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Immanuel Approach Emotional Healing, Mental Illness, and Medication

In *Genuine Recovery* and *Beyond Tolerable Recovery*, Dr. Ed Smith comments briefly on mental illness. His comments could be understood as antagonistic to mental health professionals and medical mental health care. In working closely with Dr. Smith and discussing these issues in more detail, I have not found this to be the case. I have written out some thoughts that provide a wider context in which to understand mental illness and emotional healing. I am hoping these comments will prevent needless conflict and/or confusion between medical mental health care and approaches to emotional healing such as the Immanuel approach and Theophostic.[1]

Genuine Recovery, 2000 edition, page 44:

> "When a person is suffering from true mental illness or brain damage, this method will not work. True mental illness and/or brain damage is a physical problem resulting in a mental failure. True mental illness or brain damage is not the consequence of faulty thinking. It is not rooted in lies embedded in memories.
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> Many people we see have been labeled as mentally ill, when in fact they were suffering from lies. I do not question the reality of mental illness. It is real and has a crippling effect on those who bear it. What I question is the number of people who have been written off as beyond help through this labeling system.
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> Sometimes it is difficult to know when a person is truly mentally ill and when they are merely in bondage to faulty thinking. I assume it is lies people suffer from and will pursue this until I am convinced otherwise. It has become too easy to diagnose and prescribe without seeking to free people from their real sources of pain.[2]"

Thoughts, comments, reflections:

Most of the mental health professionals in the United States are using the Diagnostic and Statistical Manual, fifth edition (DSM V) – a descriptive and empirical[3] approach to diagnosis. These same mental health professionals also tend to take an empirical approach to treatment (double-blind, placebo-controlled research looking for any treatment that results in statistically significant improvement in observable signs and symptoms). There is a core of validity in this approach. Clinical patterns can be identified that do correspond to real and legitimate underlying illnesses even before the specific mechanisms of the underlying illnesses are understood. If people with a certain group of signs and symptoms also display a consistent pattern with respect to risk factors, exacerbating factors, beneficial factors, course of illness, effective treatments, etc., the identified group of signs and symptoms probably does correspond to a real underlying illness. This is the primary theoretical foundation for the whole series of DSM manuals. And this descriptive, empirical approach to diagnosis provides very practical benefits – correctly identifying these

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[1] Theophostic is a trademark of Dr. Ed Smith and Alathia, Inc. We do not claim any endorsement by the trademark-holder.

[2] Smith, Ed. *Genuine Recovery*. (Campbellsville, KY: Alathia Publishing), 2000. See Smith, Ed. *Beyond Tolerable Recovery*. (Campbellsville, KY: Alathia Publishing), 2000, pages 170-171 for very similar comments.

[3] Empirical: Based on practical observations and not relying on theory about underlying causes.

patterns can provide valuable guidance in practical treatment, since people with the same underlying illness will respond to the same treatments. And effective *treatment* can also be discovered empirically, even before the underlying causes of the illness are understood and/or the mechanism of action of the treatment is understood.

Medical history provides good examples of this kind of descriptive and empirical approach to diagnosis and treatment. For example, the clinical picture of pneumonia was accurately identified and described before either the underlying microbial cause was understood or effective antimicrobial treatment was discovered. Doctors *correctly concluded* that all patients with a certain pattern of fever, cough, sputum, chest pain, trouble breathing, etc. had a common underlying illness. This was many years before germs were discovered as the cause of pneumonia, and centuries before penicillin was discovered as the cure for pneumonia.

Furthermore, when penicillin was discovered, we knew it worked by killing the bacteria causing certain infectious illnesses, but we didn't understand the biological and chemical mechanisms of *how* it killed the bacteria without harming the patient. It was used with great benefit for many years before we figured out the specific mechanisms of action through which it worked.

Yet another example – the clinical picture of malaria was accurately identified and described, *and* treatment was available, before we understood what caused the illness or how the treatment worked. Doctors accurately concluded that any patient with a certain pattern of recurrent fevers, pain, shakes, and chills had a common underlying illness. The Native Americans had discovered that chewing the bark from a certain plant could cure this illness. Making the correct diagnosis of malaria could guide the physician to the appropriate treatment even though these correct discoveries about the diagnosis and treatment of malaria were made many years before the underlying microbial cause of malaria or the mechanism of action of quinine were understood.

Note that with each of these examples, it was important to continue the search for deeper understanding. Discovering the microbial basis for malaria, the insect vector of transmission, and quinine as the active ingredient in the curative bark dramatically improved both preventative measures and the effectiveness of treatment. Understanding the microbial basis for pneumonia lead to the excellent decision to use penicillin as the primary treatment for this illness. And understanding the mechanisms of action of penicillin allowed us to be much more deliberate in designing antibiotics with the best possible benefits and the least possible side effects.

I see an appropriate role for diagnosis (labeling), even though there is certainly painful stigma with any "mental illness" label. Identification of real clinical patterns, for example panic disorder, corresponds to certain underlying patterns of brain chemistry abnormality. Identifying this pattern and making the correct "diagnosis" can guide the use of medication as palliative treatment. My experience is that palliative treatment in the form of appropriate medication can reduce impairment until the underlying wounds and lies can be found and resolved. I think it is a worthwhile benefit if Paxil can reduce panic and depression so that a person can keep his or her job and support his or her family during the healing process. In my assessment, mental illness diagnosis and medication treatment are a problem when they are accompanied by the fallacious conclusion "Since we can identify a consistent clinical pattern, and medication reduces and/or resolves the symptoms, it must be *only* a biological illness and there is no point in pursuing underlying causes or other treatment options." *The key is to* ***continue looking for the underlying causes*** *and to use the Immanuel approach and/or Theophostic®-based emotional healing as a* ***curative*** *treatment*.

I think there will be less confusion and conflict with mental health professionals if we talk about mental illness within the currently accepted wider framework of descriptive and empirical research. Instead of making distinction between "real" and "false" mental illness, I think it would be more helpful to make a distinction between 1.) mental illnesses with an irreversible biological injury or illness as the core cause (for example, traumatic brain injury or schizophrenia), and 2.) mental illnesses which have unresolved psychological wounds and lies as the primary source of the illness and for which we have *curative* treatment (any emotional healing intervention that effectively identifies and resolves the underlying traumatic memories).

My assessment at this time is that illnesses like depression, obsessive compulsive disorder (OCD), somatization disorder, panic disorder, phobias, post traumatic stress disorder (PTSD), eating disorders, and chemical dependence are caused by unresolved old wounds and their associated lies. (Medical problems, such as thyroid deficiency, can trigger and/or exacerbate the problem, but unresolved wounds and lies are always present as the primary root). These unresolved wounds and their associated lies actually cause the medical brain chemistry and function to change. Medication can reverse or reduce this abnormality in the brain chemistry and function, and thereby reduce the observable signs and symptoms of the mental illness (depression, OCD, panic, etc.). *However*, medical psychiatric research and my own clinical experience indicate that medication does *not* permanently resolve the underlying problem (wound and lies). If the medication is stopped, the signs and symptoms of mental illness return. I am not aware of medical research regarding the Immanuel approach or Theophostic-based emotional healing, but my clinical experience is that when the underlying wound and associated lies are neutralized, the palliative treatment is no longer needed – the medication can be stopped and the mental illness does not return.

Additional note: Even though research indicates there is an irreversible biological core (unrelated to psychological trauma and that cannot be cured by healing psychological wounds) with illnesses such as traumatic brain injury, schizophrenia, and bipolar disorder, my personal clinical experience indicates that thoughts and emotions from unresolved psychological wounds can clearly exacerbate the overall clinical picture for these people as well. Once I identified this it seemed obvious and straightforward: "Of course people with irreversible biological mental illness can also have psychological wounds and core lies. Of course these wounds and lies will exacerbate their biological mental illness. Of course they will do better if these old wounds and lies are resolved and removed from the overall clinical picture." Unfortunately the co-existing biological mental illness makes emotional healing work more difficult and risky – the stressful work of emotional healing can exacerbate the illness and/or trigger relapse.

The above thoughts are based on my own clinical experience, as well as synthesis of years of reading psychiatric and neurological research. There are several research results that seem particularly relevant:

1. In one study, rats were placed in an experimental set-up where they had no way to prevent or escape mild shocks. After initial protest, they appeared to learn "I am helpless" and became clinically depressed (as indicated by all signs and symptoms of depression that can be observed in a rat, such as decreased activity, social isolation, abnormal eating, abnormal sleep, etc.). The brain chemistry in the rats also became abnormal, consistent with neurochemical depression. The experimental set-up was then changed so that the rats did have options, but they appeared to continue functioning with what in Theophostic® terms would be a metamorphic lie. Even though they had options, they still appeared to believe what was now a lie: "I am helpless." They continued to lie (despondently?) in their cages, displaying

the same indicators of depression and making no attempt to escape or stop the shocks. The rats were then given antidepressants. The observable signs and symptoms of depression resolved, the brain chemistry returned to normal, and the rats quickly discovered the new levers in their cages and learned to press them to escape the shock.

The second part of the experiment is even more intriguing. A second group of depressed, "learned helpless," brain chemistry abnormal rats did not receive antidepressants but did receive "therapy." The researchers manually moved their paws to the new levers and taught them how to use the new levers to stop the shocks. The rats appeared to learn that they were no longer helpless, and began to use the levers on their own. Amazingly, the brain chemistry in this second group then returned to normal and all observable signs and symptoms of depression disappeared. This research indicates that traumatic experience can result in internal negative beliefs (hypothesized – but it sure looks like it) which can then cause both the behavior and brain chemistry of "mental illness." It shows that medication can decrease the signs and symptoms of the mental illness. Furthermore, it shows that when the "lie" ("I am helpless") is eliminated, the behavior and brain chemistry of mental illness also resolves.

I wondered about the ease with which these rats "unlearned" their lies. The review I read did not mention whether the antidepressants were ever stopped and if so, did depression and helplessness return. The impression given was that antidepressants chemically neutralized the immobilizing effects of the "I am helpless" lie, enabling the rats to experientially "unlearn" the "I am helpless" lie. In the second experiment, the rats clearly "unlearned" the lie with brief "therapy" work. I think one point is that the rats learned the "I am helpless" as adults, and then had new experiences only weeks later that would help them "unlearn" the "I am helpless" lesson. That would be different than lies learned in childhood and carried for many years.

2. A second study used Positron Emission Tomography (PET) scans to observe the "real time," living activity of the brains in people with obsessive compulsive disorder (OCD). People who met full DSM IV criteria for OCD were shown to have a consistent abnormal pattern on their PET scans. One group was treated with Prozac. The signs and symptoms of OCD decreased and the abnormal PET scan results were seen to return to normal as the signs and symptoms of OCD decreased. A second group received no medication, but rather used cognitive-behavioral therapy to challenge and change the behaviors, distorted negative beliefs, and emotions associated with OCD. This group also demonstrated decreased signs and symptoms of OCD and their abnormal PET scans also returned to normal as the signs and symptoms of OCD decreased. The striking point of this research is that therapy targeting distorted thoughts, feelings, and behavior can change the medical PET scan in the same way that medication does and at the same time as it reduces the signs and symptoms of OCD.

3. Medical psychiatric research and my own clinical experience indicate that both medication and cognitive-behavioral therapy must be maintained. For example, in both panic disorder and OCD, signs and symptoms almost always return if maintenance treatment (medication or therapy) is stopped. Although research regarding the Immanuel approach and medication discontinuation has not yet been done, my clinical experience is that maintenance treatment can be stopped when the underlying wound and associated lies are neutralized.