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Cognitive Therapy and Theophostic Ministry

Cognitive therapy is one of the most widely used forms of psychotherapy, and competes with Exposure therapy and Eye Movement Desensitization and Reprocessing (EMDR) for the psychotherapeutic technique with the most research documentation of efficacy.[1] Cognitive therapy is probably the technique most often recommended by general practice physicians, mental health providers, and insurance providers. Even many pastors and Christian mental health providers recommend cognitive therapy as an established, proven technique, instead of Theophostic ministry, which they see as a new and unproven technique. Also, many Christian mental health professionals are currently using cognitive therapy techniques. They know from their own experience that these techniques are helpful, and like the additional confidence of using a technique with research verified efficacy. When someone suggests they learn about Theophostic, the overworked therapist often replies, "Why should I take the time and energy to learn something new – I already do cognitive therapy." In response to all of this, we thought it would be helpful to write a brief essay comparing and contrasting cognitive therapy and Theophostic ministry.

I. Shared foundational principles: One of the most significant points is that four of the foundational principles of Theophostic ministry are also foundational principles of "traditional"[2] cognitive therapy theory:

   A. Our thoughts, "what we *really* believe," drive our emotions and choices.[3]

   B. Patterns of cognitive distortion, and specific false negative cognitions, drive the emotions and choices seen in many mental health conditions (for example, depression, phobias, panic disorder, obsessive compulsive disorder, eating disorders, and all forms of addiction). "Underneath" each mental illness, one will find patterns of cognitive distortion and specific false negative cognitions consistent with the signs and symptoms of the mental illness in question.[4]

   C. These false negative cognitions and patterns of cognitive distortion are "learned" from previous experiences.[5] Past events are therefore the source of current mental health concerns by being the source of cognitive distortions.

   D. Resolution of dysfunctional emotions and relief from the compulsion to dysfunctional choices will flow naturally from the correction of cognitive distortions (lies) – the signs and symptoms of the current mental illness will resolve when the underlying patterns of cognitive distortion and specific false negative cognitions are corrected.[6]

II. Points of disagreement:[7]

   A. In the 1970's, many considered the psychodynamic focus on childhood memories to be endless, expensive, and of questionable value. Several psychotherapy modalities developed in this historical context, including cognitive therapy, intentionally focused away from earlier experiences and downplayed the importance of "root" memories.

With this history it should not be surprising that, although traditional cognitive therapy understands how current cognitive distortions have been learned from previous experience, it does not understand that the original traumatic memories continue to energize and anchor the present cognitive distortions. Traditional cognitive therapy insists that the therapist and client work only in the present to address the cognitive distortions. Theophostic ministry, on the other hand, recognizes the continuing power and importance of the root memories. Theophostic ministry insists that permanent resolution can only be accomplished by addressing the cognitive distortions at their roots – *in* the source memories that continue to energize and anchor them.

B. Traditional cognitive therapy sees the therapist as the guide and teacher in the process, and the source of insight regarding true positive cognitions. Theophostic ministry sees Jesus as the primary guide and teacher in the process, with the therapist/minister playing a minor assistant role. Theophostic ministry sees Jesus as the sole source of the truth that replaces the cognitive distortions (lies).

C. Traditional cognitive therapy theory holds that the client must replace the false cognitions with true positive cognitions through their own persistent effort and continued mental discipline. Theophostic ministry teaches that the person receiving ministry must be willing to "stir up the darkness" by focusing on the cognitive distortions and connecting to the painful memories and emotions, but that it is then the Lord's job to permanently replace the cognitive distortion (lie) with truth.

III. Additional shared foundational principles between Theophostic ministry and "PTSD" cognitive therapy: Leading cognitive therapists have now been working with posttraumatic stress disorder (PTSD) for the past ten years. Even though traditional cognitive therapy has intentionally focused away from earlier memories, applying cognitive therapy to PTSD inherently required these intelligent and conscientious therapists to work with the original traumatic events. My perception is that as these cognitive experts worked more closely with the root traumatic memories, they began to get a more experiential understanding of the continuing power and importance of unresolved past psychological trauma. This understandably lead to careful study of the original traumatic events, study of the connections between the original traumatic events and the current signs and symptoms experienced by the person with PTSD, and persistent searching for tools and techniques that could resolve the toxic power of the root traumatic memories. It should not be surprising that this careful investigation on the part of some very competent mental health professionals has lead to the "discovery" of more of the principles that are also central to Theophostic ministry. This type of historical convergence has occurred before, when different scientific teams, completely independent of each other, focused their research tools on the same target and (predictably) "discovered" the same patterns in creation. Unfortunately, these principles discovered in working with PTSD have not yet been applied to the other mental illnesses with which cognitive therapists work. For this reason, I currently think of cognitive therapy as consisting of "traditional" cognitive therapy and "PTSD" cognitive therapy.

The most current cognitive therapy for PTSD includes the four foundational principles described in I., and the following additional Theophostic principles:[8]

A. The distorted interpretations (core lies) anchored in the traumatic memory are important active ingredients that contribute to the traumatic memory's toxic power.[9]

B. Flowing logically from A, replacing the cognitive distortions (core lies) with accurate, undistorted cognitions (truth) is a central and necessary part of resolving the ongoing negative effects of traumatic events.[10]

C. All components of the original trauma (memory of the event, negative cognitions, and associated negative emotions) must be present for healing/resolution to occur.

D. The healing work must be done while the person is connected to the place in the mind where the lie is believed (they must receive the truth while in the "dark room" of Dr. Smith's Theophostic teaching analogy).

E. There are hindrances (clutter) that can block the healing process, and these hindrances must be removed for treatment (ministry) to be successful.

IV. Specific tools and techniques: Traditional cognitive therapy focuses entirely on current cognitive distortions and other miscellaneous current symptoms, and does not address underlying roots. Theophostic ministry focuses entirely on permanently resolving underlying roots, and does not address management of acute symptoms. Predictably, there is little overlap of specific techniques. Many of the specific techniques of cognitive therapy are tools for challenging and/or managing cognitive distortions in the present. Most of the remainder are other miscellaneous tools used for acute symptom control. Theophostic ministry shares none of these tools. Most of the specific techniques of Theophostic ministry are tools for finding and working with root traumatic memories. Cognitive therapy shares none of these tools.

One important area of possible overlap are techniques used to identify cognitive distortions/ core lies. The identification of patterns of cognitive distortion and specific false negative cognitions is an important part of cognitive therapy. The identification of core lies is an important part of Theophostic ministry. I am familiar with the Theophostic tools and techniques for identifying core lies, but I am not familiar with the specific cognitive therapy tools and techniques for identifying patterns of cognitive distortion and false negative cognitions. I am hoping that rigorously trained and experienced cognitive therapists will join the Theophostic community, and that they will bring helpful insights, tools, and techniques for identifying core lies (patterns of cognitive distortion and specific false negative cognitions).[11]

V. Potential for cooperation/integration: If the Christian cognitive therapist is willing to accept that all cognitive distortions must be addressed in the root memories that are their source and anchor instead of in the present, if he is willing to make the shift from himself to Jesus as the guide for the process and the provider of truth/positive cognitions, and if he is willing to exchange persistent mental discipline for "stirring up the darkness" and asking Jesus to come with permanent healing truth, then there is nothing that is contradictory or incompatible between cognitive therapy and Theophostic ministry. With these three concessions, cognitive therapy and Theophostic ministry can work together. The process and specific techniques of Theophostic ministry can be used to permanently resolve the cognitive distortions that are the primary focus of cognitive therapy. As mentioned above, I am hoping that cognitive therapy techniques for identifying cognitive distortions and Theophostic ministry techniques for identifying core lies can be combined, hopefully augmenting each other. The remainder of the tools and techniques of cognitive therapy can be useful in much the same

way as medication – they can help to decrease disability by moderating the severity of acute symptoms (while the person is receiving Theophostic ministry to permanently resolve the underlying roots).

One might say that Theophostic ministry fulfills cognitive therapy. By resolving cognitive distortions (core lies) at the traumatic memories where they are rooted, Theophostic ministry accomplishes the objectives of cognitive therapy, but permanently instead of temporarily.

VI. Frequent relapse versus permanent resolution, maintenance versus maintenance free: As mentioned above, traditional cognitive therapy focuses only on the present, and manages symptoms by addressing only the present patterns of cognitive distortion and false negative cognitions. Theophostic theory would predict relapse, since this approach does not permanently resolve the cognitive distortions at their traumatic memory roots, and this theoretical prediction is consistent with clinical results. I have personally observed cases of depression, panic disorder, and obsessive compulsive disorder where the patients received excellent initial symptom relief from participating in high quality cognitive therapy treatment programs, but then suffered relapse when they did not continue maintenance exercises. My assessment is that cognitive therapy techniques provide excellent tools with which to manage any given episode of mental illness symptom exacerbation – tools that help to resolve any given episode by wrestling the cognitive distortions to the ground and locking them in the closet. However, the cognitive distortions come back each time the underlying root memories are triggered.

Note that research can be misleading at this point. There are many studies reporting that clinical improvement is maintained even after cognitive therapy is discontinued. However, careful review reveals that most of these studies only follow the patients for 3, 6, or 12 months after therapy is stopped, and some of these studies report maintenance of treatment results as long as the person doesn't meet certain research criteria – even though some symptoms have returned. I have not found one study that documents consistent and complete maintenance of treatment results for more than 18 months. One recent article acknowledges this painful reality: "Clinical experience and controlled studies confirm the efficacy of pharmacologic and cognitive-behavioral therapy.... However, despite the availability of effective treatment options, panic disorder often remains a chronic condition characterized by intermittent remissions and relapses over many years."[12] Another possible source of confusion is that the best treatment programs and practitioners teach their clients to continue "unofficial" maintenance therapy indefinitely by learning to continue the mental disciplines of cognitive therapy on their own.[13] These people often prevent relapse, even without "official" maintenance cognitive therapy, by using the tools they have learned to catch and subdue the cognitive distortions as soon as they are triggered.

One of the blessings of Theophostic ministry is that when Jesus resolves cognitive distortions in the traumatic memories where they are rooted, they are permanently and completely gone. They are no longer there, so they can't be triggered to cause symptomatic relapse. No maintenance work is required.

VII. Efficacy: Theophostic ministry has not yet been studied with empirical research, but my assessment is that Theophostic ministry is more effective than cognitive therapy. Theophostic ministry usually accomplishes more clinical improvement in less time, and also resolves

the cognitive distortions at their roots, so that they never return.

VIII. Training required: Professional training is an asset, but it is not required to be able to learn or successfully use Theophostic ministry. There is an intricate dance between what Jesus expects us to learn and what Jesus provides in the way of specific guidance during Theophostic sessions; nevertheless, the living Jesus Christ is very present as the guide and leader in Theophostic ministry. Our experience is that Jesus leading the process makes it possible for non-mental health professionals to successfully use Theophostic. Many pastors and lay people are able to begin using Theophostic ministry after reviewing the basic training videos (6 hours) and reading the basic training manual (400 pages). With a small amount of supervision, and especially the opportunity to address any of their own lies that are hindering the process, some of these lay people become amazingly effective as Theophostic facilitators/ministers. Several of the lay people we supervise are now seeing major healing breakthroughs in a significant percentage of the sessions they facilitate. Even lay people without special gifting usually have some success (often using Theophostic ministry with family and friends). Cognitive therapy requires more training and requires more expertise to use. In my assessment, one must have thorough training and significant experience in rigorous cognitive therapy techniques in order to get the kind of results obtained in the research studies.[14]

End notes:

1. As of spring 2003, I have seen articles written by proponents of EMDR, articles written by proponents of Exposure therapy, and articles written by proponents of cognitive therapy, each claiming that their respective psychotherapy approach has the most research documentation of efficacy. The good news is that there is strong research evidence supporting the efficacy of each of these techniques.

2. In this essay, I use “traditional” cognitive therapy to refer to the mainstream principles and techniques of cognitive therapy that have been applied to a wide range of mental illnesses, including depression, phobias, panic, and obsessive compulsive disorder.This is in distinction from “PTSD” cognitive therapy, which I perceive to be a recent development, and which includes many new principles and techniques.

3. This is the primary foundational principle of cognitive therapy .For an extensive discussion of this principle, and its place as the foundation of cognitive therapy, see Beck AT. *Cognitive Therapy and the Emotional Disorders*. New York, NY: International Universities Press, 1976.

4. Kaplan, HI, Sadock, BJ, Grebb, JA. *Kaplan and Sadock’s Synopsis of Psychiatry, Seventh Edition*. Baltimore, MD: Williams & Wilkins; 1994, pp 860, 861. For extensive discussion of two specific examples, see Beck, AT, Emery, G, Greenberg, RL. *Anxiety Disorders and Phobias: A Cognitive Perspective*. New York, NY: Basic Books; 1985, and Beck, AT, Rush, AJ, Shaw, BF, Emery, G. *Cognitive Therapy of Depression*. New York, NY: Guilford; 1979.

5. Kaplan, HI, Sadock, BJ, Grebb, JA. *Kaplan and Sadock’s Synopsis of Psychiatry, Seventh Edition*. Baltimore, MD: Williams & Wilkins; 1994, p. 859.

6. Beck, AT, Rush, AJ, Shaw, BF, Emery, G. *Cognitive Therapy of Depression*. New York, NY: Guilford; 1979, p. 47.

7. All three of these aspects of cognitive therapy are clearly presented in the excellent review of cognitive therapy in Kaplan, HI, Sadock, BJ, Grebb, JA. *Kaplan and Sadock’s Synopsis of Psychiatry, Seventh Edition*. Baltimore, MD: Williams & Wilkins; 1994, pp 859-864.

8. In a 2000 professional journal article on PTSD, Dr. Hembree and Dr. Foa (international authorities in cognitive therapy) state: "...we propose that successful processing of traumatic events involves emotional engagement with the traumatic memory, organization of the traumatic narrative, and correction of dysfunctional cognitions that often follow trauma. We further propose that the success of psychosocial treatments of posttraumatic stress disorder hinges on the ability of treatments to address impairments in these processes." This quote includes: 1. A clearer recognition of the connection between cognitive distortions (core lies) and traumatic events. 2. Recognizing that resolving the negative cognitions/lies connected to traumatic events is a central and necessary part of resolving the ongoing effects of the traumatic event . 3. The need for the person to connect with the emotions from the traumatic event for treatment to be successful. 4. The awareness of hindrances/"clutter" that can block the healing process, and the need to address/remove any hindrances/clutter that is present. Hembree, EA, Foa, EB, "Posttraumatic stress disorder: psychological factors and psychosocial interventions." *J Clin Psychiatry* 2000; 61 [suppl 7]: p. 33.

9. To my assessment, even the most current PTSD cognitive therapy does not recognize that the cognitive distortion (core lie) is the *primary* active ingredient giving the traumatic memory toxic power, or that resolving the cognitive distortions associated with the traumatic events is the *central mechanism* in healing traumatic memories. This is ironic, in that the foundational principle of cognitive therapy is that cognitive distortions are the true source of current problems, and the central focus of traditional cognitive therapy has always been to find and resolve the cognitive distortions in whatever mental illness is being addressed.

10. See endnote #5

11. Please contact me at drkarl@kclehman.com if you are a rigorously trained and experienced cognitive therapist and you have helpful insights, tools, or techniques, or if you know that Theophostic ministry already incorporates the relevant cognitive therapy insights, tools, and techniques (I will then edit this document accordingly).

12. Rosenbaum. JF, Pollack, MH, Pollock RA, "Clinical issues in the long-term treatment of panic disorder." *J Clin Psychiatry*. 1996; 57 Suppl 10: 44-8; discussion 49-50.

13. One of my clients who completed a rigorous treatment program for panic disorder reports that they strongly encouraged her to continue the cognitive therapy techniques on her own. It is significant that she lost the initial dramatic benefit when she stopped the maintenance therapy.

14. If I were to be painfully honest, I would say that many mental health professionals (including myself) are familiar with the principles of cognitive therapy, have some experience with cognitive therapy techniques, but are not sufficiently trained and experienced in rigorous cognitive therapy techniques to get the benefits described in research.