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Bipolar Disorder and the Immanuel Approach/Theophostic®-based[1] Emotional Healing: General Comments and Frequently Asked Questions

Being a psychiatrist who does medical psychiatric evaluations, prescribes medications, and also uses the Immanuel approach and Theophostic®-based psychotherapy,[2] I am often asked for my thoughts and recommendations regarding the place of emotional healing in the treatment of bipolar (manic depressive) disorder. This essay summarizes some of my general thoughts and also the answers to frequently asked questions. This essay is *not* a comprehensive discussion of bipolar disorder, but rather focuses on issues especially relevant to using the Immanuel approach and/or Theophostic-based emotional healing in the treatment of bipolar disorder. For example, this essay includes a careful discussion of the differential diagnosis between true bipolar disorder and dissociative Post Traumatic Stress Disorder (PTSD) because this is very relevant to questions regarding emotional healing work with people who have been diagnosed with bipolar disorder; but this essay does not discuss the rest of the differential diagnosis, such as bipolar disorder vs schizoaffective disorder or bipolar disorder vs various neurological problems that can mimic it.[3]

"True" bipolar disorder vs "mimic" bipolar disorder: One of the most important comment-questions I receive from those doing emotional healing work goes something like "I worked with someone who was bipolar and they were completely healed with Theophostic – isn't bipolar disorder just another manifestation of trauma and lies?" Both review of the medical research and my personal clinical experience with hundreds of patients that have been previously diagnosed with bipolar disorder have lead me to the conclusion that there are two separate clinical

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[1] Theophostic Ministry is a trademark of Dr. Ed Smith and Alathia Ministries, Inc., of Campbellsville, Kentucky. We use the term "Theophostic®-based" to refer to emotional healing ministries that are built around a core of Theophostic® principles and techniques, but that are not identical to Theophostic® Prayer Ministry as taught by Dr. Ed Smith. Our own ministry would be a good example of a "Theophostic®-based" emotional healing ministry – it is built around a core of Theophostic® principles and techniques, but it sometimes also includes material that is not a part of what we understand Dr. Smith to define as Theophostic® Prayer Ministry (such as our material on dealing with curses, spiritual strongholds, generational problems, and suicide-related phenomena, and our material on journaling, spiritual disciplines, and medical psychiatry).

[2] I use the term "Theophostic®-based *psychotherapy*" to refer to psychotherapy that is built around a core of Theophostic® principles and techniques, but that is not restricted to *only* Theophostic® principles and techniques. Theophostic-based *psychotherapy* differs from Theophostic-based *ministry* in that TP-based psychotherapy includes other psychotherapy tools used by mental health professionals, such as EMDR, relaxation techniques, and cognitive therapy tools for symptom management, *as long as these other psychotherapy tools are not inherently incompatible with Theophostic*.

[3] For additional discussion of bipolar disorder, see "Mood Disorders," Chapter 13 in Kaplan, Harold, and Sadock, Benjamin (Eds.), *Comprehensive Textbook of Psychiatry, eighth edition*, (Baltimore, MD: Williams and Wilkins) 2004, pages 1559-1717, and American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM IV), (American Psychiatric Association: Washington, DC, 1994) pages 317-391.

situations, "mimic" bipolar disorder and "true" bipolar disorder, both currently included in the group of people carrying the diagnosis of bipolar disorder.[4]

What I call "true" bipolar disorder 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 bipolar disorder have biological brain vulnerabilities that *predispose* them to respond to emotional and spiritual problems (truth-based pain in the present, unresolved trauma, immaturity, sinful defenses, other sin, and demonic infection) with the clinical picture that I call true bipolar disorder. 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 out-of-control spirals of true bipolar disorder (both manic and depressive episodes). True bipolar disorder 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" bipolar disorder is a clinical picture that looks a lot like true bipolar disorder but that is actually a combination of unresolved trauma getting stirred up, dissociative phenomena, lack of maturity skills, and demonic infection. Mimic bipolar disorder *is* "just" the manifestation of emotional and spiritual problems in an otherwise normal brain, and it *can* be completely resolved with emotional healing.

Note that the combination of unresolved trauma, dissociative phenomena, lack of maturity skills, and demonic infection do not always cause mimic bipolar disorder. Sometimes this combination 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 brain biology abnormalities, such as Attention Deficit and Hyperactivity Disorder (ADHD) or schizophrenia. Mimic bipolar disorder 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 bipolar disorder.

Medical psychiatric research: There is a HUGE collection of medical research supporting the existence of a "true" bipolar disorder 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,[5] studies of neuroreceptors, neurotransmitters, and neurotransmitter

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

[5] Note that the evidence for genetic factors contributing to mental health problems is *NOT* just family patterns that could be explained by psychological and/or spiritual phenomena being passed down in families. A number of current books discuss this extensive evidence supporting genetically-based neuro-biological components contributing to true bipolar disorder. See, for example, Mellon, Charles David. *The Genetic Basis of Abnormal Human Behavior*. (Genetics Heritage Press), 1997. Another good source is Kelsoe, John R. "Chapter 13.3: Mood Disorders: 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 1582-94. 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*

metabolites, studies of hormonal regulation, neuroanatomical studies, cerebral metabolism and blood flow studies, and studies of sleep neurophysiology.[67] 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 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[8] 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 bipolar disorder – identical twins show ~60% concordance and fraternal twins show ~10% concordance.[9] To my assessment, the results of these twin studies alone prove that there is a "true" bipolar disorder where 1) primary biological brain abnormalities make certain people vulnerable to the illness; and 2) environmental stressors (for example, truth-based pain,

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of Mental Disorders: A Guide for Students, Clinicians, and Researchers. (New York, NY: Guilford Press), 1999.

[6] 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 Thase, Michael E. "Chapter 13.4: Mood Disorders: Neurobiology," 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 1594-1603; and *Kaplan and Sadock's Synopsis of Psychiatry*, Seventh Edition (Williams & Wilkins: Baltimore, MD 1994), pg 521.

[7] An important caveat regarding the many neurobiological abnormalities seen in patients with true bipolar disorder 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 neurobiological abnormalities.

[8] 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 bipolar disorder).

[9] See Merikangas, Kathleen R., and Kupfer, David J. "Mood Disorders: Genetic Aspects," Chapter 16.4, in Kaplan, H.I., and Sadock, B.J. (Eds.) *Kaplan and Sadock's Comprehensive Textbook of Psychiatry, sixth edition*, CD version, (Williams & Wilkins: Baltimore, MD), 1996.

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 bipolar disorder and true bipolar disorder are separate clinical conditions, both currently included in the group of people carrying the diagnosis of bipolar disorder.

Severe impairment and need for hospitalization: I have cared for a number of patients with what I perceive to be severe true bipolar manic episodes. These patients have been agitated, explosive, hyperactive, hypersexual, euphoric, non-redirectable, delusional, pressured, and disorganized to the extent that safety concerns necessitated inpatient psychiatric care with 24 hour/day observation for 2 to 6 weeks. If there is not a true biological brain vulnerability in bipolar disorder – if bipolar disorder 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 manic episodes just described. However, I am closely familiar with many ritual abuse survivors who have *not* had these severe manic episodes – they have experienced many intense acute symptoms (for example, emotional lability and anger outbursts from triggering, dissociative phenomena, and demonic harassment), but not prolonged and severe manic episodes like those I have seen in patients with true bipolar disorder. The acute symptoms I have seen in patients with mimic bipolar disorder rarely require 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 true bipolar manic episodes were so agitated, distractible, pressured, disorganized, and non-redirectable 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 present continuously for 1 to 6 weeks*. Similary, people with severe true bipolar depression had thought processes that were so severely slowed, and energy and motivation that were so severely impaired, that they were also unable to participate in any kind of emotional healing work. *And this severe impairment was present continuously for weeks to months.* People with the trauma-dissociation-immaturity-demonic infection *mimic* bipolar disorder are *occasionally* so triggered that they are unable to participate in therapy or ministry, but this always resolves in a matter of hours (or at most days). Even people with the extreme trauma of ritual abuse do not have the prolonged episodes of being unable to participate in emotional healing work.

The place of medication: My experience with people who have true bipolar disorder is that those with *severe* or *moderate* episodes have always needed medication as a part of their care. True bipolar depression can persist continuously for many months if not treated with an antide-pressant, and I have never seen a severe manic episode resolve without appropriate mood stabilizing medication. Those with *mild* true bipolar episodes can often get through without medication, but they do much better with appropriate medication. In contrast, my experience with people where trauma-dissociative phenomena-lack of maturity skills-demonic infection are mimicking bipolar disorder 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).[10]

Rate of onset: My experience with people who have true bipolar disorder is that episodes[11] of mania or depression have always begun gradually, slowly developing over days, weeks, or even months (for depression). In contrast, my experience with mimic bipolar is that changes *can* occur over days or weeks, but that they are usually much more rapid (hours, minutes, or even seconds). The changes in mood and behavior from dissociation or a specific trigger will occur over the span of seconds to minutes. An episode of general symptom exacerbation can develop gradually if the person is progressively triggered, causing progressive decompensation over the course of days or weeks, but in mimic bipolar it is more common for intense triggering to cause an episode of general symptom exacerbation to develop over the course of hours, minutes, or even seconds. An episode of mimic bipolar mania or depression caused by "manic" or "depressive" internal parts will sometimes begin gradually if the internal parts are progressively triggered forward over the course of several days, but manic or depressive internal parts being triggered forward will often cause the sudden onset of a manic or depressive episode (seconds, minutes, or hours).

Rate of resolution: My experience with people who have the trauma-dissociation-immaturity-demonic infection combination (mimic bipolar) is that any given episode of acute decompensation will resolve *over the course of seconds or minutes*[12] if the corresponding traumatic memory source is resolved. An acute decompensation 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.[13] On the other hand, I have never seen a true bipolar episode of mania or depression resolve suddenly.[14] In my experience, true bipolar episodes have always resolved over the course of days or weeks.

Intervals without symptoms: My experience with people who have only[15] true bipolar disorder is that they have episodes where they display mania or depression continuously for weeks or

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[10] See " ... " (forthcoming) on the Articles and FAQs page of our web site for a more thorough 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.

[11] Mood and behavior can be labile in the middle of a manic episode (people with mania will often change suddenly from euphoria to anger if they are thwarted, they can quickly change from interest to boredom in a given subject, and they will occasionally have sudden bouts of crying), but the onset of the overall manic episode is always slow.

[12] The ministry session may take several hours, but the acute symptoms will usually be present during most of the session, and then resolve over the course of seconds or minutes when the underlying traumatic memory finally resolved.

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

[14] 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.

[15] "Only true bipolar disorder" meaning *not also* trauma-dissociation-immaturity-demonic infection "mimic" bipolar disorder.

even months, but then they will go for months or years[16] between episodes with no significant symptoms of mania or depression. During these extended intervals between episodes they are *not* experiencing sudden, dramatic changes in mood and behavior. People with mimic bipolar disorder, on the other hand, may go for hours or days without symptoms, but seldom have intervals of longer than several days without significant symptoms. Sudden, dramatic changes in mood and behavior are one of the most significant symptoms caused by triggering, dissociation, and demonic infection. I have rarely seen a person with mimic bipolar disorder go a week without sudden, dramatic changes in mood and behavior, and I have never seen a person with mimic bipolar disorder go for a month without sudden, dramatic changes in mood and behavior.

Insight regarding the need for help: A number of years ago I was given a narcotic injection in preparation for a surgical procedure. I can still remember the brief euphoria I experienced after receiving the injection and before going into the operating room. I lost *all* awareness of the many stressors in my life that I had been worrying about (as opposed to still being aware of anxiety or uncertainty, and feeling like it was just managed or temporarily stuffed away). I felt *really good*. When the nurses wheeling me to the operating room asked me if I was ready for the procedure, I waved airily and commented "I feel great! You can cut my head off for all I care." My experience with people who have true bipolar disorder mania is that they usually have a profound euphoria much like that experienced by people using narcotics. They experience a very powerful subjective sense of happiness and confidence (often to the point of grandiosity). They are usually not interested in medication, therapy, or ministry because they feel good, and truly believe that they do not need help. On the other hand, my experience with internal parts causing mimic mania (see below) is that there is some impairment of insight regarding their need for care, but never to the degree I see with true bipolar mania. The person still seems to realize at some level that he has deep pain and needs help. In my experience so far, the person (including his "manic" internal parts) has always been willing to engage in emotional healing work.

All together in the same patients: An especially significant point is that all the features of true bipolar disorder described here have been present in the same patients. The patients who have had the severe manic episodes requiring extended hospitalization have been the same people who were unable to participate in ministry or therapy for weeks, who required medication, who experienced slow onset and recovered slowly, who had poor insight regarding their need for care, and who have had years of normal functioning between episodes of mania or depression. The people I have worked with who had severe true bipolar disorder manic episodes have had *all* of these features together, and most[17] of the people with mimic bipolar have not had *any* of these features. Note: People with *both* true and mimic bipolar 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 bipolar *are two different, distinct clinical pictures*.

Frequent misdiagnosis: As is clear from the above comments, I believe there is such a thing as true bipolar disorder, and I also believe that many people with a combination of trauma, dissociative phenomena, lack of maturity skills, and demonic infection are misdiagnosed as

[16] People with true bipolar disorder can go for five years, ten years, or even longer between episodes of mania or depression.

[17] A few have had mimic mania or acute exacerbation of other symptoms with gradual onset (days) and gradual resolution (days), and a few have had poor insight regarding their need for care.

bipolar disorder. Many mental health professionals, especially those trained primarily in the medical psychopharmacology model, have a poor understanding of trauma, dissociative phenomena, immaturity, and especially demonic infection[18]. 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 these phenomena into the diagnostic box that is the next best fit. This is usually bipolar disorder.

Triggering: I have seen mental health professionals misdiagnose the rapid and dramatic changes in thoughts and emotions that come from an old wound being triggered as the mood changes of rapid cycling bipolar disorder.

Dissociative switching: I have seen the rapid and dramatic changes in thoughts and emotions that come from dissociative switching misdiagnosed as the mood changes of rapid cycling bipolar disorder. In addition to dramatic and sudden changes in mood, we have also seen switching between different internal parts produce other dramatic behavior changes that are typically thought of as "diagnostic" for bipolar disorder, such as changes in rate of speech, energy and activity level, sleep patterns, appetite and eating behavior, and sexual interest and activity level.

Depressed and manic internal parts: We have had clients with a part (or group of parts) that carries depression, and another part (or group of parts) that carries mania. The person can have "depression parts" that carry depression lies, such as "I'm worthless," "It's hopeless," or "There's nothing I can do about it," and when these parts get triggered forward the person experiences the emotions of clinical depression, such as worthlessness and hopelessness/despair. I have also worked with parts that caused the person to appear depressed because they learned to cope with overwhelming situations by "escaping" into social withdrawal and sleeping all the time. When these parts get triggered forward the person will display behaviors which are classic symptoms of major depression (social withdrawal and increased sleeping). The person will present an especially convincing clinical picture of major depression if parts that escape into social withdrawal and sleep get triggered forward along with parts that carry depression lies.

The person can also have "mania parts" that learned to cope through denial, and when these parts get triggered forward the person will appear manic because he will insist that he is much more gifted and that his life is much better than the painful reality. I have worked with "manic parts" with such extreme denial that their unrealistic assertions met criteria for manic grandiose delusions. I have also worked with "manic parts" that carry lies along the lines of "I will be loved/get what I need/be safe if I am perfect, if I perform well enough." When these parts get triggered forward the person appears manic because he will go into an episode of intense, pressured performance activity. One aspect of working with these patients that has been especially clinically dramatic is that they can come into an emotional healing session after being stuck for days (or even weeks) in a mood episode that meets DSM IV criteria for either depression or mania, and the mood episode will resolve completely by the end of the session if the internal part(s) responsible for the mood episode release control.

Demonic spirits: Demonic spirits can cause or dramatically exacerbate many of the signs and

[18] 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.

symptoms of depression (for example, fatigue, sadness, low self esteem, hopelessness, suicidal thoughts)[19], and they can also cause or dramatically exacerbate many of the signs and symptoms of mania (for example, irritability, anger outbursts, racing thoughts, grandiose delusions). In one consultation case I was involved in, the person receiving ministry had "text book" manic grandiose delusions that persisted in spite of full doses of mood stabilizing medications for his mania and antipsychotic medications for his delusions. His text book manic grandiose delusions then resolved immediately and completely when the emotional healing facilitator working with him identified and removed a demonic spirit that admitted to being the direct cause of the delusions.

Flashbacks, dissociation, demonic harassment, and manic psychosis: We have seen mental health professionals mis-diagnose a mixture of PTSD flashbacks, dissociative phenomena, demonic harassment, and core lies from hidden trauma as bipolar disorder with manic psychosis. These patients did actually meet the diagnostic criteria for psychosis, but the mental health professionals were mistaken regarding the cause and meaning of the psychosis (see "Psychosis and Psychotic Symptoms: Definitions and Diagnostic Considerations" for additional discussion of psychotic symptoms).

Self medication, and especially cocaine and/or amphetamine abuse: People with painful psychological and spiritual issues (such as trauma, dissociation, immaturity, and demonic infection) often use some kind 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.[20] Any compulsive self medication will contribute to "mimic" bipolar disorder by exacerbating the sudden changes in mood and behavior, but self medication with cocaine and/or amphetamines will especially increase the chances that the person will be misdiagnosed with bipolar disorder. The elevated mood, increased energy, increased activity, decreased sleep, pressured speech, and increased irritability from cocaine and/or amphetamine abuse look a lot like signs and symptoms of true bipolar disorder mania, and the depressed mood, decreased energy, decreased activity, increased sleep, and increased irritability from withdrawal look like signs and symptoms of true bipolar disorder depression.

Response to medication: The bipolar-like signs and symptoms caused by trauma, dissociative phenomena, immaturity, and demonic infection sometimes improve with the same medications used to treat bipolar disorder, and this is misinterpreted as confirming that the person has bipolar disorder.

Differential diagnosis – "true" bipolar disorder vs trauma-dissociation-immaturity-demonic infection *mimicking* bipolar disorder: It is beyond the scope of this essay to provide thorough descriptions of true bipolar disorder and mimic bipolar disorder. Hopefully the "summary of points of divergence" and "practical thoughts" sections below will help clarify and focus diagnostic thinking for clinicians who already have some understanding of true bipolar disorder, psychological trauma, dissociative phenomena, lack of maturity skills, and demonic

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[19] "Case Study: Major Mental Illness, Demonic Oppression, and Deliverance" on the Case Studies page of our web site, which describes the experience of Charlotte's grandmother, provides a good example of a demonic spirit exacerbating the signs and symptoms of depression.

[20] 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).

infection.

Summary of points of divergence:

1. Severe impairment requiring hospitalization – common and extended vs. rare and brief: With true bipolar, severe manic episodes always include extended severe impairment, and this extended severe impairment almost always requires 2 to 6 weeks of hospitalization. With mimic bipolar, episodes of exacerbated symptoms will sometimes cause severe impairment, but this severe impairment is brief and rarely requires hospitalization.
2. Inability to participate in emotional healing work – common and prolonged vs. rare and brief: With true bipolar, the severe impairment associated with severe manic or depressive episodes usually includes inability to participate in emotional healing work, and this inability to participate in therapy or ministry is almost always prolonged (1 to 6 weeks for mania, weeks to months for depression). With mimic bipolar, exacerbated symptoms will sometimes cause the person to be unable to participate in therapy or ministry, but this inability is almost always brief (as long as several days on rare occasions, but usually minutes to hours).
3. Place of medication – more important vs. less important: With true bipolar, medication is almost always helpful and is usually a necessary part of the treatment plan. With mimic bipolar, medication is sometimes helpful and is usually not a necessary part of the treatment plan.
4. Onset – gradual vs. sudden: True bipolar episodes almost always[21] develop gradually (days, weeks, even months). Episodes of mimic mania or other kinds of mimic bipolar decompensation will sometimes develop gradually (days, weeks), but will often develop suddenly (seconds, minutes, hours). Specific changes in mood and behavior from dissociation or from a specific trigger will always occur suddenly (seconds, minutes).
5. Resolution – gradual vs. sudden: True bipolar episodes always resolve gradually (days, weeks, even months). Episodes of mimic mania or other kinds of mimic bipolar decompensation will sometimes resolve gradually (days, weeks), but can also resolve suddenly (seconds, minutes, hours). Episodes of mimic bipolar exacerbation will always resolve rapidly once the underlying emotional and spiritual issues are resolved.
6. Intervals without symptoms – extended vs. brief: True bipolar includes long intervals (months, years) without symptoms. Mimic bipolar includes short intervals (usually hours or days) between symptoms, rarely going more than a week without significant symptoms (such as sudden changes in mood and behavior).
7. Impaired insight – common and severe vs. uncommon and mild-moderate: People with true bipolar mania almost always have dramatically impaired insight regarding their need for care, and are rarely willing to receive ministry. People with mimic bipolar mania usually have mild-moderate impairment of insight regarding their need for care, and usually *are* willing to cooperate with ministry.

Practical thoughts regarding diagnostic clarification:

It is important to remember that *both* true bipolar disorder and the combination of trauma,

[21] I have never seen this in my own experience, but research and case studies indicate that episodes of true bipolar mania or depression can develop suddenly (hours-days) in response to catastrophic stressors.

dissociative phenomena, lack of maturity skills, and demonic infection may be present.

Try to find someone who understands true biological bipolar disorder, psychological trauma, dissociative phenomena, lack of maturity skills, and demonic infection so that he or she can specifically consider the differential diagnosis between true bipolar and mimic bipolar as described in this essay. The best possible scenario is to find someone who has all of this and who is also an experienced emotional healing facilitator, so he or she can specifically check for unresolved trauma, dissociative phenomena, lack of maturity skills, and demonic spirits contributing to mimic bipolar symptoms.[22] Unfortunately, it can be very hard to find an emotional healing facilitator who also understands true bipolar disorder, PTSD, dissociation, and maturity skills. One option is to find Christian mental health professionals who have this knowledge and convince them to learn the Immanuel approach/Theophostic-based emotional healing. Another option is to form teams composed of Immanuel/Theophostic facilitators who are aware of the questions raised in this essay and mental health professionals who understand true bipolar disorder, PTSD, dissociation, and maturity skills.

If the clinical picture *does* include the combination of trauma, dissociation, lack of maturity skills, and demonic infection mimicking bipolar disorder, it may be very difficult to determine whether or not there is *also* true biological bipolar disorder. In this case, I would encourage addressing the trauma, dissociation, lack of maturity skills, and demonic infection, and then see what is left after these are resolved. Even though this may take months or even years in some situations (SRA survivors, for example), it is a very good long term investment, and the diagnostic picture will get progressively clearer as the bipolar mimic signs and symptoms are removed.

It is important to remember that true bipolar disorder is an episodic illness. As described above, a person with true bipolar disorder will not display the signs and symptoms of the disorder between episodes of depression or mania. It is valuable to carefully review the clinical picture of previous episodes. In some situations you won't know for sure until trauma, dissociation, immaturity, and demonic infection have been resolved, the medications for bipolar disorder have been stopped, and the person has been followed over time to see if any signs or symptoms of bipolar disorder return.

Practical thoughts regarding the use of the Immanuel approach and/or Theophostic®-based emotional healing with people who have been diagnosed with bipolar disorder:

If a person does have true genetic, biological bipolar disorder, it is very important that he take an appropriate mood stabilizing medication. But I would also strongly recommend emotional healing work as *part* of his treatment plan. Any truth-based pain, unresolved trauma, lacking maturity skills, sinful patterns of self protection (defenses), other sin, or demonic infection will exacerbate true biological bipolar disorder. It is especially important to address trauma, dissociation, inadequate maturity, and demonic infection that confuse the treatment by causing signs and symptoms that mimic the signs and symptoms of the true bipolar disorder, but even if the person does *not* have issues that specifically mimic the signs and symptoms of true bipolar she will certainly have other unresolved spiritual and emotional issues (we all do). People with true bipolar disorder will greatly improve as they resolve emotional and spiritual issues that precipitate and/or exacerbate their depressive and manic episodes. They will require lower maintenance doses of medication, they will have fewer depressive and manic episodes, and the episodes they do have will be less severe and will resolve more quickly.

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[22] Unfortunately, we are not able to provide consultations of this sort. If you find anyone who meets the "best case scenario" description, please send me a note at drkarl@kclehman.com

If the person has been *mis-diagnosed* with bipolar disorder, and actually has mimic bipolar trauma-dissociation-immaturity-demonic infection, then the most important part of her care will be emotional healing work with a facilitator who is experienced with dissociation.

My experience is that most people with trauma, dissociative phenomena, inadequate maturity skills, and demonic infection sufficient to mimic bipolar disorder will need a significant amount of Immanuel and/or Theophostic-based emotional healing work.

Cooperation during manic episodes: With true bipolar disorder, *during the actual manic episodes* the person is usually convinced that he doesn't need emotional healing. In these cases, simply wait until the manic episodes resolve. As mentioned above, people with mimic bipolar mania usually *are* willing to participate in Theophostic Ministry. When working with mimic mania it is important to address guardian lies about releasing the manic denial.

Practical thoughts regarding the use of medication with people who have been diagnosed with bipolar disorder:

Making the correct diagnosis is important because the usual approach to medications for mimic bipolar is different than the usual approach to medications for true bipolar disorder. As mentioned above, if the person has mimic bipolar disorder medication will often not be necessary. If medication is used, a selective serotonin re-uptake inhibitor (SSRI), like Zoloft or Paxil, will usually be the best medication. The mood stabilizing medications usually used for true bipolar disorder will be somewhat helpful (especially with respect to the dramatic changes in mood and behavior caused by triggering and dissociation), but an SSRI will usually provide more benefit and cause fewer side effects. As mentioned above, if the person has true bipolar disorder medication will usually be a necessary part of their treatment. If the person has true bipolar disorder it is important for them to take a mood stabilizing medication, especially during manic episodes, but also as a preventative measure *between* episodes.[23] Using the most common medication plan for mimic bipolar (an SSRI without an accompanying mood stabilizer) will put a person with true bipolar at increased risk for manic episodes.

This can be a challenge, but the best case scenario is to find a psychiatrist who believes in and understands trauma, dissociation, lack of maturity skills, and demonic infection so he/she can carefully consider the differential diagnosis between true bipolar disorder and mimic bipolar disorder.

As mentioned above, the disrupted brain chemistry in severe true bipolar mania or depression will often disturb the person's thoughts so severely that he will not be able to participate in therapy or ministry. A person with severe true bipolar mania or depression may require treatment with medication to correct his brain chemistry before he is able to participate in emotional healing work.

Emotional and spiritual issues (truth-based pain, trauma, inadequate maturity, dissociation, sinful defenses, other sin, and demonic infection) *exacerbate* true bipolar disorder and are the *whole cause* of mimic bipolar disorder. With true bipolar disorder, less medication should be required as the person resolves emotional and spiritual issues that exacerbate the illness. This is important, since many of the mood stabilizing medications used for true bipolar disorder are expensive, and all of them have significant side effects. Both the cost and the side effects will decrease as the dosage decreases. As mentioned above, some people with mild true bipolar disorder appear to be able to stop medication completely if they resolve enough of their

[23] People with true bipolar disorder will have fewer episodes of either mania or depression if they stay on a maintenance dose of mood stabilizing medication.

emotional and spiritual issues. When medication is included in the treatment for a person with mimic bipolar disorder, less and less medication will be needed as the person resolves more and more of the underlying emotional and spiritual issues, and it should usually (always?) eventually be possible to stop the medication entirely. As also mentioned above, it will be important to evaluate the possibility that truth-based pain, trauma, dissociative phenomena, etc are complicating an underlying true bipolar disorder. If this is the case, addressing the spiritual and emotional issues will dramatically improve the overall clinical picture of the underlying biological illness.

Mild true bipolar disorder: Most things in the physical, medical world occur on a spectrum. For example, there is not only one size of person, but rather a continuous spectrum from those that are under four feet tall to those that are over seven feet tall. In the same way, true genetic bipolar disorder does not occur only in the most dramatic, easiest to recognize, severe form, but rather occurs on a spectrum from severe to mild. Several new diagnostic categories (bipolar type II, cyclothymic disorder, rapid cycling bipolar, and bipolar NOS) have been developed in the last 10 to 20 years as researchers have come to recognize this spectrum reality.[24] Many of the same observations and principles apply for mild true bipolar as for severe true bipolar, but I would like to make several points specifically regarding the mild clinical picture:

Mild true bipolar disorder is more difficult to distinguish from mimic bipolar disorder, but I believe a clinician who understands the differences between these two conditions can learn to distinguish even mild true bipolar from the trauma-dissociation-immaturity-demonic infection mimic. Some of the points of divergence between true and mimic bipolar won't apply at all (true bipolar requiring extended hospitalization and including extended inability to participate in therapy or ministry). With mild bipolar, the most helpful diagnostic features are slow onset, slow resolution, and extended periods (months to years) with no signs or symptoms.

The new diagnostic categories developed to acknowledge mild bipolar disorder also make much more room for mis-diagnosing trauma-dissociation-immaturity-demonic infection as bipolar disorder.

It is especially hard to spot mild true bipolar disorder when it is present along with trauma, dissociation, lack of maturity skills, and demonic infection. When considering the possibility of simultaneous mild true bipolar and mimic bipolar, it is especially important to address the healing issues in order to simplify the diagnostic picture.

One point of good news is that the stakes aren't as high with mild true bipolar disorder. People with this condition do better with appropriate mood stabilizing medication, but it is a much smaller problem if the bipolar disorder is not identified and treated.

Another point of good news is that some people with mild true bipolar disorder will no longer need medication if they resolve their major healing issues. I have worked with a number of patients that I believe have mild true bipolar and also had major emotional and spiritual healing issues. The mild true bipolar disorder became less and less problematic as they resolved more and more healing issues, and some of these people have been able to stop medication entirely and still remain free of bipolar episodes.

Hospitalization/inpatient care:

Is it necessary?: The first task is to discern whether inpatient care is truly needed. Inpatient care is sometimes necessary due to safety concerns because of the intensity of symptoms, but

[24] Kaplan & Sadock, *Comprehensive Textbook of Psychiatry, sixth edition*, CD version, Chapter 16.6, "Bipolar II Disorder (and the soft bipolar spectrum)"

many people seem to believe that an inpatient program is inherently better. I have not found this to be the case. If somebody is stable enough to be outpatient, it is usually easier to build a team with a basically competent psychiatrist to manage the medication and a therapist who is competent with the Immanuel approach and/or Theophostic-based emotional healing than it is to find an inpatient program that includes the Immanuel approach and/or Theophostic-based emotional healing.

Inpatient programs that include the Immanuel approach and/or Theophostic-based emotional healng?: We don't know of any inpatient psychiatric units that include the Immanuel approach and/or Theophostic-based emotional healing. Please let us know if you find one (e-mail me at drkarl@kclehman.com).

Emotional healing for the support network: It is very painful and stressful to have a family member or close friend with either true or mimic bipolar disorder. My experience is that the family and friends that comprise the person's support network are usually intensely triggered by the emotions, behaviors, and other symptoms of the person with true or mimic bipolar disorder. This triggering drains the emotional resources and dramatically impairs the discernment of those in the support network. *I strongly encourage those in the person's support network to do their own emotional healing work* so that they will have the discernment required to make many important and difficult decisions and so they will have the emotional resources necessary to support the person through difficult times.

Regarding our place in the Theophostic® community: We respect Dr. Smith tremendously and value our friendship with him, however, we are not in any way officially connected with or endorsed by Dr. Smith and Theophostic® Prayer Ministry. We want to share our reflections, experiences, and discoveries regarding the Christian ministry of emotional healing, and many of the thoughts we share have arisen as we have integrated Theophostic® principles and process into our professional psychiatric and lay pastoral counseling practices. But we want to be clear that the material on our web site does not *define* Theophostic® ministry. "Theophostic®" is a trademarked name, and Dr. Ed Smith, the founder and developer of Theophostic® ministry, is the only one who has the right to define Theophostic® ministry.

We have studied many sources, including medical psychiatry and neurology, psychological research, various secular psychotherapies, and various Christian emotional healing ministries. Our emotional healing ministry includes the core Theophostic® principles and techniques, but we also include "non-Theophostic®" material. For example, our material on medical psychiatry and the biological brain, EMDR, dealing with curses, dealing with spiritual strongholds, dealing with generational problems, and our material on journaling, spiritual disciplines, community, and on dealing with suicide-related phenomena are not a part of what we understand Dr. Smith to define as Theophostic® Prayer Ministry.

The material on our website is not a substitute for the Basic and Advanced Theophostic® Ministry Training provided by Dr. Smith. For further information about Theophostic® Ministry, its developer Ed Smith, D.Min., or to order training materials, please visit www.theophostic.com.