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Healing of Memories: Models, Research, Future Directions

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This article examines several of the more recent models of healing of memories (HM) as they are found in the clinical and pastoral care literature. A wide variety of approaches are present, including models from David Seamonds, Siang-Yang Tan, Leanne Payne, and Ed Smith (Theophostic Ministry). These models are compared and contrasted in terms of an intervention strategy. While few empirical studies on religious imagery interventions currently exist in the literature, available data has produced positive findings. Given these limited results, the need for specific research on HM techniques is advocated and an agenda for such research is proposed.

Increasingly, spiritual interventions have emerged as an area of study in clinical psychology and other healthcare professions. While a variety of interventions have been studied, intercessory prayer and forgiveness are among the most frequently evaluated. Current results have been encouraging (e.g., Byrd, 1988; Freedman & Enright, 1996; Coyle & Enright, 1997; McCullough, Worthington, & Rachal, 1997).

One group of interventions however, inner healing, has seen advances that many clinicians and researchers may not be aware of. These new developments focus on healing of memories (HM) interventions and serve as potential sources of investigation. Such investigations appear to be a natural next step to the empirical explorations of forgiveness and intercessory prayer done in the last decade.

Frequently in the inner healing literature, healing of memories and inner healing are terms used interchangeably. Hurding (1995) defines inner healing as "a range of 'journey back' methodologies that seek under the Holy Spirit's leading to uncover personal, familial, and ancestral experiences that are thought to contribute to the troubled present" (p. 297). This article however focuses on a more narrow definition of healing of memories that seems to fit the work of some of the latest authors (e.g., Seamonds, 1985; Tan & Ortberg, 1995a, 1995b; Smith, 2000a). Healing of memories may be defined as a form

of prayer designed to facilitate the client's ability to process affectively painful memories through vividly recalling these memories and asking for the presence of Christ (or God) to minister in the midst of this pain. While the processing of these memories and the ministry given often take on the form of visual imagery, at times other elements of the client's sense experience predominate.

The healing of memories may be a useful intervention when the client is experiencing trauma-based symptomatology arising from past events such as sexual and physical abuse, rejection, abandonment, and neglect or deprivation (Tan, 1996). Most HM writers place the intervention in the context of ongoing pastoral care or clinical treatment rather than as a stand-alone treatment. The prayer emphasis and explicitly spiritual focus make it an excellent adjunctive intervention to consider for some Christian clients. Several situations preclude HM techniques, at least in the early stages of therapy and sometimes completely. Clients with thought disorder symptoms would be inappropriate candidates for this intervention. These clients need to be distinguished from dissociative disorders, which may be more amenable to such an intervention in combination with a more comprehensive treatment plan (Sandford & Sandford, 1992). Additional disorders that some HM writers recommend caution with include active or early recovery substance abuse, severe depression, and burnout (Sandford & Sandford, 1992). In each of these, timing and comprehensive treatment are essential.

After a brief review of inner healing's history, more recent HM models will be considered. Comparisons between the models will be made, and the current empirical literature on healing of memories will be examined. This update will then

serve to provide a framework for future HM research and theory development.

A Brief History of Inner Healing

Beginning in the 1950's, the ministry and writings of Agnes Sanford (e.g., Sanford, 1950, 1966/1984) began influencing pastoral caregivers from a variety of Christian traditions. These caregivers were soon to be labeled "inner healers." Unlike some biblical counseling approaches which are generally hostile toward psychology, many inner healing approaches actively incorporate principles and techniques appearing similar to psychology, while maintaining a thoroughly Charismatic Christian perspective. Ministers such as Francis MacNutt (1977), Ruth Carter Stapleton (1976), and John and Paula Sandford (1977, 1982, 1985) developed much of their own systems of inner healing from the principles found in Agnes Sanford's writings. Healing of memories was a primary technique she advocated.

Several leaders have emerged in the ongoing development of HM techniques. David Seamonds, a professor and pastoral counselor, has written several books describing his methods (Seamonds, 1981, 1982, 1985, 1988, 1990). One book, his 1985 work, was devoted entirely to healing of memories. Leanne Payne, a pastoral caregiver and prolific writer, has also written extensively about her approach (Payne, 1991). Others who have written on this topic include Siang-Yang Tan (1996) and Ed Smith (2000a).

While healing of memory interventions are now being found in the clinical as well as pastoral care literature (e.g., Tan, 1996; Tan & Ortberg, 1995a, 1995b; Propst, Ostrom, Watkins, Dean, & Mashburn, 1992; Propst, 1996), many clinicians and researchers are unaware of these interventions. This article will highlight several prominent and more recent HM models. Once these models have been compared and contrasted, relevant research will be examined, and suggestions for future research, along with theoretical considerations, will be made.

Models of Healing of Memories

David Seamonds's Approach

Perhaps the best known current author of HM techniques is David Seamonds. He described his intervention in most detail in his work *Healing of Memories* (1988). The description that follows, unless otherwise noted, arises from this work. David Seamonds integrates this technique into pastoral treatment and caregiving and does not

see the intervention as a "stand-alone" type of technique.

Seamonds (1988) takes time to explore the client's situation and minister to him or her prior to considering specific techniques as part of the HM intervention. Great care is taken to make sure the client understands both the rationale and model for this approach. Jesus is conceptualized as the Lord over time and, as such, He is able to minister to our past wounds personally as well as our present condition and future circumstances. Seamonds emphasizes that a great part of the client's distress arises from the wounded child of the past. Thus, HM is one method to allow Christ to minister to the place that needs the most healing.

In preparing for the HM intervention, the client is asked to make a list of the most painful, troubling memories that have been seen as causing the most problems (Seamonds, 1988). These have likely already been discussed in therapy and they need not be written out in great detail. Instead, they provide a brief directional blueprint for the counselor utilizing Seamonds's HM approach. When distorted concepts of God have been apparent in the client's history and previous sessions, the counselor may assist the early visualization process by helping the client find their most comfortable picture of God. Sometimes the clinician may ask, "Who is more comfortable for you to talk to, God or Jesus?" The response then guides the therapist in his or her verbal prayers as well.

The clinician opens in prayer reminding the Lord of divine promises and asking God's Spirit to guide the prayer time. At an appropriate point, the therapist might pray "Now, Lord Jesus, I want to bring before you a little ____-year-old boy/girl named _____. He/She wants to talk to you about some things which have caused a lot of pain. I know you are going to listen. So I bring you _____. Now, _____, just talk to Jesus and tell him whatever is most on your heart" (Seamonds, 1988, p. 142).

At this point, the client begins praying. Time should be allowed for the client to begin. One cannot formalize this process and each session is unique. The counselor can be active and directive, if appropriate, when the client appears too general and appears to be avoiding facing painful issues. The therapist endeavors to help the client relive the original emotions. Coaching and encouraging may take place. Statements such as "Why don't you also tell Jesus what you were feeling when that happened?" or "Don't be afraid

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to let the feelings come up and the sounds come out as you talk to God about that" (Seamonds, 1988, p. 143). Sometimes, if the counselor feels led, prayers using the editorial "we" are appropriate. For example, "O Lord Jesus, You know how we felt, we really wanted _____ to die" (Seamonds, 1988, p. 143). At other times, there may be a lull in the client's prayers. When this occurs, it is sometimes useful to help clarify issues and emotions by asking questions such as "What was it that hurt you so much and made you so angry?" Or, "Is there a word or feeling that the Spirit is giving you about this?" (Seamonds, 1988, p. 144).

When the memory has been explored and the client is in touch with his or her feelings, the clinician might pray, suggesting some imagery of Jesus that matches the specific needs of the client at that time. For example, when dealing with feelings of rejection, the counselor might help the client visualize Christ, the one who was "despised and rejected by men" and who sought to care for people's needs. When dealing with abandonment issues, the therapist might help the client picture Christ as the understanding one because of his experience of abandonment by his disciples (Seamonds, 1988, p. 149).

The HM session ends with the process of forgiveness—forgiveness of others, oneself, and God. Moving forward toward forgiveness is considered key for Seamonds in making the HM technique truly effective. One can only forgive to the depth that one has acknowledged one's hurt. Seamonds's HM technique has that specific purpose in mind (Seamonds, 1988).

As is clear from the above description, Seamonds HM technique often takes more than the typical therapy hour. Accordingly, the therapist should schedule at least 2 hours for this intervention. Once the session is complete, follow-up appointments are scheduled to process the experience and continue the work. Sometimes more than one HM session may occur in a client's course of treatment.

Siang-Yang Tan's Approach

Siang-Yang Tan excels both in Christian integration techniques and cognitive behavioral therapy. Given this combination of skills, his method seeks to integrate elements of sound, empirically tested interventions with an openness to the Holy Spirit's guidance. Tan consistently stresses the importance of assessing the appropriateness of HM techniques in terms of therapeutic alliance, client characteristics (religious and diagnostic), and tim-

ing. While the steps to his approach are described in abbreviated form here, more in-depth descriptions can be found in Tan (1992, 1996) as well as Tan and Ortberg (1995a, 1995b):

1. Open with prayer for God's healing and protection for the client during the session.
2. Conduct a brief relaxation training to help the client relax as deeply as possible.
3. Ask the client to go back to the past traumatic event in imagery (if possible) and relive it.
4. Following sufficient time, pray again, asking God to come and minister his healing grace and love to the client in whatever way is appropriate or needed. No specific guided imagery is provided, unless it appears necessary and useful.
5. Quiet, contemplative waiting occurs to allow God to minister, and, at an appropriate point, the therapist asks, "What's happening? What are you feeling or experiencing now?"
6. After enough time and processing has occurred, the intervention ends in prayer, usually by both the client and clinician.
7. Debriefing and discussion of the experience follow.

Tan (1996) notes that this intervention technique will eventually lead to dealing with forgiveness issues with the client.

Leanne Payne: Practicing the Presence of God

For over 25 years, Leanne Payne has been active in the healing ministry. She is the founder and president of Pastoral Care Ministries, which provides healing conferences in the U.S., Canada, and throughout Europe. An artistic and creative writer, Payne's approach to soul restoration defies categorization into clearly operationalized constructs and methodology. Various Christian themes are woven together to create a unique tapestry of soul care.

For example, vital to Payne's approach to ministry is the concept of incarnational reality. In Christ alone we find our true self, our true identity. With God living within us, according to Payne, we are linked to ultimate truth and ultimate reality. To be a Christian means that we are "born from above." Christ, the Hope of Glory, is the other who lives within each Christian. This understanding and awareness that we are in Christ and Christ is in the Father, is key to embracing the nature or position of our true selves. By abiding in Christ, we embrace the

essence of who we are, and therein lies the potential for healing in every aspect of our being (Payne, 1995a, 1995b). Like other approaches, the healing of memories within this ministry addresses painful events from the past; however, from Payne's perspective, healing takes on a far greater dimension than that of mending old wounds. The totality of an individual is ministered to by the presence of God and the awareness that "another lives in me." Jesus meets the individual at the point of whatever need may exist.

"To speak of prayer for the healing of the soul is, primarily, to speak of prayer for releasing someone from psychological sickness and emotional pain due to hurts and deprivations of the past. Prayer for healing of memories is in this category" (Payne, 1991, p. 70). The healing of the soul takes place in the light of incarnational reality, or the understanding that a complete, whole place exists within the person. It is in practicing the presence of Christ within, that an individual receives the affirmation and confidence of God as their Healer.

Within this approach is the understanding that brokenness within any area of our being, whether it be body, soul or spirit, is connected with the conscious or subconscious consequences of sin. "The truth is that any wound to the soul so deep that it is not healed by our own self-searching and prayers is inevitably connected with a subconscious awareness of sin, either our own sins or our grievous reactions to the sins of others" (Payne, 1991, p. 68).

In another unique aspect of this approach, the healing of memories is considered almost synonymous with the forgiveness of sin. Three barriers to personal and spiritual wholeness in Christ can exist and the individual ministering God's healing presence assists in the hurdling of these barriers during ministry times. Payne (1991) defines these barriers as, "the failure to gain the great Christian virtue of self-acceptance, the failure to forgive others, and the failure to receive forgiveness for oneself. Every time we more fully understand and accept our true identities in Christ, forgive another, or confess a sin, barriers to our becoming mature disciples ... fall down" (p. xiii). Again, the importance of Christ ministering to the totality of an individual versus one aspect of his or her being is seen. It is important to note that this intervention is placed in the larger context of Payne's other Christian growth and restoration themes; thus, this prayer time is not

considered a separate technique but rather one of many steps in the ongoing process of personal wholeness and growth in Christ.

The time set aside for healing ministry begins with the invocation of the presence of the Lord such as "Come Holy Spirit come, give us the eyes to see what you see and the ears to hear what is really going on in this individual." Listening prayer, which is related to the gifts of the Holy Spirit, is a vital aspect of the prayer time. The Spirit of the Lord works through humble vessels, speaking wisdom and knowledge of the situation. The prayer minister endeavors to follow God's leading. Individuals are brought through confessional prayers. Following the confessional prayers, forgiveness is proclaimed and the person is released from the bondage of sins committed against and by him or her. The healing presence of Christ flows to the wounded areas of the soul, bringing restoration and wholeness.

Theophostic Ministry

Theophostic ministry was developed by Ed Smith in the mid 1990's. Whereas Leanne Payne's approach might be considered the least operationalized of the more recent models discussed, Smith's model appears to be the most operationalized. Detailed basic treatment manuals and client manuals are available (Smith, 2000a, 2000b). An advanced training seminar is also offered. The basic technique involves a series of steps noted in Table 1.

Clients are prepared for the theophostic approach both by therapist dialogue and the manual written for them. Once the process is understood, the therapist listens for key words in the client's story that may suggest links to pertinent client history. The therapist may reflect back these words in order to generate further client affect. Using a process similar to the affect bridge technique, the clinician asks the Lord to take the client to the place where these feelings and maladaptive core beliefs originally came from. The client then usually drifts to a memory (or memories) related to the emotions and cognitions.

It is at this point that theophostic ministry significantly differs from the other HM approaches noted. A unique "exposure protocol" is utilized. The clinician focuses on exploring in more specific detail the maladaptive core beliefs that are generating affective intensity. Once he or she believes the core beliefs have been found, the client is asked to rate the believability of each belief on a scale of 1 to 10, ten being very believable. If the client rates the beliefs at a 9 or 10, assessment

Table 1
Basic Steps in Uncomplicated Theophostic Ministry

1. Client preparation.
2. Identifying memory cues in the presenting problem.
3. Identifying historical emotional echoes.
4. Identifying matching memory pictures or sensations.
5. Discerning the original maladaptive core belief (lie).
6. Rating the believability of the core belief (lie).
7. Having the client experience the emotions and repeat the lie(s) found in the memory. The lies are not resisted.
8. Inviting the Lord to reveal divine truth in whatever way the Lord chooses ("Divine cognitive and affective restructuring").
9. Addressing any issues that may be inhibiting restructuring, such as "guardian lies" (beliefs that may prevent a person from receiving from God), unconfessed sin, or anger.
10. Confirming successful restructuring.
11. Processing other residual lies or going to other memories associated with the original memory.
12. Prayer of affirmation and blessing.

stops and the client is asked to begin repeating these core beliefs over and over mentally, all the while staying in the painful memory. Once sufficient affect has been generated, the therapist, in a non-directive fashion, asks the Lord to minister truth to the client in whatever way God chooses. A common way of phrasing this is, "Allow the Lord Jesus to bring truth in whatever form he chooses and you report to me whatever you see, sense, or hear" (Smith, 2000a, p. 141). If the client does not experience the Lord ministering to the pain and revealing truth within a few minutes, potential obstacles are explored.

Examples of such hindrances include avoidance of pain, the need to be accepted by the therapist, logical thinking (not embracing the core belief; trying to reason in the memory instead of allowing God to speak), unconfessed sin, failure to accurately discern a key maladaptive core belief, dissociation, the presence of anger, hate, or revenge, "guardian lies," demonic interference, or the clinician's own woundedness. Smith's manual deals with each of these with the exception of dissociation, which is dealt with in the advanced seminar. "Guardian lies" are beliefs which impede identifying core affects and beliefs. Examples include, "Oh, it wasn't all that bad ... They did not really mean to hurt me ... I cannot go to the memory because it is too painful ... " (Smith, 2000a, pp. 81-82). Smith includes procedures that

are consistent with his approach for dealing with demonic interference, but also points out that one does not have to believe in such entities to apply the method successfully (Smith, 2000a).

Once hindrances are addressed and the procedure has been applied to the core beliefs, the clinician asks the client to rate the believability of each cognition. If the client rates the believability as 0-1, it is likely that the procedure has been a success. If higher ratings are given, it may suggest the presence of other memories linked to the core belief which should then be processed.

Often, after one set of core beliefs have been processed, another emotion or feeling will emerge that was previously less prominent. A similar procedure is used in which the maladaptive cognition is again assessed, affective and cognitive exposure is again implemented, and petition for the Lord's ministry is again made. The process repeats until the client has a sense of complete peace when viewing the memory (Smith, 2000a). Sometimes while processing a core belief involved in a memory, a client will have another memory emerge. It is important to simply note the original memory (often writing it down) and then to "follow the client" until he or she settles on the most prominent memory. The therapist then implements the procedure on this memory, processing maladaptive cognitions present, and "works backwards" as appropriate.

Once it appears the process is complete, prayers for the Lord's blessing and affirmation toward the client are made. As with the other ministry approaches, the number of sessions will vary depending on the severity of the client's presenting problem.

Commonalities, Differences, and Therapeutic Considerations

Each of these approaches acknowledge the importance of the therapeutic alliance in making the technique effective. Tan, Seamonds, and Payne do not consider the healing of memories technique to be a stand-alone type of treatment, but rather place the interventions in the context of a more comprehensive treatment program or soul care approach. Smith advocates that Theophostic Ministry can bring about significant symptom relief as the central intervention strategy by itself, while noting that coping skills training and other more present-oriented strategies are useful after the Theophostic intervention. Smith (2000a) cites numerous anecdotal case histories to highlight his claim. While the temptation might be to dismiss his intervention off-hand because of these claims, this writer has found his technique to be a very helpful addition in his own clinical work. Other clinicians in this writer's local area have also reported similar results. Currently, case study data and survey research is being done to more fully evaluate the Theophostic approach. The need for balance in any claims made is warranted.

Each of these approaches differs in the degree of directiveness involved in the imagery itself. Payne appears least directive in terms of minimizing or increasing affect, while Seamonds, Tan, and Smith are intentional in their efforts to modulate affect. However, intent is where Seamonds, Tan, and Smith's similarity ends. Seamonds engages in more dialogue during the imagery process in order to help the client get in touch with affect. Tan utilizes relaxation techniques to create a peaceful state prior to the HM technique. Smith, on the other hand, asks the client to make cognitive self-statements to build negative affective intensity rather than relieve it. The experience of Christ himself is what returns the client to a peaceful, restful state in Smith's approach. All the HM techniques noted, except for Seamonds, are generally nondirective in terms of guiding the specific images of Jesus that may be seen or experienced.

In each HM model described, another Christian intervention is closely related—forgiveness. Several models of forgiveness interventions have been

proposed in the clinical literature (e.g., Enright and The Human Development Study Group, 1991, 1996; McCullough, Sandage, & Worthington, 1997). These may be useful in combination with the HM intervention.

Current Research

The closest thing to an empirical investigation of healing of memories approaches is found in the work of Rebecca Propst (Propst, 1980; Propst et al., 1992). She has written a manual (Propst, 1988) describing the utilization of religious imagery in cognitive therapy. Maintaining the present-oriented focus of cognitive behavioral therapy, clients are taught to connect their depressogenic cognitions and images with depressed mood. Treatment interventions focus on having the clients identify depression-engendering situations and then develop religious coping visual imagery and self-statements to deal with the depressogenic situations. For example, "I can visualize Christ going with me into that difficult situation in the future as I try to cope" (Propst, 1980, p. 171). While part of her protocol included healing of memories of past trauma, the breadth of the interventions used and the present-oriented focus prevents clear assessment of the efficacy of the HM techniques applied.

In Propst's 1980 research, she utilized a within sample matching technique to divide 44 mildly depressed volunteers into four different groups—religious imagery cognitive therapy, nonreligious imagery CBT, therapist contact plus self-monitoring, and self-monitoring. The religious imagery treatment showed significantly more treatment gains as measured by the MMPI-D scale (short form), and when comparing the number of individuals still scoring in the depressed range of the BDI at treatment's end (14% in religious imagery group versus 60% in the nonreligious imagery group and 27% in the self-monitoring plus therapist contact). The self-monitoring plus therapist contact treatment was intermediate in effectiveness.

In 1992, Propst compared standard cognitive therapy, religious content cognitive therapy, pastoral counseling, and a waiting-list control group. Each group contained 10-11 religious clients, each of whom had approximately 18 one-hour sessions. Religious cognitive therapy and pastoral counseling clients reported significantly lower depression and adjustment scores post-treatment than did either the nonreligious cognitive therapy or waiting-list control groups. At 3-month and 2-year follow-ups, improvements in

the three treatment conditions were all significantly better than the waiting-list control group; however, group differences between active treatments were not significant. Interestingly, nonreligious therapists had the best results utilizing the religious imagery techniques.

These two studies are encouraging in that they indicate the potential usefulness of religious imagery in doing therapy with appropriate clients. The primary imagery techniques used, however, were qualitatively different from HM techniques because they focused on having the client visualize images of Christ for present or future-oriented situations as opposed to situations that have already occurred in the past. Thus, while claims vary concerning the HM technique, research on these approaches as a technique is presently nonexistent. Anecdotal stories and case histories are the current sources of data for evaluating each HM intervention's efficacy. As mentioned, Smith is reporting a significant degree of success with his Theophostic technique.

Future Empirical and Theoretical Directions

Though no research to date has been done specifically on HM interventions, the time is right for such research to begin. Such a movement would promote a profitable dialogue with the more scientifically minded Christian therapeutic community, and, given the mental health field's increasing emphasis on empirically supported treatments, simultaneously safeguard the ability of clinicians to use these techniques in the future.

Potential research strategies are numerous. Survey designs could help determine the types of practitioners who now use HM techniques, how effective these practitioners believe the techniques are, and how effective clients receiving such interventions perceive the techniques to be. Thoresen, Worthington, Swyers, Larson, McCullough, and Miller (1998) have outlined a general series of steps for the exploration of spiritual interventions that could easily be applied to HM techniques.

First, Thoresen et al. (1998) advocate operationalizing the religious intervention. Several of the HM models have at least begun such operationalization as seen in their writings (e.g., Seamonds, 1988; Smith, 2000a; Tan & Ortberg, 1995a). Once this has been done, quasi-experimental designs should be implemented. One group pretest-posttest designs, quasi-control-group pretest-posttest designs, and single subject designs are examples suggested. After initial

studies have gathered descriptive data and demonstrated efficacy, more empirically valid studies should follow. If these produce positive results, comparative studies would be warranted with other established treatments. Nonrandomized and randomized two group pretest-posttest designs are possibilities. Depending on the results, more in-depth questions can then be asked. Kazdin (1986) recommends identifying the critical ingredients of any effective approach through dismantling and constructive experimental strategies. For example, in HM approaches, the level of therapist directiveness could be manipulated to see whether this is a key ingredient in outcome.

Clearly, HM interventions as psychotherapeutic techniques must be explored on a variety of levels. The ethical application of these techniques must be well thought out, and the models need to be examined in the light of clinical theories such as those related to trauma recovery (e.g., Chard, Weaver, & Resick, 1997; Herman, 1992). Comparing and contrasting HM approaches with clinical techniques such as exposure therapy, systematic desensitization, flooding, implosive therapy, eye movement desensitization and reprocessing, hypnosis, cognitive therapy, and constructivist narrative techniques also would be valuable, especially if HM research supports efficacy. For an excellent summary of clinical trauma interventions, treatments, and research, the reader is referred to Foa and Keene (2000).

As new models of HM techniques continue to emerge, the importance of beginning empirical, ethical, and theoretical discussions will grow. This article has highlighted some of the latest developments in the HM field and suggested future directions. In this new millennium, the place for HM interventions must be thoroughly evaluated.

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