Title: CAPS Convention Panel Discussion – Concerns Re Theophostic/Immanuel

May 11, 2005

Greetings all,

Sending out a note to thank everyone who was praying for the panel debate/discussion at the CAPS convention in TX. The very, very short summary is that it went well – even better than having a fight and winning is not having a fight at all.

Below I have included the initial summary comments that I presented at the panel discussion, and we will try to send out a longer note with some additional comments about the panel discussion some time soon.

**2024 update:** Note that many of my comments regarding Theophostic can be applied to the Immanuel Approach.

Blessings,

Dr. Lehman/Karl

**Initial summary comments for 4/8/05 CAPS panel discussion/debate regarding Theophostic®:**

I'd like to begin by making several summary points:

1. I'm a licensed physician and board certified psychiatrist, and my personal clinical experience provides empirical data in the form of a series of case studies. In my psychiatric practice, I've diagnosed and treated patients with major mental illnesses, such as major depression, phobias, Post Traumatic Stress Disorder, panic disorder, addictions, and eating disorders. Using Theophostic®-based therapy, many of these patients have found and resolved traumatic memories that seemed, intuitively, to be connected with the signs and symptoms of the presenting illnesses. The signs and symptoms then decreased, and almost all of these patients have had sustained improvement significant enough to allow decreased medication dosages. *Some* of these patients appear to have had *complete* resolution, even allowing complete discontinuation of medication. Benefits have been maintained over time, some now with more than 6 years of follow-up.

2. *My* assessment is that Theophostic® is Theoretically sound. My perception is that the core principles of Theophostic® include the most important core principles of cognitive therapy, exposure therapy, and EMDR – *the psychotherapy modalities that have the most empirical research support*. Furthermore, I perceive that Theophostic® includes important additional principles that further enhance it's efficacy beyond these therapy modalities.

3. Dr. Smith has responded to many of the concerns that have been raised. For example, the basic training manual that's just being released responds to concerns about suggestibility and memory errors by including MANY clear, specific, emphatic warnings against using suggestive memory access tools, such as hypnosis, guided imagery, or asking questions that suggest specific memory content.

4. Dr. Entwistle and others have raised concerns about the core theory and core process of Theophostic® being inherently suggestive, possibly leading to iatrogenic memory errors. This concern contains a valid point: theory based on the foundational principle that current symptoms are often coming from underlying traumatic memories, and process based on "lets go look for experiences from your past that match your current symptoms" *are* inherently suggestive. *Not* suggestive regarding any specific content, but suggestive in a general way with respect to "you probably have traumatic memories that are contributing to your current symptoms, lets go and look for them."

I offer several thoughts in response to these concerns:

A. The most important point is that there are no zero risk options, and we must therefore *balance* opposing concerns. For example, it's important that the Theophostic® therapist/minister inform his clients regarding the basic theory and process of Theophostic® – it's important to discuss the principles that unresolved traumatic events usually contribute to current symptoms, that some traumatic memories are not accessible to the conscious mind, that the ministry process might result in remembering previously unconscious upsetting memories, and that during the actual ministry process, the client should watch for past experiences that feel the same as their current symptoms.

Most clients *want* this kind of information in order to make an informed decision about whether to trust you and pay you to help them with their problems, and even if the person receiving therapy/ministry *doesn't* seem to want this, we're ethically and professionally bound to provide this information as a part of *informed consent*.

Furthermore, if the clients understand some of the theory regarding the phenomena involved, what they are trying to accomplish, and what to expect during the process, they will experience less fear, surprise, or confusion during the process. This will make the process less painful, and will also enable them to participate in the process more efficiently. However, as Dr. Entwistle points out in his articles, this information is inherently suggestive in a general way, and may increase the risk of memory error.

On the other hand, if the only concern was to protect the client from the consequences of memory error, and to protect others from false accusations, we would not discuss the possible role of unresolved traumatic memories, we would not discuss the possibility of repressed, dissociated, or recovered memories, and we would not direct the process in

any way that would lead them to watch for traumatic memories. However, this would seriously hinder the healing process for anybody who *is* truly suffering from unresolved traumatic events, and would also require the unethical omission of informed consent.

Again, we must realize that there are no options with zero risk. With respect to wider society, we must find the place that best balances consideration for those who might be falsely accused and consideration for those who were truly abused. With respect to the person receiving ministry, we must find that place that best balances the importance of adequately informing the client and the importance of avoiding suggestion and memory error. Truth, society, and the individual client are best served by *balancing* these opposing concerns.

B. Dr. Smith's new basic training manual is more careful, conservative, and explicitly cautioning regarding suggestion and false memory, than any other therapy approach or Christian healing ministry that deals with traumatic memories that I'm aware of.

C. Research indicates that repeated guided imagery, hypnotic "recovery" tools, and repeated suggestive questioning can lead to sobering memory errors, such as the iatrogenic induction of "false" memories. However, as far as I'm aware, there's *no empirical evidence* that the kind of mildly suggestive principles presented as basic Theophostic® theory in the current edition of Dr. Smith's basic training manual, or the mildly suggestive Theophostic® process as taught in the current edition of Dr. Smith's basic training manual, can result in this kind of significant memory error.

Therefore, I ask that you not throw the baby out with the bath-water. If you have concerns about specific aspects of Theophostic, then work *with* Dr. Smith (and/or others who are using Theophostic) to address these specific concerns, but don't attack Theophostic® as a whole. Please don't attack or hinder this powerfully effective ministry, as a whole, because of specific concerns.