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A Christian Multi-Modal Approach to Therapy Utilizing Inner Healing Prayer: The Life Model

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This article presents the Life Model, a contemporary ecumenical project proposing attachment with God, inner healing prayer, and healthy interpersonal relationships as key elements to promote psychological and spiritual change. The authors note significant works associated with the approach and the underlying relational theological framework. They operationalize one intervention, the Immanuel Prayer Approach, for clinicians to consider. The article addresses some perceived theological controversies, possible psychological and spiritual benefits, and potential difficulties with the method. Similarities and differences with secular and Buddhist practices are highlighted. The writers clarify the theoretical and empirical support for the model and encourage further involvement of mental health professionals in this project, which is very receptive to collaboration.

Numerous Christians in a variety of denominational contexts today experience spiritual struggles (Exline, 2013), and many evangelicals are not satisfied with their level of progress in the Christian life (Hawkins & Parkinson, 2011). Licensed Christian therapists working with predominantly Christian populations likewise sometimes experience disillusionment with the level of spiritual and biopsychosocial change they observe in their clients (Porter, Hall, & Wang, 2017). The contemporary church often falls short of facilitating the growth in Christian virtues, like love, patience, and kindness, and communion with God and others that union with Christ is intended to promote. Individuals can attend church services for years, read Scripture, pray, participate in Bible studies, and actively engage in various religious programs and still not meaningfully grow in psychospiritual maturity. While a consistent use of the traditional spiritual disciplines does promote change in some persons, perhaps the level of as-yet-unresolved psychopathology present in some Christians requires the development of new methods of therapy that bring together the best contemporary neuroscience and psychotherapy research with the traditional "means of grace" (prayer, Scripture reading, church community) within a Christ-centered orientation to promote the deeper psychospiritual healing some people need.

Christian spiritual growth has been focused historically on an increase in what are called the "fruit of the Spirit"—joy, peace, patience, kindness, gentleness, faithfulness, self-control, and especially a greater love for God and one's neighbor (Gal. 5:22-23; Mt. 22:37-39; 1 Cor. 13). It seems likely that these virtues are related in the case of Christians to what some psychologists would see as an enhanced biopsychosocial capacity for healthy attachment relationships (Kirkpatrick & Shaver, 1992; Kirkpatrick, 2005). This article describes a Christ-centered model of holistic growth (both psychological and spiritual) that uses the spiritual disciplines to promote secure attachment relationships. Before discussing it, however, we should probably justify why Christian therapy researchers might consider looking for Christian-derived models of therapy to investigate in a grassroots movement of Christian soul care that has been around for the past 50 years, in addition to the more common practice of accommodating Christian practice to secular, evidence-based models that have arisen from the contemporary scientific community (Johnson, Worthington, Hook, & Aten, 2013).

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Inner Healing Prayer Models

Since the advent of modern psychology in the late 1800s, questions have arisen about the value of the folk or lay psychology of normal adults in everyday life. Some psychologists have rejected it as fallacious, comparing it to the falsehoods of pre-modern astronomy (a geocentric universe) and biology (the four humors), or illustrated by the mistaken confidence humans have in their self and social perceptions (Ross & Nisbett, 1980; Wegner, 2002). Others have argued that scientific psychology has already demonstrated the value of studying lay psychology both by borrowing from it (e.g., need, motive, memory, belief, and reward were lay psychological categories before cognitive and social psychology subjected them to experimental investigation), as well as by critiquing it (Fletcher, 1995), and, more strongly, that scientific psychology needs to take lay psychology into consideration, or it risks creating a science of psychology that lacks validity through correspondence to actual human life (Taylor, 1985; consider, e.g., the phase that modern psychology went through from the 1930s to 1950s, when it was dominated by experimental research on the white rat). Some psychologists, in fact, have recently argued that doctrinal writings within local religious communities are a valuable source of psychological knowledge (Pankalla & Kosnik, 2018).

God communicated his revelation of himself and his salvation to the world through the ordinary, non-academic discourse of the Bible, originally written to average people living in Ancient Near Eastern, Greek, and Roman cultures. Millennia before the scientific revolution gave shape to modern versions of the human sciences, the first principles of a Christian version were expressed in the occasional, unsystematic, yet divinely inspired, writings of the Bible. It should not be surprising, then, if the Christian psychology community were interested in doing research on Christian therapeutic practices that have emerged among everyday Christians practicing their faith in everyday life.

In light of such considerations, coupled with Western psychology's more recent attempts to operationalize and empirically investigate Buddhist mindfulness, an Eastern meditative practice that was also developed a few thousand years ago, likewise before the formal founding of psychology as a science, Christians in psychology are warranted in employing contemporary research methods to investigate models of soul care developed by lay people and ministers, mostly untrained in modern psychology. The emergence and popularity of many such models over the past few decades, often outside the institutions of scientific psychology and professional therapy and largely independently of each other, constitutes a remarkable historical phenomenon—and possibly a movement of the Holy Spirit. Consider, for example, Leanne Payne's Pastoral Care Ministries (Payne, 1979; 1990; now called Ministries of Pastoral Care; https://ministriesofpastoralcare.com); Francis MacNutt's model (1977); the Elijah House model (Sandford & Sandford, 1983; https://elijahhouse.org/); Neil Anderson's Freedom in Christ Ministries (1990a; 1990b; https://ficm.org/); Transformation Prayer Ministry (Smith, 2002; https://www.transformationprayer.org/; formerly called Theophostic Ministry); Restoring the Foundations (Kylstra & Kylstra, 2003; https://www.restoringthefoundations.org/); and Sozo Ministry (http://bethelsozo.com/). Mention should also be made of the renowned Christian psychologist Siang-Yang Tan's (2011) healing prayer model, as well as the contributions of the IGNIS Akademie (https://www.ignis.de/) in Germany and the member-based organization ACTheals (https://www.actheals.org/), both of which utilize healing prayer and involve mental health professionals. (For general overviews of inner healing prayer, see Flynn & Gregg, 1993; Kraft, 1993; Richardson, 2005; Rustenbach, 2011.)

Some psychologists have raised serious questions about these models (see, e.g., the mostly critical special issue of the *Journal of Psychology and Christianity* on theophostic prayer; "Theophostic Prayer Ministry," 2009), citing the need for practitioners to have an adequate clinical understanding of negative religious dynamics and cautioning Christian mental health professionals to rely primarily on evidence-based models in their practice, given contemporary therapy ethics, rather than indigenous Christian therapy models that have not been properly tested by modern standards of validity (Hathaway, 2009; Hunter & Yarhouse, 2009). Such concerns can be taken seriously, without rejecting the models. Given the proven value of lay psychology

models, the proliferation of inner-healing-prayer models, and their widespread, reputed benefit, the next step would seem to be a major program of *emic* research on inner healing prayer by clinical researchers. Should the findings be encouraging, some of these models may be worthy of further development in light of contemporary clinical understanding and standards of professional care in the pursuit of Christian-derived models of psychotherapy and counseling that are just as scientifically sophisticated as those developed within a naturalistic worldview (Johnson, Worthington, Hook, & Aten, 2013).

Such a step would also be consistent with two recent developments in Western psychology. First, the indigenous psychology movement, currently identified with the Society of Humanistic Psychology of the American Psychological Association (https://www.indigenouspsych.org/), advocates for the right of local cultural groups to define for themselves an understanding of health, dysfunction, and healing, rather than merely accepting Western psychology's global attempts to colonialize psychological functioning and monopolize the human sciences (Marsella, 1998). Western psychology is itself only one of many psychologies in the world, and it promotes a wide variety of secular assumptions (e.g., individualism, materialism, hedonism) that may not be consistent with the beliefs and practices of a plethora of cultural groups (Marsella, 1998).

Second, while randomized trials are currently the "gold standard" in clinical psychology, contributing to the empirically supported treatment movement (https://www.div12.org/treatments/), some authors have recently critiqued this over-reliance on manualized approaches and specific techniques (Duncan & Reese, 2013). In fact, the American Psychological Association (2006) more broadly defines "evidence-based practice" as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 273). Thus, in the context of this special issue, we are arguing that research is increasingly needed that is sensitive to the faith, culture, and preferences of Christians.

The Life Model

All inner healing prayer models originated within a Christian subcultural context and are based on Christian worldview assumptions. Of all the models available, we focus in this article on one that holds particular promise for clinical researchers and therapists working with Christian clients, given (a) its consistent psychospiritual benefits observed anecdotally for over three decades in America and repeatedly in various cross-cultural settings; (b) from the beginning, it has involved licensed Christian mental health professionals; (c) it has already incorporated some empirical research from contemporary attachment theory; and (d) some of its features (particularly the Immanuel Prayer) provide a safeguard against misuse by paraprofessionals (as discussed below).

The Life Model (Friesen et al., 1999) proposes a relational theological foundation that promotes attachment with God and human persons as a key component of spiritual and psychological change. Attachment has an extensive research base regarding its importance in childhood development (Bowlby, 1969), adult relationships (Shaver & Mikulincer, 2009), and attachment with God (Granqvist & Kirkpatrick, 2004). The Life Model applies principles from the attachment literature that still need to be evaluated empirically. God attachment, in the Life Model sense, involves more than experiencing God as a secure base and sense of safety in exploring the world, but includes a more active awareness of His presence in daily life and the cultivation of an intentional, communicative relationship, much like a close supportive adult relationship. Forms of interactive prayer and the spiritual disciplines may foster this quality, and skills promoting healthy adult attachment in family, groups, and community become the basis of this approach. The model developers seek to promote joy, even in the midst of significant life stressors, as a key emotional state for growth and attachment (Wilder et al., 2015). Joy in the Christian sense is a more complex affective-relational experience than either of the analogues that have been the focus of secular positive psychology research, e.g., subjective well-being or optimism. Christian joy is based in the love of God (Pieper, 1998) and usually related to one's attachment bonds with others, even when one is experiencing significant stressors (Schore, 1994), It allows us to weep with those who weep (Romans 12:15).

The Life Model recognizes that the methods derived from its understanding of Scripture and theology intrinsically cohere with knowledge gained in other academic disciplines related to the production and amelioration of psychological symptoms. Over time, for example, fields such as neuroscience should provide support for its interventions. The approach intentionally draws upon neuroscience in some of its strategies. In addition, the Model extends beyond the clinical setting in its desire to create healthier multigenerational communities (e.g., churches, villages, tribes, regions) that can foster the development of spiritual and emotional maturity, including the healing of relational trauma, lessening of chronic negative emotions and internal conflict, and beneficial relationships with God and others. Thus, it has a community psychology setting base, rather than merely a private practice base. Understanding how the Life Model developed will facilitate understanding its breadth.

Origin and History of the Model

Van Nuys First Baptist Church was a megachurch in California in the mid-1960s that established a professional counseling service, Shepherd's House, to reach adolescents without a home, individuals with substance abuse issues, and families in crisis. Within a decade, about 200 diverse churches in the San Fernando Valley sought its services. Treatment providers used many divergent treatment models. Licensed therapists with different kinds of training espousing the various methods regularly debated which strategies were superior clinically. Behavioral therapy, deliverance models, cognitive therapy, inner healing models, the "Minnesota model" for addictions, trauma recovery models (particularly those related to dissociative states), and psychodynamic strategies did not blend well conceptually, so the debates had no resolution. Many individuals participating in these discussions recognized that an agreed-upon, comprehensive therapeutic model would service a wide range of church communities. Ideally, the model would also have core elements that paraprofessionals could readily grasp and implement in a variety of ministry and clinical settings.

Sometime around 1990, over thirty experienced practitioners (composed mostly of ministers and licensed professionals) assembled at Shepherd's House to determine the essentials of an inner healing model. The main discussants represented Anabaptists with a history of creating multigenerational communities of Christians; Wesleyans who consistently consider human maturity and sanctification to entail human and divine activity; Calvinists/Reformed Christians who expected special revelation (i.e., biblically derived methods) and common-grace derived, scientific findings would be congruent; and Charismatics who emphasized spiritual renewal and also believed that God's active presence needed to be involved in any lasting psychospiritual improvement. A unified model gradually took shape through subsequent case analysis, discussions, current healing prayer literature, and visits to other similar communities.

The Shepherd's House team began looking for anecdotal case evidence of those with long-term positive psychological and spiritual outcomes. They defined such outcomes as significant psychological symptom reduction (demonstrated through testing and/or clinician appraisal at the end of treatment) and counselee self-report of spiritual growth by termination. The members discovered that those counselees who had a healthy support system that included relationships resembling a well-functioning family were most likely to maintain their clinical gains. Individuals who had experienced significant trauma and/or neglect during their early developmental years had the greatest challenges thriving in communities longitudinally, even when a positive support system was present. In these cases, despite treatment that apparently resolved symptoms of posttraumatic stress disorder (PTSD), the lack of a secure attachment style still impaired how they engaged relationally with those in their environment. The team noticed exceptions occurred when such counselees could establish ongoing relationships with relatively mature members of their community (i.e., they themselves had secure attachment styles and adaptive cultural perspectives). Such counselees grew in their interpersonal relational skills, sense of identity, and eventually an earned secure attachment style seemed to emerge over time (Holmes, 2017).

Members of the group also visited and studied recovery communities around the world. They defined recovery communities as a Christian community centered on psychospiritual

healing. Examples included a community of counselors and abuse survivors in the United States and another group of counselors helping people whose fathers were German SS officers and mothers Jewish. Curiously, in these early years, most were run by either women or men who believed the opposite sex was there for support only. Many of the communities had unique cultural features that were at variance with one another, and most had strong theologies they viewed as essential, but were not present in the others. For example, cessationist-Reformed and Pentecostal, "Spirit led" communities differed in their ministry styles, worship, observance of Sabbath, deliverance practices, and gender roles. The Shepherd's House team members also recognized divergent practices within their own group.

Accordingly, when the final Shepherd's House model was composed, great effort was made to insure that (a) women recovery group leaders were just as involved in designing the model as men; (b) a diversity of cultures was represented, so the methods might be transcultural; (c) it incorporated the best science available; (d) the strategies could be accepted by team members who represented various Christian traditions; (e) the methods would include community interventions, along with individual; (f) a positive lifespan developmental perspective would be incorporated, rather than just a psychopathological perspective; and (g) a healthy sense of one's Christian identity and worth (i.e., seeing oneself as valuable in God's eyes) would be promoted. The components of the Life Model started to emerge, along with its theological underpinnings (see below for details), but a unifying basis in scientific research remained elusive until 1997. At this time, the staff discovered the interpersonal neurobiology of Allan Schore through attending local conferences where he was presenting. Schore's (1994, 2003) work identified the centrality of joyful attachments for healthy individual and group identity formation. From this perspective, psychologically healthy systems informally model and teach positive interpersonal relational skills to members, which promote the formation of stable self-representations. These skills enable community members to handle suffering and relational conflict more effectively, tend to be self-propagating in healthy families, and appear to be missing in more dysfunctional families. Schore's (1994, 2003) writings indicated that missing skills could be acquired in adulthood through establishing healthy relationships with securely attached individuals. His treatment setting was primarily individual therapy sessions, but the team hypothesized the principles could be applied in broader community contexts.

Schore's (1994, 2003) work also proved useful for those who practiced Christian healing prayer (or inner healing prayer). Such prayer represented a set of "journey back" strategies "that seek under the Holy Spirit's leading to uncover personal, familial, and ancestral experiences that are thought to contribute to the troubled present" (Hurding, 1995, p. 297). At the time, many of these methods seemed to induce abreactions or PTSD flashbacks when traumatic memories began to be explored. Next, the counselor would help the person out of this highly dysregulated, neurophysiological state through prayer intended to bring in an awareness of God and a sense of peace. The Shepherd's House team moved away from this traditional inner healing model sequence through a technique they called Immanuel Prayer. Applying Schore's principles, practitioners first sought to intentionally activate brain regions associated with secure attachment with God and others. In this process, the counselor was nondirective regarding what memory the counselee might process subsequently, and the participants relied on God to lead the prayer process in the present moment through asking Him questions. If the counselee became dysregulated and this was not resolved quickly in prayer, the clinician would facilitate a return to the affectively stable, secure attachment condition that had occurred at the opening portion of the prayer session. Informal anecdotal results encouraged the Shepherd's House team to cautiously begin applying versions of the prayer form in individual, group, church, and community settings. The team continued developing other strategies as well, many of which were eventually integrated into the Life Model.

True to its ecumenical roots, the Life Model has been presented and adopted in churches or ministry organizations representing a variety of traditions, such as Lutheran, Evangelical, Anglican, Coptic, Roman and Eastern Rite Catholic, Salvation Army, Old Line Pentecostal, Reformed, Orthodox, and Messianic

traditions. Model developers hypothesize that many of these groups recognize the need for Christians to grow in love for God, display more Christian virtues, and maintain healthier relationships, particularly in the context of suffering and trials, and that most are searching for methods that can be applied safely in their communities by both mental health professionals and lay people (when appropriate).

Major Works Associated with the Practice

Early Life Model works focused on what was being learned about working with severely traumatized people (e.g., Willard & Wilder, 1988; Friesen, 1991). The emphasis on lifespan development, spiritual and psychological change, and the importance of cultivating joy in a relational community context became more pronounced in later works (e.g., Coursey & Coursey, 2013; Friesen, Wilder, Bierling, Koepcke, & Poole, 1999, 2013; Holsclaw & Holsclaw, 2020; Lehman, 2011, 2016; Warner & Coursey, 2018; Warner & Wilder, 2016; Warner, 2011; Wilder, Kang, Loppnow, & Loppnow, 2015; Wilder, 1993, 2018, in press). *The Life Model: Living from the Heart Jesus Gave You* (Friesen et al., 1999, 2013) laid the foundation for the approach. A variety of videos and other resources can be found through two main websites (https://lifemodelworks.org/ and https://www.immanuelapproach.com/), as well as other online retailers.

Relationship Between Scripture/Christian Theology and the Life Model

There are four distinctives of the Life Model: (a) the importance of attachment love for virtue development through the spiritual disciplines (attachment love is conceptualized as a secure, caring, mutual relationship with the triune God and others in community); (b) "Immanuel lifestyle"—the active awareness of God's attachment presence; (c) a focus on maturity development across the lifespan in multigenerational Christian community; and (d) the value of attachment-enhancing, neuroscience-based, interpersonal skills (called "relational brain skills" in the Life Model [Coursey, 2016, p. 1]) for building healthy communities. Several streams of Christian spiritual formation history and theology combine in the Life Model and are described below.

Attachment love and virtue development through the spiritual disciplines. First, attachment love is considered theologically, then applied to a current theory of Christian transformation through the spiritual disciplines (Willard, 2002). While this article's brevity limits a full exposition, from the Old Testament to the Gospels to the Epistles to the early church fathers and medieval saints, the triune God as love and the love of God and neighbor as the interdependent, chief goals of life have been central themes of Christian spiritual formation. In the Old Testament, the commandment to love God with all of our being is clear (e.g., Deut. 6:5). Two Hebrew terms seem to connect this love to aspects of attachment. *Dabaq* means to cleave, cling, stick with, follow closely, or keep closes to (Kalland, 1980). It is used in passages describing our relationship with God (e.g., Deut. 4:4, 10:20, 11:22, 13:4, 30:20; Josh. 22:5) and people (e.g., Ruth 1:14; Pr. 18:24). The Hebrew term, *Hesed*, is used almost 250 times and is often translated as loving-kindness or (Harris, 1980). Wilder (in press) suggested that replacing the English translations with attachment-love qualities maintains the essence of the passages with these terms. The New Testament Greek term *agape* and its famous love passage (1 Cor. 13) likewise fit with an attachment love theme. Most importantly, God reveals himself as a Trinity in the New Testament, so that the Old Testament's emphasis on love reflects the eternal love of Father, Son, and Spirit (Jn. 1:1-17, 13:34, 17), providing a new basis for the Christian's love of God and neighbor (1 Jn. 4).

Elements of an attachment love emphasis may also be found in the early church fathers and some of the medieval saints. For example, Augustine of Hippo described his journey from carnal lusts to genuine love of God in his *Confessions*, and his numerous writings and sermons elucidate the centrality of love as a virtue (Prelipcean, 2014). Clare of Assisi (1194-1253) advocated for contemplative prayer as a vehicle to deepen love for God. "We become what we love" was an underlying emphasis, so in her letters to Agnes of Prague, for example, she emphasized beholding various qualities of Jesus in ways that fit the characteristics of a noble woman looking in a mirror of the day (Armstrong, 1986). One might suppose that this beholding enhances attachment love to Jesus.

Theories of Christian virtue development through the spiritual disciplines have always

included a role for a construct similar to the attachment love defined above, although sometimes its presence is more implicit than explicit. For example, Willard (2002) stressed "vision," "intention," and "means" as key features in the application of the spiritual disciplines for spiritual change or transformation. *Vision* involved "teaching the availability and nature of the kingdom of the heavens" (p. 86.). *Intention* focused on the will, which Willard equated with the spirit and heart in biblical terms (p. 88). The will's primary act is to rely upon God and create or bring about good (p. 33). The will in reliance on God and His grace is the centerpiece to motivate practice and spiritual change (p. 89) through the spiritual disciplines. Over time, Willard and others observed that this paradigm worked well for some people, but others (for example, those exposed to trauma and with significant attachment wounds) needed more than the disciplines to produce transformation (Wilder, in press).

Willard's early works paralleled the development of the Life Model. He wrote a strong recommendation for one of its early key publications (see Friesen et al., 1999). His wife had a long relationship with Shepherd's House as its director of training. In his last years, Willard began to consider a soteriology of attachment (Wilder, in press). He encouraged Life Model developers' more overt inclusion of attachment love as a component of the *Intention* element of his model. Unfortunately, his untimely death prevented a fuller collaborative effort to increase the role of attachment love in his theory. Further efforts to expand the place of attachment love in Willard's (2002) conceptual model are now beginning (Wilder, in press).

The Immanuel lifestyle. Immanuel lifestyle is based on the realities of God being immanent, as well as transcendent. Its various forms apply principles from both the *kataphatic* (using words and images) and *apophatic* (imageless, wordless) models of contemplative prayer in an interactive relationship with God in the present moment. Two historical examples of relating with God in the present moment are briefly noted below, and Immanuel Prayer will serve as the example of an Immanuel Lifestyle intervention that extends these principles in the next section of this article.

Brother Lawrence, a cook in a monastery in the 1600s, lived a life that so influenced his fellow monks that a compendium of his letters and teachings, *The Practice of the Presence of God*, was created to capture his simple lifestyle (Hale, 2010). Brother Lawrence emphasized that one can have an active loving awareness of God being present in each moment, no matter how seemingly "trivial" the moment appeared, and that this loving awareness was the key to meaningful spiritual change. Jean-Pierre de Caussade (also in the 1600s) conveyed a similar sentiment in his work, *Abandonment to Divine Providence*, and highlighted seeing the present moment as sacred. Abandoning oneself to God's providence in all current circumstances was the key to spiritual growth, from his perspective (Caussade, 1975). As is described below, the Life Model agrees with these foundational principles and utilizes Immanuel Prayer to extend these ideas in an interactive, attachment-promoting manner.

Maturity development. Maturity, according to the Life Model, incorporates both psychosocial and spiritual aspects. Wilder (in press) proposed a secure attachment style (or earned secure attachment) and developmentally appropriate affect regulation and interpersonal social skills as reflective of psychological maturity. Spiritual maturity subsumes psychological maturity and includes an emphasis on growth in Christian virtue and secure attachment to God. Thus, spiritual maturity and psychological maturity are synonymous in the Life Model.

While the major Christian traditions have a long history of spiritual formation through the spiritual disciplines and Christian community to promote elements of maturity development across the lifespan, this has been a much neglected area (until the last 35 years) in fundamentalist, evangelical, and Pentecostal churches, where spiritual maturity did not appear meaningfully connected to psychological maturity (Wilder et al., 2015; Wilder, in press), and spiritual maturity appeared to be less important than education, gifting, or charisma. If scriptural terms like "elder" were intended to refer to older Christians who led a multigenerational community into spiritual maturity, such a meaning appears to be slowly returning in some Christian denominations. The Life Model seeks to restore an emphasis on psychosocial maturity as a main component of spiritual maturity (Warner, 2011; Wilder et al., 2015; Wilder, in press).

Attachment-enhancing, neuroscience-based interpersonal skills. The neurophysiological basis of healthy relational skills can

be traced back as far as Bishop Nemesius of Emmesa around the year 390 AD. In his treatise, *On the Nature of Man*, he proposed the main functions of the soul, such as memory, thinking, sensing, and imagination, were located in different areas of the brain (van der Eijk, 2008). While modern brain scans and research might lead to criticisms of some of the specifics of his brain-mapping conjectures, they were ground-breaking for the time and helped displace Aristotle's cardiocentric theory (van der Eijk, 2008).

Contemporary neurobiological models support loving attachment as the mechanism for maturity development and healthy interpersonal skills (Schore, 1994). The emotional energy behind loving attachment that develops both the attachment and nervous system of the infant is joy (Schore, 1994, p. 82). With regard to human attachments, joy is the emotion that comes from being glad to be together (p. 83). The relational expression of joy arises from the anterior cingulate segment of the limbic system that, unlike subjective well-being and optimism, very few people can control voluntarily (Damasio 1994, pp. 141-143). Damasio distinguished the voluntary and social "pyramidal smile" of Brodmann area 4 from the nonconscious smile expressed by the limbic system. Joy is amplified by the intersubjective interaction of two minds, whereas happiness is the experience of one mind reacting to something it likes. Relational joy, therefore, rather than individual happiness, builds attachments and emotional capacity. In the Christian tradition, joy finds its fulfillment in communion with God in this life and the beatific vision in the life to come (Pieper, 1998).

Based on the relational theology and contemporary neuroscience described above, the Life Model proposes 19 "relational brain skills" that are key components of building genuine spiritual maturity that incorporates psychological maturity and creates healthy communities (for a description of these skills, see Coursey, 2016).

Operationalized Definition and Steps Associated with Immanuel Prayer

As already mentioned, a core strategy of the Life Model is Immanuel Prayer, which extends the idea of Christian present-moment awareness found in Brother Lawrence, de Caussade, and others. It is the process of expanding our awareness of a current or past event to include the active presence of the God, who is always with us. Theologically, we may know God is/was present in each event, but conscious experiencing God's presence relationally may be missing.

Immanuel prayer can be practiced individually, with a prayer partner, in groups, or with a licensed professional (when complex conditions are present). As the process unfolds, the clinician/prayer partner monitors the counselee's sense of God's presence or active attachment connection with God. Like Peter walking on the waves (Mt. 14:22-33), if the person's attention shifts from God's presence to the trauma, the process may become disorganized and attention may have to be redirected to repair the attachment. Immanuel Prayer is not an exercise in imagining what God would think, but rather seeking to experience God's presence in relation to what is occurring in the present. The three basic steps for Immanuel Prayer (adapted from Lehman, 2016) are described below. The second person pronoun ("you") will be used when appropriate for ease of flow.

Some elaboration on Table 1 will be helpful. In step 1, Immanuel Prayer begins with thankfulness for God's presence in our lives, as a simple strategy to engender being consciously present in a state reflective of secure attachment to God. The goal in step 1b (Locating a current or past event for which the person is thankful) is for the prayer recipient to recall an instance where they felt close to God, along with a sense of appreciation, gratitude, or joy. It can also be a positive memory, whether there was a sense of God's presence or not. Examples of both might be the birth of a baby, one's wedding day, experiencing nature's beauty, a memory of a special experience with God, and so on. When someone cannot feel thankful, the Immanuel Prayer method stops at this point and the situation is explored. Often, the counselee is simply tired and needs to pause for a brief period of time, before the prayer can resume.

If the person can cultivate a sense of gratitude and thankfulness, then the process moves to step 2 (Contemplation seeking peace), which involves noticing God's response to our gratitude and putting God's response into words. The question pertaining to peace can be open ended or specific. While this question

Table 1

Steps to the Basic Immanuel Prayer Process

1. Deepening Appreciation, Gratitude, and Thankfulness. Invite the prayer recipient to do the following:
   a. Recognize that God is present now with you in this moment.
   b. Find something specific for which to give thanks to God (current or past).
   c. Stay with this current or past memory of appreciation for about two minutes, describing it in detail to God (what you noticed, liked, appreciated, etc.).
   d. Become aware of how the body responds physically to thankfulness.
2. Contemplation Seeking Peace. Encourage the prayer recipient to do the following:
   a. Ask, "God, what would You have me know that would bring me peace?" or "God, what would You have me know about [briefly state a situation] that would bring me peace?"
   b. Stay open and notice anything that comes to mind.
      i. Thoughts
      ii. Images
      iii. Nonverbal imageless sensing (for example, feeling God's peace and love kinesthetically)
   c. The therapist waits for 15 seconds, monitoring for signs that the engagement with God has begun or been blocked.
      i. When appropriate, the clinician/prayer partner reminds the recipient not to intentionally imagine what they might think God is saying, but rather to allow it to emerge.
      ii. If the person reports no sense of awareness, they sometimes may not want to say what came to mind due to its nature. Return to the step 1 current or past positive memory to re-regulate emotionally in this case.
      iii. If other blocks occur and initial processing does not clarify them, return to the current or past memory in step 1.
   d. The thought is shared in "God's voice or perspective" to the clinician/prayer partner
   e. Test the thought's effect for peace.
      i. If the thought leads to complete peace, proceed to step 3.
      ii. If the thought leads to partial peace, thank God for this and ask another question similar to 2a until there is complete peace.
      iii. If the thought produces a negative emotional reaction instead of peace, return to the current or past positive memory in step 1.
      iv. Debrief the experience when time is running out or the prayer is complete.
3. Sharing.
   a. If peace is achieved, the prayer recipient is encouraged to share the thought that brought peace with someone. In the clinical setting the thought is shared with the therapist and any precautions about sharing are considered.

Note. Adapted from Lehman (2016).

seeks God's perspective on our lives and can be worded many different ways, "why" questions are almost always unanswered by God in this life, and so are unhelpful therapeutically. Practitioners of the Immanuel Prayer discourage a person from intentionally imagining what God might say. While imagination has its purpose, Christian contemplation is, in part, about noticing in relation to God (Hildebrand, 1960). It requires giving attention and importance to the thoughts and images that pass through the mind, no matter how trivial or irrelevant they may appear. The 15-second pause by the counselor after the question gives time to "notice." If the person has not responded by then, the clinician may ask, "What came to your mind?"

Whatever has come to mind is then expressed. Two criteria help to evaluate the content: if (a) it promotes a deepened sense of peace, and (b) the content appears biblically sound. Sometimes both criteria are not met. In such cases, the utterance may not in fact be true; rather, it may be the opposite of what we know from Scripture, or it may be completely unrelated to God. For example, a person

might say, "God hates me and wants to slap my face." If this statement reflects the person's perception of God, it should not surprise us that God sovereignly wants the thought exposed, but not because the content is true; rather, only because it reflects the person's negative God image, which needs to be explored in therapy (for a discussion of negative God images, see Moriarty & Hoffman, 2007; Moriarty, 2006). It is also possible that the perception appeared scripturally sound, but does not produce an increased sense of peace. This may be due to the person attempting to imagine intentionally what God is saying. Occasionally, moreover, a disturbing image might occur that is totally unrelated to God (e.g., seeing an image of genitals). In such cases, the counselor would investigate the first criterion, "Does that thought feel peaceful to you?" The answer will usually be "No." The clinician then redirects the process back to step 1 to resume engagement with the thankful memory, reconnect with God in the event, and re-regulate emotionally. Once the prayer recipient reestablishes a felt sense of God's presence, the original prompt is repeated ("God, what do you want me to know [in a specific situation] that would bring me peace?") and the cycle repeats.

If time is running out and only partial peace has occurred in the memory, the counselee is to return to the positive memory in step 1 to re-regulate, and the experience is debriefed. Any mixed prayer experiences are explored. For example, negative God images related to the terms "God" or "Jesus" may need to be recognized and explored. The goal is to end this phase with the prayer recipient calm and emotionally regulated. Traumatic events are often only partially processed in each session. Thus, the limits of resolution should be considered carefully and checked for enduring peace at subsequent sessions.

Step 3 (Sharing) focuses on the thought that brings peace, rather than the actual event processed. This prevents the creation of secondary PTSD effects in others that might occur through the counselee sharing the specifics of a traumatic event with someone. Telling another the peaceful thought increases the likelihood that the counselee will seek God the next time they need peace. It also builds hope and ends the complete process with a positive relational interaction. In a clinical context, care is shown in reflecting on how the sharing takes place and with whom. Sharing peaceful resolutions with another implicitly promotes the self-propagation quality of most Life Model interventions. The desire is to get others interested in connecting with God and each other in healing ways that are simple to learn and can spread in a community context.

Immanuel Prayer can be practiced alone, guided by an individual, or practiced in groups. A wide variety of resources are available for learning the model. Anecdotally, mature adults may be generally able to pass on the Immanuel Prayer techniques to others after experiencing the prayer themselves several times. In one case example, the widows of martyrs in Colombia, South America, were guided through Immanuel Prayer, seeking peace after seeing their husbands murdered. With a half-day's experience of being guided individually, the women reported they were able to go home and guide their children and families through an Immanuel experience. A year later, the widows indicated they were still experiencing peace over what had happened and stated the prayer form had been shared throughout a network of relationships and was being passed on within a variety of relationships in the local community. (See https://www.immanuelapproach.com/ for a variety of resources on the prayer form.)

Perceived Controversial Theological Considerations Associated with the Practice

Some Christians might object to the Life Model's emphasis on strategies to generate the perception of the presence of God if they view the Bible as the only means of God's contemporary communication; if this is the case, the suggestion that God communicates to the heart directly is either too ambiguous or has discontinued after the first century. Of course, the Bible is the primary filter for evaluating whether what someone senses God is communicating is actually consistent with His character. However, even understanding Scripture rightly requires active participation by God through the Holy Spirit. There is also a sense of peace that comes with the awareness of His interaction, even if the information perceived in prayer might consist of biblically appropriate confrontation.

Other Christians might question the idea that fostering attachment love toward God and people in community can be developed through learning neuroscience-based relational skills. However, the Life Model assumes a fundamental relationship and compatibility between human attachment and attachment to God, while also recognizing the need for the Holy Spirit in any healing intervention (Friesen et al., 1999, 2013).

Some might challenge the Life Model's emphasis on personal psychospiritual change and maturity in community, believing it would be better left to mental health professionals. Actually, this might be optimal, especially when dealing with complex cases that can arise unanticipated. However, the shortage of clinicians and level of need for strategies that promote psychological and spiritual change in Christian communities, both within the United States and globally, makes this argument less than compelling. As a parallel, mindfulness-based stress reduction (MBSR) is an evidence-based program that is utilized in both clinical and community settings among both licensed mental health professionals and non-licensed, trained group leaders (Grossman, Niemann, Schmidt, & Walach, 2004), suggesting Christian communities might also benefit from a similar strategy to teach psychological principles in a variety of worldview-sensitive contexts. Nevertheless, we agree that mental health professionals should be involved in as many levels of the Life Model intervention as possible to prevent unintentional harm and utilize their clinical skills. As a result, the Life Model encourages lay community members to interact with such professionals as appropriate referral and consultation resources to assist them when complexities arise (Keyes, Wilder, & Todd, 2018).

Perceived Psychological and Spiritual Benefits of the Practice

Moving forward, careful empirical investigations of the possible psychosocial and spiritual benefits of the Life Model are needed, focusing on both individuals and communities. On an individual level, it is hypothesized (based on anecdotal observations) that humans can become more psychosocially and spiritually healthy through developing securely attached relationships with others and God via the Immanuel Prayer.

On a community level, it is hypothesized (based on anecdotal observations) that the methods of the Life Model may positively impact local communities by enhancing the healthy attachments community members have with God and each other, across generations. The Life Model employs strategies that may be easy to learn among Christians and can be passed on to others in the community. To be sure, interventions often end with some form of sharing as the final step.

Possible Psychological and Spiritual Difficulties/Barriers Associated with the Life Model

Several difficulties may occur in implementing the Life Model. For some women who have been traumatized by men, the idea of Immanuel Prayer with God as Father or Jesus may be perceived as initially threatening. Forming a healthy therapeutic bond with a female counselor who can embody the caring qualities of God may be necessary for an extended period before the prayer form is warranted. The Life Model suggests that complex trauma survivors are best served by mental health professionals familiar with its principles and evidence-based trauma treatment strategies in the context of a community seeking to incorporate Life Model principles (Keyes, Wilder, & Todd, 2018). In such cases, wise collaboration between the mental health professionals, pastors, and lay people involved is warranted, while respecting the counselee's need for confidentiality. In this process, the community may still be able to play an important role as a caring support system that can gradually help foster healthy attachments as the counselee's healing progresses (Friesen et al., 1999).

The Life Model's Immanuel Prayer is purposefully nondirective to reduce the risk of iatrogenic injury (specifically, retraumatization as a result of the treatment itself). As described previously, the clinician does not seek to direct the prayer recipient towards any particular memory or suggest a sense of what God is communicating. This openness may reduce the risk for false memories or other harm, and efforts are made to keep the prayer recipient in an emotionally regulated state.

The above-noted emphasis on positive interactions between mental health professionals

and churches/communities implementing the Life Model does have some systemic barriers. Health Insurance Portability and Accountability Act (HIPAA) laws and insurance company reimbursements only for symptom-focused, medically necessary treatment tend to hinder professionals from considering broader interactions with churches or communities. However, individuals who are interacting therapeutically with a group of people, rather than just one person in an office, increases the opportunities for interpersonal skill development and growth substantially. Also, the level of psychopathology present in some victims of complex trauma may increase the risk for litigious behavior. Finally, leaders in such communities, including the counselors involved, have the responsibility to be mindful of their own countertransference dynamics, taking care to prevent any acting out of such dynamics through accountability within both church and professional communities.

Similarities and Differences Between Buddhist Meditation, Secular Meditation, and the Life Model

The key difference between the Life Model meditation strategies, Buddhist meditation, and secular meditation relates to the role of one's relationship with God. The cultivation of a healthy secure attachment with God, as is promoted in the Life Model, is a legitimate extension of attachment theory (Kirkpatrick, 2005). However, in the Christian scheme of things, God is the ultimate attachment figure, and human attachments were created in order to image the God-human relationship and prepare humans for attachment to God (Roberts, 1997).

The Life Model might be objectionable to adherents of traditional Buddhism, which eschews the practice of attachment to anything and so defines the term quite differently. Attachment to people and things, from this view, connotes a grasping or clinging that does not accept the impermanence of all things (Wallace, 2005; Wallace & Shapiro, 2006), so Buddhism advocates *detachment* as a growth strategy. At the same time, we recognize that internal working models might not correspond well to current relationships and, thus, could lead to suffering. Interestingly, harmful clinging in Buddhism seems to have some similarities with the Western notion of an anxious attachment style (Mikulincer & Shaver, 2007). As a result, mature persons in Christian attachment and Buddhist detachment systems may both demonstrate a healthy degree of interdependence and deep care for other people (Sahdra et al., 2010).

Western mindfulness practitioners may have less of an objection to the attachment emphasis of the Life Model, given its broad empirical support, but they might be skeptical of the promotion of a therapeutic reliance on a supernatural being. We suspect, moreover, that persons practicing the Life Model might be more intentional about the promotion of joy through positive relationships as a component of health, in contrast with practitioners of either of the other models of meditation.

Burgeoning Theoretical and/or Empirical Support for the Practice

The theoretical/empirical support for the Life Model found in attachment theory has previously been addressed, so the focus here will be on available theoretical/empirical support that directly might support the Immanuel Prayer strategy. The Life Model conceives of Immanuel Prayer as an application of a mutual mind state, which Siegel calls "mental state resonance" (1999, p. 70), and further develops as a "system that mirrors minds" (Siegel, 2007, pp. 166-170). However, in this case, one is experiencing such a mind state with God. Mutual mind states occur when dyadic resonance permits the intercoordination of affective brain states in the context of relationship, awareness, and interest. Schore (2003) used the term *intersubjectivity* (p. 12) to describe a similar concept, from Aitken and Trevarthen (1997). Intersubjectivity is the interpersonal medium by which visual and prosodic auditory signals induce instant emotional effects in the securely attached dyad.

Current interpersonal neurobiology models such as Seigel (2007) and Schore (2003) suggest that attuned/mutual mind states promote healthy development. The Life Model extends these theoretical foundations by suggesting that one's relationship with God can also create the same kinds of healing experiences. In short, we hypothesize that conscious awareness of God's presence within one's personal experiences (regarding past memories or in

the present) can also contribute to trauma resolution and build connectedness with other persons. The technique of sharing positive mutual mind states with God at various points in an Immanuel Prayer session may reduce the risk for iatrogenic injury, potentially making this a safer healing prayer model to use than healing prayer models that do not have similar safeguards.

The next step is to conduct outcome-based studies on this approach. Unfortunately, to date, few Life Model practitioners have the research background needed to conduct such studies. However, a number of research projects focusing on the Life Model are currently underway.

Relationship Between the Life Model and Clinical Issues in the 21st Century

Ideally, healthy multigenerational communities are characterized by an underlying joy in individual, marriage, and family life, even in the midst of suffering and the internal and external conflicts that inevitably occur in such systems in the 21st century (Gal. 4:4). Families and communities that are "good enough" are open to sharing positive and negative mind states with one another and secure attachment is passed on across generations and promoted within communities. However, such ideal communities are rare in the 21st century. The effects of sexual and physical child abuse, violence of various kinds (including domestic), displacement, discrimination, and many other factors negatively impact lives, preventing or limiting experiences of relational joy. Restoring healthy attachment where it has been disrupted involves the interpersonal regulation of positive affect (Schore, 2003) and repair of interpersonal disruptions. Immanuel Prayer may be one useful strategy to include in such restoration efforts.

We believe that the Life Model, in combination with professional mental health services (wherever possible), can be helpful in promoting psychospiritual healing in the 21st century in the United States, as well as globally. The Life Model has already been applied to trauma recovery in Colombia (as noted above), as well as Nigeria, Mexico, Southeast Asia, Uganda, Rwanda, and Tibet, including work with refugee populations. There are also anecdotal reports of it being used effectively with survivors of a terrorist bombing of a cathedral in Kathmandu, tsunami victims, Tamil Tiger violence in Sri Lanka, and sexual abuse victims in Korea. We have no reason to believe such tragedies will decrease in the 21st century, so strategies that are relatively easy to learn and can impact large numbers of victims are desperately needed.

The group method of the Life Model used in the above locations can be learned in half a day (See "Passing the Peace: After a Crisis" for a brief booklet summary and "Peace" as a mobile application; https://lifemodelworks.org/experience-peace/). Of course, it is optimal to have mental health professionals available to offer more individualized services, psychoeducation, and follow-up care after such events. Unfortunately, many places around the world have very limited mental health resources. Therefore, we hope that well-designed studies on the efficacy of cross-cultural interventions using the Life Model will become frequent.

Future Possibilities and Applications to Individual, Couple, Family, and Group Psychotherapy

The relational skills and trauma resolution methods of the Life Model have been applied, anecdotally, to group and individual programs for addiction recovery. There have also been anecdotal reports of marital and family conflicts being reduced through a combination of relational skills, obtaining peace from God through Immanuel Prayer before engaging with a spouse, and improvements in family relationships through meaningful attachments in church community. Yet, since these reports have not been written up, well-designed research is still needed.

As with many therapeutic models, the ultimate goal would be to develop manualized guidelines for training in the neuroscience-based interpersonal skills and Immanuel Prayer of the Life Model in order to conduct a series of randomized controlled trials to evaluate its efficacy (a) with different groups of participants (individuals, couples, families, and communities); (b) with various clinical conditions; and (c) in comparison with current evidence-based models. Such a line of research, if launched, may keep researchers busy for years. Overall, we hope that the foregoing discussion might provide the warrant to get such a research project underway in the near future.

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