The Place of Theophostic-based[1] Therapy/Ministry[2] in the Treatment of Clinical Disorders

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Critics have expressed concern that Theophostic is being included in the treatment of serious mental health problems without adequate research support. Some of the critics who raise this concern argue that empirical research demonstrating the efficacy of Theophostic-based therapy/ministry for each specific application is the only kind of evidence that would supply adequate, legitimate support for the use of Theophostic in the treatment of clinical disorders. These critics then imply that practitioners should wait for this research, and that it is irresponsible, unsafe, unprofessional, and unethical to use Theophostic in the treatment of any specific clinical disorder before this kind of empirical research has been published.

As a licensed physician and board certified psychiatrist who has completed the basic and advanced Theophostic training seminars and attended the basic and advanced apprenticeships I have invested more than 7,000 hours in researching and writing about Theophostic and subjects related to Theophostic. In addition, I have more than 30,000 hours of clinical experience, which includes providing more than 6,000 hours of Theophostic-based therapy. In the context of this professional training, clinical experience, specific study, and personal experience and based on the considerations discussed below, my assessment is that this demand for published empirical research specifically addressing the application in question, before trying any new treatment method, is not realistic in the world of actual medicine, mental health care, and emotional healing ministry.

1. Treatment decisions on the basis of case studies: It is a very common practice, in all branches of medicine, in mental health care, and in emotional healing ministry, for care providers to use treatment methods and/or medication applications described in case studies, even though the treatment methods and/or medication applications have not yet been "proven" in "published empirical research." There are often many years between the case study description of a new treatment method and/or medication application, and confirmation of the new method/medication application in "published empirical research." In fact, empirical research, such as blinded, controlled studies, are often undertaken only after many practitioners have begun to use a new treatment on the basis of case study reports, and enough patients report positive results to justify embarking on more systematic research (which is tedious, time-consuming, and expensive). Millions of patients have been effectively treated with treatment methods and/or medication applications described in case studies, but not yet supported by "published empirical research."

For example, several years ago I read a case study in one of my professional journals describing a patient with treatment-resistant rapid cycling bipolar disorder. The patient described in the case study had improved dramatically with the addition of a certain kind of thyroid medication to their previous medications. I had a patient whose clinical picture was very similar, and so tried the medication combination described in the case study. The thyroid medication was not FDA approved for rapid cycling bipolar, and had not been confirmed as effective for rapid cycling bipolar in any kind of empirical research study; however, I tried the proposed treatment plan on the strength of the carefully described case study. My patient experienced dramatic and lasting improvement, for which she is profoundly grateful.

Furthermore, many practitioners in the real world of actual medical and mental health care make treatment decisions on the basis of informal case studies described by respected and trusted colleagues. It is VERY common for a medical or mental health professional to get together with several of her colleagues, and ask "I have a patient with the following clinical picture....(fill in the blank). I have already tried....(fill in the blank – usually the established treatments that have already been supported by published empirical research), but they have not been effective in this case. Have any of you found something that worked in a case like this?" The others present then exchange stories about any discoveries made in their personal practices. If one of her colleagues – someone she knows, respects, and trusts – reports discovering a medication and/or method that seemed effective in a similar situation, many (most?) practitioners will then begin to test this treatment option in their own practice.

There are already several carefully described case studies of Theophostic principles and techniques being used in the effective treatment of various serious mental health conditions (for example, the bulimia and panic attack case studies referenced in footnote #3). There are probably some practitioners (both mental health professionals and lay ministers) trying Theophostic for these conditions based on these published case studies. And I'm sure there are also many practitioners who are trying Theophostic in response to informal case studies described by respected and trusted colleagues.

2. Shared principles and techniques with research-supported psychotherapies provide indirect research support for Theophostic: As of April 2002, extensive medical and psycho-logical research shows that psychiatric medication, EMDR (Eye Movement Desensitization and Reprocessing), exposure therapy, and cognitive-behavioral therapy significantly reduce the signs and symptoms of a number of

[1] I use the term "Theophostic®-based" to refer to therapies and/or ministries that are built around a core of Theophostic® principles and techniques, but that are not exactly identical to Theophostic® Prayer Ministry as taught by Dr. Ed Smith. The therapy/ministry that my wife and I provide would be a good example of "Theophostic®-based" therapy/ministry – it is built around a core of Theophostic® principles and techniques, but it sometimes also includes material that is not a part of what we understand Dr. Smith to define as Theophostic® Prayer Ministry (such as our material on dealing with curses, spiritual strongholds, and generational problems, and our material on journaling, spiritual disciplines, suicide-related phenomena, and medical psychiatry).

[2] There has been a lot of discussion about whether Theophostic® is prayer ministry or psychotherapy. My perception is that Theophostic® principles and techniques can be applied in either context. Pastors and lay ministers can apply Theophostic® principles and techniques in the context of prayer ministry, and build a "Theophostic®-based" form of Christian emotional healing ministry that is Theophostic® Prayer Ministry. Christian mental health professionals can apply Theophostic® principles and techniques in the context of psychotherapy, and build a "Theophostic®-based" form of psychotherapy that is both psychologically and spiritually sound. Since this essay is written for mental health professionals, pastors, and lay ministers, I use the term "Theophostic®-based therapy/ministry." Also, I realize that additional discussion of the differences between TP-based therapy and TP-based prayer ministry would be helpful, but this discussion will have to wait for another essay.

mental illnesses, inclu-ding Post Traumatic Stress Disorder (PTSD), Obsessive Compulsive Disorder (OCD), and panic disorder. See, for example, Sherman, C. "Two Modalities Rival Prolonged Exposure for PTSD." Clinical Psychiatry News April 2002, p. 40; Foa EB, Keane TM, Friedman MJ eds. Effective Treatments for PTSD: Practice Guidelines from the International Society for Trau-matic Stress Studies. (Guilford Press: New York, NY), 2000; Ballenger, J. "Current treatments of the anxiety disorders in adults" Biol-Psychiatry. 1999 Dec 1, Vol. 46, No. 11, pages 1579-94. See also "Theo-phostic & EMDR: F.A.Q.'s and Common Misunderstandings" on the Articles and FAQs page of www.kclehman.com, pages 7-8 for careful discussion of the research regarding EMDR.

My assessment is that Theophostic® includes the best principles and techniques from each of these other modalities, and then adds important principles and techniques not included in cognitive therapy, exposure therapy, or EMDR. If these other techniques have strong research support for efficacy, and Theophostic®-based therapy/ministry includes the best principles and techniques from these psychotherapies, then the research demonstrating that these other psychotherapies are effective would predict that Theophostic®-based therapy/ministry will probably also be effective. The theoretical connections to research-supported psychotherapies provide strong indirect research support for the efficacy of Theophostic®-based therapy/ministry. Medical researchers frequently use this logic in developing new treatments. For example, if a certain medication is effective for a particular illness, then there is a good chance that similar chemical compounds will also be effective for this same illness. When medical researchers are looking for additional treatment options, they often start with these similar chemical compounds since they are "good bets."

3. Application of Theophostic principles and techniques on the basis of theoretical considerations

Medical and mental health professionals often make treatment decisions based on theoretical considerations, even though there is not yet empirical research proving that the specific treatment in question is effective for the specific application in question. For example, there is strong case study support for Theophostic principles and techniques being effective for resolving the psychological effects of traumatic events. And there is also a lot of data indicating that unresolved psychological trauma contributes to many mental illnesses, such as dysthymia, depression, eating disorders, anxiety disorders, addictions, somatization disorders, personality disorders, and the obvious posttraumatic stress disorder (PTSD). If unresolved psychological trauma contributes to these mental health problems, and Theophostic® principles and techniques are thought to be helpful in working with psychological trauma, then it is reasonable to include Theophostic®-based therapy/ministry in the overall treatment plan of people with these mental health concerns.

This approach is a long established and widely accepted practice in medicine and mental health care, and it has resulted in good outcomes in many individual cases, as well as leading to many important discoveries. For example, the cure for malaria was discovered when Jesuit priests at missions in the foothills of the Andes mountains observed that the Native Americans drank powdered cinchona bark in hot water to calm their trembling muscles when they were shivering from cold exposure. It occurred to the priests that cinchona might therefore also be helpful for the intense shivering that is associated with malaria, and they tested the powdered bark on several patients suffering from malarial fever. They were pleased when this treatment proved helpful in controlling the shivering, but much more excited to discover that it also cured the underlying illness!

I have used this approach of making treatment decisions on the basis of theoretical considerations in my own psychiatric practice, with respect to both psychotherapy tools and psychiatric medications, and have seen great benefit and minimal difficulty.

4. Comparison to other therapies

Somewhere in the middle of my psychiatric residency training, I briefly reviewed a book that summarized the different psychotherapies available in the United States at that time. This book listed ***almost six hundred*** different psychotherapy approaches, and I'm sure a number of new psychotherapies have been developed in the 15+ years since this book was published. As far as I am aware, there

See Hobby, Gladys L. Penicillin: Meeting the Challenge. (Binghamton, NY: Vail-Ballou Press) 1985, especially "New Penicillins Introduced," Chapter 11, pages 213-231, for a well documented historical account of this pattern of investigation with respect to the penicillin family of antibiotics.

See "Mind and Brain: Separate but Integrated (expanded version)" on the "Articles and FAQs" page of www.kclehman.com, pages 29-31, for a brief summary of the extensive evidence indicating that unresolved psychological trauma contributes to these many mental health problems.

See Rocco, Flammetta. The Miraculous Fever-Tree. (New York, NY: HarperCollins), 2003, pages 60-63.

is published empirical research support for only a handful of psychotherapies – cognitive behavioral therapy, exposure therapy, eye movement desensitization and reprogramming (EMDR), and biofeedback. Furthermore, these psychotherapy modalities have empirical research demonstrating efficacy for certain, specific mental health problems, but they are also often used for other mental health concerns – specific applications for which there is not yet research support. What this means is that the vast majority (~99+%?) of specific psychotherapy applications are currently not supported by published empirical research.

It is good to keep working towards empirical research support, but in the mean time, it does not seem reasonable to demand that Theophostic®-based therapy/ministry abide by standards that are not met by 99% of the psychotherapies currently available to the general public in the United States.

5. Comparison to other emotional healing ministries

There are a large number of Christian emotional healing ministries other than Theophostic® prayer ministry. As with Theophostic® prayer ministry, the materials published by these other ministries include many individual case descriptions indicating that these ministries are helpful for a wide variety of different mental health concerns, but there are not any published empirical research studies demonstrating that any of these other Christian emotional healing ministries are effective for the many different mental health problems to which they have been applied. It seems unreasonable to conclude that the many case reports do not qualify as valid data, and to insist that none of these Christian emotional healing ministries can be included in the treatment plan for a given mental health concern until there is published empirical research proving efficacy.

6. Informed consent

A simple and important part of addressing lack of published empirical research support is to clearly acknowledge this in the informed consent process. In the field of mental health care, this is the accepted way to deal with the humbling reality that most psychotherapy tools do not have published empirical research demonstrating efficacy for many of the specific clinical problems to which they are applied (and this same practice would be appropriate for Christian emotional healing ministries). For example, the informed consent form I use for Theophostic®-based therapy/ministry in my psychiatric practice includes the following text: "There is not yet any empirical research proving that Theophostic®-based therapy/ministry is effective (several research projects are in process, but we do not yet have statistically significant empirical research results proving that Theophostic®-based therapy/ministry is effective)." I explain the reasons why I think Theophostic®-based therapy/ministry would be helpful, and also inform them that there is not yet published empirical research demonstrating efficacy. In this context, it is neither inappropriate nor unethical to allow the person receiving therapy/ministry to make his own informed decision regarding whether or not to include Theophostic®-based therapy/ministry in his treatment plan.

In conclusion, I agree that there is a need for empirical research to verify the efficacy of Theophostic® for specific clinical conditions, however, pending published empirical research, I think it is appropriate to use Theophostic®-based therapy/ministry in the care of various mental health concerns, including some major mental illnesses, on the basis of case study evidence and theoretical considerations. My assessment is that both case study evidence and theoretical considerations indicate that Theophostic-based therapy/ministry can be helpful for any mental health concern where unresolved traumatic memories are contributing to the overall clinical picture. Furthermore, shared principles and techniques with research-supported psychotherapies already provide indirect research support for Theophostic,® and the current lack of direct research support can be addressed in a simple and straightforward way via adequate informed consent.

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Over the last 20 years, I have noticed that case studies and other articles in the professional literature have often describe these psychotherapy modalities being used for applications that do not yet have research support. I have also observed this same pattern in the practice of most of my mental health professional colleagues, and in my own private practice. As described elsewhere in this essay, most mental health professionals apply logic regarding theoretical considerations, use their best clinical judgment regarding what would be helpful, and then address the lack of empirical research support by including adequate informed consent.

See, for example, Anderson, Neil T. The Bondage Breaker, (Eugene, OR: Harvest House) 1993; Anderson, Neil T. Victory of the Darkness, (Ventura, CA: Regal Books) 1990; Bennett, Rita. You Can Be Emotionally Free. (Old Tappan, NJ: Fleming H. Revell) 1982; Flynn M. & Gregg D. Inner Healing, (Downers Grove, IL: InterVarsity Press), 1999; Kraft, Charles. Deep Wounds, Deep Healing, (Ann Arbor, MI: Servant Publications), 1993; Linn Dennis & Linn Matthew. Healing of Memories, (New York, NY: Paulist Press), 1974; MacNutt Francis. "The Inner Healing of Our Emotional Problems," chapter 13 in Healing (Notre Dame, IN: Ave Maria Press) 1974; Payne Leanne. Chapters 6-10 in Restoring The Christian Soul, (Grand Rapids, MI: Baker Books) 1991; Sandford John & Sanford Paula. The Trans-formation of the Inner Man (Tulsa, OK: Victory House Inc.) 1982; Sanford Agnes. "The Heal-ing of the Memories," chapter 7 in The Healing Gifts of the Spirit, (New York, NY: Trumpet Books) 1966; Shlemon Barbara. Healing the Hidden Self (Notre Dame, IN: Ave Maria Press) 1982; Wimber & Springer. "Overcoming the Effects of Past Hurts," chapter 5 in Power Healing, (San Francisco: Harper & Row) 1987.

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