Karl D. Lehman, M.D. Charlotte E.T. Lehman, M.Div.

# The Immanuel Approach and Cognitive-Behavioral Therapy

(K.D.Lehman MD & C.E.T.Lehman MDiv, New 10/6/2001, revised 3/10/20)

Cognitive-behavioral therapy is one of the most widely used forms of psychotherapy, and competes with Exposure therapy and Eye Movement Desensitization and Reprocessing (EMDR) for the psychotherapeutic technique with the most research documentation of efficacy.[1] Cognitive-behavioral therapy is probably the technique most often recommended by general practice physicians, mental health providers, and insurance providers. Even many pastors and Christian mental health providers recommend cognitive-behavioral therapy as an established, proven technique, instead of the Immanuel Approach, which they see as a new and unproven technique. Also, many Christian mental health professionals are currently using cognitive-behavioral therapy techniques. They know from their own experience that these techniques are helpful, and like the additional confidence of using a technique with research verified efficacy. When someone suggests they learn about the Immanuel Approach, the overworked therapist often replies, "Why should I take the time and energy to learn something new – I already do cognitive-behavioral therapy." In response to all of this, we thought it would be helpful to write a brief essay comparing and contrasting cognitive-behavioral therapy and the Immanuel Approach.

**I. Shared foundational principles:** One of the most significant points is that the Immanuel Approach recognizes and agrees with four of the foundational principles of "traditional"[2] cognitive-behavioral therapy theory[3]:

A. Our thoughts, "what we *really* believe," drive our emotions and choices.[4]

B. Patterns of cognitive distortion, and specific false negative cognitions, drive the emotions and choices seen in many mental health conditions (for example, depression, phobias, panic disorder, obsessive compulsive disorder, eating disorders, and all forms of addiction). "Underneath" each mental illness, one will find patterns of cognitive distortion and specific false negative cognitions consistent with the signs and symptoms of the mental illness in question.[5]

C. These false negative cognitions and patterns of cognitive distortion are "learned" from previous experiences.[6] Past events are therefore the source of current mental health concerns by being the source of cognitive distortions.

D. Resolution of dysfunctional emotions and relief from the compulsion to dysfunctional choices will flow naturally from the correction of cognitive distortions (lies) – the signs and symptoms of the current mental illness will resolve when the underlying patterns of cognitive distortion and specific false negative cognitions are corrected.[7]

**II. Points of disagreement:**[8]

A. In the 1970's, many considered the psychodynamic focus on childhood memories to be endless, expensive, and of questionable value. Several psychotherapy modalities developed in this historical context, including cognitive-behavioral therapy,

intentionally focused away from earlier experiences and downplayed the importance of "root" memories. With this history it should not be surprising that, although traditional cognitive-behavioral therapy understands how current cognitive distortions have been learned from previous experience, it does not understand that the original traumatic memories continue to energize and anchor the present cognitive distortions. Traditional cognitive-behavioral therapy insists that the therapist and client work only in the present to address the cognitive distortions. The Immanuel Approach, on the other hand, recognizes the continuing power and importance of the root memories. The Immanuel Approach insists that permanent resolution can only be accomplished by addressing the cognitive distortions at their roots – *in* the source memories that continue to energize and anchor them.

B. Traditional cognitive-behavioral therapy sees the therapist as the guide and teacher in the process, and the source of insight regarding true positive cognitions. The Immanuel Approach sees Jesus as the primary guide and teacher in the process, with the therapist/minister playing a minor assistant role. The Immanuel Approach sees Jesus as the primary source of the truth that replaces the cognitive distortions (lies).

C. Traditional cognitive therapy theory holds that the client must replace the false cognitions with true positive cognitions through their own persistent effort and continued mental discipline. The Immanuel Approach teaches that the person receiving ministry must be willing to go to the underlying traumatic memories and to work *inside* of the underlying traumatic memories, but that it is then the Lord's job to permanently replace the cognitive distortion (lie) with truth.

**III. Additional shared foundational principles between The Immanuel Approach and "PTSD" cognitive-behavioral therapy:** Leading cognitive-behavioral therapists have now been working with posttraumatic stress disorder (PTSD) for the past 25+ years. Even though traditional cognitive-behavioral therapy has intentionally focused away from earlier memories, applying cognitive therapy to PTSD inherently required these intelligent and conscientious therapists to work with the original traumatic events. My perception is that as these cognitive experts worked more closely with the root traumatic memories, they began to get a more experiential understanding of the continuing power and importance of unresolved past psychological trauma. This understandably lead to careful study of the original traumatic events, study of the connections between the original traumatic events and the current signs and symptoms experienced by the person with PTSD, and persistent searching for tools and techniques that could resolve the toxic power of the root traumatic memories. It should not be surprising that this careful investigation on the part of some very competent mental health professionals has lead to the "discovery" of more of the principles that are also central to The Immanuel Approach. This type of historical convergence has occurred before, when different scientific teams, completely independent of each other, focused their research tools on the same target and (predictably) "discovered" the same patterns in creation. Unfortunately, these principles discovered in working with PTSD have not yet been applied to the other mental illnesses with which cognitive-behavioral therapists work. For this reason, I currently think of cognitive-behavioral therapy as consisting of "traditional" cognitive therapy and "PTSD" cognitive-behavioral therapy.

The most current cognitive-behavioral therapy for PTSD includes the four foundational principles described in I., and the following additional Immanuel Approach principles:[9]

A. The distorted interpretations (core lies) anchored in the traumatic memory are important active ingredients that contribute to the traumatic memory's toxic power.

B. Flowing logically from A, replacing the cognitive distortions (core lies) with accurate, undistorted cognitions (truth) is a central and necessary part of resolving the ongoing negative effects of traumatic events.[10]

C. All components of the original trauma (memory of the event, negative cognitions, and associated negative emotions) must be present for healing/resolution to occur.

D. The healing work must be done while the person is connected to the place in the mind where the lie is believed (they must receive the truth while the traumatic memory is activated and while working *inside* of the traumatic memory).

E. There are hindrances (clutter) that can block the healing process, and these hindrances must be removed for treatment (ministry) to be successful.

**2020 update:** More recent research on memory reconsolidation provides even stronger support for this assessment regarding "traditional" vs more recent iterations of exposure therapy. This new research shows even more clearly that there are two different categories of therapy with respect to psychological trauma: In some forms of psychotherapy (for example, traditional exposure therapy and traditional cognitive therapy), we are only training one part of the brain to manage and moderated the unresolved traumatic memories that are still carried in a different, separate part of the brain; in contrast, with other forms of therapy (for example, EMDR, Coherence Therapy, newer cognitive therapy for PTSD, newer Exposure therapy for PTSD, and the Immanuel Approach), the underlying traumatic memories are activated, and then after working inside the traumatic memories to reprocess their content, the now resolved memories are reconsolidated as new, changed, different memories that are no longer traumatic. For an excellent discussion of this more recent research on memory reconsolidation, and its implications with respect to different forms of therapy for psychological trauma, see *Unlocking the Emotional Brain* by Bruce Ecker, Robin Ticic, and Laurel Hulley.[11]

**IV. Specific tools and techniques:** Traditional cognitive-behavioral therapy focuses entirely on current cognitive distortions and other miscellaneous current symptoms, and does not address underlying roots. The Immanuel Approach focuses entirely on permanently resolving underlying roots, and does not address management of acute symptoms. Predictably, there is little overlap of specific techniques. Many of the specific techniques of cognitive-behavioral therapy are tools for challenging and/or managing cognitive distortions in the present. Most of the remainder are other miscellaneous tools used for acute symptom control. The Immanuel Approach shares none of these tools. Most of the specific techniques of The Immanuel Approach are tools for finding and working with root traumatic memories. Cognitive-behavioral therapy shares none of these tools.

One important area of possible overlap are techniques used to identify cognitive distortions/ core lies. The identification of patterns of cognitive distortion and specific false negative cognitions is an important part of cognitive-behavioral therapy. The identification of core lies is an important intervention for intermediate-advanced Immanuel Approach work. I am familiar with the Immanuel Approach tools and techniques for identifying core lies (tools we learned from Ed Smith's Theophostic teaching), but I am not familiar with the specific

cognitive therapy tools and techniques for identifying patterns of cognitive distortion and false negative cognitions. I am hoping that rigorously trained and experienced cognitive-behavioral therapists will join the Immanuel Approach community, and that they will bring helpful insights, tools, and techniques for identifying core lies (patterns of cognitive distortion and specific false negative cognitions).[11]

**V. Potential for cooperation/integration:** If the Christian cognitive-behavioral therapist is willing to accept that all cognitive distortions must be addressed in the root memories that are their source and anchor instead of in the present, if he is willing to make the shift from himself to Jesus as the guide for the process and the provider of truth/positive cognitions, and if he is willing to exchange persistent mental discipline for working with Jesus to find and resolve the underlying trauma, then there is nothing that is contradictory or incompatible between cognitive-behavioral therapy and the Immanuel Approach. With these three concessions, cognitive-behavioral therapy and The Immanuel Approach can work together. The process and specific techniques of The Immanuel Approach can be used to permanently resolve the cognitive distortions that are the primary focus of cognitive therapy. As mentioned above, I am hoping that cognitive-behavioral therapy techniques for identifying cognitive distortions and Immanuel Approach (Theophostic) techniques for identifying core lies can be combined, hopefully augmenting each other. The remainder of the tools and techniques of cognitive-behavioral therapy can be useful in much the same way as medication – they can help to decrease disability by moderating the severity of acute symptoms (while the person is using the Immanuel Approach to permanently resolve the underlying roots).

One might say that The Immanuel Approach fulfills cognitive-behavioral therapy. By resolving cognitive distortions (core lies) at the traumatic memories where they are rooted, The Immanuel Approach accomplishes the objectives of cognitive-behavioral therapy, but permanently instead of temporarily.

**VI. Frequent relapse versus permanent resolution, maintenance versus maintenance free:** As mentioned above, traditional cognitive-behavioral therapy focuses only on the present, and manages symptoms by addressing only the present patterns of cognitive distortion and false negative cognitions. Immanuel Approach theory would predict relapse, since this approach does not permanently resolve the cognitive distortions at their traumatic memory roots, and this theoretical prediction is consistent with clinical results. I have personally observed cases of depression, panic disorder, and obsessive compulsive disorder where the patients received excellent initial symptom relief from participating in high quality cognitive-behavioral therapy treatment programs, but then suffered relapse when they did not continue maintenance exercises. My assessment is that cognitive-behavioral therapy techniques provide excellent tools with which to manage any given episode of mental illness symptom exacerbation – tools that help to resolve any given episode by wrestling the cognitive distortions to the ground and locking them in the closet. However, the cognitive distortions come back each time the underlying root memories are triggered.

Note that research can be misleading at this point. There are many studies reporting that clinical improvement is maintained even after cognitive therapy is discontinued. However, careful review reveals that most of these studies only follow the patients for 3, 6, or 12 months after therapy is stopped, and some of these studies report maintenance of treatment results as long as the person doesn't meet certain research criteria – even though some

symptoms have returned. I have not found one study that documents consistent and complete maintenance of treatment results for more than 18 months. One recent article acknowledges this painful reality: "Clinical experience and controlled studies confirm the efficacy of pharmacologic and cognitive-behavioral therapy.... However, despite the availability of effective treatment options, panic disorder often remains a chronic condition characterized by intermittent remissions and relapses over many years."[12]

Another possible source of confusion is that the best treatment programs and practitioners teach their clients to continue "unofficial" maintenance therapy indefinitely by learning to continue the mental disciplines of cognitive therapy on their own.[13] These people often prevent relapse, even without "official" maintenance cognitive therapy, by using the tools they have learned to catch and subdue the cognitive distortions as soon as they are triggered.

One of the blessings of the Immanuel Approach is that when Jesus resolves cognitive distortions in the traumatic memories where they are rooted, they are permanently and completely gone. They are no longer there, so they can't be triggered to cause symptomatic relapse. No maintenance work is required.

**VII. Efficacy:** The Immanuel Approach has not yet been studied with empirical research, but my assessment is that The Immanuel Approach is more effective than cognitive therapy. The Immanuel Approach usually accomplishes more clinical improvement in less time, and also resolves the cognitive distortions at their roots, so that they never return.

VIII. **Training required:** Professional training is an asset, but it is not required to be able to learn or successfully use The Immanuel Approach. There is an intricate dance between what Jesus expects us to learn and what Jesus provides in the way of specific guidance during Immanuel Approach sessions; nevertheless, the living Jesus Christ is very present as the guide and leader in The Immanuel Approach. Our experience is that Jesus leading the process makes it possible for non-mental health professionals to successfully use the Immanuel Approach. Many pastors and lay people are able to begin using The Immanuel Approach after attending a three-day basic training seminar and reading the first part of the big lion book. With a small amount of supervision, and especially the opportunity to address any of their own wounds that are hindering the process, some of these lay people become amazingly effective as Immanuel Approach facilitators. Several of the lay people we supervise are now seeing major healing breakthroughs in a significant percentage of the sessions they facilitate. Even lay people without special gifting usually have some success (often using The Immanuel Approach with family and friends). In contrast, cognitive-behavioral therapy requires more training and requires more expertise to use. In my assessment, one must have thorough training and significant experience in rigorous cognitive-behavioral therapy techniques in order to get the kind of results obtained in the research studies.[14]

End notes:

1. As of spring 2003, I have seen articles written by proponents of EMDR, articles written by proponents of Exposure therapy, and articles written by proponents of cognitive-behavioral therapy, each claiming that their respective psychotherapy approach has the most research documentation of efficacy. The good news is that there is strong research evidence supporting the efficacy of each of these techniques.

2. In this essay, I use "traditional" cognitive-behavioral therapy to refer to the mainstream principles and techniques of cognitive-behavioral therapy that have been applied to a wide range of mental illnesses, including depression, phobias, panic, and obsessive compulsive disorder. This is in distinction from "PTSD" cognitive-behavioral therapy, which I perceive to be a recent development, and which includes many new principles and techniques.

3. Note that basic Immanuel Approach work does not require this detailed theory regarding distorted negative cognitions (lies). We just help the recipient connect with Jesus, coach her to engage with Jesus directly, and let Jesus sort out all of the details with respect to healing. For example, Jesus can recognize and resolve lies anchored in trauma without our needing to know more detailed principles or techniques regarding distorted negative cognitions. However, advanced Immanuel Approach theory includes understanding of the pain-processing-pathway, which includes understanding that failed processing at Level 5 results in lies anchored in traumatic memories, and then all of the associated cognitive-behavioral theory with respect to distorted negative cognitions (lies).

4. This is the primary foundational principle of cognitive-behavioral therapy .For an extensive discussion of this principle, and its place as the foundation of cognitive-behavioral therapy, see Beck AT. *Cognitive Therapy and the Emotional Disorders*. New York, NY: International Universities Press, 1976.

5. Kaplan, HI, Sadock, BJ, Grebb, JA. *Kaplan and Sadock's Synopsis of Psychiatry, Seventh Edition.* Baltimore, MD: Williams & Wilkins; 1994, pp 860, 861. For extensive discussion of two specific examples, see Beck, AT, Emery, G, Greenberg, RL. *Anxiety Disorders and Phobias: A Cognitive Perspective*. New York, NY: Basic Books; 1985, and Beck, AT, Rush, AJ, Shaw, BF, Emery, G. *Cognitive Therapy of Depression*. New York, NY: Guilford; 1979.

6. Kaplan, HI, Sadock, BJ, Grebb, JA. *Kaplan and Sadock's Synopsis of Psychiatry, Seventh Edition*. Baltimore, MD: Williams & Wilkins; 1994, p. 859.

7. Beck, AT, Rush, AJ, Shaw, BF, Emery, G. *Cognitive Therapy of Depression*. New York, NY: Guilford; 1979, p. 47.

8. All three of these aspects of cognitive therapy are clearly presented in the excellent review of cognitive therapy in Kaplan, HI, Sadock, BJ, Grebb, JA. *Kaplan and Sadock's Synopsis of Psychiatry, Seventh Edition*. Baltimore, MD: Williams & Wilkins; 1994, pp 859-864.

9. In a 2000 professional journal article on PTSD, Dr. Hembree and Dr. Foa (international authorities in cognitive therapy) state: "...we propose that successful processing of traumatic events involves emotional engagement with the traumatic memory, organization of the traumatic narrative, and correction of dysfunctional cognitions that often follow trauma. We further propose that the success of psychosocial treatments of posttraumatic stress disorder hinges on the ability of treatments to address impairments in these processes." This quote includes: 1. A clearer recognition of the connection between cognitive distortions (core lies) and traumatic events. 2. Recognizing that resolving the negative cognitions/lies connected to traumatic events is a central and necessary part of resolving the ongoing effects of the traumatic event . 3. The need for the person to connect with the emotions from the traumatic event for treatment to be successful. 4. The awareness of hindrances/"clutter" that can block the healing process, and the need to address/remove any hindrances/clutter that is present. Hembree, EA, Foa, EB, "Posttraumatic stress disorder: psychological factors and psychosocial interventions." *J Clin Psychiatry* 2000; 61 [suppl 7]: p. 33.

10. See endnote #5

11.Bruce Ecker, Robin Ticic, and Laurel Hulley,*Unlocking the Emotional Brain: Eliminating Symptoms at Their Roots Using Memory Reconsolidation* (New York: Routledge, 2012). Note: These authors present an excellent discussion, but make one major logical error in interpreting the research. To my assessment, the actual memory reconsolidation research shows that in order to permanently resolve traumatic memories, the memory must be activated, and then reprocessing work to finished all processing

tasks must be done from the *inside* of the activated traumatic memory. The resolved memory is then put back in long-term storage (reconsolidated) as a new, modified, resolved memory that is no longer traumatic. And this (my) interpretation of the memory reconsolidation research TOTALLY supports the Immanuel Approach. In contrast, the authors of this otherwise excellent book recognize only one part of the processing pathway. They *correctly* perceive and describe how it is very important to focus the dysfunctional emotional learning that is carried as part of the toxic content in traumatic memories; and they *correctly* perceive that to resolve this dysfunctional emotional learning, the recipient must have a new experience that provides disconfirming knowledge *that feels true from the inside of the activated traumatic memory*. But their logical error comes in not recognizing that there are usually other processing tasks that also need to be completed to resolve traumatic memories. Their logical error comes when they declare that resolving the dysfunctional emotional learning is the only reprocessing work needed from the inside of the activated traumatic memory. To my assessment, their interventions usually also included other important pieces, like helping the recipient to get her relational circuits back online from the inside of the trauma. So they often "accidentally" include all of the pieces and the process works. But I think that it is optimal for theoretical explanation to explicitly recognize the whole processing pathway.

11. Please contact me at drkarl@kclehman.com if you are a rigorously trained and experienced cognitive therapist and you have helpful insights, tools, or techniques, or if you know that The Immanuel Approach already incorporates the relevant cognitive therapy insights, tools, and techniques (I will then edit this document accordingly).

12. Rosenbaum. JF, Pollack, MH, Pollock RA, "Clinical issues in the long-term treatment of panic disorder." *J Clin Psychiatry*. 1996; 57 Suppl 10: 44-8; discussion 49-50.

13. One of my clients who completed a rigorous treatment program for panic disorder reports that they strongly encouraged her to continue the cognitive therapy techniques on her own. It is significant that she lost the initial dramatic benefit when she stopped the maintenance therapy.

14. If I were to be painfully honest, I would say that many mental health professionals (including myself) are familiar with the principles of cognitive therapy, have some experience with cognitive therapy techniques, but are not sufficiently trained and experienced in rigorous cognitive therapy techniques to get the benefits described in research.