”

Then the righteous will answer him, “Lord, when did we see you hungry and feed you, or thirsty and give you something to drink? When did we see you a stranger and invite you in, or needing clothes and clothe you? When did we see you sick or in prison and go to visit you?”

The King will reply, “Truly I tell you, whatever you did for one of the least of these brothers and sisters of mine, you did for me.”

As Seifert and Baker stated, through the application of scripture, extending Jesus’s love toward others will spread and continue his grace. This love can be taken into clinical practice and research settings.<sup>21</sup>

The aforementioned authors provided a foundation for the application of faith in psychology and related professions. Their work points to uniting Christ-centeredness and person-centeredness in practice. In essence, one can combine two great commandments: “... love the Lord your God with all your heart and with all your soul and with all your strength and with all your mind” and “love your neighbor as yourself” (Luke 10:27; Leviticus 19:18). The present authors have identified reflective practice as a way to explore faith and the person-centered approach in psychological science and practice; this can lead to more-effective application of God’s will in concert with professional expertise in clinical practice and research settings. As was mentioned, faith integration with reflective practice can be applied across disciplines to one’s interactions with clients, patients, research participants, colleagues, administrators, and students, as well as with laypersons.

## What Is Reflective Practice?

The goal of reflective practice is to learn and improve one’s practices (usually pertaining to professional work). This occurs in clinical practice and research settings through dissecting one’s performance and client context. A clinician performs duties and then presents the details of the case to their supervisor or supervisory group.<sup>22</sup> Donald Schön has served as an architect of reflective practice, outlining its organization as relationship centered and intentional.<sup>23</sup> Awareness, openness, and humility are needed to continuously improve one’s practice, and these three are used repeatedly as one engages in reflection on what has happened and how it might have turned out differently.<sup>24</sup> If one does not recognize that an outcome could have occurred differently, that event may reinforce unaddressed biases and perpetuate maladaptive or ineffective behaviors.<sup>25</sup> Reflective practice has been widely used among clinicians and their trainees,<sup>26</sup> but what distinguishes reflective practice from other awareness-based training models such as reflexivity or standard multicultural training? The latter two may be part of reflective practice, but they are not equivalent to it.



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Reflexivity is a research practice for increasing self-awareness to improve cognizance as well as to maintain ethical practice.<sup>27</sup> While the distinctions between reflectivity and reflexivity are enduringly debated, this article's use of reflective practice is differentiated by its target and implementation. Reflexivity involves cycles of practice, evaluation, and improving performance. There are various types of reflexivity, but it is epistemic reflexivity that we find in reflective practice. Reflexivity dwells on what is unknown,<sup>28</sup> while reflective practice dwells on what is known. As a tool in reflective practice, epistemic reflexivity may open one up to further evaluate assumptions, beliefs, perceptions, motivations, and behaviors. Multicultural training is another method akin to reflective practice; however, its implementation occurs before or after reflective practice. This purely educational experience is also limited in its broad scope of application whereas reflective practice can approach the entirety of a unique client-clinician interaction. It is common for reflective practice to include epistemic reflexivity, and it may lead to multicultural training if biases have been exposed which indicate it is needed.

### Our Reflective Process

For us, reflective practice was critical, cyclical, and cumulative as we worked to improve our performance with a particular client from week to week. After sessions with the client, the first author reviewed his notes and consulted with his supervisor (the second author); the goal of these discussions was to evaluate client performance and progress and to expose biases in the first author's perceptions which might lead him to sub-optimal care or errors. Epistemic reflexivity was part of our deliberations, as we repeatedly questioned our perceptions and our motives and the ways that they manifested in actions that affected the client and his care. And this is where faith entered our reflective process. For the authors, an edifying and personal chapter is 2 Corinthians 10, which recommends humility. Our reflection is prayerful, with the hope that the resulting thoughts and behaviors are God's will.

### *An Illustrative Case*

This exemplary case study involved "neurocognitive work" in a twelve-week regimen of memory assessments and cognitive tasks for an eighty-five-

year-old, white male post-surgical participant with adult hydrocephalus (after ventriculoperitoneal [VP] shunt placement). Weekly visits consisted of asking the client/patient/participant (which, for the sake of uniformity and clarity, will be called "client") to state any self-perceived challenges in emotional, cognitive, or physical status; he also completed several trials of a mobile trail-making task. The client was provided (verbally) with a sentence or a counting/math problem and asked to walk to large pages on the floor that represented the word-by-word order of the sentence or number-by-number order of the counting/math problem and its solution. This mobile trail-making task helped the client with locomotion as well as with cognition. Additional exercises included trivia (for example, about age-relevant music titles and apothegms) and making "small talk." The client's surgeon commented that trail-making and similar tasks were "absolutely necessary" for the client's recovery.

The authors engaged in meetings for reflective practice during the weeks of the case study and afterward. Topics for discussion in reflective practice sessions included questions of client assessment, challenges during the client's rehabilitation, and ways to incorporate faith into work with the case-study participant. We began our sessions as Christ-followers with a call to reflection, shown both in scripture (for example, Romans 12:2) and by the nature of Jesus's actions (for example, in the desert, Matthew 4:1-11; and on the Mount of Olives, Luke 22:39-44). Discussions were structured to regard the behaviors of the client, behaviors of the client's spouse (who was sometimes present at sessions, especially at the beginning or end), perceptions and actions of the first author in regard to the client, perceptions of the supervisor, and ways that scripture might inform and assist as we addressed our concerns in relation to all aspects of the case.

An important part of our discernment during reflective practice was the supervisor's use of questioning to help the first author gain insights about his self-awareness and regarding his examinations of his interactions with the client. A vital aspect of the first author's reflective practice was his tendency to apply relevant scripture when conversing about particular elements in the case. Furthermore, both authors were prayerful about their reflections, discussions, and about the first author's interactions with the cli-

ent. We asked the Lord to enter all of our work and improve it. In scripture, God provides general guidelines for our behaviors, and in calling upon him, we asked that this guidance would be specifically and deliberately applied to the first author's case. For us, self-awareness through reflective practice became the bridge between our faith and our work.

Taking the time to be held accountable for one's actions shines light on opportunities to behave more professionally and faithfully. Utilization of reflective practice is an action that not only offers enhanced therapeutic outcomes for clients, but also allows clinicians and clinical researchers to act in a self-sacrificial manner modeled after Jesus's own sacrifice and his commandments. We will refer to the foregoing case description in our discussion of faith integration with secular professional perspectives and practices.

## How Can Faith Integration and Reflective Practice Improve Clinical Research and Practice?

In reflective practice regarding the illustrative case of a participant with adult hydrocephalus, the present authors examined their professional practices and their faith. First, reflective practice must be *regular* and *pervasive* to practically improve outcomes. Research and practice are fundamentally progressive, and there is a demand for efficiency and effectiveness.<sup>29</sup> Therefore, reflective practice serves as a structured learning tool that can be used to improve outcomes. Intrapersonal awareness and interpersonal understanding, as additions to clinical practice and research, are crucial to client outcomes.<sup>30</sup>

In order to assist the reader in understanding how faith integration can happen with reflective practice, below are discussions of three fundamental aspects of clinical research and practice: (1) bedside manner; (2) rigor and authenticity; and (3) professional growth. In turn, each is discussed along with faith integration in the illustrative case.

### *Bedside Manner*

Bedside manner is the etiquette and concern mental health and healthcare professionals show when approaching their client(s). This concept originated as far back as 1869, and it was the literal manner a researcher or clinician portrayed while at a client's

bedside.<sup>31</sup> However, a lack of bedside manner creates a division between client and professional, building a barrier to quick and efficient outcomes. For some clinicians, high expertise may lead them to behave in arrogant or forceful ways. Reflective practice may improve a practitioner's awareness and reduce such attitudes and behaviors. This may increase good rapport with clients and advance understanding. Overall, it may lead to positive outcomes. For example, reflective practice might enhance a practitioner's empathy and her or his ability to assuage client fears. Through enhanced understanding, both stakeholders might collaborate more effectively.

It is common practice for psychotherapists to reflect on their treatment of a client and adjust their behaviors accordingly. However, there is limited literature on applying faith-based values to reflective practice in psychology. While practitioners may have adapted to certain methods of treating clients, using reflective practice *with faith-integration* warrants additional illustration.

In the case of the man with adult hydrocephalus, the current authors went to the participant's home and conducted exercises, assessments, and education. The client was also seeing other health providers: physicians, an occupational therapist, and nursing staff. Through reflective practice, the first author identified characteristics about himself that could be intimidating (for example, large frame, muscular build, youthful [20-year-old] appearance compared to the smaller frames of the octogenarian client and his spouse-caregiver). Careful consideration led to adoption of styles of behavior and speaking that reduced any perceived threat and improved rapport (such as sitting down with the client and his wife, rather than standing over them when speaking). Furthermore, reflective practice included prayer and consideration of scripture that could guide the first author's behaviors when he was next with the client (as mentioned above, Luke 10:27). Together, prayer and reflection led the first author to seek rapport with the client and God's will in the situation, while being attentive to the client's own wishes and fears.

### *Rigor and Authenticity*

Reflective practice serves as a refining technique in clinical practice and research settings, as a professional sifts through emotional and cognitive details in a working alliance. Uncovering these details can

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signal physiological or behavioral changes with specific sensations, and it is important to acknowledge them. In addition, taking inventory of a client's perspective provides subjective clinical indicators. Clients know their bodies best, and ignoring clients' perceptions of their physiological alarms potentially omits key subjective indicators that could assist in treatment. Through reflective practice, a therapist can examine overlooked or invalidated client perceptions or sensations. These evaluations can improve rigor and authenticity in assessment, treatment planning, and practice.<sup>32</sup> While the practitioner may possess enhanced experience and knowledge, and may notice client changes, caregivers' and clients' own abilities to identify changes should not be denied. Hence, consideration of all stakeholders as sources of information will enhance the cooperative experience and may improve care.<sup>33</sup> Reflective practice reinforces self-awareness and assessment skills that help a practitioner to cross-examine clinical interpretation and cross-check it against client and caregiver perceptions.

Regularly seeing a client may have positive effects, such as building rapport, while also negatively affecting the ability to observe objectively. The assumption that certain areas of client recovery are within normal limits can be dangerous to the client's future health. For example, intake and weekly assessments documented a baseline for the participant with adult hydrocephalus, but, after reflective practice, the first author realized that weekly assessments had become more mundane than informative or enriching. Moreover, it appeared that, as weeks proceeded and the client was progressing, the first author was missing important cues to client "backsliding," because he expected that the client was improving. Reflective practice aided the first author to uncover these problems and work toward correcting them. Through reflective practice, the first author identified that he had been overlooking important, potential indicators. Thankfully, the indicators turned out to be unremarkable, and the client's progress continued. Reflective practice allowed the authors to discuss concerns and improve their awareness, which ultimately improved their stewardship and shepherding of client sessions. In addition, the first author developed and honed clinical assessment skills.

Admittedly, there is a complex interplay between seeking Christ's will *and* respecting the free will

that God has given the client (for example, as in Revelation 3:20, where people are invited to "open the door" when Christ knocks). The current authors believe that seeking God's will in reflective practice and attending to a client's free will are both Christ-focused *and* person-centered, because they can involve prayer and thoughtful consideration of what might be God's will for a client while identifying that a client may or may not choose to follow advice (even if a professional has sought God's will and believes that the advice is in keeping with it). Just as in all of life, when another person chooses not to follow what the faith-led professional believes is God's will for her or him, it provides an opportunity for the practitioner's continued prayer and reflection (as indicated by such passages as Jonah 2 and 1 Thessalonians 5:17). In the illustrative case, the authors opened each session with the client by asking him and his spouse to describe their perceptions about how the past week had been and about their goals and desires for the future. This helped the authors to better understand the client and to have specific items/concerns about what to pray for at later reflective practice sessions.

### *Professional Growth*

In clinical and research settings, reflective practice can be implemented in consultation with supervisors before, during, and after a professional-client relationship. These sessions provide opportunities for better preparation, and to receive feedback on not only one's actions, but also on one's emotions and cognitions during client interactions. Such guidance provides opportunities to develop bedside manner, rigor, and authenticity in caring for others. In addition, reflection and feedback should take into account well-known concepts such as counter-transference and transference that can pose threats to a therapeutic alliance in which an analyst emotionally reacts to a client or vice versa. Essentially, one individual in a relationship treats the other according to previous experience in other relationships.<sup>34</sup> Counter-transference is something a professional must autonomously manage. Reflective practice can assist the clinical researcher or clinician to expose parochial views which have developed before or during client interactions.

The first author's experience with reflective practice challenged his responses to the client, whose mem-

ory and ambulatory abilities were different each week. So, the second author challenged the first to recognize the client's perspective and more authentically evaluate him. To do so included moving into the client's viewpoint and engaging empathy. This practice encouraged the first author in self-discovery, in exploration of other people's pain and suffering, and in seeking God's will for his work with the client. This set of actions is not only Christ-like in nature but utilizes key spiritual themes to enable the "healing hands" that practitioners are called to be. For the first author, reflective practice increased humility, and humility improved engagement with the client. Ultimately, this led the first author to improve practice, which led to better outcomes for the client.

## What Is the Foundation on Which the Foregoing Are Built?

The general application of scripture in clinical research and practice can be modeled after the dramatic change in the characterization of God from the Old Testament to the New Testament. The omnipotent God of the universe lost himself to step into life as a human. For example, in Luke 2, in the birth of Jesus Christ, God became a vulnerable infant who needed his parents to survive, and Jesus grew and developed under the tutelage of Mary and Joseph. Why would God voluntarily give up power? It was to bring humanity closer to him. As Christ is portrayed in Mark 10:45, God surrendered his omnipotence in order to show servitude and so that humans could see him as human and relate to him more completely.<sup>35</sup>

Two key verses identify a clear priority for interpersonal interactions that represent Jesus's intent. First, 1 Corinthians 13:13 identifies love as the most important action beyond faith and hope. Love is earlier described as patient, kind, and humble. The passage directly connects to John 15:13 where self-sacrifice for friendship is identified as the pinnacle of love. Thus, if the most important transaction in the world is love, and sacrifice is the ultimate form of love, then that is the priority for Christ-followers. Scripture indicates love's importance and how to carry it out through the actions God calls us to, but "to give up a life" can be accomplished in ways other than dying for someone. Christ-like sacrifice is often regarded solely as sacrificial death for another, such as jumping in front of a bullet to protect someone. However,

the verb "sacrifice" can entail surrender of something important or valued, for the sake of others. Sacrifice includes being willing to surrender one's perspective for the viewpoint of another in order to help him or her.

Surrendering perspective, even if it is an educated one, is an act of meekness, something also highly valued in scripture. Matthew 11:29, Psalm 37:11, and Psalm 25:9 all proclaim the amazing quality of those who are meek. Even if one does not agree with another's worldview, it would be empathic, meek, and Christ-like to step into that perspective. To grasp such a process, one must comprehend that two perspectives can coexist at the same time. One does not have to accept another's perception as truth but can accept the existence and development of the other individual's perspective. Proverbs 17:27 depicts individuals of such understanding and knowledge as nonjudgmental and receptive through listening. This scripture passage can inform the use of Carl Rogers's work, including unconditional positive regard,<sup>36</sup> which provides a "safe space" for a client to explore what is and what might be.<sup>37</sup>

As mentioned, restraining one's tendency to judge and forfeiting the desire for superiority is part of love. Jesus self-limited his godly perspective to experience the perspective of humanity. His sacrifice was like the unconditional positive regard that can be offered to clients; it does not deny the practitioner's expertise or reality, but it empowers a client to know and explore. This may lead to discoveries that move treatment forward as the client builds his or her understanding. However, as was mentioned above, this must include the practitioner's recognition that the client has a will of her or his own that can be exercised and which is God granted. And so, through reflective practice, the clinical researcher or clinician can exercise sacrifice and explore the beliefs, values, and goals of her or his client. The clinician should use both their own professional vantage and the client's perspective to inform their work.

The clinical researcher or practitioner can choose to sacrifice the powerful role in order to better help the client—with humility. In our illustrative case, sacrificing the position of power and seeking God's will led the first author to take the client's perspective and understand his worries and frustrations. On a day when the client miscalculated a math problem in



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the trail-making test, he focused on it and brought it up repeatedly. The first author reflected on this, and it led him to say, “You are right. You did get one of the math problems wrong, but you got many more of them correct. That’s why we are doing these exercises ... so that you can get more of them right every week” (paraphrased). The client looked surprised and responded that he saw the first author’s point. “Oh. Right. That *is* why we are doing this.”

Clinicians and clinical researchers are poised to show God’s love through the aforementioned sacrifices of power and perspective. Galatians 6:2 indicates that to completely fulfill God’s law people must “carry each other’s burdens.”<sup>38</sup> While this can apply to physical burdens, it also applies to the emotional, cognitive, and social burdens of life. Sharing perspectives can improve empathy and rapport with clients, leading them to place more trust in the therapeutic relationship.

### **Ethical Considerations in Faith Integration**

At the majority of clinical sites in the United States, a psychologist or counselor is prohibited or discouraged from identifying personal spiritual or religious beliefs as this may cause transference, counter-transference, or disruption of the working alliance.<sup>39</sup> As such, the clinician or clinical researcher may need to refrain from disclosing details about her or his faith/religion. One can act on Jesus’s behalf without disclosing details about personal faith. One of the first author’s mentors once said, “Don’t force his name on them, but act in the way [of Christ] until they ask you why you behave differently, and that’s when you say his name.” When clients ask such questions, this opens a door for limited disclosure. More importantly, it gives them cause to reflect on the loving, therapeutic behaviors of practitioners who have faith. Among the behaviors that might lead a client to question the reason for a professional’s behavior is faith-infused unconditional positive regard. When one spends more time listening and validating than stating conclusions, and more effort giving empathetic affirmations than wielding social power, then clients wish to know why. Nevertheless, a clinician or clinical researcher must be abundantly cautious about personal disclosures—whether regarding faith or other.

Sometimes, it may be in the best interest of the client not to identify oneself as a Christian. Here, again, is the importance of sacrificing self and exploring a client’s perspective. Some clients may have negative views about terms like “Christian” or “religion” and to identify with them could compromise the client’s trust. For those clients, one can be truthful by displaying Christ in actions rather than in explicit discussion. This manner of introducing Christ into clinical work complies with American Psychological Association mandates while permitting a practitioner who is a believer to live in truth (for example, as in 2 John 1).

Overall, reflective practice allows clinical researchers and practitioners in psychology and related fields to engage in and explore experiences that they have had with clients while considering God’s will for their work. The ways in which a practitioner carries out the actions of his or her professional life provide opportunities to leave impressions of trust and care. The model of Christ is one that involves both washing individuals’ feet and dying for all of humanity (for example, John 13:1–17; Luke 23:26–43).<sup>40</sup> Thus, the example is one that is loving at “micro” and at “macro” levels. The call to be like Christ can be translated into caring behaviors at both levels: for example, offering to hold the door for a client as he or she exits the therapeutic environment; engaging in regular episodes of reflective practice with faith integration in order to seek God’s will for one’s decisions about a client’s care.

In keeping with Hearn’s assertion (mentioned above), science and practice must be subsidiary to the authority of Christ.<sup>41</sup> As God directs those who need healing to those who are prepared to give it, so God should be invited to guide the therapeutic endeavor. To help one’s neighbor explore her or his experiences and move toward healing is part of “loving a neighbor as oneself” (Luke 10:25–37). Reflective practice may serve as an avenue for the practitioner to advance God’s will through human actions. This additional exercise may preserve the working alliance and promote positive treatment outcomes by preventing transference or counter-transference, and enhancing perspective-taking and unconditional positive regard. Reflective practice is a strategic tool for clinicians and clinical researchers to use in order to follow God’s second commandment. Ultimately,



by “loving our neighbors” we are also loving the Lord (Matthew 25:40–45).<sup>42</sup>

## Beyond Psychology and Counseling: Faith Integration with Reflective Practice in Other Fields

The illustrative case in the present article focused on clinical research and practice in psychology and related secular fields. However, as was noted in the introduction, the proposal of faith integration with reflective practice also has relevance to those in other fields such as health care, who can use similar techniques to those proposed here as they prepare for or reflect about sessions with patients, meetings with clients or colleagues, and/or hours of teaching students. Several fields incorporate reflective practice, including psychology, nursing, social work, pharmacology, and education.<sup>43</sup> Indeed, similar methods of reflective practice with faith integration can be used by just about any Christian professional in his or her interactions with other people—whether they are patients, clients, customers, research participants, or coworkers.

When the person of faith tempers the perspective of authority in order to better understand the views and wishes of others, it can be done in ways that seek God’s will and that recognize the free will of “the other.” Ultimately, this can lead the professional to further prayer and reflection regarding the circumstances and to move forward in wisdom (as noted in Proverbs 17:27). When one acts from wisdom, through Christ-seeking, then she or he can trust that God will guide—even when the situation seems dire (as in Jonah 2). Whether one is working in a lab alone with chemicals, in a veterinary clinic with patients and their owners, in a client-oriented field like psychology, or somewhere else, actively seeking God in everything and setting aside time to do so *deliberately* through reflective practice can be a key to infusing faith into one’s work. As George Washington Carver noted when asked about his scientific achievements, his morning walk in the garden alone with God was his way of seeking God’s will and guidance for his scientific work.<sup>44</sup> He stated, “Without God to draw aside the curtain, I would be helpless.”<sup>45</sup> Similarly, professionals across disciplines can endeavor to gain clarity and understanding through regular reflection that is integrated with an invitation for God to guide the way. ◀

## Notes

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# Article

## Reflective Practice and Faith Integration: An Example from Psychology That Can Be Applied Across Disciplines

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