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Theophostic Ministry: Preliminary Practitioner Survey

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Theophostic Ministry: Preliminary Practitioner Survey

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This exploratory survey investigated Theophostic Ministry, a recently developed inner healing prayer technique that has simultaneously garnered much anecdotal support and criticism. Specifically, the survey sought to assess who is using Theophostic Ministry, what disorders are being treated, and regular practitioners' perceptions of this technique's efficacy. The survey was administered during an advanced training seminar given by Ed Smith, the technique's developer. Of the 148 participants 74% completed the survey (Respondent N = 111*). Survey results suggested a wide variety of people are using Theophostic Ministry - from pastors to lay counselors to psychologists. Overall, the respondents believe this technique is very effective and have used the prayer ministry in treating a wide variety of disorders including some quite complex. Training level issues therefore emerged from this survey's findings. These issues are explored and recommendations made. The limitations of the survey are discussed.*

KEY WORDS: Theophostic Ministry; prayer; inner healing; healing of memories; lay counseling.

INTRODUCTION

In the last eight years, a rapidly growing inner healing approach has swept through the evangelical Christian church. More recently, the approach has gained some support in the Christian mental health community (Anderson, Zuehlke, & Zuehlke, 2000). Theophostic Ministry, "God's Light," as coined by its creator, Ed Smith, has both proponents and opponents in the Christian community (Bidwell, 2001).

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What is Theophostic? Who is using it? With whom are they using it? How effective do regular practitioners perceive the technique to be? Such questions beg to be answered, indeed, the sooner the better. Since no empirical research has been reported on Theophostic Ministry at the time of this writing, the need for exploratory, descriptive studies becomes self-evident.

What Is Theophostic Ministry?

Theophostic Prayer Ministry (TPM) is a form of inner healing prayer (sometimes known as healing of memory prayer) developed by Ed Smith, a pastoral counselor. The prayer approach has a detailed basic treatment manual, an audio/video course for practitioners, a problem-solving book, an advanced training seminar, a manual written to prepare clients to receive TPM, and an apprenticeship training program. More than 15,000 people have taken the basic Theophostic training, and Smith estimates that more than 300,000 Christians have received some type of ministry using TPM (Bidwell, 2001). Anecdotal reports of TPM's efficacy abound and some psychologists and ministers have already endorsed Theophostic as a helpful therapeutic intervention (e.g., Anderson, Zuehlke, & Zuehlke, 2000). The endorsement of TPM by professionals without any empirical research is somewhat disconcerting to these authors. To its developer's credit, Mr. Smith is encouraging empirical investigations and is open to dialogue with his critics (Smith, personal communication, March 8, 2001). He was very cooperative in the current exploratory study.

TPM's primary focus lies in identifying maladaptive cognitions (i.e., lies as described by Smith), asking God to take the client to the "source and origin" of the pain, and in that place asking Jesus to reveal His truth to that client in regards to these lies in whatever way the Lord chooses. Great care is taken to avoid leading and guided imagery (Smith, 2000). Thus, while having some similarities to a trauma-based cognitive therapy approach, TPM substantially diverges from such an approach in the most important area—the actual cognitive restructuring itself. Instead of the practitioner working with the client to generate alternative explanations and sources of evidence for a more balanced cognition, the Lord is petitioned to do this work.

In a basic TPM session, the practioner listens to the client tell his or her story, highlighting affectively laden key words or phrases that may indicate the presence of lies. The prayer minister may subsequently utilize these key words in reflections to generate further client affect. With appropriate timing, an affect bridge technique ensues, with the prayer minister asking the Lord to take the client to the place where these strong emotions and lies originated. Usually, the client then drifts to a memory (or memories) associated with the feelings and cognitions, and the practitioner writes these down.

An "exposure protocol" then follows. The prayer minister investigates in more detail the lies being believed. Once the core cognitions have been found, the client rates the believability of each belief on a 1 to 10 Likert Scale, ten being very believable. If the client rates several beliefs at a 9 or 10, assessment ends and the client is requested to repeat these core beliefs mentally. The client is encouraged not to resist these beliefs but rather to experience the entire pain of them in the midst of the painful memory(ies). At this point the prayer minister, in a non-directive fashion, asks the Lord to reveal truth to the client in whatever way He chooses. One way of phrasing this might be "Allow the Lord Jesus to bring truth in whatever form He chooses and you report to me whatever you see, sense, or hear" (Smith, 2000, p. 141). The TPM practitioner then waits. Should the client not report the Lord ameliorating the pain and dispelling the lies within a few minutes, potential obstacles are investigated.

Smith's basic manual (2000) details various potential blockages. Examples of such obstacles include logical thinking (not embracing the core belief; trying to reason in the memory instead of allowing God to speak), avoidance of emotional pain, failure to accurately discern a key maladaptive core belief, unconfessed sin, dissociation, the presence of anger, hate, revenge, demonic interference, the need to be accepted by the therapist, the prayer minister's own woundedness, or "guardian lies." Guardian lies are underlying assumptions or beliefs that make identifying core emotions and lies difficult. Examples include "Oh, it wasn't all that bad . . . They did not really mean to hurt me . . . I cannot go to the memory because it is too painful . . ." (Smith, 2000, pp. 81–82). Regarding demonic interference, Smith includes strategies that are consistent with his approach for dealing with such a circumstance, but in addition highlights that one does not have to believe in such entities to apply the prayer form successfully (Smith, 2000). He acknowledges dissociation as an issue for consideration, but addresses it more fully in the advanced seminar.

Once hindrances are removed and the procedure has addressed key maladaptive cognitions, the prayer minister asks the client to re-rate the believability of the cognitions. If the client reports a sense of complete peace and calm (0–1), the procedure is considered a success. Should higher ratings be reported, it may indicate the presence of other memories linked to the maladaptive cognition, which then would be processed beginning with an affect bridge to access them.

Sometimes after one set of key beliefs has been processed, more work is still needed. Another feeling or emotion may emerge in the memory(ies) that was previously less prominent. The overall procedure is then repeated, with assessment of new maladaptive cognitions, affective and cognitive exposure, and petition for the Lord's healing presence. The prayer form should continue until the client has a sense of complete peace when experiencing the memory (Smith, 2000). At times when processing a core belief, a client will have another prominent memory emerge. The prayer minister simply notes the original memory and then

"follows the client" to the new memory. The TPM practitioner then implements the procedure on this memory, processing maladaptive cognitions present, and "works backwards" to the previous memory as appropriate. Once the process appears complete, petition for the Lord's blessing and affirmation of the client are made. Smith believes TPM can shorten treatment for many people; however, the number of sessions and the length of these sessions may vary, contingent on the severity of the client's presenting issues (Smith, 2000). The basic Theophostic technique is described in Table 1.

Table 1. Theophostic Ministry with an Uncomplicated Case

Affective bridge phase
1. The TPM practitioner listens closely for "cue words" or phrases in the client's current problem that might suggest negative affect and the presence of "lies."
2. S/he directs the client to focus on these emotional reactions and thoughts.
3. S/he asks the client to drift back in his or her mind to an earlier memory or image that connects with these strong feelings.

Cognitive/affective exposure phase
4. With the help of the client, the prayer minister identifies the key lie(s) believed in this memory.
5. The client rates the believability of the lie (e.g., "How true does it feel on a scale of 1–10, 10 being totally true and 1 being totally false?").
6. The client focuses on the memory and repeats the lies being believed at the same time.

Prayer for cognitive restructuring
7. The TPM practitioner prays aloud and asks Jesus (or God) to reveal His presence and truth to the client in whatever way He chooses.
8. The prayer practitioner waits a few moments and checks with the client to see what's happening.
9. The TPM minister monitors the client's experience to see whether it is consistent with Scripture and the character of Jesus.
10. If the client is not experiencing a sense of God's presence and truth, the prayer practitioner explores potential blockages such as guardian lies, anger, unconfessed sin, and so forth.
11. If the client is experiencing God's presence and truth, the prayer minister waits until there is a sense of closure on this process.

Evaluation of initial prayer
12. Upon closure, the prayer minister has the client rate the believability of the originally identified lies (1–10, as in step 5).
13. If client rates original lies at 0 or 1 and experiences complete peace when viewing the memory, the ministry is complete.
14. If the memory is not totally peaceful, the client is asked to focus on any remaining emotions.
15. The TPM practitioner helps the client identify any remaining affect around the original lies and searches for any "cluster lies" (lies not previously recognized in the intervention).
16. The client rates the original and cluster lies (1–10, as in step 5).

Further prayer intervention as needed
17. The client focuses on the memory and repeats the remaining original and/or cluster lies in the memory.
18. The prayer minister repeats steps 7–14 focusing on the original lies ≥ 2 and other identified lies.
19. Additional Theophostic-related intervention as needed, such as initiating an affect bridge in regards to a remaining lie.
20. Closing prayer ends the technique, asking the Lord to bless and affirm the client.

SURVEY METHODOLOGY

Participants

Participants for this survey were adults attending a four-day Advanced Theophostic Training conference in the eastern United States. The minimal requirements recommended by Smith (2000) for attendance included having taken the Theophostic Basic Training seminar, completing 30 hours of Theophostic Ministry with other people (clients, friends, prayer partners, etc.), and having received 10 hours of personal Theophostic Ministry. Theophostic Ministry, prior to granting permission to attend the conference, investigated the requirement of previous attendance at a basic training seminar. Irregular queries also were made in regards to the last two criteria. Given this lack of consistency, it is unclear how many of the participants actually had received 10 hours of personal ministry and how many had 30 hours of ministry experience.

Survey Instrument

The Theophostic survey instrument was developed in coordination with mental health professionals and lay counselors trained in Theophostic. The survey contained closed and open-ended questions, step scales, along with a variety of questions in checklist endorsement format. Demographic, religiosity, mental health training, and level of TPM training items were included.

Procedure

Announcements regarding the anonymous, optional survey were made during the second day of the conference. Survey forms were passed out and collected during breaks between sessions. To facilitate debriefing, the survey conductors remained in the building during breaks to answer any questions. No controls were available to prevent participant collaboration in completing the forms.

Results

The response rate on this survey appeared acceptable. Of the 148 participants present on the second day of the conference, 74% completed the self-administered survey (Respondent $N = 111$). Two of these surveys had incomplete information and subsequently were discarded.

Overall, the sample appeared to contain well-educated, mature, actively practicing Christians of varying degrees of mental health training. Respondents were

34% male and 66% were female. Average age was 50 (+/−8) and the median age was 51. Formal education included 1% M.D.s, 11% Ph.D.s, 32% MA degrees, 28% college degrees, 19% some college, 8% high school, and 1% less than high school.

About one-fifth of respondents were pastors or pastoral counselors ($N = 23$), one-fifth licensed mental health professionals ($N = 24$), 44% lay counselors, and 10% described themselves as "none of the above."

TPM appears to be used a great deal by participants in this survey. Sixty-five percent use TPM in 75% or more of their cases and 10% use it in over half of their cases. Concerning licensed mental health professionals responding to this item ($N = 22$), 18% (4) use TPM in 75% or more of their cases, 18% (4) use it in 50–75% of their cases, 32% (7) use it in 26–50% of their cases, and 32% (7) use TPM in 25% or less of their cases.

Several survey items queried religiosity dimensions. In examining the denominations of respondents, 27% described themselves as Pentecostal or Charismatic, 33% nondenominational, 9% Baptist, 7% Presbyterian, 3% Episcopal, and 21% described themselves with other denominational categories. Of the respondents 93% endorsed being "Spirit-filled" and 97% of respondents identified themselves as evangelical Christians. Church attendance three times or more per week was endorsed by 45% of respondents, 41% twice a week, 12% once a week, 1% on major holidays, and 1% rarely or never.

Most participants had personally received TPM (95%), and many self-administer the prayer form. Concerning personally receiving TPM, 54% stated that TPM was the most beneficial thing they had tried, 40% described the technique as very helpful, 5% as a little helpful, and 1% as not helpful. Concerning self-administration of TPM, 51% responded that they practice TPM on themselves at least once or more a week, 24% a few times a month, 18% rarely, and 7% stated that they had never practiced TPM on themselves.

In assessing the value of TPM when treating others, 82% of licensed mental health practitioners and 95% of the remainder of the sample reported seeing TPM as "more" or "much more" effective than other approaches that they use. Table 2 compares licensed mental health professionals with the rest of the sample more specifically in terms of how TPM is perceived with a variety of conditions. The number of licensed/non-licensed practitioners is noted and the percentage of those reporting TPM as more/much more effective is reported.

An association between nonlicensed/licensed providers of care and the percentage of cases implementing TPM was also noted, with nonlicensed providers utilizing TPM more in their cases than licensed providers ($r = -.48$, $p < .001$). Overall perception of TPM efficacy was correlated three variables—percentage of cases in which TPM is used ($r = .50$, $p < .001$), length of time using TPM ($r = .27$, $p < .01$), and self usage of TPM ($r = .20$, $p < .05$).

Table 2. Practitioner's Seeing TPM as More Effective for Various Client Conditions

Condition	Licensed MH	All others
Overall	82% (22)	95% (80)
Depression	73% (22)	81% (68)
Gen. anxiety	74% (17)	83% (64)
Anger	79% (14)	78% (69)
Sexual abuse	86% (14)	85% (41)
DID/MPD	79% (14)	83% (23)
Panic attacks	85% (13)	100% (29)
Personality d/os	70% (10)	100% (15)
Physical abuse	66% (9)[a]	88% (34)
Sexual addictions	88% (8)[a]	100% (20)
Phobias	100% (7)[a]	100% (30)
Drugs/alcohol	100% (7)[a]	96% (23)

Note. Percentages are of practitioners who have used TPM with the condition and who see it as more effective than other techniques they've used. Respondent Ns for each type of practitioner are in parentheses.

[a] Particular caution is advised in making comparison because the Licensed category contains less than 10 practitioners reporting usage with the particular condition.

DISCUSSION

Characteristics of TPM Practitioners

The TPM practitioners of this sample appear to be well-educated, mature, deeply religious adults from a wide variety of denominations and with a wide variety of mental health training levels. Over 90% endorsed being Spirit-filled and evangelical Christians. A large number of participants attend church twice or more per week. Most practitioners also regularly practice TPM on themselves without a counselor. This sample's Spirit-filled self description and self usage of TPM may suggest a greater openness to the more experiential elements of the Christian faith than the general Christian population.

Practitioner Perception of Efficacy

For many of the participants in this survey sample, TPM appears more effective than other intervention strategies that they have employed. None of the survey participants indicated that TPM was less effective overall than other interventions, and most regarded TPM as "more" or "much more" effective overall (93% of the total sample). These survey respondents also used TPM on a wide variety of client conditions.

The only variables found to correlate with overall perception of TPM efficacy were length of time using TPM, the percentage of cases in which TPM was used, and self usage of TPM. Naturally, practitioners trained in a technique that experience success both in their personal lives and with a variety of clients will continue using the intervention and perceive it as efficacious. They will also likely pursue additional training opportunities (i.e., advanced training seminars such as the one in this survey). The lack of significant correlation for some variables (education level and licensure level, for example) was surprising; however, a more heterogenous sample is needed before current findings can be generalized.

Level of Training Issues

TPM is a relatively well operationalized inner healing prayer strategy compared to other such approaches (Garzon & Burkett, 2002). Given its various facets, training and practice appear necessary to learn to appropriately implement the prayer form. Accordingly, more training opportunities appear needed. Smith (personal communication, March 8, 2001) has recognized this need and is currently working on a regional apprenticeship training program that involves licensed mental health professionals.

Indeed, counselor level of training and the types of conditions being treated merit careful assessment, especially when examining the lay counselor data. The importance of further training, supervision, and consultation with Christian mental health professionals is apparent. Lay counselors and other treatment providers are working with complex disorders such as Dissociative Identity Disorder, eating disorders, drug/alcohol abuse, and sexual addiction with potentially limited knowledge of these disorders. Sound models of lay counseling with referral and professional supervision options are found in the literature (e.g., Tan, 1991, 1992). Without appropriate supervision and additional resources, lay counselors working with difficult clients can easily become overwhelmed with the myriad of issues involved in such clients' care. Without a doubt, client welfare is a critical issue in considering the Theophostic phenomenon. Fortunately, according to another survey recently analyzed (Garzon & Poloma, 2003), the majority of non-licensed TPM practitioners are open to receiving supervision and continuing education from licensed Christian mental health professionals who are trained in TPM. 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. Sadly, the fact that lay counselors are even seeing such conditions fits into the context of the current mental healthcare crisis in the United States. Many people don't have insurance. Others only have short-term managed care benefits. With limited options, the church and community resources become the default place of treatment for many people suffering from

severe disorders. Informal conversations with persons practicing in non-TPM church lay counseling centers suggest that a similar circumstance may be taking place in these centers as well. Taken in the greater healthcare context, the concerns about level of training, while appropriate, beg for a more realistic solution than telling disturbed individuals not to go anywhere for care.

Recommendations and Directions for Research

Training level issues apparent in this survey need to be addressed. Since lay counselors appear open to supervision by licensed Christian mental health professionals trained in TPM (Garzon & Poloma, 2003), such clinicians should become more involved with church counseling centers using this model of ministry. This would increase the quality of client care while reducing the clinical abandoning of the non-insured/under-insured. Increases in the referral of cases beyond the training level of the prayer ministers using TPM would also occur.

Further research is equally necessary. Outcome-based case studies and randomized clinical trials should proceed on TPM to ascertain whether the therapeutic perception of efficacy displayed in this survey actually has merit.

Limitations

This survey has provided useful descriptive information; however, its limitations provide impetus for additional surveys and empirical studies. Perhaps the three greatest limitations of this survey are its sample size, limited scope, and the nature of the population studied. Concerning sample size, the respondent N and response rate were acceptable for descriptive investigation; however, more in-depth analysis of the survey's results had to be avoided due to the survey size. The limited scope of the survey prevented the answering of important questions, such as the number of non-licensed counselors receiving supervision or continuing education for ministering to people with significant psychopathology. Current results support gathering this information. It is also unclear how many of all survey participants trained in TPM are actually utilizing the prayer intervention in the manner prescribed by Ed Smith. In his writings (e.g., Smith, 2000, 2002), he cautions clearly against New Age or guided imagery mixtures. Surveys of clients receiving TPM would be helpful to ascertain what is actually transpiring and clients own perception of TPM's efficacy. Finally and most importantly, the sample population itself significantly limits generalizations that can be made to the broader group of people who have tried TPM as an intervention. Specifically, more variability is needed in terms of surveying people who have been trained in TPM but may be displeased with the prayer approach. Such people will not be attending an advanced training conference! Accessing a broader population

for future surveys will be important, but this survey has been useful in providing descriptive data on persons regularly utilizing TPM and seeking further training.

Summary

In this survey, TPM practitioners report getting good results and helping a wide variety of clients through Theophostic Ministry. The authors of this study advocate increased interaction between licensed mental health professionals and those with limited training who are utilizing TPM on complex clinical conditions. Though theological and in-depth clinical critiques of TPM have been beyond the scope of this article, it is encouraging that Mr. Smith appears receptive to dialogue with open-minded critics. It's time to move beyond anecdotal reports of TPM efficacy to more systematic research to evaluate the prayer form's clinical utility.

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