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Schizophrenia and the Immanuel Approach/Theophostic-based Emotional Healing: General Comments and Frequently Asked Questions

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"True" schizophrenia vs "mimic" schizophrenia: One of the most important questions I receive from those doing emotional healing work goes something like "Isn't schizophrenia just a manifestation of trauma, dissociation, lies, demonic harassment, and other spiritual/ psychological issues?" Both review of the medical literature and my personal clinical experience with many patients that have been diagnosed with schizophrenia have lead me to the conclusion that there are two separate clinical situations, "true" schizophrenia and "mimic" schizophrenia, both currently included in the group of people carrying the diagnosis of schizophrenia.[1]

What I call "true" schizophrenia is a mental illness that includes an important component of what I call *primary* biological brain abnormalities – biological brain abnormalities that contribute to the mental illness *and that are **not** simply caused by spiritual and/or psychological issues*. People with "true" schizophrenia have biological brain vulnerabilities that *predispose* them to respond to psychological and spiritual problems (such as truth-based pain in the present, unresolved psychological trauma, inadequate maturity skills, unhelpful defenses, sin, and demonic infection) with the clinical picture that I call true schizophrenia. The exact mechanisms are unclear, but my perception is that in people with these vulnerabilities, emotional and spiritual problems can push their biological brain function into the persistent dysfunction of true schizophrenia. True schizophrenia is *not* "just" a manifestation of emotional and spiritual problems in an otherwise normal brain, and it *cannot* be completely resolved with emotional healing ministry.

What I call "mimic" schizophrenia is a clinical picture that looks a lot like true schizophrenia but that is actually a combination of unresolved trauma getting stirred up, dissociative phenomena, lack of maturity skills, and demonic infection. As discussed in "Psychosis and Psychotic Symptoms: Definitions and Diagnostic Considerations," PTSD flashbacks, other dissociative phenomena, and demonic harassment can produce psychosis. I have seen mental health professionals mis-diagnose psychosis from these causes as schizophrenic psychosis. Mimic schizophrenia *is* "just" the manifestation of emotional and spiritual problems in an otherwise normal brain, and it *can* be completely resolved with emotional healing. That is, a person with flashback-dissociative-demonic psychosis, who has been *misdiagnosed* as schizophrenic, should experience complete recovery with adequate therapy/ministry addressing these psychological and spiritual issues. I have worked with people who had been mis-diagnosed with schizophrenia due to psychotic symptoms caused by trauma, dissociative phenomena, lack of maturity skills, and demonic oppression, and in these cases the psychotic symptoms have steadily resolved as the underlying roots have been resolved.

Note that the combination of unresolved trauma, dissociative phenomena, lack of maturity skills, and demonic infection do not always cause mimic schizophrenia. Sometimes this combination

[1] Of course there are also some people with *both* the trauma-dissociation-immaturity-demonic infection combination *and* true, genetic schizophrenia, and a few people with various other problems that occasionally mimic schizophrenia.

can cause suffering and dysfunction, but not cause symptoms severe enough to meet criteria for any of the clinically recognized mental disorders. And sometimes this combination can cause symptoms that mimic other mental illnesses with prominent genetically determined brain biology abnormalities, such as Attention Deficit and Hyperactivity Disorder (ADHD), or bipolar disorder. Mimic schizophrenia results only when unresolved trauma, dissociative phenomena, lack of maturity skills, and demonic infection are *sufficiently severe* and also *interact in certain ways* so as to produce a clinical picture that is similar to true schizophrenia.

Medical psychiatric research: There is a HUGE collection of medical research supporting the existence of "true" schizophrenia as described above. For example: case-control family pattern studies, studies comparing fraternal vs identical twins, studies comparing twins reared apart vs twins reared together, adoption studies, gene mapping association studies, other molecular genetics research,[2] studies of early developmental abnormalities in people who later develop schizophrenia, neuroanatomical studies, neuropathological studies, histopathological studies, studies examining neurobehavioral deficits, cerebral metabolism and blood flow studies, neuro-receptor studies, metabolite studies,[3] studies of early development environmental factors (such as prenatal viral exposure and Rh incompatibility, and research regarding increased risk with abuse of illegal drugs.[4] A thorough discussion of this research is beyond the scope of this essay, but I would like to briefly summarize the results from twin studies, an especially compelling and easy

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[2] A number of current books discuss this extensive evidence supporting genetically-based neurobiological components contributing to true schizophrenia. See, for example, Mellon, Charles David. *The Genetic Basis of Abnormal Human Behavior*. (Genetics Heritage Press), 1997. Another good source is Riley, Brien P., and Kendler, Kenneth S. "Chapter 12.3: Schizophrenia: Genetics," in Kaplan, H.I., Kaplan, Virginia A. (Eds.) *Kaplan and Sadock's Comprehensive Textbook of Psychiatry, 8th edition*, (Baltimore, MD: Lippincott Williams & Wilkins), 2004, pages 1354-71. For a good general discussion of genetics and mental illnesses, and an understandable explanation of the different kinds of research examining genetic contribution to mental illnesses, see Faraone, Stephen V., Tsuang, Ming T., Tsuang, Debby W. *Genetics of Mental Disorders: A Guide for Students, Clinicians, and Researchers*. (New York, NY: Guilford Press), 1999.

[3] An important caveat regarding the many neurobiological abnormalities seen in patients with true schizophrenia is that we need to consider the possibility that these brain abnormalities could be caused by psychological and spiritual issues (as discussed at length in the essay "Mind *and* Brain: Separate but Integrated." In fact, I am convinced that this *is* the case for some of these abnormalities, but the reason I include the reference to neurobiological abnormalities in support of my conclusions regarding true bipolar is that *each* mental illness is associated with it's *own* constellation of neurobiological disturbances. My perception is that some of this can be explained by certain mental illnesses also being associated with their own constellations of spiritual and psychological issues (for example, traumas with "It's hopeless, I'm worthless" will be associated with depression, while traumas with "I'm gonna die" will be associated with panic); However, I don't think this can adequately account for all of the consistent and dramatic neurobiological abnormalities seen in illnesses such as schizophrenia.

[4] For discussion of these additional sources of evidence indicating a true bipolar disorder that includes neurobiological abnormalities *not* simply caused by spiritual and/or psychological issues, see Brown, Alan S., Bresnahan, Michaeline, and Susser, Ezra S. "Chapter 12.4: Schizophrenia: Environmental Epidemiology," Murray, Robin M., and Bramon, Elvira. "Chapter 12.5: Developmental Model of Schizophrenia," Gur, Raquel E., Gur, Ruben C. "Neuroimaging in Schizophrenia: Linking Neuropsychiatric Manifestations to Neurobiology," and Roberts, Rosalinda C., and Tamminga, Carol A. "Chapter 12.7: Schizophrenia: Neuropathology," all in Kaplan, H.I., Sadock, B.J., Grebb, (Eds.) *Kaplan and Sadock's Comprehensive Textbook of Psychiatry, eighth edition*, (Baltimore, MD: Williams & Wilkins), 2004, pages 1371-81, 1381-96, 1396-1408, 1408-16; and *Kaplan and Sadock's Synopsis of Psychiatry*, Seventh Edition (Williams & Wilkins: Baltimore, MD 1994), pg 521.

to understand component of the medical research.

One type of twin study works with sets of twins that have been reared together, and then compares the concordance rate[5] in fraternal twins with the concordance rate in identical twins. The two key points in these studies are 1) both the fraternal and identical twins have shared very similar intrauterine and family environments; and 2) the identical twins have *exactly the same genetic blueprint*, whereas fraternal twins share genes in the same way siblings do. Under these conditions, if a particular illness is *completely genetic*, identical twins will be concordant (both twins either having the illness or not having the illness) *100%* of the time because their genes are *100%* identical, whereas fraternal twins will be concordant at the same percentage as *non-twin siblings* (50%). In contrast, if a particular illness is *completely the result of environmental factors*, there will be *no difference between identical twins and fraternal twins*. And if an illness is *partially genetic* and *partially environmental* – that is, there is a genetic predisposition/ vulnerability, but some kind of environmental factor causes the underlying vulnerability to manifest as actual disease – then identical twins will be concordant at a greater percentage than fraternal twins, but at a percentage less than 100%. This is exactly what is found with schizophrenia – identical twins show ~50% concordance and fraternal twins show ~15% concordance.[6] To my assessment, the results of these twin studies alone prove that there is a "true" schizophrenia where 1) primary biological brain abnormalities make certain people vulnerable to the illness; and 2) environmental stressors (for example, truth-based pain, unresolved trauma, demonic infection) are required for the biological brain predisposition to be expressed as clinical schizophrenia.

Clinical experience: Below is a brief summary of the most significant clinical observations that have contributed to my conclusion that mimic schizophrenia and true schizophrenia are separate clinical conditions, both currently included in the group of people carrying the diagnosis of schizophrenia.

Severe impairment and need for hospitalization: I have cared for many patients with what I perceive to be schizophrenia with severe psychotic exacerbations. These patients have been delusional, troubled by hallucinations, confused, agitated, and disorganized to the extent that safety concerns necessitated inpatient psychiatric care with 24 hour/day observation, usually for at least one to three weeks (and sometimes much longer). If there is not a true biological brain vulnerability in schizophrenia – if schizophrenia is nothing more than a particularly severe combination of unresolved trauma, lack of maturity skills, dissociative phenomena, and demonic infection – then ritual abuse survivors (people with *extreme* trauma, dissociation, lack of maturity skills, and demonic infection) should *routinely* experience the severe psychotic episodes just described. However, I am closely familiar with many ritual abuse survivors who have *not* had these severe psychotic episodes – they have experienced many intense *acute* symptoms (for example, emotional lability, anger outbursts, and *transient* psychotic symptoms from triggering, dissociative phenomena, and demonic harassment), but not the prolonged severe psychotic episodes like those I have seen with patients who have true schizophrenia. The acute, transient symptoms I have seen in patients with mimic schizophrenia rarely require

[5] The concordance rate simply indicates the percentage of twin pairs where both twins are the same with respect to whatever is being measured in the particular study (for example, eye color, the presence of diabetes, or the presence of schizophrenia).

[6] Riley, Brien P., and Kendler, Kenneth S. "Chapter 12.3: Schizophrenia: Genetics," in Kaplan, H.I., Kaplan, Virginia A. (Eds.) *Kaplan and Sadock's Comprehensive Textbook of Psychiatry, 8th edition*, (Baltimore, MD: Lippincott Williams & Wilkins), 2004, pages 1354-71.

hospitalization, and when hospitalization is necessary a brief "crisis" stay of one to several days is usually adequate.

Inability to participate in psychotherapy or ministry: The people in these severe schizophrenic psychotic episodes were so agitated and distracted by their delusions and hallucinations, and so confused and disorganized by their thought disorders that they were not able to think clearly enough, focus long enough, or cooperate enough to participate in any kind of emotional healing work. *And this severe impairment was usually present continuously for at least 1 to 3 weeks*. In contrast, people with *mimic* schizophrenia have *occasionally* been so impaired by triggering, dissociative phenomena, lack of maturity skills, and demonic harassment that they were unable to participate in therapy or ministry, but this has almost always resolved in a matter of hours (or at most days). In my experience, even people with the horrifying trauma of ritual abuse *very rarely* have prolonged episodes of being unable to participate in emotional healing work.

The place of medication: My experience with people who have true schizophrenia is that they have always needed medication as part of their ongoing baseline treatment, and when they have developed psychotic exacerbations they have always needed additional medication as part of treatment to accomplish re-stabilization. In contrast, my experience with people where trauma-dissociative phenomena-lack of maturity skills-demonic infection are mimicking schizophrenia is that medication is usually optional. These people will sometimes receive benefit from certain medications, but medication is usually *not* a necessary part of the treatment plan (especially if they are in a situation where they can receive effective emotional healing when they are in crisis).[7]

Rate of onset: My experience with people who have true schizophrenia is that episodes of psychotic exacerbation have usually[8] begun gradually, slowly developing over days or weeks. In contrast, my experience with mimic schizophrenia is that changes *can* occur over days or weeks, but that they are usually much more rapid (hours, minutes, or even seconds). For example, hallucinations from trauma flashbacks will develop over the span of seconds to minutes. Episodes of general symptom exacerbation that eventually include psychotic symptoms will occasionally develop gradually when subtle triggers are progressively activated, causing progressive decompensation over the course of days or weeks, but in mimic schizophrenia it is more common for intense triggering to cause psychotic symptoms to develop over the course of hours, minutes, or even seconds.

Rate of resolution: My experience with people who have the trauma-dissociation-inadequate maturity skills-demonic infection combination (mimic schizophrenia) is that any given episode of acute psychotic symptoms will resolve *over the course of seconds or minutes*[9] if the

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[7] See "Depression & Immanuel/Theophostic-based Emotional Healing: General Comments and Frequently Asked Questions," and section VIII. (Some practical implications of working from a 'mind *and* brain' paradigm) in "Mind *and* Brain: Separate but integrated" (available as free downloads from www.kclehman.com) for additional discussion of the appropriate place of medication in mental illnesses caused primarily by some combination of truth-based pain, unresolved trauma, lack of maturity skills, sinful defenses, other sin, and demonic infection.

[8] I have seen psychotic exacerbations in patients with schizophrenia develop over the course of hours in response to sudden, overwhelming stress, but this has been very rare.

[9] The ministry session may take several hours, but the acute symptoms will usually be present during

corresponding traumatic memory source is resolved. Acute psychotic symptoms will sometimes even *spontaneously* resolve suddenly (over the course of seconds, minutes, or hours) if something causes the triggered traumatic memory to return to a dormant, disconnected state.[10] On the other hand, I have never seen an episode of psychotic exacerbation in a patient with true schizophrenia resolve suddenly.[11] In my experience, psychotic exacerbations in true schizophrenia have always resolved over the course of days or weeks.

Insight regarding the need for help: My experience with people who have true schizophrenia is that they usually have very poor insight regarding the need for help. They are usually unaware of any thought disorder, and they usually perceive their hallucinations and delusions as real and true (as opposed to symptoms of mental illness that require treatment). They almost never perceive their thought disorders, hallucinations, and delusions as being caused by underlying issues that can be addressed through emotional healing. In marked contrast, my experience with mimic schizophrenia is that there is no impairment of insight regarding their need for care (that is, they tend to have the same blend of insight, self awareness, denial, and self deception as the rest of us). In fact, the stressors stirring them up, the pain from the material getting stirred up, and the alarming nature of the acute psychotic symptoms usually push people with mimic schizophrenia past a lot of their usual denial and self deception. In my experience they are usually at least partially aware that underlying psychological and spiritual issues are causing their psychotic symptoms, and they are usually willing to participate in emotional healing in an attempt to address these issues.

All together in the same patients: An especially significant point is that all the features of true schizophrenia described here have been present in the same patients. The patients who have had the severe, prolonged psychotic exacerbations requiring extended hospitalization have been the same people who were unable to participate in ministry or therapy for weeks, who required medication, who experienced slower onset and recovered much more slowly, and who had poor insight regarding their need for care. The people I have worked with who had true schizophrenia with severe psychotic exacerbations have had *all* of these features together, and most[12] of the people with mimic schizophrenia have not had *any* of these features. Note: People with *both* true and mimic schizophrenia will present a more complicated and confusing picture for diagnosis and treatment, but the point here is that the "simple" cases (where only one or the other is present) demonstrate that true and mimic schizophrenia *are two different, distinct clinical pictures*.

Frequent mis-diagnosis: As is clear from the above comments, I believe there is such a thing as

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most of the session, and then resolve over the course of seconds or minutes when the underlying traumatic memory finally resolved.

[10] This disconnection "resolution" is only temporary relief, as opposed to the permanent healing the person receives with resolution of the underlying traumatic memory source.

[11] If anybody in our reading audience observes sudden resolution of true bipolar mania or depression with the Immanuel approach or Theophostic-based emotional healing, please e-mail me at drkarl@kclehman.com.

[12] A few have had mimic schizophrenia with gradual onset (days) and gradual resolution (days), a few have had poor insight regarding their need for care, and one person I worked with had an extended period of severe impairment requiring hospitalization and precluding emotional healing work. Interestingly, the onset and resolution were very rapid (hours) in this one case with the extended period of severe impairment.

true schizophrenia, and I also believe that many people with a combination of trauma, dissociative phenomena, lack of maturity skills, and demonic infection are misdiagnosed as schizophrenic. Many mental health professionals, especially those trained primarily in the medical psychopharmacology model, have a poor understanding of trauma, dissociative phenomena, maturity skills, and especially demonic infection[13]. If you are working with someone who doesn't understand (or even believe in) psychological trauma, dissociation, lack of maturity skills, or demonic infection, he or she will try to fit psychotic symptoms caused by these phenomena into the diagnostic box that is the next best fit. This is often schizophrenia.

I think there are a number of reasons for this common mis-diagnosis:

1. Unresolved trauma (especially trauma flashbacks): Many mental health professionals are poorly informed regarding about the lingering effects of unresolved psychological trauma. Sadly, to my assessment, this is especially true regarding psychiatrists because their training focuses on the biological abnormalities present in mental illness and on the corresponding medication-based treatment of these abnormalities. In trauma flashbacks the subjective experience of reconnecting with visual, auditory, olfactory, and physical memory content that had been dissociated is exactly the same as the subjective experience of perceiving psychotic hallucinations. Furthermore, trauma flashbacks can also cause confusion and disorganized behavior. If a mental health professional doesn't recognize that these pseudo-psychotic/psychotic signs and symptoms are being caused by flashbacks he will understandably try to make the clinical picture fit into the next closest diagnostic box (often schizophrenia).
2. Memory anchored distorted interpretations: As discussed at length elsewhere,[14] distorted interpretations regarding the meaning of the experience are a prominent component of many traumatic memories, and these distorted interpretations can sometimes look like mild psychotic delusions. If a mental health professional does not recognize that these pseudo-psychotic distorted interpretations are actually coming from underlying traumatic memories he will understandably try to make the clinical picture fit into the next closest diagnostic box (often schizophrenia).
3. Dissociative Phenomena: Mental health professionals tend to be even less informed regarding dissociative phenomena as a part of unresolved trauma. Dissociative internal parts can produce the subjective experience of "hearing voices," which can look a lot like auditory hallucinations.[15] Dissociative phenomena can produce confusion and disorganization, which can look a lot like psychotic thought disorder. Internal dissociative parts can hold memories

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[13] Most mental health professionals have *no* place in their assessment for demonic infection. It causes the clinical picture look strange and respond poorly to treatment, but they have no idea what is going on or what to do about it.

[14] See, for example, the discussion of level 5 processing in Part II of the "Brain Science, Psychological Trauma, and The God Who is With Us" essay series.

[15] Internal dissociative parts can produce the subjective experience of hearing voices "inside my head." Note that this is actually not the same as auditory hallucination, which by definition is hearing voices or other sounds that are experienced as coming from "outside my head." However, mental health professionals who are not familiar with internal dissociated parts will usually fail to make this distinction, and will therefore incorrectly conclude that comments from internal dissociated parts are auditory hallucinations.

and/or core lies that appear to be psychotic delusions.[16] Dissociative phenomena can cause disorganized behavior, and dissociative phenomena can produce trance states that look like psychotic catatonic behavior. If a mental health provider does not recognize these pseudo-psychotic/psychotic signs and symptoms as dissociative phenomena he will understandably try to make the clinical picture fit into the next closest diagnostic box (often schizophrenia).

4. Demonic Infection, Opposition, Harassment: Secular mental health professionals can't see or understand any ways in which demonic infection, opposition, or harassment contribute to the clinical picture because they have no place in their world view for these phenomena. Unfortunately, many Christian mental health professionals (and pastors) hold the same "demons don't exist" world view as their secular colleagues. Demonic harassment and/or deception can cause fixed beliefs that appear to be psychotic delusions.[17] Demonic infection, opposition, and harassment can produce "voices," images, and physical sensations that can look exactly like visual, auditory, and tactile hallucinations. Demonic spirits can produce confusion and disorganization that look very much like psychotic thought disorder, and demonic spirits can produce disorganized and/or catatonic behavior. Again, if a mental health provider does not recognize these pseudo-psychotic/psychotic signs and symptoms as demonic phenomena he will understandably try to make the clinical picture fit into the next closest diagnostic box (often schizophrenia).

   For example, during one of my temporary assignments at a state psychiatric hospital, I was asked to perform a psychiatric evaluation on a young man who had been sent from an outpatient mental health clinic with the request that he be admitted to our inpatient unit. His chart indicated that he had been carrying the diagnosis of chronic paranoid schizophrenia for a number of years, and his case worker had sent him for admission because he seemed to be having an acute psychotic exacerbation and she was concerned that his psychotic symptoms might cause him to harm himself or someone else. When I went into the examination room I found a young man who was pacing back and forth across the room in an anxious, agitated fashion, and who began to explain that he needed to stay in the hospital "until I can get things back under control."

   He described how he had been a very lonely, unhappy teenager until, while looking through an occult bookstore one day, he had discovered an Ouija board with a friendly looking spirit attached to it. "People are so ignorant," he commented, "The other Ouija boards didn't even have spirits, but people bought them anyway – what a waste! The boards without spirits are totally worthless." The friendly looking spirit offered to be his friend, so he bought the board and invited this new "friend" into his life. He could describe its visual appearance in detail, and claimed that it had introduced itself, by name, when they had first met in the occult bookstore. "At first, it was great," he explained, "I finally had a friend. The spirit would go everywhere with me, and I could talk to it any time I wanted to." "But then it started telling me to hurt children. (Pause) Now, it tries to get me to hurt children all of the time. Whenever

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[16] This is especially the case with occult ritual abuse victims. The real memories carried by the internal dissociated parts are so horrific that most mental health professionals not familiar with ritual abuse would mistake them for psychotic delusions.

[17] One of the most common examples of demonic phenomena resulting in beliefs that can be mistaken for psychotic delusions is very simple: if you are, indeed, being harassed by demonic spirits, and you talk about the possibility that demonic harassment could be the explanation for your experiences, many mental health professionals will automatically conclude that you are experiencing psychotic delusions. The "revelations" people receive from new age spirit guides provide another good example of demonic deceptions that produce fixed beliefs that can look a lot like psychotic delusions.

I walk past the park, it tells me to kidnap, torture, rape, and kill the children....Whenever I feel like I'm getting weak, and I'm afraid I might give in, I come into the hospital until I can get things back under control."

One of the most striking things about this young man was that, other than the content of his story, and his anxious, agitated pacing, he seemed to be completely normal. I had worked with hundreds of patients with chronic schizophrenia, and my experience was that patients with true schizophrenia always had many other signs and symptoms in addition to the more dramatic psychotic symptoms (such as hallucinations and delusions). In my experience, patients with true schizophrenia also had abnormalities in their social interactions, nonverbal communication, cognitive functioning, and thought organization. For example, people with schizophrenia will display abnormalities of facial expression and other details of body language, abnormalities of voice tone and vocal inflection, abnormalities of timing with respect to social responses, characteristic abnormalities of thought organization (the "thought disorders" described above), and a variety of subtle problems with other cognitive functions.

This young man, however, displayed social interactions, nonverbal communications, cognitive functioning, and thought processes that were all completely normal. Furthermore, he didn't have any other hallucinations or delusions – other than his perceptions and beliefs regarding his "spirit friend" his sensory perceptions and thought content were completely normal.

So it occurred to me: "Maybe he actually *is* being oppressed by a demonic spirit, and is otherwise normal – maybe he doesn't even have schizophrenia at all."[18] With this thought in mind I decided to pursue a treatment option that would certainly be considered unusual for schizophrenia: "I notice that you're wearing a cross. Is Christian spirituality important to you?" When he answered that he had grown up in a Christian home, and that he had been baptized as a child, I suggested that we might pray and ask the Lord to remove this spirit that was now pushing him to hurt children.

As soon as I suggested this he backed against the wall with wild-eyed fright, fending me off with his hands as if I were coming at him with a large knife, or maybe a red hot branding iron: "No! No! Don't take it away! I don't want you to take it away – just help me get back in control – just make it be nice again, like it was at first." I tried to explain that he could invite the Holy Spirit to come and be with him, in place of this dangerous spirit, but he kept begging me not to take his spirit friend away from him. When I finally explained that I would not pray without his permission he calmed quickly and dramatically, and was then able to go through the rest of the admission evaluation without incident.

After completing a careful and thorough evaluation, my honest assessment was that he probably *was* being oppressed by a demonic spirit, and that he probably did *not* have any mental illness.[19] But the mental health professionals at the state hospital couldn't even

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[18] Note that it's important to ask if demonic phenomena has been mis-diagnosed as schizophrenia, or vice versa, but it's also important to realize that a person can have both. Just because a person is harassed/oppressed by demonic spirits does not rule out the possibility that he may also be schizophrenic, and just because a person has true schizophrenia does not rule out the possibility that he may also be harassed/oppressed by demonic spirits. See the "False dichotomy" section of the "Mind and Brain, Separate but Integrated" essay for additional discussion of demonic "infection" and schizophrenia occurring together.

[19] It would be good to discuss whether or not demonic oppression should be considered a mental illness, but for the purpose of this essay I am using "mental illness" as mainstream medical psychiatry is currently using the term.

consider this possibility, so they put him in the next closest diagnostic box. The *only* symptoms contributing to his diagnosis of schizophrenia were his beliefs and perceptions regarding this demonic spirit – his beliefs about how he had discovered it, his beliefs about his ongoing relationship with it, his perceptions that he could see it and hear it, and his beliefs that it was trying to get him to harm children. But even though he was otherwise completely normal, and had no other signs or symptoms of schizophrenia, the mental health professionals involved had concluded that he had chronic paranoid schizophrenia on the basis of his "visual hallucinations" (seeing the demonic spirit), "auditory hallucinations" (hearing the demonic spirit), and "delusions" (all of his beliefs regarding the demonic spirit). Since they did not even *consider* the possibility that the demonic spirit could be real, schizophrenia was the best diagnosis they could come up with.[20]

5. Self medication with hallucinogens and/or stimulants: The first part of the picture is that people with painful psychological and spiritual issues (such as trauma, dissociation, immaturity, and demonic infection) often use various kinds of "self medication" as a part of their attempts to manage their pain. This self medication can be engaging in endorphin releasing activities, such as masturbation or gambling, or it can be using "pain killing" substances, such as alcohol or street drugs.[21] The second part of the picture is that both stimulant abuse and hallucinogen abuse can cause a variety of psychotic symptoms, including agitation, confusion, disorganization, hallucinations, delusions, and even catatonic behavior.[22] Therefore, when people with painful psychological and spiritual issues self medicate with stimulants and/or hallucinogens they will sometimes experience dramatic psychotic signs and symptoms that are being directly caused by the substance abuse. However, if the mental health providers do not identify stimulants/hallucinogens as the true cause of the psychosis they will understandably try to make the clinical picture fit into the next closest diagnostic box (often schizophrenia).
6. Lack of maturity skills: Lack of maturity skills can make a person more vulnerable to all of the above.
7. Improvement with medications for schizophrenia: In some situations psychological trauma, dissociative phenomena, immaturity, and demonic oppression can actually cause the brain chemistry abnormalities associated with psychotic symptoms, and in these situations medications that benefit schizophrenia can provide symptomatic improvement (but not cure) by "manually" correcting these brain chemistry abnormalities. Some mental health profes-

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[20] Sadly, I realized that I couldn't deal with the demonic spirit until he was willing to renounce his decision to invite this spirit into his life, and I didn't think it would work to write "demonic oppression, pursue deliverance prayer as the patient is willing" as the diagnosis and treatment plan in his chart. I prayed for him as a part of my personal intercessory prayer, and I continue to pray for him whenever he comes to mind, but as far as the state hospital was concerned I didn't know what else to do besides leaving his diagnosis and treatment plan unchanged.

[21] A recent prospective study found that PTSD increased the risk of subsequent substance abuse by 450% (Chilcoat HD, Breslau N. "Posttraumatic stress disorder and drug disorders: testing causal pathways," *Arch Gen Psychiatry* 1998;55:913-917).

[22] For detailed discussion of stimulant and hallucinogen abuse as potential causes of psychotic symptoms, see Jaffe, Jerome H., Ling, Walter, and Rawson, Richard A. "Chapter 11.3: Amphetamine (or Amphetamine-like) - Related Disorders;" and Jones, Reese T. "Chapter 11.7: Hallucinogen-related disorders," both in Kaplan, H.I., Sadock, B.J., Grebb, (Eds.) *Kaplan and Sadock's Comprehensive Textbook of Psychiatry, eighth edition*, (Baltimore, MD: Williams & Wilkins), 2004, pages 1188-1200 and 1238-47, respectively.

sionals then take the erroneous logical step of concluding that because the psychotic symptoms improved with medication that benefits schizophrenia *the psychotic symptoms must therefore have been caused by schizophrenia*.

Summary of diagnostic pitfalls with respect to psychotic signs and symptoms:

1. Delusions: Dissociative phenomena, demonic deception, distorted interpretations from underlying trauma, and substance abuse can all cause fixed beliefs that can appear to be psychotic delusions.
2. Hallucinations: Trauma flashbacks can produce all forms of hallucinations (sight, sound, smell, taste, and physical sensation). Thoughts/comments from internal dissociative parts can be mistaken for auditory hallucinations. Demonic infection/oppression can produce "voices," images, smells, and physical sensations that can look exactly like visual, auditory, olfactory, tactile, and somatic hallucinations. And abuse of stimulants and/or hallucinogens can cause a person to experience all forms of hallucinations.
3. Thought disorder: Dissociative phenomena, demonic infection/oppression, and stimulant/hallucinogen abuse can all produce confusion and disorganization that look exactly like psychotic thought disorder.
4. Grossly disorganized or catatonic behavior: Trauma flashbacks, dissociative phenomena, demonic infection/oppression, and stimulant/hallucinogen abuse can each produce disorganized and/or catatonic behavior. The *combination* of trauma flashbacks, dissociative phenomena, demonic infection/oppression, and substance abuse can produce a clinical picture that is especially similar to psychotic grossly disorganized and/or catatonic behavior.
5. Response to medication: the psychotic symptoms caused by flashbacks, dissociative phenomena, lack of maturity skills, demonic infection/oppression, and substance abuse often improve with the same medications used to treat schizophrenia, and this is misinterpreted as confirming that the person has schizophrenia.

Schizophrenia and trauma: A 1998 study supports my clinical impression that unresolved psychological trauma is a significant exacerbating factor in biological mental illnesses such as schizophrenia, and also my personal experience that many care providers do not recognize the importance of unresolved trauma in these illnesses. Mueser and colleagues studied 275 patients with severe chronic mental illness, and found that 98% reported significant trauma exposure, that 43% met full diagnostic criteria for PTSD, but only 2% had the diagnosis of PTSD recognized in the medical chart.[23]

The Immanuel approach/Theophostic-based emotional healing and schizophrenia:

Correct diagnosis: One of the most important considerations, in my assessment, is correct diagnosis since the treatment plan will be very different for mimic schizophrenia as opposed to true schizophrenia. People with trauma-dissociative-immaturity-demonic psychosis (mimic schizophrenia), who have been *misdiagnosed* as schizophrenic, should experience complete recovery as the underlying issues are resolved. With these people the primary focus of treatment should be emotional healing work to address the underlying psychological and

[23] Mueser K, Trumbetta S, Rosenberg S. "Trauma and Posttraumatic stress disorder in severe mental illness." *J Consult Clin Psychol* 1998;66:493-499.

spiritual issues, with medication sometimes playing and auxiliary role (helping with symptom control while the underlying issues are being addressed). In contrast, even optimal emotional healing work will not resolve the prominent biological brain component in true schizophrenia. With these people medication is almost always necessary to stabilize the overall clinical picture before emotional healing can even be considered; and although they may experience dramatic improvement as exacerbating psychological and spiritual issues are resolved, ongoing, long term medication is usually still required.[24]

Research re emotional healing work with true schizophrenia: There are research studies from many years ago that indicate typical psycho-dynamic therapy usually exacerbates the overall clinical picture for people with true schizophrenia. I am not familiar with any research on using techniques such as the Immanuel approach or Theophostic-based emotional healing with schizophrenia. The other relevant research I am aware of would be the study just mentioned, clearly demonstrating that psychological trauma and Post Traumatic Stress Disorder (PTSD) are important issues for people with schizophrenia.

Thoughts re emotional healing work with true schizophrenia: If a person has true schizophrenia, it will be essential to include appropriate medication as part of the overall treatment plan. It will also be important to be especially careful in the emotional healing work – the emotional healing facilitator must be especially aware of the impaired capacity and vulnerability to psychotic exacerbation caused by the biological brain abnormalities present in true schizophrenia. It would be important to work in a context where there was support for possible exacerbation of symptoms if the emotional healing work stirs the person up but does not get all the way through to healing in a single session. In light of this concern, I strongly recommend using the process described for group exercises with the Immanuel approach, since the "safety nets" that minimize problems in the group setting will also be helpful in working with people who are especially fragile due to schizophrenia.

Doing emotional healing work with true schizophrenia will also be challenging due to the ways in which the illness impairs a person's ability to process information normally. The degree of thought disorder can be quite variable from one person to the next, so this concern will be mild in some cases, but emotional healing work will be especially difficult with people who have severe thought disorder.

I have not yet seen a case of true schizophrenia resolve with emotional healing work, but it is clear to me that psychological and spiritual issues such as triggering of unresolved trauma, unhelpful defenses (especially dissociative phenomena), lack of maturity skills, and demonic harassment exacerbate the overall clinical picture in people with schizophrenia. Theoretically it makes sense that the overall clinical picture would improve dramatically if the Immanuel approach and/or Theophostic-based emotional healing ministry could be used with schizophrenic patients to resolve any exacerbating psychological and spiritual issues; and as of October 2009 I am aware of one case study where a person with true schizophrenia has experienced dramatic and sustained improvement in response to emotional healing work.[25]

The possibility of prevention?: Another schizophrenia-related reason to address psychological

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[24] The overall clinical picture may improve dramatically, and this dramatic improvement may even be maintained on much lower doses of medication, but long term medication is still usually required.

[25] A close colleague has been working with this patient for almost a year.

trauma and other spiritual and psychological issues is the possibility of prevention. Twin studies once again provide us with especially helpful data. Twin studies are usually emphasized as proving the genetic neurobiological component in schizophrenia, but they also prove that primary neurobiological predisposition is not the only factor. Since identical twins have exactly the same genes, if schizophrenia were completely determined by genetic factors *then both twins in **every** pair would be the same*. The concordance rate will be 100%. However, twin studies for schizophrenia reveal identical twin concordance of ***50% , as opposed to 100%***. That is, in identical twin pairs where one twin has schizophrenia, and the second twin in each pair shares the *exact same genetic predisposition* to schizophrenia, *only ~50%* of the second twins will actually develop clinical schizophrenia. This means that environmental factors, developmental factors, and unresolved mind/spirit issues *determine whether the underlying genetic vulnerability will ever be "exposed" – whether or not the genetic biological brain predisposition will ever manifest as an actual mental illness.* Therefore, helping people to resolve their spiritual and psychological issues might actually prevent schizophrenia in those who have the underlying neurobiological vulnerability but who have not yet developed the actual clinical illness.

Recent hopeful case study: As mentioned above, I have a close colleague who has been using the Immanuel approach[26] with a person with true schizophrenia. She has been going slowly and working carefully, especially emphasizing perceiving the Lord's presence, connecting with Jesus, and turning to the Lord for guidance, and so far the patient has been experiencing steadily increasing and sustained improvement. Trauma, dissociative phenomena, and demonic oppression are all present and have clearly been exacerbating the overall clinical picture, and as these issues are being addressed the overall clinical picture has been steadily improving.

As also mentioned above, I have seen great results with both the Immanuel approach and Theophostic-based emotional healing work with people who had been *mis-diagnosed* with Schizophrenia, but whose psychotic symptoms were actually being caused by trauma, dissociative phenomena, and demonic oppression. However, I have not yet had the opportunity to do emotional healing work with anyone who actually turned out to have true schizophrenia. Please let me know about your experience if you have the opportunity to use the Immanuel approach and/or Theophostic-based emotional healing with true schizophrenia (drkarl@kclehman.com).

Are there other diagnoses that can be erroneously applied to a person with psychotic symptoms caused by a combination of trauma, dissociative phenomena, lack of maturity skills, and demonic infection?: The "Psychotic Disorders" section in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth edition (DSM IV) includes schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder, brief psychotic disorder, shared psychotic disorder, psychotic disorder due to a general medical condition, substance induced psychotic disorder, and psychotic disorder not otherwise specified.[27] Severe depression and severe mania can also include psychotic symptoms. The person with psychotic symptoms being caused by some combination of trauma, dissociative phenomena, lack of maturity skills, and demonic infection can be erroneously diagnosed with any of these other mental illnesses. In my experience, bipolar disorder with psychotic features and schizophrenia are the most common. Schizoaffective disorder, brief psychotic disorder, and psychotic disorder

[26] Arthur Burke's "blessing the spirit" has also been an important part of the healing work with this patient.

[27] *Diagnostic and Statistical Manual of Mental Disorders*, Fourth edition, (1994) p. 273-315.

not otherwise specified would be next in line.

Find new mental health professionals if necessary: If this essay leads you to suspect that a friend, family member, or person receiving ministry actually has *mimic* schizophrenia, but has been *misdiagnosed* as schizophrenic, I would encourage you to share this material with the mental health professional(s) involved and raise your concern about the possibility of mis-diagnosis. Obviously, for this suggestion to be a good idea the mental health professionals need to understand trauma, dissociative phenomena, lack of maturity skills, and demonic phenomena, and be open to including these phenomena in their diagnostic considerations. If this is not the case you may want to find new mental health professionals. This may be very difficult. Pray for guidance and don't give up easily – the correct diagnosis is very important and diagnostic errors are common.

Thoughts regarding differential diagnosis between true schizophrenia and mimic schizophrenia due to extreme trauma: Extreme trauma, such as ritual abuse and trauma-based mind control, produces a combination of flashbacks, dissociative phenomena, programmed behavior, and demonic oppression that can be especially easy to mis-diagnose as schizophrenia. I have included several thoughts here, excerpted from a much more extensive discussion[28] of the differential diagnosis between schizophrenia and the clinical picture produced by extreme trauma:

1.) Subtle aspects of interpersonal interaction (vocal quality and nonverbal communication):

True schizophrenia: I have never heard anybody else talk about this (it's probably in the literature somewhere), but my clinical experience is that most schizophrenics also have difficulty with other subtle aspects of interpersonal interactions, such as vocal quality (tone, inflection, etc) and nonverbal communication (such as body language, mannerisms, gaze, eye contact, etc). I sometimes feel, with respect to voice quality and nonverbal communication, that schizophrenics are similar to people with mild autism. The consequent subtle abnormalities in the usual flow of interpersonal interactions contribute to the overall feeling of "oddness."

Mimic schizophrenia due to extreme trauma: Extreme trauma survivors, on the other hand, almost always feel "normal" with respect to vocal quality and nonverbal communication. In my experience, a few extreme trauma survivors have had a number of different aspects of PTSD, dissociation, demonic oppression, and other sequella of extreme trauma combine in such a way as to produce an "odd" feeling with respect to non-verbal communications, but this oddness feels qualitatively different than that seen with schizophrenia, and becomes understandable as more subtle details of the dissociative processes, trauma history, and posttraumatic fear responses are understood.

2.) Thought disorder:

True schizophrenia: The majority of people with schizophrenia have thought disorder. Furthermore, many people with schizophrenia have severe thought disorder during exacerbations, and in contrast to the extreme trauma survivors described below, *people with severe*

[28] Lacter, E. & Lehman, K. (2008). Guidelines to Differential Diagnosis between Schizophrenia and Ritual Abuse/Mind Control Traumatic Stress. In J.R. Noblitt & P.S. Perskin (Eds.), *Ritual Abuse in the Twenty-first Century: Psychological, Forensic, Social and Political Considerations*. Oregon: Robert D. Reed Publishers.

thought disorder don't make sense no matter how hard you try to understand them. Also, thought disorder in a given schizophrenic patient is much more consistent that the transient/intermittent thought disorder occasionally seen in extreme trauma survivors. With schizophrenia, mild thought disorder is often present at baseline (present all the time for many years), and more severe thought disorder will be present consistently for weeks at a time during psychotic exacerbations.

Mimic schizophrenia due to extreme trauma: Extreme trauma survivors can sometimes display mild to moderate thought disorder[29] when they are switching rapidly and/or intensely triggered. However, most extreme trauma survivors I have worked with have *not* been thought disordered. Also, thought disorder displayed by extreme trauma survivors is much more variable than thought disorder observed in patients with schizophrenia (the thought disorder seen in extreme trauma survivors appears only when they are intensely triggered and/or switching rapidly, and disappears when these conditions are not present). Furthermore, even when they appear thought disordered you can understand them if you follow closely, and especially if you consider the possibility that they are switching between different parts. Other than very briefly during times of especially intense crisis, I have never seen an extreme trauma survivor with severe thought disorder. Therefore, one easy point in logic is: "if the person has persistent severe thought disorder (profoundly disorganized),[30] and doesn't make sense even when considering the possibility of switching, then they have true schizophrenia as opposed to mimic schizophrenia.

3.) Overall oddness of presentation:

Schizophrenia: The combination of many factors, such as inappropriate affect, hallucinatory internal stimuli (often bizarre), delusional thought content (often bizarre), responses to hallucinations and delusions (often bizarre), thought disorder, abnormal vocal quality, and abnormal nonverbal communication all contribute to an overall clinical impression of a specific, schizophrenic variety of oddness, or being "not right." This may sound vague, and it takes some practice to learn to recognize this subjective, qualitative "feel" to schizophrenic oddness, but in my experience this is a valuable differential point in actual clinical practice.

Extreme trauma: In my experience, there are two phenomena that are important to identify separately. 1.) Before the extreme trauma programming and dissociative switching are

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[29] The mild thought disorder occasionally seen in extreme trauma survivors is what mental health professionals call tangential thinking, where the sequence of thoughts are logically connected but increasing veer from the original target. For example, if I ask "Where are you from?" and the person responds with "I grew up in Evanston, IL, a suburb just north of Chicago. One thing about Chicago is the baseball – it's depressing to have a baseball team that hasn't won the world series for almost a hundred years. My grandfather lived to be a hundred years old, and he spent his entire life in the same house...etc." In the moderate thought disorder seen in a small number of extreme trauma survivors, the logical connections are not discernable at all. For example, if I ask "Where are you from?" and the person responds with "I grew up in Evanston, IL, a suburb just north of Chicago. One depressing thing about growing up in Chicago is having a baseball team that never wins." (Brief pause) "I was at the store the other day, and the clerk kept insisting that I had gone to highschool with her even though I had never seen her before. That kind of thing happens to me a lot." (Brief pause) "I have some friends at church that are going on a camping trip, but I don't think I want to go along because I hate being in the woods at night."

[30] Severe thought disorder looks like this: I ask "Where are you from?" and the person responds with: "I was looking at new cars, but sometimes people are blue and they never call. What really makes me angry is when that happens! I wish they would stop making candy – do you like horror movies? The last Christmas tree will never grow in Michigan because the president can't get anything done..."

identified, the clinician will often feel that "something isn't right," or "something strange is going on here." This "something isn't right" feeling is especially common with clinicians who are not experienced with respect to extreme trauma programming and dissociative phenomena, and is not so much "oddness" as the clinicians intuitive sense that the picture "doesn't quite make sense because there are pieces missing." The overall presentation then makes sense when the "missing pieces" are identified. 2.) Rarely, a number of different aspects of the PTSD, dissociation, demonic oppression, and other sequella of extreme trauma combine to produce an overall subjective oddness that is more than just the feeling of "the picture doesn't quite make sense." As with "subtle abnormalities of interpersonal communication" discussed above, this oddness feels qualitatively different than that seen with schizophrenia, and becomes understandable as more subtle details of the dissociative processes, trauma history, and posttraumatic fear responses are understood.

I would like to offer several particularly practical thoughts regarding this "overall oddness" factor: Ninety-eight percent of the schizophrenics I have worked with have felt subjectively "odd," so if a person does *not* feel odd then they almost certainly have mimic schizophrenia as opposed to true schizophrenia. On the other hand, Ninety percent of the extreme trauma survivors I have worked with do *not* feel odd, so if the person *does* feel odd they are much more likely to have true schizophrenia, and I am especially careful to consider schizophrenia as the most likely diagnosis.

One final thought regarding differential diagnosis: It is important to remember that an extreme trauma survivor can also develop schizophrenic symptoms or even full schizophrenia. The several patients I have had that were the most confusing had both severe trauma with marked dissociation AND schizophrenia.

Additional thoughts regarding schizophrenia, demonic manifestations, and medications (e-mail exchange with Dr. Grant Mullen):

E-mail to Dr. Grant Mullen:

Charlotte and I have gotten a copy of your book and I have been reading it as I have time. We have also thought a lot about the connections between mental illnesses, biological abnormality, emotional wounds, and demonic harassment & oppression. I think many people who see only the medical model believe that if an illness responds to a medication it must be only biological. Our experience seems to indicate more complicated connections between mental illness, brain chemistry, emotional trauma, and demonic harassment and oppression. We work with many patients who have been on medication for years and who have experienced dramatic and sustained relief with medication from their initial problems of panic &/or mood disorder &/or OCD &/or sleep disorders &/or ADD/ADHD &/or trouble with intense anger outbursts. An increasing number of these patients have been improving as we work and pray (EMDR, TheoPhostic, and prayer) to facilitate healing for old wounds and to bring deliverance from spiritual oppression attached to those old wounds. They will say things like "I have been feeling for the last couple months like I don't need as much medication", and they have often been right. We now have patients who came into our practice on high doses of several different medications, who had relapsed repeatedly in the past with decreases in medication, and who have now been able to come off all medication. These patients are much like the case study you describe on pages 63-65 - the lady with the diagnosis of bipolar disorder who improved dramatically with medication but then experienced healing and deliverance and has since been able to stop medication.

A number of years ago I met a schizophrenic patient who described typical psychotic thoughts and auditory hallucinations, but also certain "voices" that were especially negative and hateful.

These voices would consistently tell him not to pray, go to church, read the Bible, or talk to Christians, and would threaten to punish him if he did. It occurred to me that these "voices" might be demonic harassment, and I began asking my other psychotic patients about this phenomena: "do any of your voices talk about religious things?" I was surprised to discover that many of them had certain "voices" that said similar things – "don't participate in any Christian activities, we will punish you if you do".

At the time I worked with these patients I had read a number of books about spiritual warfare and had observed deliverance prayer as a part of healing ministry, but had never initiated spiritual warfare prayer for a person sitting right in front of me (especially with no prayer team and for a person in a secular state hospital suffering from a major mental illness and displaying active psychosis). I did not understand the place for simple binding prayer and I had not thought carefully about possible interactions between medication biology and spiritual harassment &/or oppression. None of my medical training nor the books about spiritual warfare and deliverance provided advice about what to do with an actively psychotic patient in a state hospital who was hearing voices threatening to punish him if he engaged in any Christian activities.

These patients usually improved with appropriate medication, but in most cases I didn't think to carefully and specifically evaluate whether the auditory hallucinations &/or internal voices opposing Christian activity resolved along with other improvement. In one situation, the patient described past history of other psychotic symptoms (fairly unremarkable paranoia, no demonic or spiritual content apparent) in addition to voices opposing Christian activity. His psychotic symptoms, including voices opposing Christian activity, had resolved before I became involved in the patient's care. He had received appropriate antipsychotic medication, but family members had also been praying (general prayer for healing but no specific spiritual warfare prayer that I am aware of).

I met most of these patients while doing temporary assignments in state hospitals between 1989 and 1995, and am unfortunately no longer working with any of them. If I was still working with these patients, I would pray simple binding prayers and test their effects on the anti Christian "voices". I would also specifically and explicitly monitor the anti Christian voices as the other psychotic symptoms improved with medication. I have been wondering about this for years, but it has been very difficult to find other psychiatrists with whom I can compare notes (who won't think I need an antipsychotic myself). It was helpful to find your comments on page 62:

> "..., Satan loves depression and all mental illnesses. When you have poor or weak control of your thoughts, Satan will want to insert his thoughts into your mind....<u>It has been my experience that if a person's mood disorder can be successfully treated medically, their vulnerability to demonic thoughts insertion is greatly reduced</u>."

I think this same principle might apply even more intensely for psychotic illnesses. I would very much like to compare notes – it would be valuable to hear more about your experience with the effects of medication on demonic harassment and oppression.

Dr. Mullen e-mailed the following response:

"I too think that some of the psychotic voices are demonic but it's hard to separate those voices from the ones of the illness. <u>As medications clear their minds the demonic voices improve too</u>. There is an itinerant evangelist up here with a powerful ministry that I greatly appreciate who told me that he was a severe paranoid shiz. with multiple hospitalizations. He was instantly healed at the moment of conversion and has had no symptoms in the past 10 yrs on no medications." ****Note: I think this case would be miraculous physical healing of the person's biological brain, as opposed to emotional healing for traumatic memories that exacerbate schizophrenia.***