AN EFFECTIVENESS SURVEY STUDY OF THEOPHOSTIC PRAYER MINISTRY

By

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Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Philosophy

Liberty University

April 2013

AN EFFECTIVENESS SURVEY STUDY OF THEOPHOSTIC PRAYER MINISTRY

A Dissertation Proposal

Submitted to the Faculty of Liberty University in partial fulfillment of the requirements of the degree of Doctor of Philosophy

by

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© May 2013

Liberty University, Lynchburg, Virginia

May 2013

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ABSTRACT

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Objective: This study assessed the perceived level of effectiveness of Thoephostic Prayer Minister (TPM) as measured by recipients' overall and specific ratings of TPM's impact on their lives, and assessed the validity of concerns that TPM leads to unusually high rates of negative outcomes. Method: Using a cross-sectional design, recipients completed a self-administered survey following their weekly session during one week of data collection at three different geographic locations across the United States. Data was analyzed for frequencies using one-way ANOVA's. Results: Findings revealed 94% of respondents indicated that their overall problems improved, with 35% indicating the highest rating of improvement. On a 1-5 scale of improvement, means of specific issues ratings ranged from 4.89 to 3.77, and for spiritual issues 4.65 to 4.49, all above a rating of no change. Respondents' negative outcomes ratings were 3-9%, within the accepted normal 5-10% deterioration rate among psychotherapy research. Conclusions: Findings support previous research, rendering TPM as deserving of consideration as a possible therapeutic option.

Acknowledgements

I would like to express my deepest appreciation to the following individuals, who have walked with me and helped me through this process:

To my husband, and best friend, Jeff Ritchey. You have been there day in and day out, supporting me, encouraging me, and showing your love for me in the most practical ways. You stayed up with me, and got up early with me, so I wouldn't have to work alone. Thank you for never letting me give up, or stop moving forward. You believed I could do this even when I doubted myself. We did it together! And you get the PHT award this time!

To my chair, Dr. Garzon. You never pushed me, but you matched my steps, always with prompt and clear direction. I greatly appreciate your professionalism and expertise in the various aspects of this process. They gave me the confidence I needed; I knew I could trust your leadership, and together we would get this done! I also greatly appreciate your heart, which so clearly belongs to Jesus; the evidence is in the way you care for people. It was truly a privilege to work with you!

To Dr. Sosin, my reader. You are someone I admire, and truly feel honored to know. I knew when you agreed to be a reader, that I could count on your prayers, your encouragement along the way, and your wonderful personal contribution to the finished dissertation; what I didn't know is just how much I would need each of those things through this process. You give of yourself so freely, and my life is one of the many you have touched and changed with Jesus' love. Thank you!

To Dr. Hawkins, my reader. I have admired you from a distance, in particular your pastoral heart, and the way you passionately integrate your faith with academic excellence. But I never imagined I would be privileged to personally benefit from your wisdom and insight. I truly feel God has blessed me by allowing me to learn from you. Thank you for stimulating my thinking and prompting me to reach a little deeper; both my dissertation and I are stronger for your input! Thank you.

And most of all, to my Lord Jesus. Your Presence made the journey sweet. Faithful to your promise, it was not by my might, nor my power, but by Your Spirit that this was accomplished. I did this for You, and for Your glory! Please use it to bless many with healing and wholeness.

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CHAPTER ONE: INTRODUCTION

Over the past several decades lay or paraprofessional help within the mental health field has seen tremendous expansion (Garzon & Tilley, 2009; Sobey, 1970; Tan, 1991). One major factor leading to this growth has been the rise in managed-care as reimbursement for mental health services, rendering non-paid or free counseling provided by clergy and lay or paraprofessionals as an attractive alternative (Austad & Hoyt, 1992). In addition, the growing diversity of the American demographics has played a role. Cultural and language accessibility to minority populations has become a challenge for professional healthcare providers (Hogan, 2003), rendering low-resource communities as particularly benefitting from the contributions of paraprofessionals (Jain, 2010).

Such helpers have provided a range of services through suicide prevention programs, telephone hotlines, religious and church-based counseling centers. Community agencies have found paraprofessionals useful in various roles, such as community outreach, initial assessment, prevention programs, and in helping the professionals overcome the local attitudinal barriers to services (Calzada et al., 2005; Musser-Granski & Carrillo, 1997). Paraprofessional counseling has become recognized and listed among available and defined options for those seeking help from a mental health practitioner (see Community Service Board, District 19, Commonwealth of Virginia, http://www.d19csb.com/hr/definitions.htm). Parrott III (2003) provides such a list and

defines paraprofessional counselors as those who "have intensive but limited training in helping approaches…[who] have gained some supervised field experience and almost always work under the direct supervision of a professional" (p. 16).

Within the Christian community of faith, an increasing number of pastors of growing congregations have also felt the effects of the advent of managed care. Many pastors, especially those of larger congregations, have come to realize their inability to adequately meet the demand for counseling among their parishioners (see Steinbron, 2004; Tan, 1991). Lay counseling and small group ministries have proliferated to meet the demand, becoming a significant component of many local church ministries and parachurch organizations (Tan, 2002).

In addition to managed care effects, the ranks of lay Christian counselors have seen growth as the result of a movement reactive to the influence of secular psychotherapies in the care of souls (see Powlison, 2001). Biblically based alternative training programs for pastors and laymen have been developed and implemented within the church context. Examples include *Nouthetic* counseling (see Adams, 1970, 1981, 1986), and *Biblical Counseling* (Powlison, 2000, 2001), described as a counseling movement which uses "applied exegesis…which primarily aims at the accurate application of Scripture to modern life" (Welch & Powlison, 1997, p. 304).

Other church member training models and programs, more favorable to some degree of integrating secular counseling strategies with Christian principles (see Entwistle, 2004), have proliferated to meet the need for the church counseling helpers who operate in a lay capacity. These include Crabb (1977; Crabb & Allender, 1984),

Collins (1976/1995, 1980), Solomon (1971, 1976, 1977, 1991), Backus (1985, 1987; Backus & Chapian, 1980/1981/2000), and Drakeford and King (1988). More recently, Carson, Lawson, Casado-Kehoe, and Wilcox (2011) have developed an international lay counselor training model, and online training has also become available through Light University Online (www.lightuonline.com), the educational arm of the American Association of Christian Counselors (AACC). Theophostic Prayer Ministry (TPM; Smith, 1997, 1999, 2000, 2002, 2005, 2007), another lay ministry model which has proliferated since its fairly recent conception in the mid-1990s, is the focus of the present study.

Theophostic Prayer Ministry

In the early years after its conception, TPM was considered among the inner healing prayer, or healing of memories, lay counseling approaches (see Garzon & Burkett, 2002; Garzon, 2004). These have been defined by Hurding (1995) 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; e.g., Sandford, 1972; Seamands, 1985, 1991; Wardle, 2001; Westmeier, 2004). However, over time Dr. Ed Smith, developer of TPM, has drawn a distinction from viewing this prayer approach as inner healing, but rather mind renewal. He explains in the latest TPM manual, Smith (2007),

> What happens in a TPM session is about exposing lies and having them divinely replaced by truth. When a person holds their falsehoods up to the Lord and He grants a change of thinking, it is renewal of the mind that occurs, not healing. Healing is taking something and restoring it back to a healthy position. (p. 155)

With its name coined from two Greek words, *theos* (God) and *phos* (light),

> TPM is defined as, "intentional, focused prayer leading to an authentic encounter with the presence of Christ, resulting in mind renewal and a subsequently transformed life" (Smith, 2007, p. 2). Through prayer, a TPM recipient is led to process emotionally painful memories, in which harmful, lie-based beliefs are embedded. Present emotional pain is thought to be caused by these faulty core beliefs, or "lies" as they are referred to in TPM. Smith (2007) explains,
> The present emotional pain is the feeling that surfaces in our current situation when a lie-based memory is triggered. The original memory container is the original event in which the lie-based thinking was implanted and stored. The original lie is the false belief that was implanted at the time of the painful memory, causing the present pain. Receiving truth from the Holy Spirit results from the connection the person makes with Christ. (p. 31)

Using a non-directive style, the TPM facilitator is trained to lead the ministry recipient through a four-part process, which can be summarized as, (a) identification of the present emotional pain, (b) discovery of the original memory which contains the lie, or lies, (c) exposure of the original lie, or lies, implanted in the identified memory, and (d) acceptance of the truth revealed by the Holy Spirit. It is through the "light of Christ" that memory sources are exposed. The individual finds freedom from his or her emotional pain through replacing the lie, or lies, with the truth revealed by the Holy Spirit. Ideally, the prayer ministry continues until the recipient experiences peace when the previously painful memory is being activated. However, blockages can hinder the process, for which the training materials outline suggested strategies for facilitators to use. Smith (2007) also openly acknowledges that, "mind renewal involves many things other than what happens in a TPM session. Mind renewal also includes the need for Bible study, growth, and discipleship" (p. 31).

Background of the Problem

In the 15 years since its conception, TPM has rather quickly expanded across the United States, and has become an internationally recognized ministry. Its website now offers memberships in the International Association of Theophostic Ministry (IATM), to individuals using TPM in over 140 countries around the world (http://theophostic.com/page1111554.aspx). Although many who received training and used this prayer ministry claim success with unknown numbers of recipients, it has also garnered critics.

Author David Entwistle wrote two articles in 2004, Entwistle (2004b) and Entwistle (2004c), outlining his critical concerns of TPM. These are summarized below. Entwistle (2004b) offers these criticisms:

1. Insufficient attempts to ground TPM in biblical concepts.
2. Inadequate and often flawed explanations of basic psychological processes.
3. Dubious claims about the prevalence of DID, SRA, and demonic activity.
4. Estimates of traumatic abuse that exceed empirical findings.
5. The failure to sufficiently appreciate the possibility of iatrogenic memory contamination. (p. 32, numbering and punctuation added for clarity)

Entwistle (2004c) offers these criticisms:

6. Smith's current methods of teaching TPM through brief seminars and videotaped materials may be inadequate to establish ethical and technical competence.
7. Claims that TPM involves divinely guided healing in which a literal appearance of God should be expected are not well supported.

8. Ethical and legal concerns exist regarding apparent claims guaranteeing healing and claiming superiority of method.
9. Application of TPM to a wide variety of mental disorders without sufficient empirical validation is troubling.
10. At issue is the legal question of whether TPM should be considered a religious intervention or a counseling procedure.
11. The ethical issue of trying to settle this question simply by changing the name from Theophostic Counseling to Theophostic Ministry.
12. Smith's failure to welcome public analysis and critique of TPM is problematic. (p. 41, numbering added for clarity)

Each of these specific criticisms is individually evaluated in Chapter Two, using the latest TPM manual (i.e., Smith, 2007) and current material from the official TPM website http://www.theophostic.com/ (see also Table One for a summary of evaluative conclusions). In each case, evidence is cited that suggests the criticisms are highly questionable. In many cases, revisions have been made in the TPM materials that render the criticisms mute issues. In other cases, (e.g., criticism 12) evidence is cited by this author that clearly renders the criticisms invalid. One issue raised, concerning the lack of empirical evidence (i.e., criticism 9), does deserve serious consideration. Anecdotal testimony of TPM's success in allaying emotional pain and decreasing symptomology associated with a variety of mental health issues has abounded. However, empirical data supporting TPM's effectiveness is scarce. In terms of outcomes research, a series of case studies (Garzon, 2008), and a descriptive study of TPM recipients' perception of their

current experience compared with previous counseling experiences (Tilley, 2008), have yielded promising preliminary findings (see Chapter Two for a more detailed examination of the literature). However, further outcomes research is clearly needed to evaluate the empirical merits of the testimonial claims of TPM's effectiveness.

In the summer of 2009, the Christian Association for Psychological Studies (CAPS) published a special edition of their *Journal of Psychology and Christianity* which highlighted TPM. According to the guest editorial page, TPM was chosen "as a case study in the relationship between religiously based interventions and professional services and to provide a backdrop for future integration conversations and research" (Hunter, 2009b, p. 99). Two specific points are salient when evaluating the issues raised in this journal concerning TPM.

Firstly, evidential citations regarding TPM as the basis for critical concerns are taken from outdated sources, and various personal communications (see Hunter & Yarhouse, 2009a, 2009b). Specifically, the outdated sources cited by these authors are a panel discussion held four years previous at the CAPS International Conference in April, 2005, and the outdated TPM manuals from 2000 and 2005 (i.e, Smith, 2000, 2005). It is notable that the Smith, (2007) manual had been available for two years prior to the publication of this journal. Moreover, Smith (2007) represents significant revisions of Smith (2005; e.g., different chapter titles, different sub-titles of chapters, major content changes, etc.). Thus, the importance of an up-to-date accurate appraisal of TPM concerns and Smith's responses is needed both for the academic community and general public.

Secondly, specifically regarding the lead article of this journal (i.e., Hunter, 2009a), authored by the Guest Editor, Linda Hunter, TPM is misrepresented in its placement along the epistemological continuum of "the integration of religiously based interventions and psychotherapeutic techniques" (p. 101). In this article, *Epistemological approaches to inner healing and integration,* Hunter (2009a) misclassifies TPM's epistemological position, based on her evaluation of Smith (1997, 1999, 2000, 2002, 2005), as "unitary," on the extreme right of the spectrum of integration. She lumps TPM with other inner healing approaches, in which she describes "their epistemology [as] informed primarily by Scripture…the *sine-qua-non* for effective counseling and inner healing…[they reject] looking outside the Scripture for the additional insight that might be gleaned from that which the discipline of psychology offers" (p. 102). She further appeals to a personal communication from Smith, dated March 11, 2004, to substantiate her position that he is among "theologians in the counseling ministry [who] have no desire for empirical validation" (p. 103).

Evidence abounds to the contrary (see Chapter Two for a detailed analysis). What is unfortunate, however, is that the journal reader who is not already informed concerning TPM and its centrist epistemological position on the integration continuum, continues reading the articles that follow with a misconstrued view of TPM. Of particular consequence in this regard is Entwistle (2009). He discusses and advocates for a centrist holistic integrative approach to the treatment of mental health issues, flowing from a biopsychosocial-spiritual view of human personhood. Although TPM is not mentioned by name, by implication, the astute reader, even those who might not have already read

Hunter (2009a), readily identifies TPM as clearly within Entwistle's classification *spiritualistic metaphysical extremism.* Chapter two will readily demonstrate that Smith positions himself in the centrist holistic integrative camp.

Dr. Smith's desire for empirical validation is further demonstrated by his assistance and willing collaboration with researchers investigating TPM (e.g., Garzon, 2008; Tilley, 2008; see Chapter Two for a detailed evaluation and citation of evidence contradicting the misconception of TPM propagated by these two articles). Additionally, links to past research studies are posted on the current TPM website, followed by,

> It is acknowledged that the research that has been done thus far is limited to case studies and surveys. However, the results that have come forth do suggest that something positive is occurring in the lives of those who have experienced this form of ministry…The outcome of this limited research merits further study. (http://www.theophostic.com/page12435058.aspx).

Hunter and Yarhouse (2009b) outline specific critical concerns of TPM, as raised and discussed during the panel discussion which took place at the CAPS International Convention four years previous, in April 2005. These are summarized as follows:

1. TPM training requirements;
2. The offering of TPM as a form of counseling;
3. Reoccurring emotions after receiving TPM;
4. Claims that TPM is maintenance free and the ensuing theological concerns;
5. And the status of current research. (Hunter & Yarhouse, 2009b, p. 149, numbering and capitalization added for clarity)

It should be noted here that the authors cite multiple personal communications as evidence for their concerns (i.e., 19 irretrievable personal communications, in contrast to

a list of 15 retrievable print or online sources), making evaluation of these concerns difficult. It is also unclear why the authors failed to reference publications available to them (e.g., Smith, 2007) at the date of their writing.

Clearly, each of these critical concerns has been addressed by Dr. Ed Smith, either in Smith (2007) or on the official TPM website (i.e., http://www.theophostic.com/default.aspx). Concerning adequate training provided TPM facilitators expressed in item 1, for example, updated and more rigorous training requirements for TPM facilitators are currently in practice (see http://theophostic.com/howtogettraining.aspx). Explanations and revisions in Smith (2007) address other concerns listed in items 2-4 (see Chapter Two for a detailed evaluation of each critical concern). However, as noted above, the need for further research of TPM, as called for in item 5, is valid. Although preliminary findings provide some indication that TPM is effective, researchers merely express cautious optimism (Garzon, 2008). Further empirical evidence is still needed to substantiate the effectiveness of TPM in alleviating symptomology.

This call for empirical validation of explicitly religious approaches, such as TPM, is also clearly indicated by Hathaway (2009). He appeals to standards of evidence-based practice when considering appropriate interventions and methods selected for use by mental health professionals as well as lay counselors. He expresses particular concern that explicit Christian counseling approaches may be producing outcomes that are harmful. Specifically concerning TPM, he cites a case he knew personally of a theophostic dropout, whose pain worsened when she invited Jesus into her situation, and she did not improve. Hathaway states,

> I do not wish to imply that theophostic counseling is harmful or ineffective based on anecdotes. My point is merely that there are anecdotal reasons to suspect some harmful effects for some individuals occur, or at least that some non-responders may be present in the treated population. That situation is not by itself dramatically different from what is often the case with most forms of psychological treatments. (p. 109)

His question is valid, that being, "whether we have good evidence to suppose a clinically meaningful average net benefit from theophostic counseling" (p. 109). As Hathaway notes, empirical investigation is needed to determine if TPM falls within the established norm of 5-10% of individuals seeking psychotherapeutic help who actually deteriorate (see Lambert & Ogles, 2004). The study reported in this dissertation will help to assess this question.

Hunter and Yarhouse (2009a) examine the ethical implications therapists must consider when integrating religiously based interventions into a licensed setting. The authors, however, compare recommendations of which issues should be considered, using in large part personal communications of various contributors (i.e., 25 unverifiable personal communications cited, as compared to 19 verifiable print or online sources), making evaluation difficult (see Chapter Two for a detailed evaluations of the main points presented by the authors). While points made by Hunter and Yarhouse (2009a) are well taken, especially concerning a comprehensive pre- ministry education of the ministry recipient and a robust informed consent, a review of Smith (2005) by this author (i.e., the TPM manual under scrutiny as the focus for this 2009 special journal edition), it seems that overall these considerations were, even at that time, already being addressed in TPM training. For example, sample forms are provided and suggested for TPM facilitator's use (see Smith, 2005, the *Hold Harmless Agreement* form, p. 202, the *Hold*

Harmless Agreement (Expanded version), pp. 199-200, and the *Evaluation of Ministry Received* form, pp. 197-198). These are essentially the same in Smith (2007). It should be noted, unless the reader has access to Smith (2005; 2007), it is not apparent from the reading of this article that TPM does in fact provide the training and tools necessary for its ethical implementation.

In sum, the central theme that arises from a critical review of the Entwistle (2004b, 2004c) articles and the CAPS 2009 journal articles highlighting TPM, is the need for further research and a current appraisal of Smith's response to critics' concerns. Specifically outcomes research, investigating the question of the effectiveness of TPM, is lacking. Critics have questioned the enthusiastic anecdotal claims made by Dr. Smith and other proponents of TPM, and, justifiably have asked for evidence to substantiate such claims.

A detailed description of TPM research to date is found in Chapter Two, but a brief summary is provided here. Preliminary descriptive results of surveys have shown a wide spectrum of mental health issues are being addressed using TPM (Garzon & Poloma, 2005), and large percentages of respondents have reported satisfaction with TPM, both as facilitators and recipients (Garzon & Poloma, 2003). Garzon and Poloma (2005) report that, overall, of the 111 TPM trainees at an Advanced Theophostic Training conference, who volunteered to self-administer a survey, 82% of licensed professionals and 95% of the remainder of the sample indicated that they valued using TPM when treating other individuals as "more" or "much more" effective than other approaches.

Tilley (2008) reports findings from an online survey completed by 2,818 individuals, who were asked to rate the helpfulness of TPM, as compared to the helpfulness of previous counseling experiences. Forty-six percent of respondents rated overall helpfulness of previous counseling as “helpful” or “very helpful,” while 4% endorsed “The most helpful thing I’ve tried.” By comparison, 62% of respondents rated TPM’s overall helpfulness as “The most helpful thing I’ve tried” and 25% as “very helpful.” Four percent rated TPM as “A little helpful” or “Not helpful.” When rating levels of improvement of various issues listed, respondents reported greater improvement levels for all issues (i.e., at varying degrees for each issue) after receiving TPM compared to previous counseling experiences (Tilley, 2008).

Garzon (2008) reports an outcome-based, time series 16 case studies project investigating the effectiveness of TPM. Special pains were taken to ensure that all lay facilitators and professional therapists administering TPM were well-trained in TPM protocol. Typical clients were used, seeking outpatient psychotherapy for typical problems met with the professional therapists, and individuals typical of those seeking help from church ministry centers met with lay counselors, supervised by mental health professionals. A battery of outcomes measures were completed every 10 hours of treatment, at the end of treatment, and as a three month follow-up. In addition, at completion of TPM, independent unaffiliated mental health professionals provided assessment of treatment effectiveness for each case. Post-treatment test results demonstrated that 13 of the 16 clients (81%) indicated positive change (i.e., either

Improved or Recovered). Only one person (7%) reported scores in the Deteriorated range. Of the 13 who improved, only two clients reported scores that showed they had lost their treatment gains at three months (Garzon, 2004, 2008).

Preliminary research findings as to TPM's effectiveness, while having obvious methodological weaknesses inherent in such research, have been encouraging, and warrant further investigation. Further documented evidence is clearly called for. Studies employing better and more sophisticated research designs are needed to evaluate the claims that TPM recipients do indeed experience improvement in their symptomology. Specifically, outcomes studies data is needed that demonstrates whether TPM is perceived as effective as compared with some form of control group or treatment as usual. With the development of the *Body Life Model,* a relevant question needing investigation is whether TPM administered individually or in the group model is more effective. As noted by Hathaway (2009), evidence is also needed to demonstrate whether the percentage of TPM recipients who deteriorate falls within the normal range of 5-10% of the treated population (see Ogles & Lambert, 2004).

Purpose of the Study

The purpose of this study was to assess the perceived level of effectiveness of therapy or lay counseling using TPM, as measured by ministry recipients' responses to survey questions. These survey questions gave respondents an opportunity to rate the relative change in the severity of their overall problems since they began therapy, and to rate how TPM had affected specific areas of their lives. To assess the validity of concerns

that TPM may produce more negative outcomes than traditional counseling therapy models (see Entwistle 2004b, 2004c, 2009; Hathaway, 2009), a descriptive analysis of respondents' ratings of perceived effectiveness of their experience in therapy with TPM was compared to negative outcomes frequency analyses found in the literature (see Lambert & Ogles, 2004).

Research Questions

Survey data was used to answer the following two research questions:

1. How do clients perceive the level of effectiveness of therapy or ministry using TPM?
2. How does the rate of negative outcomes for TPM compare with the rate of negative outcomes for psychotherapy in general?

Research hypotheses for these two research questions were as follows:

1. Clients' perceptions of the level of effectiveness of therapy or lay counseling using TPM will be positive across the three conditions of TPM administration, which are (a) Body Life model (i.e., lay group counseling with TPM), (b) individual TPM with a lay counselor or pastor, and (c) individual TPM with a professional therapist. When the three administrative conditions with TPM are compared with each other, no significant difference in levels of perceived effectiveness is anticipated.
2. The rate of negative outcomes of TPM will not be significantly higher than the rate of negative outcomes of psychotherapy in general.

Assumptions and Limitations

As with all research, the researcher makes certain assumptions. Firstly, this researcher made the assumption that participants would respond to the survey questions with honesty, and would make every effort to reflect accurately their perceptions of the effectiveness of the therapy with TPM, that they were currently receiving. Secondly, it was assumed that a reasonable rate of response would be achieved to allow for sufficient statistical power. Not being able to be at all sites at once due to the snap-shot approach of this research design, the researcher assumed that counselors and ministers would make every effort to follow the instructions given to them during training. A third assumption made by this researcher was that therapy center directors would be responsible to fulfill all of their assigned tasks according to the prescribed procedures outlined in their training.

Being cross-sectional in design, this research study compared groups in a snapshot approach during one week across all conditions. By the short-term nature of this design, alternative explanations for the results, such as the effects of history, maturation, testing, attrition, instrumentation, statistical regression, and selection bias, all common threats to internal validity (Jackson, 2006; Kazdin, 2003), were reduced but not eliminated. Effects of history as a possible confounding variable were minimized due to the short duration of the study (i.e., one week), making such effects as weather, historical events, etc., more common to all participants. The one-time data collection procedure of the design reduced but did not eliminate maturation, instrumentation, and testing as influences on the results.

Attrition and statistical regression were ruled out due to the onetime participation by survey completion (see Chapter Three for a detailed explanation).

This research study was a survey effectiveness study, and not an efficacy study. Kazdin (2003) delineates the differences as follows,

> Efficacy refers to research that is directed more toward the controlled conditions of the laboratory. An efficacy study evaluates the impact of treatment under such conditions. Effectiveness refers to intervention research that is in applied settings and under the conditions in which treatment is actually administered. (p. 140)

As Seligman (1995) notes, efficacy methodology is more popular because, within the laboratory setting, it allows for variables to be well controlled and clients to be randomly assigned to treatment and control conditions. As an effectiveness study, there was the necessary absence of these elements of experimental research.

However, as Seligman (1995) argues, "the efficacy study is the wrong method for empirically validating psychotherapy as it is actually done, because it omits too many crucial elements of what is done in the field" (p. 966). Certain properties of psychotherapy carried out in the clinical setting are absent in an efficacy study, due to the controlled nature of the methodology. These include the undetermined duration of therapy, the self-correcting nature of interventions and techniques chosen during the course of treatment, the active shopping done by clients selecting treatment and therapists, the multiplicity of presenting problems in the real-life setting, and the recognition that improvement in the general functioning of clients indicates success of treatment, not just the amelioration of specific symptomology (Seligman, 1995). Thus, empirical data collected in a natural setting through a survey of large numbers of people who rate their experience of therapy (e.g., *Consumer Reports*, 1995), is considered a valid measure of treatment effectiveness, despite the limitations.

Another limitation that should be noted here is that this study used a convenience sample, and not a random sample. There was no "master database" available which contains all the persons around the world receiving TPM at this point in time. Thus, there was no way to get a pure random sample. However, the snapshot approach of inviting all current persons available at each site to participate in the study increased this study's representativeness compared to other surveys done on TPM.

Additionally, no random assignment occurred in this study. Participants previously self-selected into their respective groups (i.e., individual therapy or the group model) through guidance by their counselor according to their individual therapeutic needs, with the necessary informed consent. This brought some limitation to the generalizability of the findings, and was therefore a threat to external validity. However, ethical considerations of random assignment of participants to either the individual or group model without their consent outweighed the benefits of true experimental research. It was, therefore, considered a necessary limitation.

Although this study had inherent limitations, the methodology was considerably stronger than previous studies investigating TPM. By inviting as a sample all individuals who were receiving TPM from the participating therapists/lay ministers at the participating centers, a more representative sample was used to investigate the effectiveness of TPM than was used in the previously published survey research. This methodology sought to eliminate the methodological weakness of previous surveys which used potentially biased samples, such as the TPM email mailing list (i.e., Tilley, 2008), and attendees at a TPM advanced training seminar (i.e., Garzon & Poloma, 2005). By

using a more representative sample, this study provided much more meaningful preliminary indications of whether TPM is effective, and whether it is more harmful than other counseling models.

Definitions of Terms

Lay Christian counseling, as used in this study, was defined as the approach to counseling employed by those within the Christian faith community who may or may not have had experience working in mental health in a counseling capacity, and who had not completed a course of formal training resulting in their gaining licensed professional credentialing in the field. They often instead had training in a specific lay Christian counseling model.

TPM was defined as a non-directive form of prayer ministry, involving a four-part process, summarized as, (a) identification of the present emotional pain, (b) discovery of the original memory which contains the lie, or lies, (c) exposure of the original lie, or lies, implanted in the identified memory, and (d) acceptance of the truth revealed by the Holy Spirit.

Therapy with TPM was defined by this study as standard therapy routinely provided to clients at the participating centers that includes TPM, as prescribed in Smith (2007) and current training procedures as outlined by TPM's official website http://www.theophostic.com/. Standard therapy was defined as the treatment routinely provided by the individual therapists or lay counselors to clients seeking psychotherapeutic or spiritual help at the participating centers. Thus, the therapist or lay counselor made the decision as to when to apply TPM or to forego TPM in a session.

Significance of the Study

With the growing demand for, and expanding involvement of, lay or paraprofessional help within the mental health field (Garzon & Tilley, 2009; Tan, 1991), there is a need to address a variety of issues that accompany this development. The literature reflects that training of paraprofessionals has been one of the key issues (e.g., Calzada et al., 2005; Musser-Granski & Carrillo, 1997; Rispoli, Neely, Lang, & Ganz, 2011), as has supervision (Tan, 1997). Another key issue is the need for evaluation of the efficacy and effectiveness of paraprofessional counselors and lay counseling techniques as they are thrust into the professional realm of evidence-based quality parameters (Montgomery, Kunik, Wilson, Stanley, & Weiss, 2010).

Within this context of emerging paraprofessional involvement and the increase in the utilization of lay counseling, there has been a concurrent increase in recognition within the mental health field of religious diversity and its implications for therapeutic practice (Richards & Bergin, 2000). Religious and spiritual therapeutic treatments and techniques have become more popular, and their integration into traditional psychotherapy has become a topic of discussion (Tan, 2007). This has been evidenced in the publication of books by the *American Psychological Association* (e.g., Miller, 1999; Richards & Bergin, 2005) and recognized clinicians in the field (e.g., Sperry, 2001, 2012). Over time, clients have come to expect that their spiritual and religious concerns will be addressed by their therapists (Post & Wade, 2009), and, particularly within the Christian faith community, counselees prefer that treatment incorporate spiritual

interventions, especially prayer, as part of the therapeutic process (Weld & Eriksen, 2007).

Unfortunately, empirical evidence supporting the efficacy and effectiveness of religious and spiritual therapies is sparse (Hook et al.,2010), making it difficult for professional Christian counselors wishing to use such interventions in the managed care dominated mental health field. This study has been a step in providing such empirical evidence. Not only does this researcher recognize the need for empirical support of spiritual interventions in general, but specifically, preliminary research of TPM (e.g., Garzon, 2008; Tilley, 2008) laid a foundation that invited further investigation. Increased empirical investigation has been needed to assess whether TPM is a validated treatment or a harmful treatment, and to determine whether it should be more available as an option for use when indicated with clients seeking either lay or professional Christian counseling.

Organization of Remaining Chapters

The following two chapters expand some of the sections covered in Chapter One. Chapter Two summarizes and evaluates the literature to date of lay or paraprofessional helping, and empirical data investigating their effectiveness, both in the secular mental health and Christian faith community settings. This leads to a consideration of the TPM literature. The literature presenting critical concerns of TPM are outlined and evaluated using current TPM manuals and website materials, and the research of TPM to date is summarized. Chapter Three provides a description of the design, instrumentation, and procedures of this study, followed by a discussion of the design's merits and limitations.

Summary

Lay or paraprofessional helping in the area of counseling and mental health has greatly expanded over the past few decades. Issues associated with this expansion have arisen, including a need to evaluate and validate the effectiveness of paraprofessionals and lay counseling ministry approaches as the demand increases for their incorporation into the professional evidenced based setting. TPM has garnered critics and supporters as it has developed into an internationally utilized Christian lay counseling approach. An examination of the literature, those presenting critical concerns and those presenting preliminary findings of research studies, leaves a question of whether TPM is effective in alleviating symptoms and providing an overall positive impact in ministry recipients' lives. This study has provided empirical data to answer that question.

CHAPTER TWO: REVIEW OF THE LITERATURE

Introduction

The demand for lay or paraprofessional mental health services has greatly increased over the past several decades (Garzon & Tilley, 2009; Sobey, 1970; Tan, 1991). Rising costs of professional mental health services has rendered the low or no cost counseling services provided by lay or paraprofessionals as an attractive alternative. As a more affordable option, counseling provided by paraprofessionals or lay counselors has played a key role in closing the accessibility gap for some low-resource communities (Hogan, 2003; Jain, 2010). Telephone hotlines, and suicide prevention programs, as well as religious and church-based counseling centers are among some of the main services provided by such paraprofessionals. Within community agencies, paraprofessionals have also been helpful with such efforts as community outreach, initial assessment, and various prevention programs. They have come alongside professionals and been effective in overcoming the local attitudinal barriers to services (Calzada et al., 2005; MusserGranski & Carrillo, 1997). Paraprofessional counseling is now recognized as a viable option to those seeking help from a mental health practitioner (see Community Service Board, District 19, Commonwealth of Virginia, http://www.d19csb.com/hr/definitions.htm). Parameters limiting the provision of lay or paraprofessional services are provided for by

local authorities. For example, in Virginia, the District 19 Community Service Board provides the following definition:

Paraprofessionals in mental health must, at a minimum meet one of the following criteria:

1. Be registered with the IAPSRS as an Associate Psychiatric Rehabilitation Provider (APRP) as of January 1, 2001.
2. An associate's degree in a related field (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services, Community Mental Health Rehabilitative Services counseling) and at least one year of experience providing direct services to persons with a diagnosis of mental illness or gerontology and special education.
3. An associate's degree, or higher degree, in an unrelated field and at least three years' experience providing direct services to persons with a diagnosis of mental illness or gerontology clients or special education clients.
4. A minimum of 90 hours of classroom training and 12 weeks of experience under the direct personal supervision of a QMHP providing services to persons with mental illness and at least one year of experience (including the 12 weeks of supervised experience). Direct personal supervision means that the QMHP is on-site at all times and countersigns all documentation.
5. College credits (from an accredited college) earned toward a bachelor's degree in a human services or related field (social work, gerontology psychology, psychiatric rehabilitation, special education, sociology, counseling, vocational rehabilitation and human services) that are equivalent to an associate's degree

> will be accepted to meet the educational requirements. One year of clinical experience is also required. The experience may include supervised internships, practicums, and field experience. (http://www.d19csb.com/hr/definitions.htm)

A distinction is noteworthy at this point. Religious lay helpers are not regulated by the state since they are practicing as faith-based helpers. The above criteria pertain to nonreligious paraprofessionals.

Lay counseling within the Christian community of faith has also seen tremendous growth. Larger church pastors have faced a challenge to adequately meet the counseling needs of their parishioners (see Steinbron, 2004; Tan, 1991). Counseling and small group ministries conducted by lay church members have proliferated as a result, and have become a vital component of many church programs (Tan, 2002).

Lay Christian counseling models and training programs have mushroomed to meet the growing demand. Some have been developed due to a movement reactive to secular psychotherapies, including *Nouthetic* counseling (see Adams, 1970, 1981, 1986), and *Biblical Counseling* (Powlison, 2000, 2001). Others have been more integrative, using some degree of secular counseling strategies along with Christian or biblical principles (see Entwistle, 2004), for example Backus (1985, 1987), Backus & Chapian, 1980/1981/2000), Collins (1976/1995, 1980), Crabb (1977), Crabb & Allender (1984), Solomon (1971, 1976, 1977, 1991), and Drakeford and King (1988), and more recently, Carson, Lawson, Casado-Kehoe, and Wilcox (2011). An online lay counseling training model is available through Light University Online (www.lightuonline.com), the educational arm of the American Association of Christian Counselors (AACC).

Theophostic Prayer Ministry (Smith, 1997, 1999, 2000, 2002, 2005, 2007), the focus of this study, is a lay counseling model which has grown in popularity and use since its conception in the mid-1990s.

Lay Helping Effectiveness Research

The natural question that follows relates to the effectiveness of lay or paraprofessional counseling helpers, both in the Christian and secular contexts. With the obvious advantage of lower-cost delivery by paraprofessionals, the question becomes, do outcomes of lay or paraprofessional counseling measure up to those of counseling carried out by professionals?

Secular Context

In the secular context, a debate has been carried out in the literature addressing this issue. Durlak's (1979) groundbreaking article, in which he reviewed 42 studies, evaluated the comparative effectiveness of these two counseling delivery systems. Even though his methodology was challenged (Nietzel & Fisher, 1981), and defended (Durlak, 1981), his surprising conclusions were not questioned. His findings suggested that professional therapy does not demonstrate superiority over paraprofessional helping. Some of the results even suggested that in certain cases paraprofessionals produced more robust effectiveness outcomes.

Meta-analyses of the same studies (Berman & Norton, 1985; Hattie, Sharpley, & Rogers, 1984; Stein & Lambert, 1995) reached the same conclusion. Christensen and Jacobson (1994) summarize the research this way:

> The later reviews often begin with a criticism of the previous reviews and then try to improve on the methodology. Yet, whatever studies are included or excluded, the results show either no difference between professionals and paraprofessionals or, surprisingly, differences that favor paraprofessionals. (p. 9)

As noted by these authors, however, the findings do not allow for broad generalization across the full scope of psychiatric disorders, or across the full scope of severity of symptoms. Further and better research was called for.

The debate continued through the 1990s and then seemed to lose steam. Much of the focus in the research literature centered around the level of education and experience of the counselor (see Beutler & Kendall, 1995; Bickman, 1999; Shadish et al., 1993). Although some have concluded from the now predominantly dated research findings that therapeutic outcomes of counseling delivered by a paraprofessional is generally as effective as therapy administered by a professional therapist (e.g., Bickman, 2008; Christensen & Jacobson, 1994; Garzon & Tilley, 2009; Montgomery et al., 2010; Tan, 1991, 2002), research has certainly also rendered findings that point to contrasting conclusions (e.g., Armstrong, 2010).

As it stands now, there are some salient factors to consider regarding this debate. First, the dated nature of the bulk of the research investigating paraprofessional therapeutic outcomes as compared to those of professionals. With the more recent emphasis on the demonstrated effectiveness of evidence based practice, current comparative investigation is needed of therapy employing empirically supported treatment outcomes. Improved research design is another factor. Research analysts have repeatedly blamed design, "Designs have generally failed to adequately address the differential effects of professionals versus paraprofessionals" (Lambert & Ogles, 2004, p.

171; see also Lambert & Bergin, 1994, in the previous edition of this same book for a similar conclusion).

Christian Context

When the focus moves to lay counseling within the Christian context, the research literature is sparse. Garzon and Tilley (2009) conducted the most recent investigation into the status of empirical evaluation of lay Christian counseling. Following the suggested classifications of Garzon, Worthington, Tan, and Worthington (2009), they provided an outline and review of studies to date, identified methodological limitations, and pointed out the paucity of well-designed outcomes-focused research in this area. Used again here, these classifications provide a means of organizing the models and their related literature for ease of presentation. They are Early Research (1980-1990), Active Listening Approaches, Cognitive and Solution Focused Approaches, Mixed Models (i.e., these models are more eclectic, with components similar to the other categories, however, distinctive enough to warrant a separate category), and Inner Healing Prayer Models (IHP).

Early research (1980-1990).

Three studies were carried out in the 1980s evaluating lay Christian counseling, mostly non-model specific (see Boan & Owens, 1985; Harris, 1985; Walters, 1987). Each lent some support to the effectiveness of lay counseling. However, serious methodological limitations call into question generalization that all lay Christian counseling is indeed effective (Garzon & Tilley, 2009; Tan, 2002, 2011). Moving toward a status of empirically supported treatment (EST), it should be noted here that general lay

Christian counseling has continued to gain some positive outcomes support for generalized psychological disorders (Hook et al., 2010; Worthington, Hook, Davis, & Ripley, 2008).

Active listening approaches.

Stephen Ministry (Haugk, 1994; Haugk, 2000) provides an example of such a lay Christian counseling model. This approach combines Rogerian-style supportive listening, empathy and positive regard with appropriate Christian interventions, such as prayer and scripture. While research has been done on the value of supportive listening skills and empathy in therapy (e.g., Mishara et al., 2007), to date, no research has been found investigating outcomes for this particular model, or any other lay Christian active listening counseling (Garzon & Tilley, 2009). Thus, support is indirect and implicit rather than explicit for this model.

Cognitive and solution-focused approaches.

Several lay counseling models fall within the Cognitive and Solution-Focused classification, including Crabb (1977), Backus (1985, 1987) and Tan (1991). No outcomes research has been found to date specifically investigating these lay Christian approaches. However, due to close proximity of lay, pastoral, and Christian counseling, it should be noted that religiously accommodating cognitive therapy (CT, e.g., Propst, 1980) and cognitive-behavioral therapy (CBT, e.g., Propst, Ostrom, Watkins, Dean, & Mashburn, 1992) approaches used by professional or graduate psychology student therapists have provided some empirical support. Tan (2007) notes several outcomes studies demonstrate efficacy of religiously oriented CBT with religious clients who are mildly depressed, and to a lesser extent generalized anxiety disorder (see Hook et al.,

2010; Tan & Johnson, 2005; Worthington & Sandage, 2001, for meta-analyses). A recent and larger meta-analysis of fifty-one samples, which included twenty-four CBT samples, arrived at similar conclusions (Worthington, Hook, Davis, & McDaniel, 2011). Consequently, like active listening approaches, their support is indirect and implicit rather than explicit.

Mixed models.

Two outcomes research studies of lay Christian counseling models, which are eclectic with distinctive CBT components, are notable. Toh, Tan, Osburn, and Faber (1994) produced preliminarily positive results, and Toh and Tan (1997) reported significant improvement on all outcome measures as compared to a no-treatment, waiting-list control group. Similarly, several preliminarily positive effectiveness results for a lay counseling model called *Freedom in Christ Ministries* (see Anderson, 1990/2001/2004) have shown promise (Combs, 2006; Fisher, 2006; Garzon, Garver, Kleinschuster, Tan, & Hill, 2001; Hurst, Williams, King, & Viken, 2008; Seitz, 2006). These two models therefore have some preliminary concrete evidence regarding their effectiveness.

Inner healing prayer models.

Inner healing prayer lay counseling models have accumulated some preliminary empirical data. Two clearly identified models have received review in the literature (Garzon & Tilley, 2009), *Christian Healing Ministries* (CHM) developed by Francis McNutt (1974/1999) and *Theophostic Prayer Ministry* (TPM) developed by Ed Smith (1997, 2000, 2002, 2007). TPM is included in this classification, “because of its emphasis on addressing current life stressors through prayer focusing on the client’s past,

frequently involving childhood memories" (Garzon & Tilley, 2009, p. 132), although Smith (2007) draws distinctions between his model and other inner healing prayer approaches.

Investigating the outcomes of CHM, Matthews, Marlowe, and MacNutt (2000), using a nonrandomized waiting list crossover design, investigated whether intercessory prayer improved clinical outcomes among rheumatoid arthritis patients. Clinical significance was demonstrated in two of the ten outcome categories measured, and approached significance in seven others, suggesting, tentatively, that this form of prayer ministry may be useful as an adjunct to standard medical care for certain rheumatoid arthritis patients. Further research was called for.

The empirical literature related to TPM is varied and will be considered following an examination of the criticisms of TPM. These will be outlined and an attempt made to evaluate them in light of TPM publications themselves. Following the review of criticisms, the research literature to date will be presented.

Aftercare in lay helping models.

Within the current mental health climate of evidence based practice, aftercare is a consideration (Thomas & Sosin, 2011). For the Christian seeking counseling, the wider context of involvement in activities of the church and in programs facilitating discipleship ideally continue before, during, and after a period of counseling. Most Christian lay helping models, either implicitly or explicitly, emphasize this ongoing holistic care. Many such models also rely on referral to mental health professionals when indicated. For example, Anderson, Zuehlke, and Zuehlke (2000) recommend an integration model of lay counseling. Depending on the assessment of the individual's

specific need, a church attender or client in conflict seeking counseling help will be referred to a mental health professional, or receive Freedom in Christ church-based ministry help. Whichever treatment plan is followed, the authors outline a holistic context for care, where,

> [T]he ultimate goal is the client's spiritual and psychological health…Once the [therapeutic] goals are accomplished, the client will be restored or introduced to full worship, prayer, praise, fellowship, ministry, and accountability in the local church. The importance of the church community in this process cannot be overestimated. (p. 317)

Some models, such as Stephen Ministries, provide for additional care needs beyond referral to mental health professions in their training manuals. These might include the assistance of medical personnel, or physical care such as help with such things as transportation, meals, or help with the maintenance of a home or care. Other types of assistance lay helpers may need to assess and refer counselees for are legal or criminal justice needs, vocational or educational assistance, and even spiritual help beyond the ability of the lay helper (Stephen Ministries, 2000).

TPM also seeks to work alongside professionals in other fields to provide the best, all-round care for those in need. Referral and concurrent care seem to be the standard. Smith (2007) provides this instruction,

> It is sometimes hard to determine when people are truly mentally ill and when they are merely in bondage of faulty thinking. The good news is that it is not the role of the [TPM] facilitator to figure this out. I [Ed Smith] assume that all people need truth and do ministry on this basis…I do not diagnose people but respect the mental health professionals who do. It is important that Christian ministers and facilitators work hand-in-hand with the mental health community…Building bridges between the church and professionals can only help the cause and provide the best possible care for those we seek to help. (p. 11-12)

Within TPM literature, the concept of "aftercare" is treated somewhat differently. This author has come to the conclusion, based on observational evidence, that this idea is somewhat of a foreign concept to the lay and ministerial community in which TPM is commonly practiced. Within this culture "ongoing" is the common practice of TPM. It is not commonly practiced as a type of therapy that is begun and terminated upon the accomplishment of attainable goals, but rather, it is a form of prayer, in which the goal is not seen as fully attainable in this life. As prayer, TPM is administered and received on an as-needed basis. It can be self-administered or administered within dyads, or groups of individuals who have come to trust and rely on each other for help in spiritual growth along the Christian journey of life transformation. As such aftercare becomes a mute issue.

Criticisms of Theophostic Prayer Ministry

TPM has garnered critics since its first publication (i.e., Smith, 1997). These criticisms are addressed here to evaluate TPM's credibility, and thus its suitability for research. An attempt is made in this section to place the criticisms in the context of the TPM resources available for review at the time of the criticism, and to evaluate the current status of the concerns. In short, has Smith responded to the concerns?

Many have written critically of TPM from the venue of the Internet, but these criticisms are considered beyond the scope of this study. Early criticism came from Bobgan and Bobgan (1999). However, based on the extremist views that these authors have taken, evidenced in several books harshly critical of well-known and widely

accepted Christian therapists (e.g., Gary Collins, Larry Crabb and James Dobson), only their criticisms as echoed by other critics will be addressed.

Theological Criticism

Maier and Monroe (2003) have offered a thoughtful, but now dated analysis of an older version of TPM (i.e., Smith, 2000) from a theological perspective. Major points will be highlighted here, and evaluated, using these earlier TPM publications, as well as the most recent Smith (2007). Elliot Miller, the Editor-in-Chief of the Christian Research Institute (CRI), has also written a two-part evaluation of TPM (see Miller, 2006a, 2006b) using both Smith (2000) and Smith (2005). His conclusions will be used to help in the evaluation of Maier and Monroe's concerns. It must be acknowledged by this author that with both, (a) the evolution in the clarity of TPM over time set against these authors' decade-old theological concerns, and (b) not wishing to veer far from the more applied nature of outcomes research as the primary focus of this study, limitation has been placed on the scope of this evaluation of theological concerns.

Maier and Monroe (2003) offer their evaluation of TPM as it relates to two theological topics relevant to the field of Christian counseling, TPM's (i.e., its author, Ed Smith's) view of sin and its view of healing. It should be noted that the authors diligently seek to use the views expressed by Smith (2000), the current source at the time, as they offer their evaluation. Their critique seems thorough, thoughtful, and sincerely fairminded.

The first set of concerns focuses on TPM's view of sin. They summarize these concerns under these headings,

Three risks of making woundedness the root of sinfulness:

1. Minimizes the seriousness of sin,
2. Minimizes the glory of forgiveness and repentance,
3. Minimizes the power of spiritual disciplines. (Maier & Monroe, 2003, p.180-181)

Maier and Monroe (2003) state, explaining their concern that "TPM minimizes the seriousness of sin,"

> Though we doubt Smith intends to minimize the effects of sin, we find his focus on wounds as the deepest problem, with sin being the pursuit of illegitimate pain relievers, troubling. Scripture does condemn looking for pain relief in all the wrong places, but it also condemns the initial act of turning away from God in the first place. (p. 180)

They further state that TPM "minimizes the glory of forgiveness and repentance," in that "whenever sin is minimized, a predictable result will be a corresponding minimization of the need for repentance and forgiveness. Thus, we will need to be healed more than we need to be forgiven" (p. 180).

Maier and Monroe (2003) are not alone in their highlighting of TPM's view of sin and repentance as an area of concern. Miller (2006b) also addresses this concern, however, apparently with a different perspective on the orthodoxy of TPM's view. It should be noted that Miller (2006b) summarizes his first critique of TPM (i.e., Miller, 2006a) by saying, "TPM per se is not compromising Christian faith with humanistic psychology and occultism, but rather operates within the parameters of orthodox Christian theology" (http://www.equip.org/articles/teachings-in-transition/). Miller

(2006b) evaluates a series of what the author calls "peripheral problems" with TPM, and here clearly addresses the concern of TPM's view of sin and repentance under a section titled "An Inadequate Explanation for Sin in Believers." In this section, Miller (2006b) states,

> In his writings published prior to his dialogue with CRI, Smith affirmed the historic Protestant belief that unregenerate human beings have a persistent inclination toward evil, but he departed from most Protestants on what happens to people when they are regenerated. He took Pauline language that is usually understood to be *forensic* (i.e., referring to a believer's legal or positional standing before God in Christ, e.g., 2Cor.5:21; Phil.3:9) as speaking not only of *imputed*, but also of *imparted* righteousness. In other words, when the Bible says believers are new creatures and the old has passed away (2Cor.5:17), Smith understood this to be saying that the sin nature inherited from Adam is replaced by the righteous nature of Christ.
> Does this mean Christians no longer have an inherent inclination toward evil? One could easily draw this conclusion from TPM's pre-2005 literature, but Smith clarified to me his belief that the same inner principle of sin that enslaves the unsaved continues to exert its pull on believers… Christians still have their old propensity to sin, but they also have a new heart that ultimately leads them to repent and obey God. We find this explanation to be biblically acceptable, and Smith explicitly stated this view in his revised 2005 (current) training manual. (http://www.equip.org/articles/teachings-in-transition/)

Miller (2006b) goes on to explain that, in spite of revisions in Smith (2005), Smith continues to find himself in the traditionally recognized theological tension between emphasizing "worm theology" or emphasizing the presence of Christ, the source of righteousness, within each regenerate person, through faith in Him. Miller (2006a) states it this way,

> Smith is concerned that what he calls "worm" theology, which he believes is prevalent in churches today, leaves Christians feeling that they are wretched sinners with no hope of radical change. We agree that to tell Christians that they have no internal source of righteousness (the indwelling Christ) is to consign

> them to spiritual defeat; however, to tell them they have no sin nature is to leave them unprepared for the battle that lies before them.
> Scripture teaches that Christians continue to possess the fallen nature inherited from Adam (called "sin," "the law of sin," and "the flesh"; see, e.g., Rom.6:11-23; 7:14-24; 1John1:8; Heb.12:1,4). The context of Romans 7 supports, and Smith does not dispute, that Paul was writing as a Christian when he proclaimed that "nothing good dwells in me, that is, in my flesh" (v.18). We know that Christ, who is Goodness personified, dwells in the Christian (e.g., Rom.8:10), and so the flesh is clearly the Christian in-and-of himself—apart from the influence of Christ… Christians throughout the ages have recognized themselves in Paul's dilemma. (http://www.equip.org/articles/teachings-in-transition/)

Maier and Monroe's (2003) certainly concur with Miller's (2006b) view that TPM clearly holds that within every human being exists a fallen nature, and apart from faith in Jesus' atoning work on the cross will continue to sin and stand condemned before God. However, the conclusion reached by Miller as to TPM's view of "the inner principle of sin" in the life of the believer is distinctly different from Maier and Monroe's conclusion. Perhaps this is due to Miller having conversed with Ed Smith, having personally witnessed his demonstration of TPM (see Miller, 2006b), and also his exposure to later TPM sources (i.e., Smith, 2005), Another factor to consider is that perhaps Miller differs in personal theological orientation from Maier and Monroe, which might place them at different perspectives on this theological issue, rendering their conclusions concerning TPM's theological positions dissimilar. In any case, based on their study of early TPM sources, Maier and Monroe state,

> According to Smith, until victims become believers, they must bear some of the responsibility for the construction of the lies due to their darkened heart which has both the capacity to deceive as well as be deceived. However, when a victim becomes a believer, suddenly they are absolved from their role in constructing the lie and they are merely responsible for taking the lie to Jesus to correct it. (p. 178)

From this author's perusal of TPM sources, even early sources, there seems to be a lack of evidence that sin and repentance are minimized within the process of TPM, for any person seeking help, whether believer or unbeliever. Under the chapter heading "When the Wound is Self-Inflicted," Smith (1997) expounds on the seriousness of sin in God's eyes, and laments that it has become unfashionable for churches to take a hard line against sin. Instead, he points out, churches seem more interested in keeping members happy by meeting what they perceive are members' needs, growing numerically, and building buildings. Concerning the TPM process, he differentiates between wounds and sins (note, without drawing a distinction between believers and unbelievers),

> Sin and woundedness are two different things and have two very different sources and remedies. The source of our personal sin is choice…Wounds were inflicted apart from our choice…Since the cross is the cure for sin through the death of Jesus, healing comes from the touch of the risen Lord. There is nothing we can do in our own power or strength to overcome, to put away or to deal with either of these two conditions since both require divine intervention…You do not heal from sin—you go to the cross of Jesus with confession and repentance. 'If we confess our sin…He will forgive us of all unrighteousness. (I John 1:8-9)…While sin requires confession and cleansing through the shed blood of Jesus healing requires a touch from the living Lord who knows and feels our afflictions…Sometimes the painful emotion [that surfaces in a TPM session] is not rooted in a lie, but rather from personal sin. (Smith, 1997, p. 51)

Smith (1997) goes on to instruct the TPM facilitator through the use of illustrative sample prayers. In the case of wounding, the instruction is given to lead the person in a prayer, confessing the act perpetrated against her/him and the emotional reaction it has stirred, asking forgiveness from God for this emotion, and expressing a choice to move toward releasing/forgiving the "wounder" from their sin, as God has chosen to release the one praying from her/his sin, in Jesus' name. In the case of "a willful act of disobedience" a sample prayer is given in which the person confesses and takes responsibility for her/his

specific sin, acknowledging sorrow for the hurt it has caused God and others, powerlessness to overcome it and the shame and guilt it has produced, and a request for forgiveness and cleansing in Jesus' name (see Smith, 1997, for sample prayers).

Later TPM sources do not seem to diminish this view of sin. Smith (2000) lists unconfessed sin among the possible reasons for Jesus not revealing truth during TPM, If there are areas in your life that are sinful, they must be confessed before Jesus will speak. Ask yourself, "Am I ready to be free of this sin, or do I want to harbor it and not be free?" (p. 59)

Smith (2007) clearly states, referring to believers,

> When people come to Jesus, an inner change occurs, releasing them to walk in more consistent victory as they grow in the knowledge of Christ…Hear me clearly when I say that I am not diminishing our responsibility for every sin we choose to commit. I am not suggesting that if we had no lies we would not sin. Lie-based pain motivates many sinful acts; however, we often sin simply because we give into the lusts and cravings of our mortal flesh…my emotional wounds may influence my choices, but never dictate them; the choice to sin still rests completely in my will. (p. 174)

Maier and Monroe (2003) express a third concern that TPM minimizes the power of spiritual disciplines. This conclusion, as the other two previously discussed concerns (see list of summary of concerns above), is based on the conclusion of these authors that TPM views "woundedness [as] the root of sinfulness" (p. 180). As noted above, Smith (1997) makes a clear distinction between woundedness and sin, their origins and how they are overcome and dealt with. It is unclear how these authors conclude that TPM's theology places woundedness as the basis of sinfulness. Based on the quotes from TPM sources above, it is unclear how these authors arrive at this conclusion, "Smith recognizes

that human beings are both wounded and sinful. However, it is clear from a Theophostic perspective that a believer's wounds do more damage and exert more permanent effects than do their post-salvation sinful desires and choices" (Maier & Monroe, 2003, p. 178). As noted above, perhaps pre-2005 TPM sources, on which these authors were basing their conclusions, were less clear on this subject.

Maier and Monroe (2003) refer to TPM's emphasis on experientially receiving God's truth in a session or series of sessions as an easy alternative to engaging in spiritual disciplines to receive healing and freedom from emotional pain and woundedness. These authors express concern that TPM leads people away from the practice of traditional spiritual disciplines as a means to spiritual maturity. Their impression is that TPM is presented as a means to spiritual formation that is faster, more effective, and maintained with minimal effort, contrasted to spiritual growth through engaging in the disciplines, such as Bible reading, meditation, prayer, etc.

Miller (2006b) expresses similar concerns, and notes the evolution TPM sources have made in clarifying its stance in this area. He explains that TPM had drawn a sharp contrast between self-effort and working to gain righteousness (i.e., "performance-based spirituality") on the one hand, and healing gained through TPM as victory over sin that is "maintenance free" on the other. Miller notes that, especially in earlier TPM sources, the choice of words may have caused confusion among readers when dealing with the concepts of salvation or sanctification. However, he points out,

> To Smith's credit, [Smith, 2005] has deleted many references found in previous editions that contrasted works-based sanctification with Theophostic moments and it makes clarifications such as, 'Whenever a believer makes the choice to obey rather than sin he is experiencing victory even if it is through some effort or

> much effort." (Miller, 2006b, http://www.equip.org/articles/teachings-intransition/)

Miller, did not think Smith (2005) went far enough, however, in distinguishing the two, and expressing the significance of each in the life of the believer. However, Smith (2007) does go further in clarifying this distinction, as well as recognizing God's use of other arenas beside TPM in the process of maturing believers, when he states,

> As Christians we understand that salvation occurs the moment we place our trust and faith in the work of Christ. However, there is an ongoing "saving," called sanctification, as the believer is set apart from the ways of the world for holiness. This is accomplished through the indwelling Christ, with the willful cooperation of the believer…In the context of Theophostic Prayer Ministry, the process would look like this. In my life something happens that triggers my lie-based emotional pain. I have to make a choice whether to deny what has been exposed, blame others, bury it or defend myself, or alternatively to submit to God working within me…This same process operates in settings outside of a Theophostic Prayer Ministry session as well. God allows or orchestrates trials to come into our lives that reveal what we believe. As we identify our faulty beliefs, it is God's desire that we confess our sin and false belief, and allow Him to minister His love, and grace to our hearts and minds. (pp. 29-30)

It seems that the above citation of Smith (2007), clearly demonstrating TPM's evolution in clarification, also goes a long way in allaying Maier and Monroe's (2003) concern regarding TPM's model of healing. They express concern that TPM might lead individuals to seek a cure for their problems other than what they outline, using biblical evidence, as "the primary ways God heals his people." In sum, they emphasize the need for engagement in "self-evaluation, repentance, and faith" (Maier & Monroe, 2003, p. 185). Maier and Monroe (2003) also express concern that TPM limits the power of the Bible to speak into an individual's deepest mind. They also express concern that TPM teaches that those who are suffering must seek a new personal truth from God, which they conclude ignores the numerous Scripture passages that speak specifically to such

human conditions. Smith (2007) clearly affirms the authority of Scripture, the importance of Bible study, and teaching and preaching of Scriptural truths as means of ministry. However, he emphasizes a personal encounter with the Holy Spirit as important in the process of sanctification in the life of the individual. He explains,

> Theophostic Prayer Ministry simply encourages people to listen as the Lord reveals His truth to their hearts and minds. Of course, bible study, teaching and preaching are important, but apart from the intervention of the Holy Spirit we cannot fully know truth. Jesus said when "THE SPIRIT OF TRUTH COMES, HE WILL GUIDE YOU INTO *ALL* TRUTH" (*John 16:13).* There is a vast difference between learning about God cognitively and encountering him relationally. Both are important, but one without the other will fall short. (Smith, 2007, p. 26)

Lastly, Maier and Monroe (2003) express concern that TPM too enthusiastically "presume[s] that we can have freedom from old habits of the heart" (p. 186). They seem to take issue with the phrase often used in earlier TPM resources "maintenance free victory." As seems to be a general trend with other concerns, later TPM sources demonstrate greater clarification. Smith (2007) explains mind renewal, the focus of TPM, as a lifelong process,

> All of us have many lies harbored in our minds and pick up additional lies along the way. If we choose not to cooperate with what God is doing through exposing our false beliefs and seeking His truth, we will remain in bondage. The truth is, we will complete this mind-renewal journey at one of two places; either when we die or when the Lord returns. (Smith, 2007, p. 29)

In sum, the theological underpinnings of TPM have generated some concerns, particularly regarding the views of sin in the life of the believer, and what constitutes the concept of sanctification. Evidence seems to indicate that these concerns are somewhat outdated. Current TPM resources seem to largely allay these concerns through greater

clarity. Upon evaluation of the literature to date, it seems criticisms address issues some regard as of more minor consequence, those things which Miller (2006b) refers to as "peripheral," where there is room for varying shades in perspective.

Entwistle 2004 Articles

David Entwistle authored two articles in 2004, Entwistle (2004b) and Entwistle (2004c), expressing critical concerns of TPM. The sources available at the time of Entwistle's critique were Smith (1997, 1999, & 2000). Entwistle's concerns will each be addressed separately.

Entwistle (2004b) asserts five main criticisms of TPM, under the sub-title "practical issues." He summarizes these as follows,

1. Insufficient attempts to ground TPM in biblical concepts;
2. Inadequate and often flawed explanations of basic psychological processes;
3. Dubious claims about the prevalence of DID, SRA, and demonic activity;
4. Estimates of traumatic abuse that exceed empirical findings;
5. The failure to sufficiently appreciate the possibility of iatrogenic memory contamination. (p. 32, numbering added for clarity)

It should be noted that Entwistle did not limit his critique to the most current manual available to him (i.e., Smith, 2000). This is curious since Smith (2000) provides significant revisions, immediately evidenced in the difference in page length of the two, as Smith (1997) has 80 pages and nine chapters, while Smith (2000) has 409 pages and

20 chapters, with revised titles and outlines. There have also been revisions since Smith (2000), and the current TPM manual (i.e., Smith, 2007) will be referred to here when assessing whether Smith has responded to Entwistle's concerns.

Investigation into the first critique of insufficient attempts to ground TPM biblically reveals that the passages of Scripture cited by Entwistle (2004b) as examples to support this assertion are no longer found in Smith (2007), along with the sections in which these examples occurred. It could be concluded that Smith gave consideration to this criticism during the manual's revision process (i.e., Smith, 2007). It should also be noted that Smith (2007) liberally refers to Scripture passages in support of the principles he presents (see Appendix one, Smith, 2007, pp. 209-214, for a comprehensive listing of biblical principles and references that apply to TPM). Further note should be taken of the CRI evaluation of TPM (Miller, 2006a), where the author states, "After an exhaustive evaluation, the Christian Research Institute (CRI) detects nothing unbiblical about the core theory and practice of TPM" (Synopsis, para. 1). Thus, it appears Smith has addressed this criticism.

With the second criticism (i.e., that inadequate and often flawed explanations of basic psychological processes are given), it seems Entwistle (2004b) may have failed to realize the nature of Smith's (1997, 2000) targeted readership. For example, following Smith's (2000) brief, simplified description of a neurological process (i.e., an example Entwistle highlights), Smith states, "I could say much more and there are volumes of information available for those with interest. But, for our interest here, I am trying to keep it as simple as possible" (p. 217). Moreover, in the immediate context Smith quotes

Dr. Karl Lehman, a psychiatrist, who provides a concise, more detailed description of the neurological process which Smith had just described in simplified terms. Consequently, the criticism does not appear to take into account the reading audience and disclaimers that Smith (2000) included when describing these processes. In his latest manual (i.e., Smith, 2007), the explanation of neurological process in question no longer exists, rendering the criticism a mute issue.

The third and fourth criticisms call into question Smith's (2000) claims regarding the prevalence of Dissociative Identity Disorder (DID), Satanic Ritual Abuse (SRA), traumatic abuse, and "demonic interference" (Smith, p. 148, as quoted in Entwistle, 2004b). Entwistle acknowledges that Smith's assertions of proportional prevalence of these particular issues are based on his own personal dealings with individuals seeking his help. However, he dismisses these as "simply not compelling" (Entwistle, 2004b, p. 29), citing discussions and studies within the professional journals.

Moreover, Entwistle (2004b) ponders, "why Smith's observed rates of abuse are above what is typically reported in research, and [asks the reader] to *consider the possibility* that TPM may promote iatrogenic memories" (p. 30, italics added). Yet, two paragraphs previous, Entwistle labels as "indoctrination and suggestion" the following counsel Smith gives to trainees who suspect demonic involvement with a client, quoting Smith, "take things slowly and gradually and lead your client along at a pace at which he is comfortable…You will have to educate them from a Biblical perspective and ask them to *consider this as a possibility*" (Smith, 2000, p. 314, as quoted by Entwistle, p. 30, italics added). One wonders why Entwistle makes suggestions of possible explanations to

the reader of his article, and yet calls into question Smith (2000) for making suggestions for possible explanations to those he counsels. Perhaps each author holds as weightier different epistemological evidence.

It is worth noting Entwistle's (2004a) own counsel regarding the integration of epistemological evidence from the fields of psychology and theology, "When faced with apparent contradictions, we re-examine the psychological and theological evidence, lending greater weight to whichever source provides greater clarity" (p. 275). In light of this, it would seem plausible that Smith (2000) might have legitimate grounds to suggest to his clients the possibility of demonic interference, given the clear and undeniable biblical acceptance of the demonic as real and actively opposing God's purposes (see Smith, 2000, p. 294, for a lengthy list of biblical references to the demonic). The reality and activity of the demonic is clearly beyond the scope of secular psychological empirical validation, due to the spiritual nature of the entity, rendering the "theological evidence" one could argue in this case as weightier. Moreover, TPM is an explicitly Christian prayer ministry (i.e., Smith, 2000, 2007; see below for a discussion of TPM's definition and name change), as opposed to a secular professional counseling model, adding weight to the plausibility of its acceptance of possible demonic involvement.

It should be noted that Smith (2007) does give attention to demonic interference, but gives this subject as a whole much less emphasis than in the previous editions. His theology appears to have changed since his 2000 manual from a more "Charismatic spiritual warfare" model of the demonic to a more reformed theological stance that emphasizes Christ's complete victory over darkness. Smith (2007) also emphasizes the role of free will and choice in any manifestations that appear demonic. It should also be

noted that scholarly works (e.g., Lewis, 2000) have delved into the weighty topic of healing of DID, and its possible connection to repressed memories, SRA, and sexual abuse. Lewis (2000) conducted an exploratory case study of a severely depressed woman with DID who showed marked improvement following an early version of TPM. This study documented the recovery of repressed memories of SRA and abuse that proved to be at the core of her depression.

Entwistle's (2004b) fifth criticism asserts that Smith (1997, 2000) fails to adequately appreciate, and thus provide adequate safeguards against, the creation of iatrogenic memories. Since ethical practice demands that every precaution must be taken to do no harm to those seeking help, the evidence must be examined carefully. However, TPM's alleged lack of adequate appreciation for this pitfall is complex. At least five points are worth noting. First, central to TPM is the identification, exposure, and ultimately the replacing, of lies associated with painful emotional events experienced by the client in the past. It is not the event itself, or the details of what is remembered, that is the focus in TPM, but the lie-based thinking that was introduced into the client's belief system at the time of the event. Secondly, in TPM, a currently triggered negative emotion is identified, and used "as a springboard to help identify the memory containing the lie" (Smith, 2007, p. 88). This seems to indicate that in TPM the client is not promoted to create a memory, but to recognize a memory associated with the present emotion. Smith (2007) instructs,

> As she focuses on these [present] feelings, the facilitator also encourages her to allow any memory that may be associated with these feelings to surface. The facilitator does not have her 'look' for a memory, but only to feel what she feels and allows her mind to surface any related memory on its own. (p. 88)

A third point to consider is that the TPM facilitator is trained to take measures to allow for the free expression of the client's will. This instruction is given that, "The facilitator does not ask the Lord [Jesus] to take the person any place [in the client's memories], since this would be asking Him to violate the person's will" (Smith, 2007, p. 88). It should be noted that this provision has been a modification to the TPM, as Smith (2007) states,

> I used to ask the Lord [Jesus] to take them to the memory or show them where the pain was coming from, but I now see that he will not violate their will...You do not need to ask the Lord to take them anywhere. They will go right to where they need to go when they willfully choose to do so. (p. 94)

Fourthly, the TPM facilitator is trained to rely on the Holy Spirit to not only direct the session, but to expose the lie(s) to the client, and reveal the truth. Smith (2007) directs, "Encourage them and ask reflective questions, but allow them to figure it out under the power and direction of the Holy Spirit" (p. 102).

Fifthly, contrary to Entwistle's (2004b) assertion, "Smith does not seem to be aware of the immense amount of suggestion inherent in his own system" (p. 32), the TPM facilitator is trained not to suggest or interpret a memory for the client. Smith (2007) states,

> During the ministry session, as the person is waiting, I ask her to report any memory pictures that may emerge. Be careful not to make suggestions concerning what the memory might be or where you think she should go. Never offer your opinions as to what you think might have occurred… "Help me! Tell me what is happening to me! Do you think I was sexually abused?" The only correct answer to a question such as this is, "I do not know." Resist the temptation to fill in the blanks. (p. 100)

Smith (2007) emphasizes,

> Some facilitators may believe that they have the gift of discernment and can

> prophetically identify the person's issues, or see pictures that they interpret as describing what is going on inside the person. THIS IS NOT THEOPHOSTIC PRAYER. Please do not do this if you are saying that you are using Theophostic Prayer. (p. 102)

These five points indicate that Smith has vigorously responded in his later manual revisions to Entwistle's (2004b) concerns about the danger of false memory creation (See also Smith, 2007, Appendix Two, pp. 215-218, for a contrasting of TPM with Recovered Memory Therapy).

Entwistle (2004c) provides further criticisms of TPM, with the subtitle "ethical and legal issues." Again, it is curious that Entwistle uses the then outdated Smith (1997) TPM manual, in addition to what was then the current and revised Smith (2000) TPM manual. He summarizes these criticisms as follows:

1. Smith's current methods of teaching TPM through brief seminars and videotaped materials may be inadequate to establish ethical and technical competence.
2. Claims that TPM involves divinely guided healing in which a literal appearance of God should be expected are not well supported.
3. Ethical and legal concerns exist regarding apparent claims guaranteeing healing and claiming superiority of method.
4. Application of TPM to a wide variety of mental disorders without sufficient empirical validation is troubling.
5. At issue is the legal question of whether TPM should be considered a religious intervention or a counseling procedure.
6. The ethical issue of trying to settle this question simply by changing the name from Theophostic Counseling to Theophostic Ministry.

7. Smith's failure to welcome public analysis and critique of TPM is problematic. (Entwistle, 2004c, p. 41, numbering added for clarity)

Firstly, in terms of TPM facilitator training, a far more extensive facilitator training protocol is currently in place, presumably in response to critics. According to TPM's official website, the training protocol has been expanded well beyond what Entwistle (2004c) describes as a limited three-day seminar, or videotapes. As listed on the TPM website http://theophostic.com TPM Basic Training requirements include:

1) Basic Training Video Seminar, which is an 8 DVD Basic Training Seminar session video series.
2) Basic Training Manual, which includes the Smith (2007) training manual, and the Video Seminar Student Workbook.
3) TPM 16 week Study Guides, which is a three-manual set of study guides designed to walk trainees in a group format through the Basic Seminar Manual over the course of 16 weeks, including homework assignments and a comprehensive exam. The group leader is preferably a pastor or other church leader.
4) Live Ministry Demonstration Training, which is a seven live session DVD series with accompanying Student Workbook.
5) Forgiveness chapter, in Smith (2002), which the trainee is required to read.
6) Eight to twelve months of weekly TPM practice among the group members before being allowed to administer TPM outside the group members is strongly encouraged.

7) Upon completion of the training, the trainee is registered by contacting the TPM home office or completing the registration form online at http://theophostic.com/basic_training_completion.aspx (http://theophostic.com/howtogettraining.aspx)

Trainees are strongly encouraged not to rush through the materials, but to follow the suggested 16-week time-frame,

> It is crucial that you learn this ministry well and you CANNOT learn it in a single weekend retreat. You will not learn to apply the principles in a "crash course" environment. This ministry deserves that you become well equipped for the sake of those to whom you will offer help. (http://theophostic.com/howtogettraining.aspx)

During the ensuing years since Entwistle's (2004c) second criticism, concerning the literal appearance of God during a ministry session as not being well-supported, some preliminary empirical data has accumulated. Garzon (2008) conducted an outcomesbased case study research project that documented actual individuals who received TPM. Each individual received 10 hours of treatment, followed by psychological and spiritual tests, and a half-hour interview with a non-TPM trained professional. The tests were also administered at a three-month follow-up. Notably, each participant reported personal encounters with Jesus during the TPM ministry sessions. One described her experience this way, following her expressed willingness to have Jesus reveal the truth concerning her agony, shame, and hopelessness,

> What happened next I can't quite describe. It was like a warm light filled the living room. I saw Jesus in the room…[he] walked over to me and picked me up. I never felt so comforted in all my life. Quietly, He whispered in my ear, "I will never leave you or forsake you." Somehow, I knew it was all right. (Garzon, 2008, p. 15)

At this point, the editor makes this note,

> It is understood that people do not see Jesus in the flesh during a ministry session, but rather a Holy Spirit created word picture representing the presence of Jesus. It is also understood that many people may never have a visual image in a session. God is free to deal with people in any form that He chooses. (Garzon, 2008, p. 15)

In fact, it should be noted, each ministry recipient included in Garzon's (2008) study reports experiencing Jesus' presence in some way. However, this experience is not always described as a visual image. More documented empirical data is needed to further evaluate Entwistle's (2004c) assertion.

Entwistle's (2004c) third criticism concerning claims guaranteeing healing and superiority of method seems to be addressed, at least in some measure, by Smith (2007), when he states,

> Before I began to practice the principles laid out in this manual, I offered traditional Christian counseling. Although I did not have the remarkable experiences of renewal that I now do, there was much good in those early sessions that cannot be duplicated using the Theophostic approach to ministry…Theophostic Prayer Ministry is not the "magic bullet" for all human maladies, although I have found it to be highly effective in resolving lie-based thinking that is often the root of much trouble. The wise facilitator will know when to use this approach and when to use another. (p. 12)

As for claims of TPM's effectiveness, Entwistle's call for empirical validation is certainly justified. As he notes, research has mostly come from case studies, which will be discussed below. Further outcomes research is needed.

Entwistle's (2004c) fourth criticism concerning the application of TPM to a wide variety of mental disorders without sufficient empirical validation is notable. Further empirical outcome research data is certainly needed to validate the generalized use of

TPM. As noted above, in the years following Entwistle's (2004b, 2004c) articles, some empirical research studies have been conducted. Garzon (2008) has gone beyond anecdotal evidence to report favorable findings from his outcomes-based case study research, as have Witherspoon (2002) and Kleinschuster (2004). Findings from Tilley's (2008) dissertation research study, which will be discussed in more detail below, have also lent support to overall positive clients' perceptions of their TPM experience. However, more rigorous outcomes studies are needed to further validate the generalized use of TPM.

Entwistle's (2004c) fifth and sixth criticisms are examined here together. He expresses concern, with legal and ethical implications, as to whether TPM actually falls within the practice of ministry or within the realm of professional counseling. As noted by Entwistle, the name was changed from *TheoPhostic Counseling* (Smith, 1997) to Theophostic *Ministry* (Smith, 2000). The name was further revised to *Theophostic Prayer Ministry* (Smith, 2005, 2007). The revision of the name seems to suggest a development or refinement in the formulation of what is now TPM. However, Entwistle discounts the name change as only cosmetic, and not improvement in terms of better reflecting what TPM actually has been all along. The ethical allegation is discounted if the name change and descriptive terminology has improved the clarity of what TPM actually is in reality. It seems this is clearly expressed in the introduction of the first manual, Smith (1997), when Ed Smith describes *TheoPhostic* this way,

> TheoPhostic is not guided imagery, but rather, divinely guided healing. The pictures and images people may or may not see are not suggestions made by the therapist. These pictures are an unfolding of truth from God…TheoPhostic allows

> God to speak a truth into the reality of the memory releasing the person from the lie which is at the heart of their pain. (p. 10)

Perhaps Smith's use of professional terms, such as "therapist," in the same context as "divinely guided healing" was confusing, leading to criticism. Such criticisms as Entwistle's have apparently proven to be instructive, as later revisions seem to reflect more consistency in ministry oriented terminology.

Smith (2007) gives this definition of TPM,

> Theophostic is a system of prayer designed to help people identify the lies they hold that are causing them emotional pain and disrupting their walk with Christ. I have defined the process as, *intentional, focused prayer leading to an authentic encounter with the presence of Christ, resulting in mind renewal and a subsequently transformed life.* (p. 2)

In terms of being exposed to legal liability, it seems that the revised name and terminology for *Theophostic Ministry* training in Smith (2000) and subsequent manuals (i.e., TPM) are following a course to minimize this liability (see Wilder & Smith, 2002). This direction in terminology revision seems to make a more distinct boundary between what is classified as ministry and the realm of licensed professional services. This is an issue addressed by several authors in articles in the summer 2009 issue of the *Journal of Psychology and Christianity,* discussed below.

Entwistle's (2004c) last criticism concerns Ed Smith's (i.e., TPM founder) alleged failure to welcome public analysis and critique of TPM. A few points are notable in addressing this critique. Firstly, some bold actions of Ed Smith point to a different conclusion. Namely, revisions and changes of the manuals and TPM training regimen (i.e., as outlined above), have addressed specific issues raised by critics (see discussion above for some pertinent examples). There is documentation that Dr. Ed Smith has been

in dialogue through personal correspondence and interviews with various critics (e.g., see Hunter & Yarhouse, 2009b, for references to personal interviews and correspondence with Dr. Smith). Secondly, Garzon (2008) makes this personal assessment of Ed Smith, after working on a case study research project investigating outcomes of TPM, "Aside from the project itself, I found Dr. Smith to be a humble, Godly man who was very receptive to my questions, concerns, and comments. This bodes well for Theophostic" (p. 112). Thirdly, the fact that Garzon (2008) and Tilley (2008) both express appreciation for Smith's help in research investigating the effectiveness of TPM speaks to Dr. Smith's openness to public analysis of this approach.

CAPS 2009 Journal

Hunter (2009b), as the guest editor for the summer 2009 edition of the CAPS *Journal of Psychology and Christianity*, outlines the background and purpose of this edition. She relates that her interest in this project originated in a graduate ethics class, culminating in her dissertation project (i.e., Hunter, 2008). Her stated goal for both her dissertation and this journal edition was not to single out TPM per se, "but rather to use the model as a case study in the relationship between religiously based interventions and professional services" (Hunter, 2009b, p. 99). As part of her dissertation research she moderated a panel discussion at the CAPS International Conference in April 2005, which addressed concerns with TPM. The panel discussion is reported in an article she coauthors (i.e., Hunter & Yarhouse, 2009b) in this journal edition. She notes in her editorial page that,

> Smith has continually acknowledged the critical discussions that have taken place regarding TPM and in some instances, has made adjustments to his model based on those criticisms. However, in order to maintain the integrity of the CAPS 2005 panel discussion, Smith's latest changes in TPM presented in his new Basic Training Manual (2008) are not included in the article. (Hunter, 2009b, p. 99)

What is immediately apparent to this author is that this journal highlights fouryear outdated discussions. The reader is therefore led to assume, based on the high standards of this organization and journal, that any revisions made by Smith to TPM, and any research data or further discussion regarding TPM that have accumulated in the intervening years from 2005 to 2009, are minor and do not address the issues forwarded here. Unfortunately, this is not the case (e.g., see Garzon, 2008; Smith, 2007; Tilley, 2008). This editorial decision to omit inclusion of material from the latest Smith manual (2007) raises questions as to the accuracy, reliability, and validity of the concerns voiced in the special edition regarding TPM.

The theme of the journal is, however, relevant to the fast paced climate of change in the field of psychotherapy regarding spirituality. Sperry (2012) notes a "warming trend" over the last decade among psychotherapists, referring to a more explicit focus on the spiritual within the psychotherapeutic process. A review of the research literature by Post and Wade (2009) reveals that clients now expect that their spiritual and religious concerns will be addressed in therapy. Since the theme of the special edition seems relevant, the question is whether TPM is a good model to use as a case study in a general discussion of possible issues to consider in the "relationship between religiously based interventions and professional services" (Hunter, 2009b, p. 99). Was the cart (i.e., TPM

as a model with alleged issues) placed before the horse (i.e., the integration of spiritual interventions into the clinical setting)?

Noteworthy is that no explanation is given by the guest editor (Hunter, 2009b) as to why TPM was singled out for scrutiny, other than it was the focus of the guest editor's dissertation, and the CAPS 2005 panel discussion. From Hunter's (2009b) own tracking of events leading to the publication of this special edition journal, it seems that her interest in TPM started in 2004 with research she conducted concerning this approach for a graduate class. Her statement that, "The goal of my project and this special edition was not to select a single model such as TPM for scrutiny but rather to use the model as a case study in the relationship between religiously based interventions and professional services" (Hunter, 2009b, p. 99) does not logically follow her description of how she arrived at conceiving of this special journal edition. Upon review of the articles it appears that unfortunately outdated, and in some cases mistaken concerns about TPM were forwarded, rather than an opportunity to hold a general discussion of integration issues as was intended. These articles are reviewed below (Note: A review of Garzon and Tilley (2009) is not included here as it was referenced in the previous discussion of lay counseling).

The first article, Hunter (2009a), authored by the guest editor, gives the reader her view of TPM's epistemological basis. Her conclusions are carefully evaluated here, in light of the evidence. In this article, Hunter (2009a) briefly discusses various current Christian approaches to the epistemological tension involved in integrating theology with psychology. She calls the readers' attention to Christian counseling approaches that

oppose integration (i.e., Adams, 1970, 1981, 1986; Powlison, 2000; Welch & Powlison, 1997), and then discusses various approaches that are more amenable to some form of integration. Within this paradigm, she places TPM alongside inner healing approaches (i.e., Sanford, 1972; Payne, 1981, 1995) within the integration opposition camp, as "hav[ing] no desire for empirical validation" (Hunter, 2009a, p. 103). This sentiment she attributes to Dr. Ed Smith, from his personal communication, March 11, 2004. This, therefore, cannot be independently verified.

In light of verifiable evidence, it would seem, however, that Dr. Smith's personal communications were misunderstood. The evidence cited above of Dr. Smith's willing cooperation and openness to research studies of TPM contradicts Hunter's (2009a) description of his position as a "unitary epistemological position" (p. 102), referring to a lack of openness to empirical validation of TPM. His views should, in fact, be placed among the more balanced epistemological approaches to integration she references, such as Jones and Butman (1991), Hill (2005), and McMinn (1996). To summarize this more balanced position at the end of her article, she quotes Hill (2005), who proposes that "the boundary between psychology and theology is one where scriptural authority cannot be simply declared, but must also be demonstrated, for at this boundary the two disciplines have much constructively to say to each other" (p. 110).

As already noted, evidence that Dr. Smith and TPM find common ground with this statement is found in the fact that both Garzon (2008) and Tilley (2008) express gratitude for the helpful cooperation of Dr. Ed Smith with the research studies they conducted investigating TPM. It is notable that these both predate by one year the

publication of this special edition journal, and so were available to Hunter (2009a) at the time of her writing. Further evidence that Dr. Smith's sentiment toward empirical research studies of TPM is not negative is the inclusion of all such studies to date on the official TPM website, accompanied by the following notation,

> It is acknowledged that the research that has been done thus far is limited to case studies and surveys. However, the results that have come forth do suggest that something positive is occurring in the lives of those who have experienced this form of ministry…The outcome of this limited research merits further study. Therefore in the near future there will be controlled studies that will be conducted to gather empirical evidence for the effectiveness of this ministry approach. (http://www.theophostic.com/page12435058.aspx#s1)

To summarize, Hunter (2009a) distinctively separates those Christian counseling approaches hostile to scientific investigation from those who find an integrative balance of being able to hold to Scriptural truth that can be informed with knowledge offered by science. It would seem that by misplacing TPM, readers of the journal are left with an inaccurate view of Smith's stance. Case in point, Entwistle (2009) leads the reader to assume that TPM is among those who hold to "spiritual metaphysical extremism" (p. 141). He parallels this with his extremist sacred version of Entwistle's (21004a) *Enemies Paradigm* in his discussion of models of integration. This position he illustrates with the tragic death of a 15-month old baby, whose parents insisted on relying solely on prayer for her healing, rather than allowing for the medical treatment of her pneumonia and secondary blood infection with antibiotics.

Entwistle (2009) approaches his topic, *A holistic psychology of persons: Implications for theory and practice,* from a dichotomist paradigm, employing his earlier framework described in Entwistle (2004a) for understanding integration positions. In this

framework, the *Enemies Paradigm* "is based on an assumption of incompatibility in which an *either/or* choice between psychology (or science) and religion (or Christianity must be made" (Entwistle, 2004a, p. 185), in which the "adherents of these models see each other as enemies, and either reject or neglect one of the two books of God: His word or His works" (p. 203). The "enemies" are the two extremist versions, the secular and the sacred. Adherents of the extremist secular version "view religious beliefs as inherently illogical and dangerous" and those who adhere to the extremist sacred version "view personal belief or practice that is based on scientific or logic as a dangerous departure from religious fidelity" (Entwistle, 2009, p. 142). Although not mentioned by name in this context, by implication of Hunter's (2009a) epistemological backdrop, to the astute reader, TPM is inaccurately positioned as extremist on the sacred end of the spectrum, opposed to science and logic.

From the outset, Entwistle (2009) takes a cautioning approach to adding the spiritual element to the bio-psycho-social perspective of personhood now commonplace in psychotherapeutic endeavors. The case he makes for a holistic approach to psychotherapy which includes the spiritual, is reasonable, when he states,

> The extreme positions that were considered at the beginning of this article, those of Albert Ellis [i.e., the secular extreme] and those that led to the death of Ava Worthington [i.e., the sacred extreme], do not leave much room for a holistic understanding of human behavior. (Entwistle, 2009, p. 147)

However, the fact that TPM is misplaced on the sidelines as extreme to those approaches considered balanced and holistic is unfortunate. Entwistle (2009) only mentions TPM once by name, and yet by implication makes some serious allegations as to harmful therapeutic outcomes. Citing Lilienfeld's (2007) identified *potentially harmful therapies*

(PHTs), Entwistle states,

> The use of techniques that may be similar to RMT [i.e., Recovered Memory Techniques] and DID [i.e., Dissociative Identity Disorder] oriented psychotherapy was a major focus of Entwistle's (2004b) critique of Theophostic Ministry (TPM), in which DID, Satanic Ritual Abuse (SRA), and RMT are commonplace. Some religiously-based interventions, especially those that reflect a "healing of memories" approach, may have an increased risk of producing harm in some individuals. (p. 145)

One must go back to the cited source (i.e., Lilienfeld, 2007) to investigate if indeed TPM uses techniques "similar to RMT and DID," and to then validate its being placed among Lilienfeld's list of PHTs. Under the subtitle "Recovered – Memory Techniques," Lilienfeld, citing Lynn, Lock, Loftus, Krackow, and Lilienfeld (2003), states, "Although the data from controlled studies are lacking, there is considerable evidence that suggestive therapeutic methods, such as repeated therapist prompting of memories, hypnosis, and guided imagery, can produce subjectively compelling but false memories in some individuals" (p. 60). Based on the evidence presented above (see discussion of Entwistle, 2004b, fifth criticism), this description of RMT clearly does not represent TPM's techniques, nor is it remotely similar. Thus Entwistle's (2009) suggestion that TPM could be considered harmful to some individuals, as one of Lilienfeld's PHTs, is questionable.

While it has been demonstrated that current TPM training clearly denounces guided imagery and therapist suggestion, very early training in TPM may have been more vulnerable to this criticism. However, both Smith (1997) and Smith (2000) clearly teach that those administering TPM do not use guided imagery or make suggestions to guide the process. Smith (1997) states,

> *TheoPhostic* is not guided imagery, but rather, divinely guided healing. The pictures and images people may or may not see are not suggestions made by the therapist…When I am working with a person, I do not suggest to them what they should see or not see. I simply ask them to simply report whatever they see, sense or hear. (p. 10)

Similarly, Smith (2000) states,

> Guided imagery is visualization created and guided by the therapist. *If this is happening in the session then this is NOT Theophostic Ministry…* The pictures and images people might see during a Theophostic session are not suggestions made by the minister. (p. 8)

Lilienfeld (2007), citing Spanos (1994), states that, "Many advocates of DIDoriented therapy use suggestive methods, including prompting and contacting purported alters through hypnosis, introducing alters to one another, and mapping out the interrelations among alters" (p. 60). Converging evidence suggests, as Lilienfeld (2007) notes, citing Lilienfeld and Lynn (2003), that "many and perhaps most alters [i.e., latent indwelling identities] are products of inadvertent therapist suggestion" (p. 60). Therefore, to be included in Lilienfeld's (2007) PHT's, TPM would need to advocate and train its facilitators to use suggestion, as defined above, in dealing with individuals who are suspected of DID. Evidence, however, demonstrates that this is not the case.

Early TPM publications give DID very little attention. Both Smith (1997) and Smith (2000) relegate discussion of DID to a final section entitled *Glossary of Terms.* In each, a brief description of DID is concluded by the following statement, "Because of the intensity of the emotional catharsis, only counselors fully trained in this area should deal with such issues" (Smith, 1997, p. 72; Smith, 2000, p. 69-70). Smith (2000) states that this topic will be addressed in more detail in the Advanced Training seminar, assumingly includes the same instruction, that professional training is needed to deal with DID cases.

The advanced level training seminars, however, did give more focus to DID and advocated procedures that might have been more concerning regarding how to address this condition. These advanced seminars no longer occur and Smith's view on working with DID has significantly changed.

Smith (2007) presents his updated perspective on DID and teaches that focusing on identifying and naming the various alters, and mapping the individual's inner world is unnecessary and a waste of time. His position on dealing with such individuals seeking ministry is to normalize the situation rather than implying pathology. He instructs TPM trainees,

> Your role is to be aware and focus on what is surfacing, such as emotional distress…You can ask "why?" and "what might happen if?" questions to move deeper in, as long as they only reflect what had been actually reported. Avoid analyzing, do not suggest what direction the session should go in, and never state your opinion about what has happened in the memory context…I simply work with whatever aspect of the person's mind he chooses to present…I know that all parts make up a collective whole…I work with each alter as a collective part of the person and just follow TPM procedures and protocol. (Smith, 2007, p. 151)

This contradicts Entwistle's (2009) claim that TPM uses DID oriented techniques, and therefore invalidates his assessment that TPM is a PHT on this basis. It seems that although Entwistle's criticisms may have been protective in nature, he was clearly unaware of TPM's oppositional stance on suggestive therapeutic methods, and the use of DID-oriented therapeutic techniques. Entwistle (2009) also claims that those religiouslybased interventions, such as "healing of memories" approaches are especially risky in terms of producing harm in some individuals. He cites no empirical studies on "healing of memories" supporting his concern, leaving the reader to assume he is referring to anecdotal testimony. He expresses cautious concern that when harm is done

that damages the religious belief system, adverse effects could be long-term. Indeed, a central tenet of his article is his concern that "religion is valued [in the psychotherapeutic context] merely for its instrumental effects" (Entwistle, 2009, p. 146). Entwistle does not make it clear how this concern pertains to TPM, so it is difficult to evaluate its relevance. Regardless, although TPM has some similarities with "healing of memories" techniques, since hurtful memories typically surface during the ministry process, TPM differs substantially in that these memories only serve as the originator of lie-based thinking, seen as the source of current distress, and so do not need healing. Instead, the mind is in need of renewal through an experiential encounter with Jesus, who brings truth to replace the lies (Smith,
2007).

Anecdotal testimonies of TPM's outcomes seem to vary greatly. While many TPM recipients and ministers make claims of effective results, there are some others who report negative outcomes. In some cases TPM dropouts report a worsening of their emotional pain (Hathaway, 2009). Smith (2007) acknowledges reports of negative outcomes, and suggests that in some cases what is being called TPM is not actually what is being administered. In this case Smith calls upon each ministry recipients to become familiar with what TPM protocols are and hold the TPM facilitators accountable. Another suggested reason for TPM's lack of effectiveness is the reality that the recipient may not have been ready to embrace his or her pain. Other possibilities are whether God may have a different path for attaining freedom and healing for some people, or whether a misunderstanding exists of what TPM can and cannot do (Smith, 2007).

How the rate of negative outcomes for TPM compares to the rate of negative outcomes for psychotherapy in general is a question that needs to be addressed. In an effort to address negative outcomes concerns in the literature, this study has sought to investigate this question. Entwistle's (2009) makes this concluding statement to his cautionary discussion of addressing religious belief within the therapeutic context, "There is a place for dealing with spirituality in psychotherapy, but doing so with a cavalier attitude is dangerous for faith as well as for clients" (p. 146). Certainly, a haughty or arrogant attitude is never becoming or desirable in someone assuming a helping posture, but particularly does not reflect the attitude of Christ, or one who assumes a helping role in his name. Indeed, such an attitude in one who offers such ministry, whether lay or professional, could harm a genuine fledgling faith. It is not clear, however, how this pertains to TPM, or any other religiously-based intervention or such protocols, as it clearly pertains to the individual therapist and his or her personal attitudes. No evidence is given by Enwistle to explain his inclusion of a cautionary reference to an attitude issue in the context of a discussion of spirituality as an element of holistic therapy.

Hunter and Yarhouse (2009b), under the title *Theophostic Prayer Ministry in clinical practice: Issues and concerns,* basically present the discussion of the CAPS International Conference 2005 panel discussion, which addressed TPM, and critical concerns with its use. The concerns discussed are,

1. TPM training requirements;
2. the offering of TPM as a form of counseling;
3. reoccurring emotions after receiving TPM;

4. claims that TPM is maintenance free and the ensuing theological concerns; and
5. the status of current research. (Hunter & Yarhouse, 2009b, p. 149, numbering added for clarity)

As already stated above, all concerns of TPM expressed in this article pertain to the already outdated Smith (2005) *Basic Training Manual*, and the CAPS International Conference 2005, panel discussion. It is curious that these authors do not include current information (e.g., Garzon, 2008; Tilley, 2008; the official TPM website http://theophostic.com) available at the date of their article submission. Also notable are the liberally referenced personal communications (i.e., 19 references to personal communications, as compared with a reference list of 15 retrievable electronic and print resources). This renders evaluation of the concerns, and selected quotes from these unavailable texts, as difficult, as these are not independently verifiable.

Hunter and Yarhouse's (2009b) first point of discussion pertaining to TPM training requirements is a mute issue, due to the fact that the training requirements have changed considerably. That is, a relevant discussion would address the merits of the current training requirements, as outlined above (see http://theophostic.com/howtogettraining.aspx). The second concern they forward echoes Entwistle's (2004c) fifth and sixth criticism. As noted above, the essence of TPM seems to have always been ministry. The name change, omitting the term *counseling*, was beneficial in that the current name better reflects what takes place within the ministry

session, and that being prayer. It seems that those who voice concern that TPM is actually counseling are merely speculative as to the motivation behind the name change being "linked to legal issues [rather] than content and process issues" (Hunter & Yarhouse, 2009b, p. 151, as citing a personal communication from Monroe, April 5, 2004).

The third and fourth concerns presented by Hunter and Yarhouse (2009b) deal with the issue of recurring emotional pain in some individuals who have received TPM, and yet who do not seem to be experiencing the "maintenance-free victory," (Smith, 2005, p. 7; Smith, 2007, p. 24). Alongside this concern are two controversial theological issues. Firstly, there is concern that TPM advocates a model of sanctification that individuals can reach perfection while still living on this earth (i.e., through transformation gained while receiving TPM). Secondly, there is reluctance to accept the possibility of actual direct involvement of Jesus or the Holy Spirit as divinely revealing truth to TPM recipients during ministry sessions.

Smith (2007) addresses much of what is expressed in these concerns (see pp. 24-25). Concerning "maintenance-free victory" he explains,

> I am not saying that if we have a session or two of TPM we will suddenly be free of all difficulties. Our Christian life is filled with struggles and we will only reach sinless perfection in eternity. But when we know His truth experientially where lies were harbored, the pain that those particular lies produced can be completely eradicated. Lies are dispelled one-by-one, memory-by-memory. Every believer can know a victory that is fully empowered by the indwelling presence of Christ, free of striving and accomplished by resting in Him in specific areas where true renewal has occurred. (Smith, 2007, p. 24)

Smith goes on to describe "moment to moment victory" in which Christians

> [H]ave to wrestle non-stop with sin's pull on us… [Someone] who battles every day against sin should not feel that his success is a second-class victory. If

> anything, God will reward him all the more for his faithfulness under pressure. (Smith, 2007, p. 25)

In terms of the Holy Spirit's or Jesus' actual involvement, the self-report of the ministry recipient is, perhaps, the only true measure (see Garzon, 2008), and perhaps effectiveness in outcomes research data would be adjunctively helpful.

The fifth concern raised by Hunter and Yarhouse (2009b) is the recurring echo of the call for validation through empirical data. Although data is accumulating (i.e., see full discussion below), more is needed to provide evidence of improvement in individual's presenting issues. Outcomes based research is needed to validate TPM's effectiveness by giving evidence that transformation of lie-based thinking through divinely revealed truth brings about change in emotional pain.

Hathaway (2009) in his article *Clinical use of explicit religious approaches: Christian role integration issues,* gives a thoughtful treatise of factors that impact the appropriate use of explicitly religious interventions by lay Christian counselors and by Christian mental health professionals. Central to his discussion is a reoccurring theme, being a call for empirical validation of any explicit Christian counseling approaches, such as prayer. Only mentioning TPM specifically once, and notably from a negative stance, he states,

> The open question is whether we have good evidence to suppose a clinically meaningful average net benefit from theophostic counseling and if we can find out whether it might be counterindicated for certain clients based on risk of iatrogenic effects. (Hathaway, 2009, p. 109)

According to Lambert & Ogles (2004), evidence suggests that 5-10% of individuals seeking psychotherapeutic help actually deteriorate. As Hathaway notes, empirical

evidence is needed to demonstrate whether TPM falls within the norm of ninety to ninety-five percent of clients who do not deteriorate while receiving therapy. Hunter and Yarhouse (2009a) continue the discussion on the theme of the integration of religiously based interventions in a licensed setting. Giving recent popular attention that TPM has received in journals and Christian conferences as the reason it was chosen a case study, these authors explore ethical considerations therapists should make if they choose to use it as a clinical intervention. The authors emphasize therapist sensitivity to client cultural and religious diversity, and idiosyncratic beliefs, a broad informed consent, as well as education of the client prior to therapy concerning TPM, its current research status, and other therapeutic options. The ethical implications of fee reimbursement for spiritual interventions are also discussed.

It should be noted that, as is the case with Hunter and Yarhouse (2009b), Hunter and Yarhouse (2009a) make extensive references to personal communications (i.e., 25 references to personal communications, compared to a reference list of 19 retrievable electronic and print resources), as well as a quote attributed to the CAPS International Conference 2005 panel discussion. A quote is also attributed in text to "Smith, CAPS presentation, 2004" (Hunter & Yarhouse, 2009a, p. 162), without a corresponding reference list item to indicate to the reader the context, title, or other identifying information. These types of references do not allow for independent verification when evaluating the points made by the authors.

The discussion in which Hunter and Yarhouse (2009a) engage, expounding Dr. Smith and other proponents of TPM as contrasted with TPM critics, is directed at

therapists and facilitators who choose to implement TPM. A significant development in the delivery options of TPM in Smith (2007) over earlier manuals, which is unfortunately not referenced in this entire 2009 CAPS special edition journal, is the *Body Life Model*. This model, distinct from the traditional one therapist with a single ministry recipient, now termed the *Therapy Model,* is a group format, comprised of three to five individuals. Under a covenant agreement, these group members minister to each other. Each prayer group, as they are called, follows a specific protocol, the *TPM Session Guidelines,* meeting in sessions determined by the needs and lifestyles of the group. Each prayer group is led by a *Prayer Group Leader,* who is trained in TPM. Although group members pray for each other, the Prayer Group Leader is the only one in the group who administers TPM, and only to his or her group members (Smith, 2007).

Had Hunter and Yarhouse (2009a) incorporated information from the then current TPM manual, Smith (2007), several of the concerns raised by TPM critics may have been allayed. For example, in response to the concern for accountability, the group format allows for accountability that is shared among the group members. This had several implications, one being that members can hold the Prayer Group Leader accountable, that the TPM Session Guidelines and protocol are followed, ensuring that pure TPM is administered. Another is that group members can share the responsibility to ensure that each member is being treated with sensitivity in terms of cultural and religious diversity, and idiosyncratic beliefs under the group covenant. Additionally, group members receive the education of what TPM is, and what can be expected, including limitations, as a group, and strengthen the informed consent measure through collective memory of what

was communicated (Smith, 2007). It should be noted that the Body Life Model is recommended for, but not limited to, use by churches and in other lay ministry settings (Smith, 2007), thus somewhat limiting in its application to concerns raised by TPM critics, as cited in Hunter and Yarhouse (2009a).

While points made by Hunter and Yarhouse (2009a) are well taken, especially concerning a comprehensive pre-ministry education of the ministry recipient and a robust informed consent, upon review of Smith (2005) by this author (i.e., the TPM manual under scrutiny as the focus for this 2009 special journal edition), it seems that by and large these things were already being addressed in TPM training, with sample forms provided (see Smith, 2005, the *Hold Harmless Agreement* form, p. 202, the *Hold Harmless Agreement (Expanded version),* pp. 199-200, and the *Evaluation of Ministry Received* form, pp. 197-198). For example, the Evaluation of Ministry Received form begins,

> I _____ have received ministry from _____ with my full knowledge that he/she would be using Theophostic Prayer Ministry as the primary prayer form during my ministry sessions. I have read the introductory materials concerning this ministry and understand the basic concepts…I have read and signed this [Hold Harmless Agreement] page as acknowledgement that he/she stayed within these guidelines as described by this ministry and that I was in full agreement with what occurred. I fully recognize that this person providing ministry may or may not be a mental health professional but rather a prayer facilitator. I understand that Theophostic Prayer Ministry is prayer and does not make any promise of outcome and has not yet been proven effective by way of professional research and or empirical evidence. (p. 197)

The *Hold Harmless Agreement* form addresses the fee reimbursement concern expressed in Hunter and Yarhouse (2009a), as follows,

> I accept this ministry opportunity as a gift and can freely give as I choose to support this cause but am under no obligation to pay for this service. If I choose

> to contribute any money to this ministry, it is a token of my appreciation and not as payment for service rendered. (Smith, 2007, p. 229; see also Smith, 2005, p. 201)

These same forms are included in Smith (2007) with only minor revisions (i.e., the *Hold Harmless Agreement*, p. 229, the *Hold Harmless Agreement (Expanded version)*, p. 227, and the *Evaluation of Ministry Received* form, pp. 230-231, along with the added *Informed Consent For Lay/Church Ministry* form, p. 226).

With this evidence, it seems that, for the most part, the concerns for the implementation of TPM in a clinical setting expressed in Hunter and Yarhouse (2009a) are justified, as directed toward potential facilitators and therapists. However, unless the reader has access to Smith (2005; 2007), it is not apparent from the reading of this article that TPM does in fact provide the training and tools necessary for its ethical implementation.

Garzon, Worthington, Tan, and Worthington (2009) provide a thought-provoking discussion of potentially unmet client expectations of clinical therapists and the therapy they offer. As these authors argue, many individuals seeking Christian counseling have already experienced some form of lay or informal helping, which sets a precedent for what they may expect of Christian clinical therapy. They do not address TPM, however, other than to mention it as "a current popular lay ministry model," (p. 115). It is noteworthy that they reference the current TPM manual, Smith (2007), as does Garzon and Tilley (2009), the other article not reviewed here.

Monroe and Schwab's (2009) well researched article entitled *God as healer: A*

closer look at biblical images of inner healing with guiding questions for counselors provides Christian therapists with a biblical context for understanding the construct of healing. Although the authors do not mention TPM by name, Hunter's (2009b) guest editorial page explains its inclusion on the basis that it allows the reader this biblical lens through which to view healing and change as it relates to the discussion at hand. Unfortunately, it reflects a disregard of Dr. Smith's characterization of TPM as mind renewal, not inner healing. In Smith (2007), Dr. Smith clearly states that his early writings used healing terminology, for example the title of Smith (2002), *Healing life's hurts through Theophostic Prayer,* which the author hopes to revise with a more current title (Smith, 2007). Dr. Smith explains that he came to realize that *mind renewal* better expresses what was actually taking place in TPM, since,

> Mind renewal is not about restoring my mind back to a healthy place, but rather replacing or renewing my old thinking with new. The Holy Spirit does not heal my thinking, but rather replaces my thinking. An exchange takes place of my falsehood for His truth. (Smith, 2007, p. 155)

It does seem to this author, however, that this editorial decision is an indication of an underlying issue that seems to echo in the TPM literature, specifically within the writings of TPM's critics. This issue could be described as a resistance to recognize the most up-to-date documented revisions or refinements of TPM as authoritative and preemptive. Notably, Smith (2005) found it necessary to address this specific point in his introduction, subtitled, *Appreciation for positive criticism and review*,

> It is the desire of this ministry to continually refine and improve, and therefore it appreciates all positive suggestions and critical review. This manual contains the current teaching on Theophostic Prayer Ministry. Any previous editions of this manual are now out of date and no longer represent the current teaching of this ministry. (p. 1)

Similar statements can be found on the TPM website (see http://www.theophostic.com/page12425022.aspx). For a relatively newly developed model for soul-care ministry (i.e., since 1996), it seems to be within reason that its training manual has been refined and revised several times (i.e., Smith, 1996, 1999, 2000, 2005, 2007). For a public critic from the vantage point of the internet to ignore current revisions in a critical review is one thing; however, for credentialed Christian authoritative figures in the field, it is quite another.

For the purpose of this study, the central theme that arises from a critical review of this CAPS 2009 journal highlighting TPM, and the Entwistle (2004b, 2004c) articles, is the clamoring for further research. Particularly outcome research seems to be needed, investigating the question of the effectiveness of TPM. Critics have pointed to enthusiastic anecdotal claims made by Dr. Smith and other proponents of TPM, and, justifiably have asked for evidence to substantiate such claims. Documented evidence is needed to evaluate whether TPM recipients do indeed experience improvement in their symptomology. As noted by Hathaway (2009), evidence is also needed to demonstrate whether the percentage of TPM recipients who deteriorate falls within the normal range.

Interpersonal Neurobiology and TPM

While Smith has not proposed a theory in neurobiology, perhaps a brief look into the empirically based developments in the interdisciplinary field of interpersonal neurobiology (IPNB) may be helpful at this point. Daniel Siegel (2012), a foundational proponent of the field, explains,

> IPNB is not a branch of neuroscience, but a broad field drawing on the findings from a wide range of disciplines that explore the nature of what it means to be human…[it] seeks to create an understanding of the interconnections among the brain, the mind, and our interpersonal relationships. (p. 3)

This approach to understanding and promoting well-being, makes some groundbreaking assertions that blend science with the subjective side of life, namely human consciousness, inner ways of knowing, and other processes such as a sense of feeling, love, and connectedness. It proposes that neural connections are shaped by human relationships, and that both neural linkages and human relationships shape the mind. The reverse is also true, that the mind shapes relationships and the brain. Specifically, the mind (i.e., mental process) is seen as a process that is both embodied and relational, meaning that it emerges not only from neural functions throughout the body, but also from communication patterns that occur within relationships. It is the mind that functions as a regulatory process for the flow of energy and information. Energy and information is shared within the context of relationships, and move through the physical mechanism of the brain and neural connections of the nervous system of the body (Siegel, 2012).

Siegel (2012) proposes that "integration is the heart of health" (p. 9). Put very simply, integration is the processing and weaving together of the various modes of information that an individual encounters throughout life. This information comes as sensory stimuli from the outside world through the sensory system, and these information patterns of neural firing are represented as mental symbols in the brain. Through the activity in its various circuitry areas, the brain creates what can be called

"representations" of the assorted types of information about both the individual's inner and outer worlds (Seigel, 2012).

Key to integration are interpersonal relationships, which are seen as facilitating or inhibiting the human drive to integrate life experience into a coherent whole. Drawing on attachment theory, developed by John Bowlby and Mary Ainsworth (Ainsworth & Bowlby, 1991), IPNB recognizes the crucial shaping influence communication patterns have on the developing mind, particularly the communication of emotion. Siegel (2012) explains,

> Research suggests that emotion serves as a central organizing process within the brain. In this way, an individual's abilities to organize emotions – a product, in part, of earlier attachment relationships – directly shapes the ability of the mind to integrate experience and to adapt to future stressors. (p. 9)

A process called by Siegel (2009; 2010; 2012) as "mindsight" largely mirrors what attachment theory conceptualizes as the interpersonal communication patterns of those individuals with a secure attachment. Through a caregiver's attunement to a child, the caregiver is reflecting back to the child an accurate picture of her internal world through attentive communication, allowing her to learn how to sense her own mind with clarity (Siegel, 2010). "Emotional communication," or dyadic regulation between the child and caregiver, and even later in adult relationships, is central to the development of emotional self-regulation, and empathic resonance. The evolving identity of a child is also closely linked, as Siegel (2012) affirms, "[e]motional regulation is initially developed from within interpersonal experiences in a process that establishes selforganizational abilities" (p. 13).

Awareness of another's state of mind largely rests on how well one knows one's own. Empathic resonance is rooted in feeling one's own feelings. However, resonance with others may even precede self-awareness. Siegel states, "[t]he mind we first see in our development is the internal state of our caregiver. We coo and she smiles, we laugh and his face lights up. So we first know ourselves as reflected in the other" (p. 62). Further supporting the brain, mind, relational inter-connection, through neuro-imaging neuroscientists can identify which brain circuits participate in this reflective and intimate dance. Such technologies have opened up new avenues to explore how one individual's attunement to another's internal world stimulates the development of these particular neural circuits (Seigel, 2010).

Mindsight begins to naturally develop in "healthy" secure relationships as infants. Central to mindsight is the ability to reflect, a construct that is described as encompassing openness, observation, and objectivity, both to the inner workings of oneself and to the inner world of others. Siegel (2010) describes mindsight as,

> [A] kind of focused attention that allows us to see the internal workings of our own minds. It helps us to be aware of our own processes without being swept away by them…it allows us to "name and tame" the emotions we are experiencing, rather than being overwhelmed by them. (p. *ix-x*)

In psychotherapeutic terms, the therapeutic relationship has been well-established as the most robust factor within the therapeutic endeavor that is linked to positive outcomes. Building on this, Siegel (2009) posits that within the common features of the therapeutic relationship mindsight is clearly active. According to Siegel, "at the heart of effective therapy may be the capacity to cultivate our human ability for empathy and insight as we promote kinder relationships…Mindsight is an internally and

interpersonally integrative process" (p. 165). He proposes that communication between individuals that honors the distinctive experiences of each other, and yet brings them together is "integrative communication." This interpersonal integration of mindsight enables individuals to be open to another's emotional states, make sense of another's needs, and respond effectively. The neurological explanation Siegel (2009) gives for what is taking place is as follows,

> Based on a wide array of scientific findings [including in the field of neuroplasticity] and their consilient analysis, we would propose that integrative communication activates neuronal firing that is integrative and produces the conditions to promote growth of integrative fibers in the nervous system…This is how "emotionally therapeutic" relationships are at their core integrative as they [stimulate neuronal activation and growth] SNAG the Brain. (p. 166)

Of particular interest in the present discussion of TPM is IPNB's framework for addressing traumatic memories. Research studies using brain imaging have shown specific mental functions, such as recalling past events, are correlated with patterns of neural firing. A brain scanner "lights up" as certain mental tasks are performed, often measuring blood flow to a specific area of the brain, implying neural activity with the increased oxygen use. An "experience" activates clusters of neurons, and as Siegel (2010) explains,

> In memory terminology, an experience becomes "encoded" by the firing of neurons in groups. The more often these neural clusters, or "neural net profiles," fire, the more likely they are to fire together in the future. The trigger that cues the retrieval of a memory can be an internal event – a thought or a feeling – or an external event that the brain associates in some way to a happening in the past… Memories shape our current perceptions by creating a filter through which we automatically anticipate what will happen next. In this way the patterns we encode in memory actually bias our ongoing perceptions and change the way we interact with the world. (p. 148)

Scientific findings of more recent years have allowed greater understanding about memory retrieval. For example, a key fact now scientifically understood is that retrieving encoded memory from storage does not necessarily enter a person's awareness as something coming from the past. Siegel (2010) explains that this type of memory is *implicit memory*, as opposed to *explicit memory*. Explicit memory is retrieved as both (a) factual, meaning that, "we *do* have the feeling that we are bringing something from the past into our awareness," and (b) episodic, meaning that, "[y]our internal images are linked both to facts and to a sense of yourself within that particular experience or episode that took place in the past" (p. 153). Implicit memory retrieval, however, is very different, due to the process of encoding. The brain, by not passing the information through the hippocampus within the limbic region of the brain – the area that integrates widely separated area of the brain, and requires focused, conscious attention to harness – does not "tag" the memory for retrieval as something emerging from the past. Encoding of implicit memory happens throughout life, but researchers believe that during the preverbal first eighteen months of life, only implicit memory is encoded. This encoded information is in the form of sense perceptions and emotional reactions within relational experiences with a caregiver in the case of an infant, and other relational experiences in the case of an adult (Seigel, 2010).

The six domains of which implicit memory is comprised are perception, emotion, bodily sensation, behavior, mental models, and priming. Implicit memories are described by Siegel (2010) as "puzzle pieces of the mind that form the foundation for how the past continues to influence us in the present" (p. 150). He explains further,

> [t]he implicit mental models that each of us has filter our ongoing perceptions and prejudge our experiences. And yes, they likely contribute to all sorts of attitudes and beliefs we carry around – whether about ourselves or other people. Our implicit models can manifest as a feeling in our bodies, an emotional reaction, a perceptual bias in our mind's eye, or a behavioral pattern of response. We do not realize we are being biased by the past; we may feel with conviction that our beliefs and reactions are based on our present good judgment. (p. 152)

The good news is that through neuroplasticity, implicit memory models can be changed, by integrating them into explicit memory. Neuroplasticity is the scientifically proven ability of the brain to stimulate new patterns of neural firing and thus new synaptic linkages. The power to shape the actual architecture of an individual's own brain, and to create new, more healthy patterns of thinking, feeling and behaving in everyday life, rests in that individual's voluntary intentional focus of mental attention. This takes place as one becomes more open to one's own body states (e.g., emotions, bodily sensations, etc.) and relational inter-connection and resonance with another or others, and the information about oneself these two sources bring into conscious awareness (Siegel, 2010).

Siegel (2010) sees integration as "the key mechanism beneath both the absence of illness and the presence of well-being" (p. 65). Therapeutic work with individuals presenting with issues rooted in implicit memories suggests they have impairment to their integration. Implicit memory, like disintegrated puzzle pieces, are like the past intruding on the present, can take many forms, such as bodily pain, flashbacks, unexplained emotional arousal, avoidance of certain behaviors, numbing, etc. According to Siegel, such fragmented experience must first be integrated into explicit memory, and then assimilated into the whole individual as a unique person. It involves a dual focus of

awareness, one in the present moment, and the other in the implicit reactivation. By retrieving the implicit memory "in the presence of an attuned other," from the vantage point of a safe place with this other person, modification of implicit-only memories to explicit, is possible "by retrieval with reflection and release" (Seigel, 2010, p. 162-163).

Although Seigel (2009; 2010; 2012) certainly does not address whether God may serve as an "attuned other" fostering the retrieval and integration of implicit memory, one wonders whether TPM promotes a prayer-based spiritual experience of sensing God as an attuned other that fosters such retrieval, integration, and healing. Likewise, Siegel (2010) never refers to the belief of "lies" embedded in memories that are influencing behavior and emotional responses in the present, the terminology he chooses to describe the integrated experience of his client, Allison, however, is curious, in Seigel (2010),

> However, finding a way to *embrace the truth* did much more than resolve Allison's symptoms. As she explored the many layers of her adaptations to the pain of her childhood, Allison wove her newly assembled explicit memories into a larger, more coherent framework for what made Allison Allison…She had recast herself not only as someone who had survived, but as a person who could thrive. (p. 163, italics added for emphasis)

It seems plausible to this author that a correlation could exist between the scientifically based theoretical framework of IPNB, as proposed by Siegel (2009; 2010; 2012), and TPM. When the two are juxtaposed, what stands out is the inclusion of the spiritual element in TPM, to the bio-psycho-social foundational structure of IPNB. Of course, since TPM was developed within the context of a biblical worldview, it is accepted that man has a spiritual element to his nature, and can be in relationship to a spiritual being; and God, a spiritual being, is capable of relating in a personal way to

humans, and is a vital player in the process of TPM and in bringing about positive therapeutic outcomes.

Apart from this stark difference, it would seem that IPNB and TPM have many points of commonality. Moreover, IPNB could offer some insightful scientifically based explanations for what might be happening with those who report positive outcomes from TPM. Some questions certainly arise from the comparison of TPM and IPNB: Could mindsight not be powerfully experienced and learned through an intentional focus and the seeking of a resonating attuned experience with Jesus himself, as facilitated by another Christ follower? Could Jesus, through the conveying of his divine insight and empathy, activate the hippocampus in the brain, and thus bring about the integration of implicit memories into explicit, and the healing of emotional pain? Could the power of the indwelling Holy Spirit in the life of the believer foster lasting victory over past unresolved implicit memories, as expressed by Smith (2007), “free of striving and accomplished by resting in Him in [the] specific areas where true renewal has occurred?” p. 24). These are questions that deserve consideration.

TPM Research

Lay Christian counseling models have very limited research, as compared to the field of paraprofessional counseling as a whole. TPM is among the few that have accumulated some empirical data. Several surveys and one outcomes-based case study research project have demonstrated promising results that merit further research (Garzon & Tilley, 2009). These studies are examined here.

As preliminary descriptive research of TPM, researchers Garzon and Poloma

(2003), with the cooperation of Theophostic Ministries, conducted an internet survey using a convenience sample. It was reasoned by the researchers that respondents must have enough knowledge of TPM to give meaningful responses, both positively and negatively. So Theophostic Ministries agreed to send a survey participation invitation to all persons for whom they had an email address (i.e., all those individuals who had ordered basic TPM materials, N=4347). A total of 1379 individuals completed the survey, with 27 of these discarded because of submission problems or insufficient information given on the survey. This left a final usable N of 1352 (Garzon & Poloma, 2003).

Garzon and Poloma (2003) made a four-fold enquiry with their survey. They wanted to know who was using TPM, whether recipients were satisfied with this prayer approach, how efficacious those using TPM perceived it to be, and how willing those using TPM were to be involved with mental health professionals trained in TPM in a supervisory role. In order to develop the best possible survey instrument to measure these responses, and yet limit it to require about ten minutes to complete, the researchers sought the input of lay and professional counselors, as well as pastors, and tested a pilot version on 111 participants. Care was also taken with the wording of the invitation, to ensure that respondents knew the researchers were not affiliated with Theophostic Ministry, and that both positive and negative responses were welcome (Garzon & Poloma, 2003).

Respondents indicated that they were largely evangelical Christian (89%), spread among a variety of denominations (i.e., Charismatic, Baptist, Pentecostal, mainline

Protestant, etc.). A majority were trained in TPM at the basic level (66%), with 36% reporting attending an advanced training seminar. In terms of mental health training, 9% reported being licensed clinicians, 2% working to collect licensure hours, and 5% counseling or psychology graduate students. Thirty-seven percent reported being lay counselors, 11% pastors, 10% pastoral counselors, and an "other" was selected by 25% of respondents, indicating they were other professionals, including teachers, chiropractors, nurses, and church administrators.

In terms of respondents' reported willingness to be supervised by TPM trained mental health professionals, 51% indicated they would be interested in it, 38% indicated they might be interested, and 11% indicated no interest in such supervision. Among the lay counselors, positive responses were even higher. Fifty-seven percent of this category responded that they were interested, and 37% indicated they might be interested in it (Garzon & Poloma, 2003).

A total of 83% of the sample reported that they had personally received TPM, with most respondents indicating a high degree of satisfaction with this prayer approach. Of those who had received TPM, 14% reported having never used it in ministry with other people. This sub-group provided the researchers with what is considered within outcomes research a typical measure of client satisfaction. Of this sub-group, 44% reported that TPM was the "most beneficial of anything I've tried," 38% indicated that it was "very helpful," 14% chose "a little helpful," and 4% found it "not helpful." Respondents who had received TPM and were using it in ministry, 52% reported that it was the "most beneficial of anything I've tried," 39% indicated it was "very helpful," 8%

said it was “a little helpful,” and 1% found it to be “not helpful” (Garzon & Poloma, 2003).

Additional information gathered from respondents concerning the setting in which TPM was being administered indicated that 72% of the total sample used ministry-related settings, 18% used a professional private practice setting, 3% used secular social service agency setting, and 16% indicated a setting not listed among the options (note from authors, respondents could indicate more than one setting option). Eight percent of respondents indicated they previously used TPM, but no longer use it, while those who indicated that they use TPM, largely use it often (i.e., 49% use it in 75% or more of their cases, 15% use it in 51-74% of their cases, 14% use it in 26-50% of their cases, and 17% use it in 25% or less of their cases, Garzon & Poloma, 2003).

Garzon and Poloma (2003) noted from their results, firstly, that since a large number of survey respondents indicated that they benefitted from TPM, this preliminary outcomes data of client satisfaction showed promise as a starting point and merit for further research. Secondly, respondents in this sample using TPM indicated a high degree of success, across a wide range of conditions, with no significant difference between lay counselor and licensed clinicians perceptions of efficacy. The researchers did note, however, that a larger sample of professionals may have demonstrated greater efficacy perception differences. Discussing the wide range and complexity of conditions being treated by these lay counselors, the authors noted the increasing role lay helping has played to mitigate the lack of adequate professional mental health services, particularly in limited-resource communities faced with managed care and limited access to insurance.

They encourage clinicians familiar with TPM to become increasingly involved with lay counselors using this model, as respondents indicated they largely were open to such supervision, and such supervision and consultation were in the interest of overall client care (Garzon & Poloma, 2003).

Garzon and Poloma (2003) point out the large N size, and the heterogeneity of the sample, as producing some interesting preliminary findings. However, they note three main limitations of this study, suggesting caution in the interpretation of the findings. Firstly, the study lacked a randomized sample, opening the possibility of selection bias, as those who chose to return the survey may differ significantly in their perceptions of TPM than those did not choose to return it. Secondly, as a self-report in which respondents summarized their perceptions of TPM over an undetermined time period, actual efficacy may vary from reported efficacy. Thirdly, information was lacking in whether respondents actually used TPM as prescribed by Dr. Smith. They concluded that initial findings call for further research with better design, such as outcome-based case studies and even quasi-experimental designs, comparing implementation of TPM in lay counselor and clinical settings. Surveys were also called for, including items pertaining to training in other counseling techniques, personality trait items or inventories, indicators of uniformity in TPM protocol among those reporting positive and negative perceptions, and the utilization of randomized sampling design (Garzon & Poloma, 2003).

Garzon and Poloma (2005) reported results of a pilot survey, seeking to ascertain who was using TPM. They also wanted to know what disorders were being treated, and practitioners' perceptions of this approach's efficacy. The survey was administered at a

TPM advanced training seminar, which had 148 attendees. Seventy-four percent of these voluntarily completed the self-administered survey, with a respondent N of 111 (Garzon & Poloma, 2005).

Survey respondents, as all Advanced Theophostic Training conference attendees, had completed a Theophostic Basic Training seminar. Completion of at least 30 hours of TPM with other people, and receiving at least 10 hours of personal TPM were suggestions for attendees, but not required. Survey respondents were invited to participate through an announcement made during the second day between-session breaks of the four-day conference. Surveys were passed out and collected during the session breaks for the remainder of the conference. The invitation to participate described the survey response as anonymous and optional. Survey conductors were available during the breaks to answer questions, but no controls were put in place to prevent collaboration while completing the forms. The survey instrument was developed by the researchers, in consultation with both mental health professionals and lay counselors trained in TPM (Garzon & Poloma, 2005).

About one-fifth of the respondents were pastors or pastoral counselors, one-fifth were licensed mental health professionals, 44% lay counselors, and 10% indicated the option “none of the above.” Various religious affiliations were indicated, with 27% of respondents Pentecostal or Charismatic, 33% nondenominational, 9% Baptist, 3% Episcopal, and 21% various other denominational categories. Ninety-three percent of respondents described themselves as “Spirit-filled,” and 97% indicated they were

evangelical Christians. Eighty-six percent of respondents reported that they went to church twice or more times a week (Garzon & Poloma, 2005).

The conditions that respondents indicated they had addressed using TPM included depression, general anxiety, anger, sexual abuse, DID/MPD, panic attacks, personality disorders, physical abuse, sexual addictions, phobias, and drug/alcohol abuse. Overall, of the respondents, 82% of licensed professionals and 95% of the remainder of the sample indicated that they valued using TPM when treating other individuals as "more" or "much more" effective than other approaches. Garzon and Poloma (2005) present a table of percentages of showing two columns, one of respondents who were licensed and the other column of the remainder of respondents' ratings. Each line reports the condition listed above that was addressed, with ratings of "more" and "much more" effective than other approaches for each condition. The percentages range from 66% to 100%, with licensed practitioners ratings averaging 10% lower, for all conditions except those with less than 10 respondents reporting usage of TPM with that condition.

Garzon and Poloma (2005) again discuss the current mental healthcare crisis in the United States, regarding the limited options for those without insurance or short-term managed care benefits, and its implications. The primary implication that is readily apparent from this survey's findings is the question of adequate training for lay counselors who appear to be addressing complex conditions in those individuals who seek their help. They note,

> Without a doubt, client welfare is a critical issue in considering the Theophostic phenomenon…Clearly, some of the burden for redressing this situation lies with licensed Christian clinical practitioners. The ethical imperative has a

> counterbalance in this situation as well – the mandate not to abandon people needing care. (Garzon & Poloma, 2005, p. 394)

The authors recognize three main limitations with this study. First, the sample size, while acceptable for a descriptive study, was small. Secondly, the scope was limited, with important questions still to be answered concerning TPM. For example, it would have been helpful to determine how many of the lay counselors were receiving supervision. Thirdly, the homogeneous nature of the sample (i.e., only those who are seeking advanced TPM training) as limiting in terms of generalization. For example, it is doubtful that this sample contained a representative group of individuals who were not satisfied with TPM (Garzon & Poloma, 2005).

Since there is indication that lay counselors using TPM are open to being supervised by TPM trained licensed Christian mental health professionals (see Garzon & Poloma, 2003), the authors recommend that such professionals become more involved with those lay counseling settings, such as church counseling centers. Further research is also recommended, particularly outcomes-based case studies and randomized clinical trials, to provide empirical clarity on whether the perceived efficacy of TPM as suggested from these findings has merit (Garzon & Poloma, 2005).

Tilley (2008) conducted a descriptive online client satisfaction survey to assess the effectiveness of TPM, with the assistance of Dr. Smith. Participants were invited to participate through a personal email from Dr. Smith using the TPM database, and through a public invitation posted on the TPM website http://www.theophostic.com. The invitation provided information about the voluntary nature of participation, how to communicate in an unbiased way to others who had received TPM and might want to

participate, and the link where the survey could be accessed. Care was taken to communicate that positive and negative experiences were welcome (Tilley, 2008).

The five stated purposes of Tilley's (2008) research was to investigate TPM clients' perceptions of the impact TPM had on their process of forgiveness, their relationships with others, issues that have most improved by TPM, and overall perceived effectiveness of TPM – all as compared to counseling experiences prior to TPM. She also wanted to investigate TPM clients' perceptions of TPM's impact on their relationship with God. The survey was specifically designed for this study by the researcher, who was not affiliated with TPM, nor had ever used or experienced TPM. The survey respondents were self-selected, and criterion for inclusion was previous experience with TPM (Tilley, 2008).

Demographical information showed that the sample, an N of 2,818 individuals, was heterogeneous in many regards. The largest category of respondents indicated they were between "46-55" years of age. Seventy-eight percent of respondents were female and 22% male. Respondents came from every state in the United States, and also from outside the United States. Denominational affiliation reported was diverse, with nondenominational the highest frequency (33%), and Pentecostal/Charismatic the second highest (14%). Fifty-three percent of respondents reported church attendance twice or more per week. More than half of respondents (53%) reported receiving TPM from a lay counselor, and 21% from a pastoral counselor, 19% from mental health professional, and 16% indicated "other" (Tilley, 2008).

Findings from the Tilley (2008) survey gave overall positive feedback from respondents. For forgiveness issues, almost half of respondents (48%) indicated that TPM was "The most helpful thing I've tried," and 26% reported TPM as "very helpful," and 1% reported TPM "not helpful." By comparison, of those respondents who had previous counseling only 4% indicated that it was "The most helpful thing I've tried," whereas 20% indicated previous counseling was "not helpful" for this issue. Similarly, with personal relationships, 61% reported that TPM had "Significant positive change," and a further 33% reported "Some positive change." From previous counseling, 14% indicated "Significant positive change," and 59% "Some positive change" (Tilley, 2008). The top five issues in order of frequency which respondents reported most improved were drugs and alcohol addictions, panic attacks, memories of sexual abuse, grief and loss, and memories of physical abuse. As compared with counseling experiences prior to receiving TPM, respondents reported greater levels of improvement for all issues. When rating the overall helpfulness of previous counseling, 46% indicated it was "helpful" or "very helpful," and only 4% endorsed "The most helpful thing I've tried." By comparison, respondents rated TPM's overall helpfulness at 62% as "The most helpful thing I've tried," and "very helpful" at 25%. Only 4% indicated TPM was "A little helpful" or "Not Helpful." Regarding their perception of TPM's impact on their relationship with God, 37% indicated it "Deepened enormously," 32% reported it "Deepened significantly," and only 6% indicated "No change" (Tilley, 2008).

Tilley (2008) discusses strengths of this research study as having been the large sample size, and the homogeneity of the sample. She also noted the low percentage of

respondents who did not find TPM helpful, even though the survey was open to positive and negative responses. It had limitations, however, in its use of a convenience sample, and the use of self-report and the potential human error involved with reporting retrospectively about emotional of emotional states. Recommendations for further study include prospective survey for those seeking TPM, to get a pre-and post-treatment perspectives. Also, Tilley (2008) recommends that this data merits further investigation with quasi-experimental and random control group studies.

Garzon (2008) reports an outcome-based, time series 16 case studies project investigating effectiveness of TPM. To ensure those administering the TPM were truly delivering the approach according to the prescribed TPM training manual, licensed mental health professionals and lay counselors were selected who had met the training requirements Dr. Smith provides (i.e., attended the Basic Training seminar, which included reading all required materials, viewed all required videos, and viewed a demonstration of TPM, plus attended the Advanced Training seminar, and attended a week of Level One Apprenticeship training), and had also attained a high level of experience using TPM (i.e., completed a minimum of 100 hours of administering TPM). The clients who met with the professional therapists in the study were typical clients who seek regular outpatient psychotherapy, for typical problems, such as depression, anxiety, etc. The lay counselors in the study worked with individuals typical of those who seek help from church prayer ministry centers. It should be noted that the lay counselors in the study were also under supervision of licensed mental health professionals (Garzon, 2008).

The tests used to measure outcomes were the Symptom Checklist 90R (SCL90R), the Dysfunctional Attitude Scale (DAS), the Spiritual Well-Being Scale (SWBS), and the Religiously Orientation Scale-Revised (ROS-R). These tests were administered after every 10 hours of TPM sessions, at the end of treatment, and as a three-month follow-up. These scales were also completed by the therapists and lay counselors administering the TPM at these same intervals, giving their opinion of how the client was doing. The clients also completed satisfaction surveys at the end of treatment, and at the three-month follow-up. Independent reviewers were also employed to assess clients following treatment. These were licensed mental health professionals in no way affiliated with the study, did not practice TPM, and were not aware of what intervention was being used. After interviewing the clients and viewing their clinical record and testing results, these independent reviewers were asked to rate client symptom levels using a Likert 1-5 scale, an overall case outcome assessment, and an overall rating of their opinion of treatment efficacy (Garzon, 2008).

Garzon (2008) describes the heterogeneity of the 16 clients in the study. Four were males and eleven females. They were varied in age, (ranged from 19 to 57), ethnicity (Caucasian – 80%, Hispanic – 6%, Asian-American – 6%, and Multiracial – 6%), denomination affiliation (Non-denominational – 31%, Evangelical Free – 31%, Baptist – 31%, and Lutheran – 7%), and education (High School – 31%, Some college – 15%, College degree – 46%, and Masters degree – 8%). Their primary diagnoses were Mood Disorder (50%), Anxiety Disorder (31%), and Adjustment Disorder (19%).

Using the Global Severity Index (GSI) of the SCL-90R, the researchers delineated four categories: Deterioration (i.e., clear evidence that the client has worsened during treatment), Unchanged (i.e., testing results do not indicate a change has occurred), Improvement (i.e., statistically significant positive change is demonstrated), and Recovered (i.e., scores indicate the high probability that symptoms now experienced are much like individuals who are not in psychotherapy). Post-treatment test results showed that 13 of the 16 clients (81%) indicated positive change (i.e., either Improved or Recovered). Only one person (7%) reported scores in the Deteriorated range. Of the 13 who improved, only two clients reported scores that showed they had lost their treatment gains (Garzon, 2004, 2008).

The DAS was employed by the researchers primarily to investigate whether TPM does, in fact, impact dysfunctional (i.e., in TPM terminology lie-based) thinking. The same four delineations were used to report outcomes, with four clients scoring within the DAS normal range both pre- and post-treatment. Of the other clients, there were 81% of clients at post-treatment whose scores placed them in either the Improved or Recovered categories. There were none who reported Deterioration, and only one client did not maintain gains at the three-month follow-up. It would seem from these results that some positive change was measured in the area of dysfunctional thinking (Garzon, 2008).

Results from the ROS-R and the SWBS were more difficult to interpret. The ROS-R was the only test that yielded no significant results. Garzon (2008) offers possible answers for this, such as the fact that the ROS-R is only normed with non-clinical populations. It is also suggested that the constructs measured by this instrument, intrinsic

and extrinsic religious motivation, are simply not impacted by TPM. The SWBS had no reliable norms by which to test significance. However, the researchers' evaluation is that "The results appear to cautiously support an association of TPM treatment with improved spiritual well-being" (Garzon, 2008, p. 89).

The client satisfaction inventory taken by clients at the end of treatment also produced favorable results (see Garzon, 2008, p. 90 for a chart displaying percentages). Overall, high satisfaction was shown with TPM, as it was administered by well-trained clinicians and lay counselors in this study. Those who had previously received other forms of therapy rated TPM very high in comparison (i.e., all 4=Often, more than anticipated, and 5=Very Much, more than was anticipated). Eighty-seven percent of clients reported their relationship with God had grown. Only one client felt TPM was below what he or she expected. Overall, very few negative ratings were reported (Garzon, 2008).

Independent reviewer ratings were also overall positive. Following TPM, 56% of clients were rated as Much Improved (i.e., the highest rating for symptom reduction), 44% were rated as Moderate Improvement. For overall outcomes assessment, 69% received a rating of Much Improvement (i.e., the highest rating), 19% received the Moderate Improvement rating, 12% a Mild Improvement rating. These ratings were consistent with testing results, therapist ratings of improvement, as well as client satisfaction results. The researchers reported that all of the independent reviewers expressed interest in this technique, due to the high rate of client improvement (Garzon, 2008).

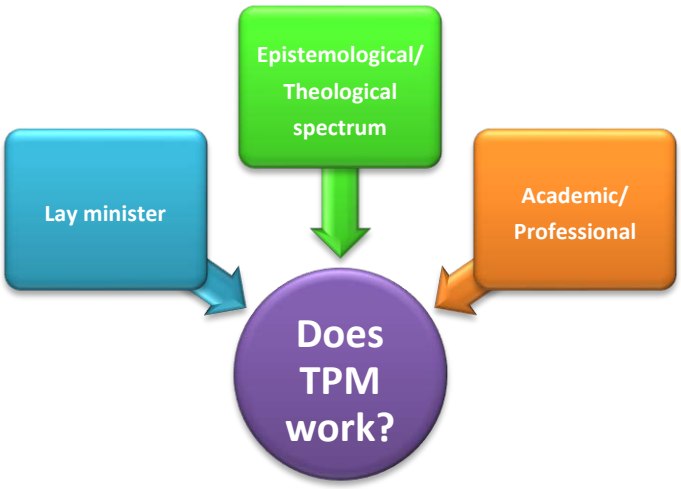
Garzon (2008) encourages caution in interpretation of the results, due to the limitations of the study. Independent Reviewers' assessment of clients before treatment, for example, would have strengthened the design. With the limitation of N in case study research means other variables could influence the results, such as the personal characteristics of the clinicians and lay counselors who participated. Randomized comparative group, or control group studies would control for these factors and others. Garzon (2008) notes that the negative outcome of one client (6%) is representative of the accepted normal 5-10% deterioration rate among psychotherapy research (see Lambert & Ogles, 2004). A mixed design, qualitative research study with people who have had both positive and negative TPM experiences is suggested by the author to investigate possible reasons. For future research, the researchers make this suggestion, "Since clients may need other interventions besides TPM alone, we recommend researching a counseling strategy plus TPM compared to that same strategy without TPM" (Garzon, 2008, p. 93).

Tensions

Within the literature there seem to be tensions surrounding the question, "Does TPM work?" This discussion in no way represents Dr. Ed Smith, nor is it exhaustive. It is merely an effort on the part of this author to bring some understanding to the emotional tensions underlying the debate over TPM in the literature. The question that arose in the mind of this author while studying the literature was why do the proponents of various view-points (positive and negative) concerning TPM and its process get heated and emotional? Based on the literature and discussion with other researchers, it seems that

there are three general perspectives from which this question, “Does TPM work?” is considered (see Figure 1).

Figure 1 Three Perspectives on Does TPM work?



Within each perspective are inherently different viewpoints, each valid in its own right. Perhaps a discussion of the differences will aid in finding common ground and mutually respectful communications through understanding.

One major area of differing viewpoints is in epistemological assumptions. For many lay Christian ministers, more subjective, personal, anecdotal testimony of TPM’s effectiveness is considered valid and sufficient. For this group, their own personal experience of TPM or acquaintance with the person reporting effectiveness of TPM (or ineffectiveness as the case may be) or prior personal knowledge of another person reporting their experience, is what counts in terms of validity judgments. Thus for this group, the criteria for validity can be highly personal. If the evidence for TPM’s effectiveness by their criteria has been very positive, disagreeing with this group’s

assessment can be experienced as a personal attack or an attempt to discredit their own personal healing or the healing they have seen in acquaintances.

From another perspective, the academic and professional community requires that objective, empirical evidence support treatment validity; the more rigorously substantiated the better. With the advent of managed care and insurance companies requiring treatments to be empirically supported for reimbursement, it has become the standard criteria in the professional mental health community by which validity judgments are made. Thus, when Smith's early works (2000 and earlier) promised "maintenance free victory", this community reacted very negatively, asking where the randomized controlled group studies were. In addition, they also might have seen clients in their practice who had received TPM but were not helped or perhaps had worsened in their condition. Since these academicians and clinicians were only interacting with clients who had had negative experiences and not with the people who had positive experiences, they might have assumed TPM was generally harmful. Perhaps they felt like they were potentially protecting the public at large from claims they considered (by their criteria) unfounded and from harm based on their limited interaction with people who had received TPM.

The unfortunate thing is that each perspective, figuratively speaking, seems to think that by "shouting louder" the other side will "hear" what is so obviously clear criteria for validity, from their own vantage point. For one side (many lay ministers) it feels like their own healing is being attacked and for the other (mental health professionals and academicians), it feels like people may be manipulated. It appears the

burden to address this situation lies with the academicians. A better tactic for academicians and professionals talking to lay ministers would be to clarify at the outset that they are not questioning or attacking anyone's sense of personal healing (or harm) through TPM; rather, the academicians are merely trying to see if this personal experience translates to larger groups of people or if it is only specific to certain individuals.

Another area of tension between the lay minster and the professional community is the blurring of lines between the two groups, and the resulting confusion and frustration this has brought. This line blurring arose, in part, out of the proliferation of lay and professional services rendered, many times substituting professional services, over the last few decades (as described above), and, in part, from the suspicion among much of the conservative Christian faith community toward professional psychologists and counselors. Within the Christian faith community, a strong movement of Christian counselors has arisen (e.g., the swelling membership of the American Association of Christian Counselors to almost 50,000 members, http://www.aacc.net/about-us/), comprised of both lay and professional counselors. This overlapping of groups, and blurring of lines, was evidenced in earlier versions of TPM (e.g., Smith, 1997; 2000), when professional terminology and concepts were utilized, while lay readership was also obviously targeted. This caused considerable confusion and even frustration, particularly for some professional readers, as evidenced in the published criticisms cited and analyzed above.

From the vantage point of professional therapists, this state of affairs drew calls for protective measures, such as adequate and standardized training, empirical testing, and regulatory accountability, which are certainly understandable. However, the historical growth in the sheer numbers of the growing need for and supply of lay ministers, as well as clarification of the ministerial nature of TPM over time, gave credence to the lay perspective that perhaps tended to overlook, minimize or at times even dismiss these measures. Once again, perspective played a considerable part in the emotional reactivity between the two groups.

Theologically, questions have been raised as to the theological soundness of TPM. While the literature has been addressed above, the possible emotionality underlying theological questions has not. Again, epistemological assumptions come into play, and varying perspectives fall along a continuum of viewpoints in this regard. One underlying question that has implications for personal experience of faith, or lack of as the case may be, is whether one believes God is personally accessible and knowable. This has profound implications for assessing the validity of TPM. For a Christian whose theology does not allow for an intimate or personal experience of God, TPM is certainly held with deep reservation.

Another underlying question falls in the area of whether human beings should consider it within their rights to call upon Almighty God to intervene at a mere request to do so. Some might feel that God has already spoken in the Bible and He does not personally speak further. For these, spiritual experiences of inner promptings (even outside of TPM) are viewed with suspicion as the Bible is the only reliable testimony.

From this perspective, the expectation for Jesus to "show up" and minister during a TPM session might be seen as far too casual and a flagrantly irreverent treatment of a holy God. For these, personal testimonies and empirical evidence are also not meaningful epistemological categories for evaluating TPM. If one holds this view, emotional reactivity and efforts to steer other Christians clear of TPM might be understandable.

Many Christians take a middle approach to this type of debate rather than an "either-or" position. Thus, they theologically believe God speaks in the Bible and that He also communicates through inner promptings in prayer and other spiritual experiences, as long as these experiences direct in ways consistent with the Scripture.

Such "middle of the road" Christians would be more likely to consider personal testimonies or empirical evidence as epistemologically valid in coming to their own conclusions about TPM because their theology permits it. They might be surprised, however, by the emotional reactivity they experience from Christians who reject such evidence based on their own theological understanding of the Bible that holds the perspective that God would not work through such ways.

Update on Key Criticisms

Table one below summarizes the key criticisms of TPM that have consistently appeared in the counseling literature along with an evaluation of their current status as an on-going concern. Figure two shows a timeline of criticisms.

Table One

Update on Key Past Criticisms of Theophostic Prayer Ministry

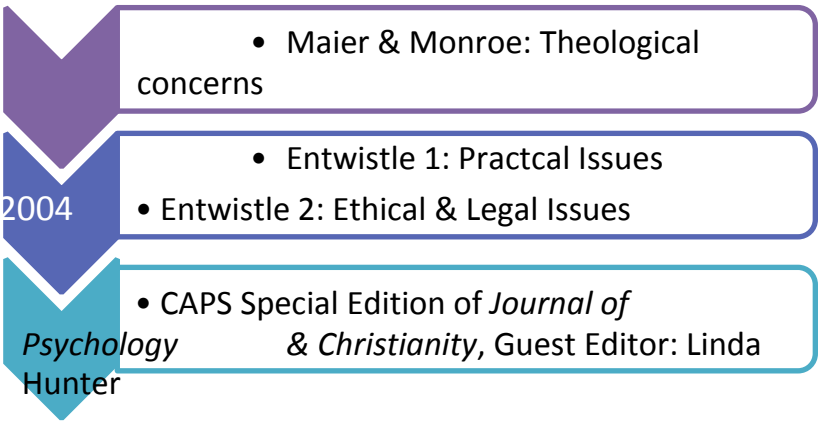
Criticism	Smith's 2007 or Other Source Update	Pertinent Quote	Current Status
Inadequate training requirements?	Currently, a seven step comprehensive training protocol is outlined on the TPM website.[a] The current training protocol is an extensive 16-week multi-facetted program.	"It is crucial that you learn this ministry well and you CANNOT learn it in a single weekend retreat. You will not learn to apply the principles in a "crash course" environment.."[a]	Substantial improvements in training requirements address this concern.
No research for claims?	Some preliminary empirical research studies have been conducted, e.g., Garzon (2008) and Tilley (2008).	"We are cautiously optimistic that TPM will eventually be found to be useful for symptom reductions in a variety of types of clients" (Garzon, 2008, p. 94).	Preliminary positive research findings support the need for further research.

False memory dangers?	See pages 87-110 of Smith's 2007 manual for key principles addressing this concern.	Smith (2007) instructs, "As she focuses on these [present] feelings, the facilitator also encourages her to allow any memory that may be associated with these feelings to surface. The facilitator does not have her 'look' for a memory, but only to feel what she feels and allows her mind to surface any related memory on its own" (p. 88), and ""Encourage them and ask reflective questions, but allow them to figure it out under the power and direction of the Holy Spirit" (p. 102).	Dr. Smith has vigorously responded in his later manual revisions to concerns about the dangers of false memory creation.

Potentially harmful treatment (PHT)?	TPM does not use techniques similar to Recovery Memory Techniques (RMT), which employs suggestive therapeutic methods such as repeated therapist prompting of memories, hypnosis, and guided imagery. See pages 215-218 of Smith (2007). Secondly, TPM does not use techniques similar to Dissociative Identity Disorder (DID) oriented therapy. Instead, Smith (2007) sees obsessive focus on alters as unnecessary and a waste of time (p. 151).	"Avoid analyzing, do not suggest what direction the session should go in, and never state your opinion about what has happened in the memory context…I simply work with whatever aspect of the person's mind he chooses to present…I know that all parts make up a collective whole…I work with each alter as a collective part of the person and just follow TPM procedures and protocol" (Smith, 2007, p. 151).	TPM does not use RMT and DID oriented techniques and cannot currently be categorized as a *potentially harmful therapy* (PHT) as conceptualized by Lilienfeld (2007).

[a] http://theophostic.com/howtogettraining.aspx

Figure 2 Timeline of TPM Criticisms



Summary

Current research supports the potential effectiveness of lay counselors for a variety of conditions. However, lay Christian counseling has sparse empirical data to support its potential effectiveness. TPM has some preliminary research that is encouraging, prompting further study. The recently developed, scientifically based approach of IPNB offers fresh insights into what may be happening with those who are experiencing positive outcomes with TPM.

TPM has not only garnered support but also critics. The interchange between those discussing TPM has been noted as being characterized on occasion by emotional reactivity. Thoughts are given by this author as to the possibility of perspective being a major factor to consider in understanding this phenomenon, in the hope that future discussions may be more mutually respectful and productive.

An evaluation of the criticisms has revealed that as TPM has been revised and refined, most of these criticisms have been addressed. However, the criticism of effectiveness claims by founder Dr. Smith and others have not been totally answered. In addition, the question of whether TPM's percentage of harmful outcomes is higher than the 10% rate found in psychotherapy research also merits investigation. The research study proposed in the next chapter uses an improved research design, modeled after the effectiveness study reported by Wade, Worthington, and Vogel (2007), to address these areas.

CHAPTER THREE: METHODS

This survey study used the descriptive research method to investigate the perceived effectiveness of therapy using TPM, as reported by ministry recipients. An explanation of the research design used, the process by which participants were included in this study, as well as a description of the instrumentation employed and procedures that were followed are covered in this chapter. These are followed by a discussion of the assumptions that were made by the researcher, and a description of how data was processed and analyzed.

Research Design

The purpose of the survey study was to assess the perceived effectiveness of therapy and ministry using TPM. Perceived effectiveness was measured by ministry recipients' responses to survey questions asking them to rate the relative change in the severity of their overall problems since they began therapy. In addition, perceived effectiveness was measured by ministry recipients' responses to questions asking them to rate how therapy with TPM has impacted 14 specific areas of their life, with a fifteenth optional blank in which a respondent could indicate an additional area of life and then provide a perceived effectiveness rating for that area. In an effort to address criticisms that TPM may produce negative outcomes (see Entwistle 2004b, 2004c, 2009; Hathaway,

2009), descriptive analysis of perceived effectiveness responses were compared to negative outcomes frequency analyses found in the literature (see Lambert & Ogles, 2004).

Survey data was used to answer the following two research questions:

1. How do clients perceive the level of effectiveness of therapy or ministry using TPM?
2. How does the rate of negative outcomes for TPM compare with the rate of negative outcomes for psychotherapy in general?

As survey research, this study was designed to examine a sample that was more representative of the true population receiving TPM than previous studies. In this case, a sample of individuals in the United States currently receiving therapy with TPM completed self-administered questionnaires designed to capture their perceptions of the effectiveness of the therapy they were receiving. A survey was chosen as the instrumentation of choice for its economy of design, and its expeditious data collection (Creswell, 2003). It was a logical next step of research, following the literature to date in the investigation of TPM as a ministry tool. Preliminary case study research findings (see Garzon, 2008) and findings of an investigation of how TPM recipients compare previous counseling experiences with their current experience of TPM (see Tilley, 2008) had been encouraging. However, more effectiveness research with better designs was needed.

Modeled after the survey research reported by Wade, Worthington, and Vogel (2007), this survey study was cross-sectional in nature, as it compared groups in a snapshot approach during one week across all conditions. The advantage of this design was that it reduced alternative explanations for the results, such as the effects of history,

maturation, testing, attrition, instrumentation, statistical regression, and selection bias, all common threats to internal validity (Jackson, 2006; Kazdin, 2003).

This cross-sectional design gave all participants in the various locations one opportunity to record their responses during the same week, following their therapy session for that week. Such a design reduced the differences in events and influences, such as historical events and season weather effects. The potentially confounding variable of maturation, or "the process of changing over time [which] includes growing older, stronger, wiser, and more tired and bored" (Kazdin, 2003, p. 25), was minimized as a possible influence on the results, due to this snap-shot design. This is particularly important for an effectiveness study to address, as therapy by nature is focused on bringing "maturation." In this study, all participants reported their perceptions of the effectiveness of the therapy they were receiving, at whatever stage of their therapy this particular week fell. Thus, the cross-sectional approach allowed for a naturally existing random distribution of participants as to stage of therapy, or "maturation" due to therapy.

Testing, or "the effects that taking a test one time may have on subsequent performance on that test" (Kazdin, 2003, p. 26), was rendered an implausible influence on results due to the one-time opportunity offered to ministry recipients. Instrumentation changes, or procedure changes, were also rendered implausible influences on results due to the single testing opportunity. Attrition during research studies is considered a common threat to internal validity, as is the possibility of statistical regression due to readministration of the testing instrument. Yet, these were also rendered implausible due to the one-time response design.

Selection of Participants

Selection bias is a threat to internal validity that must be taken into consideration when designing a research study (Jackson, 2006; Kazdin, 2003). In an effort to minimize this confounding variable, several steps were taken. First, all clients seen for therapy by participating ministers or therapists during the specified week for data collection were offered the chance to participate, thus reducing biased sampling error. Secondly, a 30minute to one-hour training was given to all participating therapists and ministers via Skype or conference call. This training addressed with counselors how to enlist their ministry recipients to participate in the study, and the importance of providing a private space within the office for completion of the printed survey. This measure promoted consistency to the process of enlisting participants.

As measures to promote construct validity and to ensure participants were indeed receiving TPM as outlined by founder Dr. Ed Smith, a few measures were taken. Firstly, his help was sought in locating participating ministry locations in the effort of gaining recommendations of therapists he knew were conducting TPM as he prescribes. To add an additional level of certainty, two qualifying questions were included in the survey to aid the researcher in identifying respondents who may be receiving ministry that has the addition of elements to the TPM as prescribed by Dr. Smith. These questions highlight the use of imagery and suggestion about what is occurring in a session by the TPM facilitator (see discussion below for a more complete description).

It should be noted that this was a sample of convenience, and not random assignment, as participants self-selected into their respective groups (i.e., individual

therapy or the group model) through informed consent and guidance by their counselor according to their individual therapeutic needs. This brings some limitation to the generalizability of the findings. However, ethical considerations of random assignment of participants to either the individual or group model without their consent outweighed the benefits of true of experimental research. It was, therefore, considered a necessary limitation.

Instrumentation

The survey that was used in the investigation of the perceived effectiveness of TPM was developed by the researcher, in collaboration with Dr. Fernando Garzon. They examined surveys used in previous TPM research and modified/adapted some items. Other items were developed specifically for this research study. The items focused on assessing the level TPM recipients rate the change in their overall problems, and how therapy to date had impacted specific areas of their lives. Two almost identical print versions were developed, printed in two different colors for ease of administration and clarity (see Appendixes A and B). These were (a) a survey with wording referencing therapy with TPM that was currently being received, and (b) a survey with wording referencing lay TPM that was currently being received.

Model of TPM

Following the first question, to which respondents indicated whether they were currently receiving TPM, respondents were asked which model of TPM they were receiving, options being either in a prayer group or individually with a lay counselor or pastor. These are referred to as *The Body Life Model* and *The Therapy Model* (see

Chapter One) in the latest TPM manual, Smith (2007). Taken together with the number of surveys completed by respondents of the survey for TPM administered by a professional therapist, the data collected from this question was statistically analyzed as to the perceived relative effectiveness of these three models of TPM.

TPM qualifying questions

As evident from the literature review, one question that had to be addressed in the survey was whether those self-identifying as using TPM with their ministry recipients were actually doing so according to Ed Smith's 2007 guidelines. In an effort to ensure that what was being investigated was indeed authentic TPM, two qualifying questions were included in the survey. The first question addressed the issue of guided imagery, giving an example of specific guided imagery that a therapist might use. The second question addressed the issue of suggestions made by a ministry facilitator to the ministry recipient as to what might have been occurring in a recipient's memory. Again, two specific examples were given to help respondents understand what was being referred to in the question. Both questions allowed for a range of answers on a Likert scale of "Never – 1" to "Always – 5", with "Not Applicable – 0" as an option. The rationale behind giving respondents a range of options was to provide a way for unequivocal indication that, based on these two criteria, what they were receiving was indeed TPM. Further qualifying questions would strengthen the survey; however, length constraints prevented their addition.

Number of sessions and reasons for seeking TPM

The next set of questions helped to clarify for the researcher the issue or issues for which respondents were seeking counseling, and how far along they currently were in the

therapeutic process. Nine common therapeutic issues were listed from which respondents could choose, and a tenth additional option of "other" was offered. Five options were given as to number of sessions, ranging from "1" to "More than 20." Data from these questions was statistically analyzed for possible insight into which issues TPM is perceived to be most or least effective, relative to when in therapeutic time frame.

Perceived effectiveness ratings

Perceived effectiveness ratings were divided into two categories, (a) overall problem(s) for which the respondent was seeking TPM, and (b) TPM's impact on specific areas of life. In the first category, respondents were asked to rate current severity, severity when they began TPM (i.e., with options ranging from "Absent – 0" to "Severe – 4"), and the relative change since they began TPM (i.e., with options ranging from "Worsened a lot – 1" to "Improved a lot – 10"). In the second category, respondents were asked to rate how TPM has impacted each of 14 areas of life (i.e., with options ranging from "Worsened a lot – 1" to "Improved a lot – 5," with "Not applicable – 0" as an option). A fill-in "other" area of life that has been impacted by TPM was also offered respondents, for which they then rated.

Previous therapy

Respondents were asked if they had received previous professional counseling therapy without TPM. If the response "yes" was indicated, respondents were then asked to rate their current experience with TPM compared with their previous professional therapy (i.e., with options ranging from "Much worse – 1" to "Much better – 10").

Respondents were also asked if they had had previous Theophostic Ministry with another person.

Demographic questions

Demographic questions were placed last, as they were considered the least interesting to respondents. Respondents were asked their age, gender, ethnicity, education, marital status, faith denomination, and frequency of church attendance. Nowhere, however, were respondents asked for their names.

Research Procedures

A total of three counseling or ministry centers from various geographical locations agreed to participate in this study, from a list of TPM administrators recommended by Dr. Ed Smith. Prospective participating counseling and ministry center directors or pastors on the list were contacted by the researcher, to confirm their participation, answer any questions, and to gain contact information of all counselors and ministry facilitators. Documented permission from each site was obtained from the appropriate pastor or center director.

Contact was made with all of these individuals and dates arranged for conference call training sessions. These sessions lasted 30-60 minutes, familiarized the counselors with the study, and helped the counselors understand the importance of a standardized approach to enlisting participants. The standardization represented an effort to counter any interviewer bias as a confounding variable (Jackson, 2006). Specific instruction was also given as to (a) what was to be said to each client/ministry recipient at the end of the

therapy session during the set week of the study, including instruction that data can only be collected the week of the study. A sample of this script was submitted to the Institutional Review Board, (b) what was to be done with the completed survey, and (c) instruction for the designation of a private place for the participant to complete the survey (see Appendix C: Enlisting Participants Instruction Sheet).

Each of the participating counseling or ministry center directors was mailed a box, or boxes according to the needs of each participating center, by USPS which arrived the week prior to the week designated for the study. This box(es) contained (a) both versions of the survey, including informed consent information, (b) printed copies of the instructions of how to enlist the participants, (c) a sealed box(es) with a slit in the top the size of a folded survey, (d) a label printed with the researcher's address, to be placed over the slit in the box, making it ready to be mailed directly to the researcher following the week of data collection, (e) a money order covering postage or postage for mailing the box(es) and the remaining surveys back to the researcher, and (f) a self-addressed manila envelope for the remaining un-used surveys, to be returned to the researcher.

The directors distributed these materials prior to the designated week to each of the participating counselors or ministers. This researcher sent each participating director a "Thank you" and reminder email over the weekend that included a query about any last minute questions. The director also collected the remaining materials and boxes containing the completed print surveys by the close of business the following Friday, at the end of the designated week. The directors were also responsible to ensure that the boxes were mailed within one week of the end of the data collection. The directors, therapists, and lay counselors all had the researcher's email and cell phone number to

facilitate answering any questions during the week. All remaining surveys were also mailed by the directors to the researcher, using the self-addressed manila envelope.

As noted, the researcher was available by phone or email during the entire designated data collection week, to address questions or issues the counseling and ministry center directors or counselors may have had. The researcher checked-in once during the week via email to make sure there were no unanticipated problems and contacted the directors at the end of the study week to ensure mailing of the boxes and extra surveys was carried out as planned. Each director had the researcher's contact information. Each survey was numbered, allowing the researcher to estimate how many clients were invited to participate in the study through the return of the unused surveys.

Data Processing and Analysis

Data collected from the survey was compiled and SPSS was used to run statistical analyses. Descriptive analyses were run on all appropriate variables, indicating means, standard deviations, and ranges of scores for these variables. To answer the first research question, an ANOVA was used to analyze the variance between the three conditions, the individual TPM model (i.e., Therapy Model), the group model (i.e., The Body Life Model), and the individual lay ministry model. A descriptive analysis was used to answer the second question, as to comparing the frequency of negative outcomes of TPM recipients in this study to the frequency analysis of treatment in general found in the literature.

Assumptions

As with all research, the researcher made certain assumptions. This researcher made the assumption that participants would respond with honesty, making every effort to reflect accurately their perceptions of the effectiveness of the TPM they were currently receiving. It was also assumed by the researcher that a reasonable rate of response would be achieved to allow for sufficient statistical power. Not being able to be at all sites at once, the researcher assumed that the counselors and ministers would make every effort to follow the instructions provided, ensuring participants were enlisted in a standardized manner. It was also assumed that therapy center directors would be responsible to fulfill all of their assigned tasks, to ensure the study was carried out according to the prescribed procedures.

Summary

In this chapter, the methodology for the proposed research study was explained. This study used the descriptive research method, with the purpose of investigating the perceived effectiveness of therapy using TPM, as reported by ministry recipients. The research design was described, and its rationale was explained. A description of the survey as the study's instrumentation was included, followed by a detailed outline of the procedures. The analysis of the data was explained. The researcher then outlined the assumptions she made at the outset of the study.

CHAPTER FOUR: RESULTS

The results of the study are presented in this chapter, prefaced by a restatement of the study's purpose. The frequencies analysis outlining the breakdown of the demographics of the respondents is reported first. These are followed by the results pertaining to each of the two research questions, presented in the sequence that they appeared in Chapter One. A summary of the results used to answer the research questions concludes this chapter.

Restatement of the Purpose

The purpose of this study was to assess the perceived level of effectiveness of therapy or lay ministry using TPM, as measured by responses to survey questions by individuals who were currently receiving TPM. Respondents were given an opportunity through their survey responses to rate the relative change in the severity of their overall problems since they began therapy or ministry, and to rate how TPM had impacted specific areas of their lives. This study also assessed the validity of concerns that TPM may produce more negative outcomes than traditional counseling therapy models (see Entwistle 2004b, 2004c, 2009; Hathaway, 2009). To assess this concern, a descriptive analysis of respondents' ratings of perceived effectiveness of their experience in therapy

or ministry with TPM was compared to negative outcomes frequency analyses found in the literature (see Lambert & Ogles, 2004).

Demographics

The paper surveys were received by USPS mail, within the sealed boxes participating centers were provided by the researcher. In the case of one center, for an unknown reason, the boxes did not arrive before data collection was to begin. In this case, the administrative assistant (who was designated by the director of the center to carry out the logistics of the study), with the researcher's permission, prepared two sealed boxes that were used in addition to the sealed boxes prepared by the researcher until those boxes arrived. All survey responses were coded using an SPSS data file by the research team. A quality assurance check of 17.5% of the data entered, conducted by the researcher, showed a rate of 0.04% error, considered well within an acceptable margin of error.

Total respondents who completed the paper survey numbered 114 (N=114). However, nine respondents' surveys were considered unusable because of their responses to the two validity check questions that indicated these participants may not have been receiving Theophostic as prescribed by TPM developer, Dr. Ed Smith. As noted in Chapter Three, the validity check questions addressed whether the TPM facilitator suggested specific imagery or suggested what might be occurring in a memory during the session. Only surveys with responses of "Not Applicable" and "Never" to these two qualifying questions were considered valid. Therefore, the usable number of respondents' surveys was 105 (N=105).

Three centers from the list provided by Dr. Ed Smith of centers he would recommend that administer TPM agreed to participate in the study. The breakdown of respondents according to these three geographic locations in the United States were Texas 58% (*n*=61), Florida 24% (*n*=25), and Virginia 18% (*n*=19). The largest group age-wise reported being within the range of "56-65," comprising 33% (*n*=35). This was followed by "46-55" totaling 29% (*n*=29), "66+" at 18% (*n*=19), ""36-45"at 11% (*n*=11), "26-35" at 7% (*n*=7), and the smallest grouping was "18-25" at 3% (*n*=3).

Sixty-five percent (*n*=68) of respondents were female, and 31% (*n*=33) male, with 4% (*n*=4) who chose not to report their gender. By far the largest ethnic grouping was Caucasian/White at 84% (*n*=88), with African American/Black and Hispanic both at 5% (*n*=5), and Asian/Pacific Islander at 4% (*n*=4). Respondents reported being predominantly educated, with 40% (*n*=42) having a Bachelor's Degree, 31% (*n*=32) as having a Master's Degree, and 6% (*n*=6) as having some type of doctorate degree. Fifteen percent (*n*=15) had some form of college, including an Associate Degree. Almost two thirds (63%, *n*=66) of respondents reported being married, and 15% (*n*=16) were single. Thirteen percent (*n*=14) indicated they were divorced, 5% (*n*=5) were remarried, 2% (*n*=2) widowed, and 1% (*n*=1) separated.

Concerning their faith community, 35% (*n*=37) of respondents reported that they describe themselves as Non-Denominational. The remaining responses were widely distributed. Baptist was the largest grouping of mainline denominations with 15% (*n*=15), followed by Methodist with 13% (*n*=13), Anglican with 11% (*n*=11), Presbyterian with 7% (*n*=7), Assembly of God/Pentecostal/Charismatic with 6% (*n*=6), Catholic with 5% (*n*=5), and Lutheran and Episcopal each with 2% (*n*=2). A small percentage (3%, *n*=3)

chose to complete the "other" category with the more generic descriptors of "Christian," "Evangelical Christian," and "Evangelical." A large majority of respondents indicated that they regularly attend church, with 31% (*n*=32) who reported that they attend once a week, 30% (*n*=31) twice a week, and 30% (*n*=31) three or more times a week.

Previous Therapy and TPM

Respondents were asked if they had had previous TPM with another person. Fifty-seven percent (*n*=60) endorsed "Yes," that they had. In order to gain some insight into respondents' view of their current experience with TPM, as compared with their experience with any previous professional counseling therapy, the researcher asked whether they had any previous professional counseling experience. Sixty-two percent (*n*=69) of respondents endorsed that they had had previous professional counseling therapy without TPM. Those who reported that they had had previous professional counseling, were then asked to rate their current experience with TPM compared to their previous professional therapy. The ten-point scale they were given ranged from "1- Much worse" to "5 – 6- About the same" to "10-Much better."

Of those respondents who indicated they had experienced previous professional therapy (i.e., *n*=60), 60% (*n*=39) gave the highest rating of "10-Much Better" when comparing their current TPM experience with their past professional therapy experience. No respondents endorsed scale categories that would indicate they considered their current TPM experience as worse (i.e., 1-4, "1" being "Much worse"). A total of 8%

(*n*=5) of respondents reported that their experience was "5 – 6-About the same." The remaining respondents endorsed responses that indicated that their current experience with TPM was varying degrees better than their previous professional counseling therapy experience. Nine percent (*n*=6) endorsed "7," 11% (*n*=7) endorsed "8," and 11% (*n*=7) endorsed "9."

Research Question One

Research Question One was stated as follows:

How do clients perceive the level of effectiveness of therapy or ministry using TPM? This question was addressed by respondents' endorsements in two ways, those being an overall perception of effectiveness rating and a rating of TPM's impact in addressing a specific reason for which TPM was sought.

Overall Perceived Effectiveness

Overall perceived effectiveness of TPM was measured through responses to a survey item that asked participants to rate the relative change in the severity of their overall problems since they began receiving TPM. A 10-point scale was provided, from "1-Worsened a lot" to "10-Improved a lot," with "5 – 6-No change" as the mid-point of the scale. Respondents' endorsements of this item ranged from 1 to 10, with a mean of 8.62 and standard deviation of 1.63. Just over one-third of respondents (35%, *n*=37) endorsed "10-Improved a lot." Almost one-third of respondents (29%, *n*=29) indicated a

"9," also high on the scale of improvement. Seventeen percent (*n*=18) endorsed "8," and 13% (*n*=14) also indicated at least some improvement by endorsing "7." Only 3% (*n*=3) of respondents indicated "5 – 6-No change." Negative ratings for overall relative change will be presented below (i.e., under Research Question Two).

Perceived Effectiveness for Specific Reasons

Respondents were asked to indicate the reason(s) for which they were seeking TPM from a list of nine mental health reasons, with a tenth option of "Other" for which they could write in a response. The survey listed these same 10 reasons again, asking the respondent to rate on a five-point scale how the TPM they were currently receiving had impacted each area, with an option to select "0-Not applicable." The five options for ratings were "1-Worsened a lot," "2-Worsened somewhat," "3-No change," "4-Improved somewhat," and "5-Improved a lot." Results are presented below in Table 2.

Table 2

Impact of TPM on Reason for Seeking Ministry/Therapy: Mental Health Issues

Reason	*n*	*M* ±*SD*	Median	Range	"Worsened"[a] (n, %)
Depression	31	4.29 ±1.16	5	1-5	1, 3%
Anxiety	46	4.35 ±0.99	5	1-5	1, 2%
Alcohol/Drug Problems	10	4.40 ±0.84	5	3-5	0, 0%
Compulsive Behaviors	21	4.10 ±0.63	4	3-5	0, 0%
Sexual Abuse Issues	9	4.89 ±0.33	5	4-5	0, 0%

Anger Issues	39	4.38 ±0.99	5	2-5	1, 3%
Couple Difficulties	22	3.77 ±1.41	4	1-5	2, 9%
Child Difficulties	18	3.83 ±1.51	4	3-5	0, 0%
Nonfamily Interpersonal Problems	18	4.39 ±1.24	5	3-5	0, 0%
Other	20	3.50 ±2.12	4.5	4-5	0, 0%

[a]Combination of respondents' endorsements of "1-Worsened a lot" & "2-Worsened somewhat."

Write-in responses listed for "other" that were rated (*n*=20) were each different. Examples included, anxiety-compulsive overeating, claustrophobia, fear, food addiction, grief, letting go of harmful emotions, low self-esteem, stress, understanding self and selfthinking, and workplace conflict.

The researcher was interested in gaining a wider view of the effect TPM has on the lives of those who receive it. Respondents were also asked to rate the impact of TPM on their spiritual lives, specifically in the areas of their relationship with God and with others. They were asked to rate, using the same zero to five scale as above, the following four items: (a) Experiencing Jesus more personally, (b) Quality of my relationship with God, (c) Ability to forgive those who have hurt me, and (d) Quality of my relationship with others. Results are presented below in Table 3.

Table 3

Impact of TPM on Spiritual Life: Relationships with God and Others

Impact Area	*n*	*M* ±*SD*	Median	Range	"Worsened"[a] (n, %)
Experiencing Jesus more personally	99	4.65 ±0.70	5	1-5	1, 1%
Quality of rel. with God	99	4.62 ±0.68	5	1-5	1, 1%
Ability to forgive	100	4.56 ±0.69	5	1-5	1, 1%
Quality of rel. with Others	95	4.49 ±0.65	5	2-5	1, 1%

[a]Combination of respondents' endorsements of "1-Worsened a lot" & "2-Worsened somewhat."

Differential in Ratings by Model

The next step was to determine if the data showed a differential of overall perceived effectiveness between the three models of TPM: (a) TPM group (42%, *n*=44), (b) individual TPM with a lay counselor or pastor (41%, *n*=43), and (c) individual TPM with a professional therapist (10%, *n*=10). A one-way ANOVA was conducted and showed no significant difference in the overall ratings of the three groups ($F(2,93) = 0.18$, $p > .05$). In fact, the means of the two groups with more meaningful *n* values were the same: (a) TPM group ($M = 8.70$, $SD = 1.47$), and (b) individual TPM with a lay counselor or pastor ($M = 8.70$, $SD = 1.49$), and the third group, (c) individual TPM with a professional therapist ($M = 8.40$, $SD = 1.51$), was only slightly different.

Differential in Ratings by Location

In order to determine if respondents from the three different locations differed significantly from each other on their overall perceived effectiveness ratings, a one-way ANOVA was run. The three locations were: (a) Florida comprised 24% (n=25), (b) Texas comprised 58% (n=61), and (c) Virginia comprised 18% (n=19). The mean ratings of the three locations were compared using a one-way ANOVA and they did not differ significantly ($F(2,101) = 1.74$, $p > .05$).

Differential in Ratings by Usable and Unusable *N* Scores

Two independent samples t tests were run to determine if there was a significant difference in the mean overall perceived effectiveness scores of those who were within the usable N=105 (i.e., those respondents who endorsed "0-Not Applicable" and "1Never" for the two qualifying questions), and those within the unusable N=9 (i.e., those respondents who endorsed 2-5, indicating varying levels of inclusion in ministry received of the elements of imagery and suggestion, addressed by the two qualifying questions).

No significant difference was found ($t(110) = -1.24$, $p > .05$) for qualifying question one (i.e., use of imagery) between the usable N group (M = 8.62, SD = 1.63) and the unusable N group (M = 7.88, SD = 1.64). However, a significant difference was found ($t(111) = 2.29$, $p < .05$) between the usable N group (M = 8.60, SD = 1.60) and the unusable N group (M = 6.00, SD = 1.41) scores for qualifying question two (i.e., use of suggestion).

Research Questions Two

Research Question Two was stated as follows:

How does the rate of negative outcomes for TPM compare with the rate of negative outcomes for psychotherapy in general?

Overall Perceived Effectiveness

As explained above, overall perceived effectiveness of TPM was measured through responses to a survey item that asked participants to rate the relative change in the severity of their overall problems since they began receiving TPM. A 10-point scale was provided, from "1-Worsened a lot" to "10-Improved a lot," with "5 – 6-No change" as the mid-point of the scale. Of all the respondents who completed this survey item (*n*=104), 1% (n=1) endorsed "1-Worsened a lot," and 2% (*n*=2) endorsed "3," a midpoint indicator between "1-Worsened a lot" and "5 – 6-No change." Taken together as an inclusion of all potential indications of worsening, the combined respondent total was 3% (*n*=3).

Perceived Effectiveness for Specific Reasons

As explained above, respondents were asked to indicate the reason(s) for which they are seeking TPM from a list of nine mental health reasons, with a tenth option of "Other" for which they could write in a response. The survey listed these same 10 reasons again, asking the respondent to rate on a five-point scale how the TPM they were currently receiving had impacted this area, with an option to select "0-Not applicable."

The five options for ratings were “1-Worsened a lot,” “2-Worsened somewhat,” “3-No change,” “4-Improved somewhat,” and “5-Improved a lot.”

Table 2 above presents the results of frequencies calculations for these survey items. As can be seen, “worsened” ratings ranged from 0% (*n*=0; i.e., no respondent endorsed that this reason for which they were seeking TPM had worsened), to the highest percentage of worsened rating of 9% (*n*=2) for “Couple Difficulties.” Table 3 above presents the results of frequencies of all respondents who endorsed the four items regarding the impact of TPM on spiritual areas of life (*n*=99). As this table shows, for each of the four items, only 1% (*n*=1) of respondents endorsed “worsened” ratings. It should be noted, these tabulations gave a wide inclusion of all potential respondents who indicated any worsening in issues for which they were seeking help and areas of spiritual impact, by combining all endorsements of “1-Worsened a lot” & “2-Worsened somewhat.”

Conclusions to Research Questions

Research Question One asked how clients perceive the level of effectiveness of therapy or ministry using TPM. From analysis of the data collected in this study, clients currently receiving TPM perceived it as effective. A summary analysis of the overall perceived effectiveness rating revealed that 94% (*n*=98) indicated that the relative severity of their overall problems since beginning TPM was improved, with over onethird (35%, *n*=37) of respondents endorsing the highest rating of “10-Improved a lot.” A summary analysis of the perceived effectiveness ratings for the specific reasons each client was receiving TPM revealed a high range of mean scores, from the highest being

"Sexual Abuse Issues" (*m* = 4.89, *SD* = 0.33) to "Couple Difficulties" (*m* = 3.77, *SD* = 1.41), which was still above a rating of "3-No change." No significant difference in perceived effectiveness ratings between models of administering TPM or between sites was found.

Analysis of respondents' ratings of TPM's impact on the four spiritually related areas of life revealed even higher mean scores. Using a larger sample (*n*=99) since these ratings were not tied to specific issues for which TPM was being sought, the highest rating was for the category "Experiencing Jesus more personally" (*m* = 4.65, *SD*= 0.70) and the lowest mean rating was for "Quality of my relationship with others" (*n*=95; *m* = 4.49, *SD*= 0.65). These mean scores are notably very close to the highest rating of "5-Improved a lot" for the areas of relationship with God/Jesus, and relationship with others, specifically in ability to forgive and quality of relationships with others.

Research Question Two asked how ratings of negative outcomes for TPM compare with the rate of negative outcomes for psychotherapy in general. From the analysis of the results of this study, negative outcomes ratings of TPM were within the accepted normal 5-10% deterioration rate among psychotherapy research (see Lambert & Ogles, 2004). A summary of overall perceived effectiveness ratings revealed a 3% (*n*=3) "worsening" rate. A summary of perceived effectiveness ratings for specific reasons for which respondents were receiving TPM revealed a negative outcome range from 0% (*n*=0) to 9% (*n*=2).

Conclusions to Hypotheses

It was hypothesized with regard to Research Question One that clients' perceptions of the level of effectiveness of therapy or lay counseling using TPM would be positive across the three conditions of TPM administration, which were (a) TPM group, (b) individual TPM with a lay counselor or pastor, and (c) individual TPM with a professional therapist. This hypothesis was supported. It was also hypothesized that when the three administrative conditions with TPM were compared with each other, no significant difference in levels of perceived effectiveness would be found. This hypothesis was also supported, with results that showed positive ratings of perceived effectiveness of TPM, both for overall effect and for specific reasons for seeking TPM, with no significant differences in levels of perceived effectiveness between the three administrative conditions.

It was hypothesized with regard to Research Question Two that the rate of negative outcomes of TPM would not be significantly higher than the rate of negative outcomes of psychotherapy in general. This hypothesis was also supported, with results that showed negative outcomes ratings, both for overall effectiveness and for the specific reasons for seeking TPM, as within the accepted normal 5-10% deterioration rate reported in psychotherapy research (see Lambert & Ogles, 2004).

Summary

This chapter has presented the results and analyses of the study. Data gleaned from demographics frequencies results reveal various personal aspects of those who completed the survey. Of particular interest was how the respondents rated their

perceived effectiveness of the TPM they were currently receiving. Results of these analyses revealed that they perceived TPM to be effective, both as an overall rating and also when the impact on the specific issues for which TPM was sought was rated. An assay of how respondents rated the impact of TPM on spiritual areas of their lives also revealed a favorable view of TPM's effectiveness. With regard to negative outcomes from TPM, respondents' ratings were within the established norms of the psychotherapeutic field at large.

CHAPTER FIVE: SUMMARY, CONLCUSIONS, AND RECOMMENDATIONS

Summary

TPM was developed in the mid-1990's by Dr. Ed Smith at a time when expansion in the utilization of the services of both paraprofessionals in the secular therapeutic field, and lay counselors in the Christian faith community was being seen. It has continued to modify and develop into its current form (See Smith, 2007, for his current version). Therapeutically leaning heavily on the direct intervention by the insight and ministry of Jesus with the recipient, TPM has taken hold primarily in the lay and ministerial Christian faith community. Although TPM has met largely with enthusiasm, in this sector of the helping community particularly, and has seen tremendous growth to be the international phenomenon it is today, it has also garnered some skeptics and critics along the way. Undeniably, even by founder Ed Smith himself, although TPM has generated many anecdotal testimonies of great therapeutic success, cases of negative outcomes have existed. These have then oftentimes eventually found their way into the offices of professional therapists. This is concerning, and has roused voices of caution and criticism from the Christian academic and professional community. Criticisms have ranged from theological to ethical, from epistemological to practical, and from reasonable to reactive.

A careful and thoughtful assessment of each criticism in the literature has been made by this author, using current TPM materials and official TPM web resources, as well as evaluations of TPM by respected authors and published research studies. As the criticisms were evaluated, and rendered either mute issues due to TPM updates and clarifications, or largely laid to rest through analytical reasoning, the criticism that seemed to surface as clearly valid was the need for more, and better, outcomes based research. Without a doubt, included in this is the need to empirically investigate whether negative therapeutic outcomes from TPM exceed the percentages of therapeutic deterioration accepted as normal among the professional psychotherapeutic community at large.

It was found that the preliminary effectiveness research of TPM is sparse, yet encouraging. Descriptive survey research, using convenience samples of TPM database email contacts (see Garzon and & Poloma, 2003) and TPM training conference attendees (see Garzon & Poloma, 2005), provided groundbreaking data of who was utilizing TPM and how they perceived TPM's effectiveness. Findings of an investigation of how TPM recipients compared previous counseling experiences with their experience with TPM (see Tilley, 2008), and outcomes based case study research findings (see Garzon, 2008) have also been positive. These studies have laid the groundwork upon which this study was built.

The methodology of the study presented here has made marked improvement over previous studies in its design. It examined a more representative sample of the true population currently receiving TPM than previous studies (e.g., Tilley, 2008). It has also

broadened the sample of TPM recipients compared with the convenience samples from previous studies (e.g., Garzon, 2008). By enlisting participants to reflect on their current experience with TPM immediately following their weekly session, the potential human error involved with reporting retrospectively, as with a previous study (i.e., Tilley, 2008), was largely eliminated. Thus, by addressing these limitations of previous TPM research, this study had taken a logical next step in the investigation of TPM's effectiveness.

Not only did this study address limitations of previous studies, care was taken to devise a study with a robust design. A survey was chosen as the instrumentation of choice for the flexibility in the customizing of its design, and its expeditious data collection (Creswell, 2003). As survey research, a sample of TPM recipients in three different geographic locations across the United States completed self-administered questionnaires, specifically designed to capture their perceptions of the effectiveness of the TPM they were currently receiving. Modeled after the design of the survey research reported by Wade, Worthington, and Vogel (2007), it was cross-sectional. By using a snap-shot approach, in varied geographical locations, all conditions were compared simultaneously, during one week of time. This design was advantageous in that it reduced alternative explanations for the results and common threats to internal validity, such as the effects of history, maturation, testing, attrition, instrumentation, statistical regression, and selection bias (Jackson, 2006; Kazdin, 2003).

The minimization of the effects of maturation is particularly important for an effectiveness study to address, as therapy by nature is focused on bringing about positive change, or "maturation." It is worth noting that a significant strength in the design of this

study is that all participants reported their perceptions of the effectiveness of the TPM they were receiving, at whatever stage of their progress this particular week fell. Thus, by utilizing a cross-sectional design, a natural random distribution of participants as to stage of therapy, or "maturation" due to TPM, was allowed.

In the selection of participants, steps were taken to minimize the confounding variable of selection bias, a common threat to internal validity (Jackson, 2006; Kazdin, 2003). A first step was to ensure that all clients receiving TPM from participating ministers or therapists during the specified week of data collection were offered the chance to participate, thus reducing biased sampling error. Another step was the provision of a 30-minute to one-hour training session via conference call for all participating therapists and ministers. As a measure to promote consistency across locations, this training by the researcher addressed how to enlist ministry recipients to participate in the study.

With reference to the occurrence of therapeutic deterioration following a TPM experience, Dr. Ed Smith has proposed various possible reasons this might have occurred (see Smith, 2007, p. 6-7). First among this list of suggested possibilities is that what is being offered is not TPM as prescribed by Dr. Smith. Two specific measures were taken in this study to promote construct validity, that is, to ensure participants were indeed receiving TPM as outlined by its developer. These are seen as measures that largely eliminate the plausibility that results of negative outcomes could be attributed to an "impure" version of TPM being administered.

Firstly, Dr. Smith's help was sought in locating participating ministry locations in the effort of gaining recommendations of therapists he, to the best of his knowledge, knew were conducting TPM as he prescribes. To add an additional level of certainty, two qualifying questions were included in the survey, highlighting the use of imagery and suggestion about what is occurring in a session by the TPM facilitator, both considered common misconceptions of what TPM includes. These aided the researcher in identifying respondents who may not have received TPM as prescribed by Dr. Smith. All respondents who indicated any level of these two elements present in their session(s) of TPM (i.e., "2-Rarely" through "5-Always" on the scale) were eliminated from the usable *N* for data analysis.

Conclusions

The purpose of this study was to assess the perceived level of effectiveness of therapy or lay counseling using TPM, as measured by recipients' responses to survey items. The survey, specifically designed for this study, gave respondents an opportunity to rate both the relative change in the severity of their overall problems since they began therapy, and also to rate how TPM has impacted both specific areas of their lives for which they sought TPM, and four areas related to their spiritual lives. Data provided by these two categories of ratings was analyzed to give empirical evidence as to the effectiveness of TPM. To assess the validity of concerns that TPM may produce a higher rate of negative outcomes than psychotherapy models in general (see Entwistle 2004b, 2004c, 2009; Hathaway, 2009), a descriptive analysis of respondents' ratings negative ratings of perceived effectiveness (again using both categories of ratings) was compared

to the commonly accepted norms of negative outcomes frequencies, as found in the psychotherapy literature (see Lambert & Ogles, 2004).

Conclusions Related to Research Question One

Research Question One asked how TPM recipients perceive the level of its effectiveness. Results from analysis of the data collected from TPM recipients in this study clearly suggest that TPM is perceived as effective. As an overall indicator of perceived effectiveness, a response of 94% (*n*=98) for improvement of relative severity of their overall problems since beginning TPM, one-third (35%, *n*=37) of whom endorsed the highest rating, is clearly positive. In specific areas ratings, the high range of mean scores (4.89 – 3.77, see Table 2) for the various areas of TPM focus also lends strong support to positive effectiveness perception of TPM.

The differential analyses of relative effectiveness for both model of TPM and location revealed no significant difference between groups. No significant difference between models was expected, since the most "active ingredient" in the TPM approach seems to be the intervention of Jesus and the insight and healing He brings. The finding of no significant difference in overall perceived effectiveness ratings between locations is important. This is because it shows that certain changes in research procedures (i.e., the additional sealed boxes the center administrator had to provide, and the accommodation of the procedure in enlistment of participants by the office administrator rather than the TPM administrators) did not affect the ratings.

The differential analysis which revealed a significant difference in perceived effectiveness of TPM between the usable *N* and unusable *N* for qualifying question two

(i.e., use of suggestion by the TPM administrator) is notable. It seems to lend support to Dr. Smith's emphasis on the non-directive role of the TPM facilitator. TPM training directs each trainee to see his or her role as a liaison, instead of a mediator (i.e., giving personal insight and suggestion), in the process of facilitating the recipient's receiving of God's illumination and mind renewal.

It is notable that the area with the highest mean of ratings is "Sexual Abuse Issues" (m = 4.89, SD= 0.33), which is very close to the highest rating of "5-Improved a lot." This is truly remarkable, since sexual abuse issues are a cluster of issues notoriously difficult to successfully treat therapeutically. However, a small n size (i.e. n=9) must be taken into consideration, limiting the strength of this finding, and its generalizability. The fact that the mean scores in all areas were above a rating of "3-No change" is significant to note (see Table 2). These results suggest that recipients of properly administered TPM have found it to be effective in bringing about significant improvement in these various mental health areas with which they struggle. This is good news, for the potential help that may be found using TPM.

The areas included in this study are major mental health pathologies which are encountered on a daily basis by most mental health workers, as seen by the numbers of respondents' endorsements (e.g., Depression n=31, Anxiety n=46). For each mental health category, the mean rating is between a "4-Improved somewhat" and "5-Improved a lot," except for "Couple Difficulties," "Child Difficulties," and "Other," which are rated between "No change" and "Improved somewhat." This is good news in terms of potential

alleviation of common pathological symptoms for many sufferers of common, but often devastating pathologies.

Results of the ratings of TPM's impact on spiritual area of life are also positive. In fact, they are even higher than for the mental health issues. The high *n* value (see Table 3) lends strength to these findings. The fact that almost all of the participants chose to respond to these survey items (i.e., *n*=95-100 out of *N*=105) is notable. What this means is unknown, but the positive endorsements are significant. The highest mean score was for the item "Experiencing Jesus more personally" (*m* = 4.65, *SD*= 0.70), and the lowest mean rating was for "Quality of my relationship with others" (*n*=95; *m* = 4.49, *SD*= 0.65). It would seem from these results that the TPM recipients attest to experiencing very positive changes in the major spiritual areas of quality of relationships with God, Jesus, and others, and being able to forgive those who have caused personal hurt. This is interesting in light of the theological concerns discussed in Chapter 2. It seems that TPM's impact on individual's spiritual lives, evidenced in such practical ways as the reporting of marked improvement in the vertical and horizontal relationships (i.e., with God and others), speaks more clearly about TPM's view of sin and sanctification than any of Dr. Smith's words ever can.

It must be noted that these findings are consistent with previous studies investigating TPM's effectiveness. Garzon and Poloma (2003) reported that, of those they surveyed, 44% of respondents who had received TPM and not used it in ministry reported that TPM was the "most beneficial of anything I've tried," and an additional 38% indicated that it was "very helpful." They also reported that respondents who had

received TPM and were using it in ministry, 52% reported that it was the "most beneficial of anything I've tried," and an additional 39% indicated it was "very helpful." Garzon and Poloma (2005) reported that of the respondents to their survey (i.e., attendees of an Advanced TPM Training Conference), 82% of those who identified themselves as licensed professionals and 95% of the remainder of the sample (i.e., pastors, lay counselors, etc.) indicated that they valued using TPM when treating other individuals as "more" or "much more" effective than other approaches.

Tilley (2008) reported that 62% of respondents to her survey rated TPM's overall helpfulness as "The most helpful thing I've tried," and 25% rated it as "very helpful." Garzon (2008) also reported TPM effectiveness, with all measures consistently positive. Using the GSI scale of the SCL-90R, he reported that post-treatment results showed that 13 (81%) of the 16 TPM recipient cases being studied indicated positive change (i.e., either "Improved" or "Recovered"). He also reported that, using the DAS, primarily as a means investigating whether TPM does impact dysfunctional (i.e., in TPM terminology lie-based) thinking, of the cases who did not report in the normal range before and after the study, 81% at post-treatment scored either in the "Improved" or "Recovered" categories. The client satisfaction inventory showed high satisfaction, and following the course of TPM administration, the independent reviewers rated 69% of cases as having a "Much Improvement" (i.e., the highest rating), 19% received the "Moderate Improvement" rating, 12% a "Mild Improvement" rating. Even the results from the ROSR and the SWBS, admittedly more difficult to interpret, were evaluated as positive.

With these, the researchers' evaluation was that the results "cautiously support" improvement in spiritual well-being with TPM administration (Garzon, 2008, p. 89).

The design of this study (discussed above) clearly advances the research conducted on TPM effectiveness. The strength of design adds credibility to the findings, since the plausibility of alternative explanations for the results are largely ruled out. Confounding variables have been reduced across conditions, leaving the results to speak for themselves. Even the plausibility of therapist qualities having a large bearing on the results has been reduced by the number of facilitators involved in the study (*n*=51; it should be noted, however, that some of these participated by praying while another minister actually administered TPM).

Conclusions Related to Research Question Two

Research Question Two asked how ratings of negative outcomes for TPM compare with the rate of negative outcomes for psychotherapy in general. The results of this study suggest that negative outcomes of TPM are within the accepted normal 5-10% deterioration rate accepted as normal in the psychotherapy literature (see Lambert & Ogles, 2004). With the overall perceived effectiveness ratings of "worsening" rate at 3% (*n*=3), and the perceived effectiveness ratings for specific reasons of a negative outcome range from 0% to 9%, the range of negative outcomes ratings for this study range from 39%.

Again, strength of design adds credibility to these findings. Several steps were taken to minimize selection bias, and reduce biased sampling error. All TPM recipients for each participating therapist and minister were enlisted to complete a survey following

their weekly session, allowing potentially equal opportunity for positive and negative responses. Participating therapists and ministers were given a training session by the researcher as to how to enlist participants, as an effort to ensure consistency across locations. Each location provided a private location for participants to complete the survey, to ensure respondents did not feel compelled to give positive responses. Sealed boxes were provided by the researcher, which were then mailed directly back to the researcher, to further ensure participants felt comfortable to give honest responses. Surveys were intentionally voluntary, confidential, and anonymous, to further ensure participants retained their privacy and could therefore feel as comfortable as possible to give honest responses.

The rate of negative outcomes results of this study is consistent with previous research of TPM's effectiveness. Garzon and Poloma (2003) reported that 1% found TPM to be "not helpful". Tilley (2008) reported for TPM's overall helpfulness, 1% endorsed "not helpful." Garzon (2008), using the GSI scale of the SCL-90R, reported that only one person (7%) reported scores in the Deteriorated range. All of these studies report negative rates of 1-7%, consistent with the accepted norm of 5-10% deterioration rate.

One wonders if Smith's (2007) suggested possibilities of why some TPM recipients report a negative experience (see p. 6-7) come to bear on the results of outcomes rates of this study. It seems that Smith's first two suggestions are supported by the design features (as described above). These two are, (a) not everything being offered as TPM really is TPM, and (b) the skill of the ministry facilitator may not be up to par (p.

6). The other three suggestions of Smith's are, (c) ministry recipients may not yet be prepared to embrace their pain and thus the emotional nature of TPM leads to discontinuing the prayer (d) God may have a different path of freedom for some people, and (e) some people have misunderstood what this ministry can and cannot do (p. 6-7). In terms of this study, the only way to be able to gain some understanding of the variable(s) related to negative outcomes would be to interview the individuals who reported a negative experience (i.e., qualitative research; see recommendations for future research below).

In terms of the concerns expressed by critics in the literature (see Entwistle 2004b, 2004c, 2009; Hathaway, 2009), the results of this study add further evidence that such concerns are no greater than the same concerns for general psychotherapy. Of course, it is always a concern for any therapeutic or ministry model when anyone deteriorates following the approach, as therapy and ministry are not supposed to harm, but to help others in need. One may reasonably question whether the many cases of positive outcomes justify the 5-10% negative outcomes found so consistently in the clinical literature. This is the dilemma for both general psychotherapy outcomes research and TPM. The academic community and public at large seem to have accepted this negative outcome rate for professional therapy. It would seem consistent to treat TPM in a similar fashion.

Implications for Practice and Research

The results of this study, added with the results of previous TPM effectiveness research, seem to be suggesting that the academic and professional community should not be so dismissive towards TPM, that clinicians should perhaps become more open to become trained in TPM, and that academicians should do further investigative research of TPM (see Recommendations below). With research support developing, TPM may become an increasingly viable option as another tool for the Christian psychotherapist's tool chest.

It is also hoped by this author that the up-to-date evaluation of the criticisms presented here will assist those who might consider TPM, as either a recipient or as a tool for a traditional Christian psychotherapist. Perhaps clarifying the current TPM methodologies, Smith's stances, and present training requirements will assist in allowing more exposure of TPM and its apparent benefits. It is also hoped that the tensions between the various perspectives may be eased through insight into how others view the issues at hand. With this, the God that all these brothers and sisters worship would receive honor.

Recommendations

Of course, research of TPM is still in the early stages. While some things are becoming clearer, such as broadly speaking, TPM seems to lead to what many recipients perceive as positive outcomes; many things are still far from clear. Research is needed to bring clarity to what types of clients, for what types of issues, is TPM indicated. It is still

not understood whether TPM is perhaps harmful for certain types of clients, or not helpful for certain types of issues. While this study took the research forward in terms of research design, more and better studies are needed. Even a replication of the present study with other centers, perhaps internationally, would add empirical credibility. Longitudinal survey studies of TPM that follow many TPM recipients over the course of treatment, or mixed survey designs that include more qualitative data would perhaps be helpful in gaining a deeper understanding of TPM and its effectiveness. Qualitative studies on persons with positive experiences of TPM and persons with negative experiences may provide meaningful findings as to what leads to positive and negative outcomes. Randomized comparative or control group effectiveness or efficacy studies would be meaningful steps forward. Since TPM does not advertise itself as a comprehensive counseling treatment, effectiveness research methods that add TPM to the treating therapists' tools seem the most logical.

Limitations of the Study

Any survey research is limited by the nature of the survey method itself (Cone & Foster, 2006). As a method that uses self-report, the researcher is depending on the participants to be honest and willing to self-disclose. Surveys also rely on the printed word, which can be misunderstood or misconstrued. Survey questions also limit the responder to only the types of responses offered, which may not entirely represent the response the participant would like to give. Using a printed survey may have limited participants to those who only had time to fill it out immediately, while still at the facility

where they received TPM. It may also have limited participants to those who did not mind using a writing instrument, as opposed to an electronic device.

Sample size is also a limiting factor. By limiting participating therapists and ministers to those the researcher could be reasonably certain were administering TPM, as prescribed by Dr. Ed Smith, sample size was most certainly limited. However, this was considered a necessary limitation due to the importance of supporting construct validity.

Although the sample was drawn from three different geographical locations across the United States, all regions (e.g., West Coast, Mid-West) were not represented. This limits the generalizability of the findings, as it is not known how variables associated with other locations might affect the ratings of TPM's effectiveness. A higher representation of recipients of professional therapists using TPM would also contribute positively to the heterogeneity of the sample.

Finally, by using a cross-sectional design, the snap-shot nature of this type of research creates the possibility that TPM is not being represented across the full spectrum of TPM sessions, from the start to completion of this ministry approach. It is entirely possible that ministry recipients who are at one particular stage in the process of TPM are overrepresented in this study. Replication of these findings would help to eliminate this as a limitation.

Summary and Conclusion

This chapter summarized the study, and discussed the implications of the results. Recommendations for future research were given, and limitations of the present study

were discussed. The hope for the present study was two-fold: (1) to investigate the current preliminary findings that suggest TPM is perceived as effective with a variety of mental health and spiritual issues, and (b) to examine concerns of TPM's potential of being harmful, beyond reasonable norms for psychotherapy. It has, it seems, added support for TPM's effectiveness and provided evidence that the negative outcome rate for the approach is no different than traditional therapy. Although limited in scope of generalization, these findings do provide an avenue for TPM to gain greater recognition, and potentially be utilized on a wider scale, hopefully to the potential benefit of many. As this study built on previous studies, so this study's findings call for more and better studies, to more clearly understand TPM and its effectiveness.

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APPENDIX A: Lay TPM Survey with Survey Consent Information Sheet (p. 1)

LAY THEOPHOSTIC PRAYER MINISTRY SURVEY CONSENT INFORMATION

An Effectiveness Study of Theophostic Prayer Ministry

Brigitte M. Ritchey
Liberty University
Center for Counseling and Family Studies

You are invited to be in a research study designed to assess the perceived level of effectiveness of Christian professional therapy or lay Christian ministry using Theophostic Prayer Ministry. You were selected as a possible participant because you are receiving lay Christian ministry which includes Theophostic Prayer Ministry at a participating ministry center. I (Brigitte Ritchey) ask that you read this form and ask any questions you may have before agreeing to be in the study. This study is being conducted by me, Brigitte M. Ritchey, a PhD student in Liberty University's Center for Counseling and Family Studies.

Background Information:

The purpose of this study is to investigate the effectiveness of the ministry you have been receiving. Some participants have been receiving Theophostic Prayer Ministry, and others have been receiving Christian professional therapy with Theophostic Prayer Ministry. I want to know what is helping and what is not.

Procedures:

If you agree to be in this study, we would ask you to complete this anonymous brief survey. You will be shown a private place in which to do this. It will take approximately 5-10 minutes to finish. There are no right or wrong answers in this survey, and both positive and negative experiences are welcome. Please answer each item as carefully and accurately as you can. You may skip an item if you are uncomfortable answering it. When you have completed your survey, please place it in the sealed box provided at your ministry center.

Risks and Benefits of being in the Study:

The study has minimal risk, meaning that you will encounter no more stress from it than in your everyday life. While there are no personal benefits to participating in this study, you will be helping us determine how helpful or unhelpful counseling ministry with Theophostic Prayer Ministry can be.

Compensation:

You will not receive payment for participation.

Confidentiality:

The records of this study will be kept private. Your ministry leader will not know specifically how you rated your ministry since the survey is anonymous. Completed paper surveys will be placed by you in a sealed box and mailed directly to me, the researcher. In any sort of report I might publish, I will not include any information that will make it possible to identify you as a participant. Research records will be stored securely and only researchers will have access to the records.

Voluntary Nature of the Study:

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with Liberty University, nor will it affect your current or future relations with NAME OF COUNSELING CENTER. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

Contacts and Questions:

I, Brigitte M. Ritchey, am the researcher conducting this study. You may contact me with any questions either at britchey@liberty.edu or by calling 434-582-2651. You may also contact my dissertation chair, Dr. Fernando Garzon, at fgarzon@liberty.edu or 434-592-4054. If you have any questions or concerns regarding this study and would like to talk to someone other than the either of us, **you are encouraged** to contact Liberty University's Institutional Review Board, 1971 University Blvd, Suite 1837, Lynchburg, VA 24502 or email at irb@liberty.edu.

You may keep this information for your records.

IRB Code Numbers: *(After a study is approved, the IRB code number pertaining to the study should be added here.)*

IRB Expiration Date: *(After a study is approved, the expiration date (one year from date of approval) assigned to a study at initial or continuing review should be added. Periodic checks on the current status of consent forms may occur as part of continuing review mandates from the federal regulators.)*

Theophostic Prayer Ministry Participant Survey

Please acknowledge your willingness to participate in this survey under the stated conditions outlined in the Survey Consent Information by circling "Yes" below. If you choose not to participate please mark "No."

Yes No

Are you CURRENTLY RECEIVING THEOPHOSTIC PRAYER MINISTRY (TPM)? Yes No

If yes, circle which MODEL OF TPM you are receiving:

Prayer Group Individual with a lay counselor or pastor

	Not Applicable	Never	Rarely	Sometimes	Often	Always
During the ministry sessions with TPM, does your ministry facilitator/counselor SUGGEST ANY SPECIFIC IMAGERY to you (for example, "I want you to imagine Jesus hugging you")?	0	1	2	3	4	5
During ministry sessions with TPM, does your ministry facilitator/counselor MAKE SUGGESTIONS TO YOU ABOUT WHAT IS OCCURRING when you are describing a memory that is unclear (for example, "I think you were abused" or "Don't you think that she hit you?")	0	1	2	3	4	5

HOW MANY SESSIONS of TPM have you had? (Please add up all sessions, including today. Circle number of sessions):

1 2-5 6-10 11-20 More than 20

REASON FOR SEEKING TPM at this time (circle all that apply):

Depression Anxiety Alcohol/Drug Problems Compulsive Behaviors Sexual Abuse Anger Issues

Couple Difficulties Child Difficulties Nonfamily Interpersonal Problems Other: _____

As of this moment, rate of CURRENT SEVERITY of your overall problem(s)/reason(s) for seeking TPM:

0-Absent 1-Doubtful or Trivial 2-Mild 3-Moderate 4-Severe

Think about the time you began TPM at this location. Rate the SEVERITY of your problem(s)/reason(s) for seeking this prayer form AT THE TIME YOU BEGAN TPM:

0-Absent 1-Doubtful or Trivial 2-Mild 3-Moderate 4-Severe

Please rate the RELATIVE CHANGE in the severity of your overall problems listed SINCE YOU BEGAN TPM:

1 2 3 4 5 6 7 8 9 10

Worsened a lot No change Improved a lot

Have you had PREVIOUS PROFESSIONAL COUNSELING THERAPY WITHOUT TPM? Yes No

If yes, how would you rate YOUR CURRENT EXPERIENCE WITH TPM compared with your previous professional therapy?

1 2 3 4 5 6 7 8 9 10

Much worse About the same Much better

Have you had PREVIOUS Theophostic Ministry with another person? Yes No

PLEASE TURN OVER PAGE

How has TPM YOU ARE CURRENTLY RECEIVING IMPACTED THE FOLLOWING AREAS of your life?	Not applicable	Worsened a lot	Worsened somewhat	No change	Improved some what	Improved a lot
RELATIONSHIP WITH GOD:						
Experiencing Jesus more personally	0	1	2	3	4	5
Quality of my relationship with God	0	1	2	3	4	5
RELATIONSHIP WITH OTHERS:						
Ability to forgive those who have hurt me	0	1	2	3	4	5
Quality of my relationships with others	0	1	2	3	4	5
Couple Difficulties	0	1	2	3	4	5
Child Difficulties	0	1	2	3	4	5
Nonfamily Interpersonal Problems	0	1	2	3	4	5
MENTAL HEALTH:						
Depression	0	1	2	3	4	5
Anxiety	0	1	2	3	4	5
Alcohol/Drug Problems	0	1	2	3	4	5
Compulsive Behaviors	0	1	2	3	4	5
Sexual Abuse Issues	0	1	2	3	4	5
Anger Issues	0	1	2	3	4	5
Other: _____	0	1	2	3	4	5

Your AGE: 18-25 26-35 36-45 46-55 56-65 66+

Your GENDER: Female Male

Your ETHNICITY/Race:

African American/Black Arab Asian/Pacific Islander Caucasian/White Hispanic

Multiracial Native American Other:_____

FROM WHOM are you receiving TPM?_____

Formal EDUCATION completed:

Less than High School High School Trade School Some College (including Associate Degree)

Bachelor's Degree Master's Degree Ph.D./PsyD/MD or other doctorate degree

MARITAL STATUS: Single Separated Married Divorced Re-married Widowed

FAITH DENOMINATION: Assembly of God/Pentecostal/Charismatic Baptist Catholic Methodist

Lutheran Non-Denominational Other:_____

CHURCH ATTENDANCE - Attendance at church-related activities: (worship services, Sunday School, group Bible studies, prayer meetings, ministries, etc.):

Rarely/never Major holidays A few times a month Once a week Twice a week 3 or more times a week

THANK YOU FOR COMPLETING THIS SURVEY. PLEASE PLACE IT IN THE SEALED SURVEY BOX PROVIDED. If YOU HAVE ANY QUESTIONS ABOUT THE SURVEY, OR WOULD LIKE TO SHARE MORE ABOUT YOUR EXPERIENCE, YOU MAY CONTACT BRIGITTE RITCHEY AT britchey@liberty.edu OR BY CALLING 434-582-2651.

APPENDIX B: Professional Therapy with TPM Survey with

Survey Consent Information Sheet (p. 1)

THERAPY WITH THEOPHOSTIC PRAYER MINISTRY SURVEY CONSENT INFORMATION

An Effectiveness Study of Theophostic Prayer Ministry
Brigitte M. Ritchey
Liberty University
Center for Counseling and Family Studies

You are invited to be in a research study designed to assess the perceived level of effectiveness of Christian professional therapy or lay Christian counseling using Theophostic Prayer Ministry. You were selected as a possible participant because you are receiving professional Christian therapy which includes Theophostic Prayer Ministry at a participating counseling center. I (Brigitte Ritchey) ask that you read this form and ask any questions you may have before agreeing to be in the study. This study is being conducted by me, Brigitte M. Ritchey, a PhD student in Liberty University's Center for Counseling and Family Studies.

Background Information:

The purpose of this study is to investigate the effectiveness of the therapy you have been receiving that includes Theophostic Prayer Ministry. Some participants have been receiving Theophostic Prayer Ministry with a lay counselor, and others have been receiving Christian professional therapy that includes Theophostic Prayer Ministry. I want to know what is helping and what is not.

Procedures:

If you agree to be in this study, we would ask you to complete this anonymous brief survey. You will be shown a private place in which to do this. It will take approximately 5-10 minutes to finish. There are no right or wrong answers in this survey, and both positive and negative experiences are welcome. Please answer each item as carefully and accurately as you can. You may skip an item if you are uncomfortable answering it. When you have completed your survey, please place it in the sealed box provided at your ministry center.

Risks and Benefits of being in the Study:

The study has minimal risk, meaning that you will encounter no more stress from it than in your everyday life. While there are no personal benefits to participating in this study, you will be helping us determine how helpful or unhelpful counseling ministry with Theophostic Prayer Ministry can be.

Compensation:

You will not receive payment for participation.

Confidentiality:

The records of this study will be kept private. Your therapist or ministry leader will not know specifically how you rated your therapy or ministry since the survey is anonymous. Completed paper surveys will be placed by you in a sealed box and mailed directly to me, the researcher. In any sort of report I might publish, I will not include any information that will make it possible to identify you as a participant. Research records will be stored securely and only researchers will have access to the records.

Voluntary Nature of the Study:

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with Liberty University, nor will it affect your current or future relations with NAME OF COUNSELING CENTER. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

Contacts and Questions:

I, Brigitte M. Ritchey, am the researcher conducting this study. You may contact me with any questions either at britchey@liberty.edu or by calling 434-582-2651. You may also contact my dissertation chair, Dr. Fernando Garzon, at fgarzon@liberty.edu or 434-592-4054. If you have any questions or concerns regarding this study and would like to talk to someone other than the either of us, **you are encouraged** to contact Liberty University's Institutional Review Board, 1971 University Blvd, Suite 1837, Lynchburg, VA 24502 or email at irb@liberty.edu.

You may keep this information for your records.

IRB Code Numbers: *(After a study is approved, the IRB code number pertaining to the study should be added here.)*

IRB Expiration Date: *(After a study is approved, the expiration date (one year from date of approval) assigned to a study at initial or continuing review should be added. Periodic checks on the current status of consent forms may occur as part of continuing review mandates from the federal regulators.)*

Theophostic Prayer Ministry Participant Survey

Please acknowledge your willingness to participate in this survey under the stated conditions outlined in the Survey Consent Information by circling "Yes" below. If you choose not to participate please mark "No."

Yes No

Are you CURRENTLY RECEIVING THEOPHOSTIC PRAYER MINISTRY (TPM) as part of your counseling?

Yes No

	Not Applicable	Never	Rarely	Sometimes	Often	Always
During the counseling sessions with TPM, does your counselor SUGGEST ANY SPECIFIC IMAGERY to you (for example, "I want you to imagine Jesus hugging you")?	0	1	2	3	4	5
During counseling sessions with TPM, does your counselor MAKE SUGGESTIONS TO YOU ABOUT WHAT IS OCCURRING when you are describing a memory that is unclear (for example, "I think you were abused" or "Don't you think that she hit you?")	0	1	2	3	4	5

HOW MANY SESSIONS of counseling with TPM have you had? (Please add up all sessions, including today. Circle number of sessions):

1 2-5 6-10 11-20 More than 20

REASON FOR SEEKING COUNSELING at this time (circle all that apply):

Depression Anxiety Alcohol/Drug Problems Compulsive Behaviors Sexual Abuse Anger Issues

Couple Difficulties Child Difficulties Nonfamily Interpersonal Problems Other: _____

As of this moment, rate of CURRENT SEVERITY of your overall problem(s)/reason(s) for seeking counseling:

0-Absent 1-Doubtful or Trivial 2-Mild 3-Moderate 4-Severe

Think about the time you began counseling at this location. Rate the SEVERITY of your problem(s)/reason(s) AT THE TIME YOU BEGAN counseling:

0-Absent 1-Doubtful or Trivial 2-Mild 3-Moderate 4-Severe

Please rate the RELATIVE CHANGE in the severity of your overall problems listed SINCE YOU BEGAN counseling:

1 2 3 4 5 6 7 8 9 10

Worsened a lot No change Improved a lot

Have you had PREVIOUS PROFESSIONAL COUNSELING THERAPY WITHOUT TPM? Yes No

If yes, how would you rate YOUR CURRENT EXPERIENCE WITH TPM compared with your previous professional counseling therapy without TPM?

1 2 3 4 5 6 7 8 9 10

Much worse About the same Much better

Have you had PREVIOUS Theophostic Prayer Ministry with another person? Yes No

PLEASE TURN OVER PAGE

How has the CURRENT COUNSELING WITH TPM IMPACTED THE FOLLOWING AREAS of your life?	Not applicable	Worsened a lot	Worsened somewhat	No change	Improved somewhat	Improved a lot
RELATIONSHIP WITH GOD:						
Experiencing Jesus more personally	0	1	2	3	4	5
Quality of my relationship with God	0	1	2	3	4	5
RELATIONSHIP WITH OTHERS:						
Ability to forgive those who have hurt me	0	1	2	3	4	5
Quality of my relationships with others	0	1	2	3	4	5
Couple Difficulties	0	1	2	3	4	5
Child Difficulties	0	1	2	3	4	5
Nonfamily Interpersonal Problems	0	1	2	3	4	5
MENTAL HEALTH:						
Depression	0	1	2	3	4	5
Anxiety	0	1	2	3	4	5
Alcohol/Drug Problems	0	1	2	3	4	5
Compulsive Behaviors	0	1	2	3	4	5
Sexual Abuse Issues	0	1	2	3	4	5
Anger Issues	0	1	2	3	4	5
Other: _____	0	1	2	3	4	5

Your AGE: 18-25 26-35 36-45 46-55 56-65 66+

Your GENDER: Female Male

Your ETHNICITY/Race:

African American/Black Arab Asian/Pacific Islander Caucasian/White Hispanic

Multiracial Native American Other:_____

FROM WHOM are you receiving counseling with TPM?_____

Formal EDUCATION completed:

Less than High School High School Trade School Some College (including Associate Degree)

Bachelor's Degree Master's Degree Ph.D./PsyD/MD or other doctorate degree

MARITAL STATUS: Single Separated Married Divorced Re-married Widowed

FAITH DENOMINATION: Assembly of God/Pentecostal/Charismatic Baptist Catholic Methodist

Lutheran Non-Denominational Other:_____

CHURCH ATTENDANCE - Attendance at church-related activities: (worship services, Sunday School, group Bible studies, prayer meetings, ministries, etc.):

Rarely/never Major holidays A few times a month Once a week Twice a week 3 or more times a week

THANK YOU FOR COMPLETING THIS SURVEY. PLEASE PLACE IT IN THE SEALED SURVEY BOX PROVIDED. If YOU HAVE ANY QUESTIONS ABOUT THE SURVEY, OR WOULD LIKE TO SHARE MORE ABOUT YOUR EXPERIENCE, YOU MAY CONTACT BRIGITTE RITCHEY AT britchey@liberty.edu OR BY CALLING 434-582-2651.

APPENDIX C: Enlisting Participants Instruction Sheet

Enlisting Participants to Complete TPM Survey

Key Points:

- Ask: Would you like to be a part of a research study about how much progress people who are receiving TPM believe they are making? It will only take about 5-10 minutes to complete the anonymous survey.
- Assure them that the survey is confidential, so you will not know what they put on it. Nor will it affect your relationship with them, whether they complete the survey or not.
  If they agree to participate:
- Hand them the Survey Consent Information form first, explaining that it is for them to keep. Explain that it is more information about the study, including the contact information of the researcher, Brigitte Ritchey.
- Next, hand them the survey, pointing out that it is front and back of the page.
- Instruct them where to complete the survey (a private place you've planned for this. Some pens/pencils placed there might be helpful).
- Show them the sealed box, placed close by. Instruct them to fold the survey twice and put it in the sealed box, which will be mailed directly to the researcher without you opening it.
- Remind him/her that the survey is confidential, so they are not to put their name on it.
- Indicate where you will be, in case they have any questions.

Sample Script:

Ask each of your TPM recipients: "A research study is being conducted on Theophostic Prayer Ministry. The researcher wants to know how much progress people who are receiving Theophostic believe they are making with the reasons that brought them to counseling. She has developed a survey for this. I am inviting all my clients to complete the survey if they are interested. Don't worry about hurting my feelings because the survey is anonymous and you will take it in a private area without me present. You will put your survey in a sealed box that I will not open. The box will be mailed back to the researcher. I will not see your personal results. Would you like to participate?"

If a TPM recipient expresses interest in completing the survey, hand the Survey Consent Information Sheet to him/her and say: "Take a look at the Survey Consent Information Sheet for more details about this study. This is your sheet to keep and it has contact information for the researcher if you have any questions that I can't answer.

Hand him/her a survey sheet, while you direct him/her to the private area: "Take your time reviewing the information sheet and survey. Please fold the survey twice when you're done, don't put your name on it, and place it in this sealed box [shows the client the box] provided by Brigitte Ritchey, the researcher. As I mentioned, the box ensures your privacy because it will be mailed without opening back to Mrs. Ritchey. I will be available over here [indicate where you will be] if you have any questions while you are completing the survey. Also, if you have questions that you would like to ask Mrs. Ritchey, her contact information is on the Survey Consent Information sheet, which is yours to keep."