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The Immanuel Approach and Exposure Therapy

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I. Purposes/goals for this essay:

Build bridges between different schools of thought, so that different therapists and/or ministers can avoid needless misunderstanding and conflict, and work together as much as possible.

Continue to clarify the "big picture" by identifying more aspects of how the Immanuel Approach fits in the wider context of other therapy principles and techniques.

Confirm/support the Immanuel Approach principles and techniques by recognizing where they are consistent with and/or shared by other established methods, and especially by identifying where they have been indirectly research validated as parts of other methods/techniques.

Provide additional information that will help mental health professionals present the principles and techniques of the Immanuel Approach in language (that is truthful and accurate) that insurance companies will understand and accept.

II. Desensitization and resolution of underlying trauma – two different mechanisms in Exposure Therapy: My hypothesis is that there are *two separate processes* operating in exposure therapy – 1) behavioral/neurological desensitization, and 2) resolution of underlying trauma by helping the recipient complete processing tasks.

A. "Traditional" exposure therapy and behavioral/neurological desensitization: With older, "traditional" exposure therapy, the primary therapeutic tools/techniques are exposure and response prevention, prolonged exposure (to the point of biological exhaustion of negative responses), and relaxation techniques. And the mechanism of therapeutic change is behavioral/neurological desensitization which produces extinction learning.

For example, in the treatment of panic disorder the recipient would be exposed to a stimuli that usually triggers a panic attack, and her usual response of fleeing the situation (or neutralizing the trigger in some other way) would be deliberately blocked.[1] A common scenario would be for a recipient who sometimes gets panic attacks when she is in elevators to get in a small elevator, close the door, and then deliberately focus on her fear of panic attacks until she feels an actual panic attack starting to develop. However, at this point, instead of her usual response of getting out of the elevator as fast as possible she allows the therapist to stand in front of her and coach her *through* the panic attack. The therapist reassures her that she won't actually die, even though she feels like it, and eventually, as she stays in the elevator instead of fleeing, she begins to calm down. Part of the calming is that her nervous system just gets tired of panicking. Part of the calming is that she realizes that she isn't having a heart attack or dying, even though she was initially terrified and convinced that she would. And part of the calming is that the

[1] With her permission, of course.

therapist coaches her to use relaxation techniques to facilitate calming once she has experienced at least some of the panic symptoms she usually fears and avoids.

Instead of fleeing the triggering situation and reinforcing negative cognitions such as "I'll have a heart attack and die if I don't get out of here," she goes *through* the panic attack and eventually calms down, even though she is still in the small, closed elevator. And as she does this over and over again, she becomes desensitized to the whole elevator scenario – she trains/teaches her body, brain, and mind to stop reacting to the trigger.

For the purposes of this discussion, the most important point is that this desensitization does *not* actually resolve the original trauma, but rather only trains the person's body, brain, and mind to not react to specific triggers. There is a large body of research, including rigorous behavioral and neurological laboratory research, demonstrating that the recording and remembering of the underlying traumatic memories is a separate process from the desensitization and extinction learning in exposure therapy that trains the person to not react to the specific triggers. And some of these studies demonstrate that these two different, separate processes actually involve different areas of the brain.[2] That is, the desensitization and extinction learning does *not* undo or resolve the original trauma, but rather just adds a second, different learned response that blocks the triggered panic. Furthermore, very rigorous, replicated research demonstrates that extinction learning fades, with eventual *spontaneous recovery* of the original panic responses to triggers related to the underlying trauma, unless the recipient continues indefinite maintenance desensitization.[3]

A couple of very important observations with respect to traditional exposure therapy are consistent with this reality that desensitization does not resolve the underlying trauma and that extinction learning fades over time:

1. Need for maintenance: Traditional exposure therapy for Obsessive Compulsive Disorder (OCD), Panic disorder, and Post Traumatic Stress Disorder (PTSD) always includes ongoing maintenance. Even proponents of exposure therapy openly acknowledge this. For example, the last chapter of *Stop Obsessing*, a book by Dr. Foa on exposure and response prevention therapy for OCD, presents a series of success story "case studies." Every one of the "success stories" describe the need for ongoing maintenance work, and in several of the case studies this need for maintenance continues even after years of "success."[4] A second book on Exposure and response prevention therapy, *Getting Control*, includes an entire chapter specifically addressing the usual experience of some lingering symptoms and the need for long term maintenance work.[5] I have also seen this in my own clinical experience. For

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[2]For a recent review discussion, see Corcoran, Kevin A., & Quirk, Gregory J., "Recalling safety: Cooperative functions of the ventromedial prefrontal cortex and the hippocampus in extinction," *CNS Spectrums*, March 2007, Vol. 12, No. 3, pages 200-206.

[3]For a recent review discussion of spontaneous recovery (spontaneous loss of learned desensitization), see Rescorla, Robert A., "Spontaneous recovery," *Learning & Memory*, 2004, Vol. 11, pages 501-509.

[4]Edna B. Foa and Reid Wilson, *Stop Obsessing* (N.Y., New York: Bantam Books) 1991, pp 194-234.

[5]Lee Baer, *Getting Control.* (N.Y., New York: Penguin Books) 1992, pp 128-142.

example, during my psychiatric residency training I worked with panic disorder patients who obtained dramatic benefit with combination exposure and cognitive therapy; but these patients would relapse if they did not continue maintenance "homework." In these situations, it seems like the dandelion grows back because the root was not removed – exactly what one would expect if the initial target symptoms are being caused by underlying traumatic memories which are not being resolved.

2. Partial relief as opposed to complete resolution: Both of the books described above also acknowledge that there are usually some lingering symptoms, even in the "success stories."[6] And in a 2003 professional journal article, Dr. Foa, one of the leading authorities on exposure therapy, makes the following comment regarding exposure and response prevention in combination with cognitive therapy: "...some patients do not benefit...at all, and most who do respond still remain somewhat symptomatic."[7]

And, finally, the fact that laboratory research and clinical observation both indicate that traditional exposure therapy does not resolve underlying traumatic memories is completely consistent with the theoretical framework for traditional exposure therapy. The theoretical framework for traditional exposure therapy does not acknowledge the importance of underlying trauma in any way, and it does not make any provision for finding and resolving underlying trauma.[8]

B. New iterations of exposure therapy and resolution of underlying trauma: Fortunately, exposure therapy has been changing over the years. As I study more recent material regarding exposure therapy, and especially recent material regarding exposure therapy for Post Traumatic Stress Disorder (PTSD), I perceive a number of new components in both the theory and process:

1. Theory: Recognition of the importance of the root traumatic memories; and process: explicitly, deliberately working with the traumatic memories as a central part of the process.
2. Theory: Recognition of the importance of connecting, emotionally with these memories; and process: using all of the exposure tools in exposure therapy, and preventing the patients usual avoidance responses, help recipients connect with the trauma they are working on.
3. Recognition of the importance of distorted, false negative cognitions (lies).
4. Recognition that the distorted, false negative cognitions are anchored in the root traumatic memories
5. Theory: Recognition of the special power of experiential truth in resolving the distorted, false negative cognitions; and process: using the corrective *experiences* that have always been at the heart of exposure therapy as an important resource for resolving distorted, false

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[6]See, for example, Edna B. Foa and Reid Wilson, *Stop Obsessing* (N.Y., New York: Bantam Books) 1991, pp 194-234; and lee Baer, *Getting Control.* (N.Y., New York: Penguin Books) 1992, pp 128-142.

[7]Foa, FB, and Franklin, ME. "Cognitive-Behavioral Therapy: Efficacy and Applications" *CNS Spectrums* May 2003, vol 8 num 5, pg 339.

[8]See, for example, the theoretical framework presented in Edna B. Foa, *Stop Obsessing* (N.Y., New York: Bantam Books), 1991.

negative cognitions.

And (at least in my assessment) the mechanism for therapeutic change with these new iterations of exposure therapy includes *both* desensitization/extinction learning *and* resolution of the underlying trauma.

For example, let's say a combat veteran is being treated for PTSD from traumatic experiences in Viet Nam. And let's say that the specific symptom being addressed at present is that he gets panic attacks whenever he hears noises that remind him of combat, such as Fourth of July fireworks or gunfire in action movies. Part of the process and mechanism for improvement would be the same. Usually this veteran tries to avoid any combat noise triggers, and if he ever accidentally stumbles into a situation with these triggers he immediately flees. However, in an exposure therapy session he would deliberately expose himself to triggers – maybe by watching the combat scenes in a movie. He would deliberately stay in the room and work with the therapist to go *through* the panic attack, instead of fleeing as soon as he started to feel the first symptoms of panic. And as he repeated this process over and over again, he would become desensitized to combat noise triggers as extinction learning trained his body, brain, and mind to suppress his previous panic response. This component would all be the same.

However, with new iterations of exposure therapy for PTSD there would also be new pieces that would sometimes result in permanent resolution of the underlying trauma. For example, when the patient started to experience panic in response to the sounds of combat, instead of just focusing on the negative thoughts and symptoms of panic in the present, the therapist would deliberately help him to realize that the triggers were causing panic because they were taking him back to his own memories, and the therapist would deliberately help him to recall and connect with the underlying traumatic memories. And then they would apply all of the usual exposure therapy tools and techniques to help him go through the panic, *but now in the context of remembering and being emotionally connected to the underlying trauma*, as opposed to just focusing on symptoms in the present. The therapist would also help him recognize that the negative thoughts associated with his panic, such as "I'm going to have a heart attack and die if I don't get out of here," and "I'm going to go crazy if I feel these emotions" are actually anchored in his combat trauma memories. Furthermore, as the patient was able to stay with the memory and go through the panic, he would generate a new, powerful corrective experience: "I stayed with the memory, I felt the emotions, I didn't have a heart attack and die, and I didn't go crazy."

If the therapist has good capacity so that she can stay emotionally present with the patient, and if the therapist intuitively, instinctively offers attunement,[9] the patient might be able to get his relational circuits back on and thereby resume his journey through the pain processing pathway. This positive result will be especially likely if the therapist also applies the usual exposure therapy relaxation tools that would help the patient calm down, and thereby make it easier for him to get his relational circuits back on. Once the patient's relational circuits are back online and his brain has initiated a new attempt to process the traumatic memory, if the therapist is able to help him stay connected by staying emotionally present and by continuing to offer attunement, the patient will be able to share her capacity and maturity skills and will usually be

[9]Many good therapists will instinctively, intuitively offer attunement in situations like this, even if they have not yet discovered any of the research or theory regarding attunement, relational circuits, and the pain-processing pathway.

able to permanently resolve the trauma by successfully finishing all of the processing tasks.[10] As an extra asset, the powerful corrective experience of actually observing for himself, "I stayed with the memory, I felt the emotions, I didn't have a heart attack and die, and I didn't go crazy," *while working "inside" the memory*, is the best possible resource for correcting the distorted, false negative beliefs that had previously been anchored in the memory.

Those using exposure therapy often don't present the principles I have just described as the theory for what they are doing (that is, they may not understand what I consider to be the correct theoretical framework for what they do). However, if they help the recipient connect with the traumatic memories, help the recipient get their relational circuits back on by staying emotionally present and attuning to the recipient, help the patient continue successful processing by staying connected and sharing their capacity and maturity skills, help the recipient generate corrective experiences, and then help the recipient explicitly process the corrective experiences, this will often result in permanently resolving the traumatic memories *even though the therapist may not understand much of what she or he is doing*.

Note: It is important to recognize that even older, "traditional" exposure therapy can occasionally, "accidentally" result in permanent resolution of the underlying trauma. Traditional exposure therapy *theory* does not make any room for this, and therapists using older, traditional exposure therapy may not understand what's actually happening with these accidental healing events, but in the usual exposure therapy process of deliberately exposing the patient to triggers and stirring up the target symptoms, they can sometimes unintentionally/accidentally cause the patient to remember and connect with the underlying trauma. And if the therapist has high capacity, intuitively offers attunement, stays with the patient with ongoing attunement and emotional connection, shares strong maturity skills, and helps the patient to generate a powerful corrective experience by going *through* the target panic (or other anxiety symptoms), the exposure therapy session can unintentionally/accidentally resolve the underlying trauma.

I think that part of the confusion people sometimes encounter when trying to understand how exposure therapy fits together with the Immanuel Approach and EMDR comes from the fact that exposure therapy sometimes produces only desensitization/extinction learning but at other times

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[10]Painful experiences become trauma when the person is unable to fully, successfully process the experience. The most common point for failure with respect to processing tasks is that the person loses access to his relational connection circuits, which causes him to feel alone in the painful experience and also interferes with higher-level processing tasks in various ways. Correspondingly, the most common first step in helping a person to resume successful processing of a traumatic memory is to help him get his relational circuits back on line, as he is working in the context of remembering and being emotionally connected to the memory. Furthermore, if someone in the person's community can stay with him and share capacity and maturity skills through attunement, he will usually be able continue successful processing through all remaining tasks and thereby resolve the trauma. For brief additional discussion of processing tasks, trauma being caused by failed processing tasks, trauma being resolved by restarting and then successfully completing these processing tasks, relational circuits, capacity, maturity skills, and attunement, see Chapters 1, 7, 12, and 18 in Karl Lehman, *Outsmarting Yourself* second edition (Libertyville, IL: This Joy! Books, 2014), or Chapters 2 and 3 in Karl Lehman, *The Immanuel Approach: For Emotional Healing and for Life* (Evanston, IL: Immanuel Publishing, 2016). For a much more thorough discussion, see Part II of the "Brain Science, Psychological Trauma, and the God Who Is with Us" essay series.

also results in finishing unresolved processing tasks. The presence of both of these therapeutic mechanisms, *in a combination that is variable, unpredictable, and usually not explicitly recognized*, explains why sometimes exposure therapy produces results consistent with behavioral, neurological desensitization (partial resolution of symptoms, benefits require continued practice to maintain, and symptoms return if regular practice is stopped), but at other times produces results consistent with permanent resolution of underlying trauma (complete and permanent resolution of symptoms, with no need for maintenance).[11]

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, 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.[12]

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[11]If you study the literature for exposure therapy carefully (especially regarding recent iterations for PTSD), you will notice that occasional, atypical case studies describe the same kind of permanent resolution that is seen with the Immanuel Approach and EMDR. These unusual cases describe complete (as opposed to partial) resolution of symptoms, and they describe long-term benefits (no spontaneous return of the original symptoms), even in the absence of maintenance work. Some of these atypical case studies also explicitly describe identifying and resolving underlying traumatic memories, or at least include clues indicating that this was part of the process. ***Unfortunately, I did not capture the reference information for these atypical case studies as I went through the thousands of pages of material I reviewed in studying exposure therapy. I will update this essay when/as/if I can track them down. If you are aware of reference information for one or more of these atypical case study examples, please e-mail me at drkarl@kclehman.com.***

[12]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*

III. Points of agreement between new iterations of Exposure therapy (especially for PTSD) and the Immanuel Approach and EMDR:

- Now, with the new iterations of Exposure Therapy specifically developed for PTSD, exposure therapy, the Immanuel Approach, and EMDR all recognize the importance of the root traumatic memories. And they all explicitly, deliberately work with the traumatic memories as a central part of the process.

- The exposure and response prevention that have always been central in exposure therapy have always been powerfully effective in making sure that the recipient actually connects, emotionally, with the unresolved content from the underlying traumatic memories. And now, with the new iterations for PTSD, the exposure and response prevention part of exposure therapy is used to explicitly help the patient connect to the actual memories, as opposed to just being used for connecting to the symptoms in the present (implicit memory toxic content), with no recognition of the underlying trauma. So now, with the new iterations for PTSD, exposure therapy, the Immanuel Approach, and EMDR all agree regarding the importance of helping the patient connect, emotionally, with the traumatic memories being addressed. And they all also include specific process components and tools for helping the patient establish and maintain this necessary connection.

- Now, with the new iterations for PTSD, exposure therapy, the Immanuel Approach, and EMDR all recognize the importance of distorted, false negative cognitions (lies). And they also all recognize that the distorted, false negative cognitions are anchored in the root traumatic memories.

- Now, with the new iterations for PTSD, exposure therapy, the Immanuel Approach, and EMDR all recognize the special power of experiential truth in resolving the distorted, false negative cognitions. And with exposure therapy, the corrective *experiences* that have always been at the heart of exposure therapy are an important resource for resolving distorted, false negative cognitions. (Note that the corrective experiences in exposure therapy are especially parallel to the corrective interactions with the living presence of Jesus that recipients experience in the Immanuel Approach, and they are parallel to recipients hearing truth from God in Theophostic.)[13]

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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.

[13]With the Immanuel Approach, some parts of the theory are not as clear or explicit in the basic material for recipients and facilitators. For example, basic training for recipients and facilitators does not discuss distorted, false negative cognitions as an especially common and important component of traumatic memories, nor does this basic training describe the special

IV. Conclusions: In conclusion, I think that the more recent iterations of exposure therapy (and especially exposure therapy for PTSD) incorporate many of the same principles and tools that are foundational components of the Immanuel Approach, and EMDR. This helps to explain the Immanuel Approach in terms of principles that are widely accepted in current, mainstream psychological theory. It also indirectly supports the efficacy of the Immanuel Approach, since the substantial empirical research proving the effectiveness of exposure therapy for the treatment of PTSD can be indirectly applied to the use of the Immanuel Approach for the treatment of traumatic memories.

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power of *experiential* truth in correcting these negative cognitions. However, intermediate and advance Immanuel Approach material does include these pieces. Furthermore, if you watch Jesus closely in Immanuel Approach sessions, you will realize that He understands and applies these principles even in basic sessions.