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The Place of the Immanuel Approach In the Treatment of Clinical Disorders

The Immanuel Approach is currently being used in the treatment of many different clinical disorders.[1] However, some critics have expressed concern that new approaches to emotional healing, such as the Immanuel Approach, are being included in the treatment of serious mental health concerns without adequate research support. These critics argue that practitioners should wait for published empirical research before using a new treatment tool; and they argue that it is irresponsible, unsafe, unprofessional, and unethical to include new approaches to emotional healing in the treatment of a serious mental health concern before empirical research has been published supporting the use of these new approaches for the specific clinical disorder in question.[2]

Based on the considerations discussed below, my assessment is that this demand for published empirical research specifically addressing the application in question, *before* trying any new treatment method, is not realistic in the real world of actual medicine, mental health care, and emotional healing ministry. Furthermore, my assessment is that case-study evidence, similarities to research-supported therapy modalities, and theoretical considerations all support using the Immanuel Approach in the treatment of many different clinical disorders, such as PTSD, major depression, obsessive compulsive disorder, phobias, panic disorder, adjustment disorder, eating

[1]For example, I am currently using the Immanuel Approach as the primary psychotherapeutic intervention for patients with Post Traumatic Stress Disorder (PTSD), panic disorder, phobias, major depression, obsessive compulsive disorder, compulsive eating disorder, bulimia, adjustment disorder, and a variety of addictions; I have used the Immanuel Approach as part of the treatment plan for patients with attachment disorders, bipolar disorder, schizophrenia, schizoaffective disorder, and a variety of personality disorders; I have colleagues who are currently using the Immanuel Approach for at least part of the treatment plan for many of these same disorders as well as others; and I get e-mails from people all over the world who are using the Immanuel Approach for at least part of the treatment plan for many different clinical disorders.

[2]For example, Dr. David Entwistle, Associate Professor of Psychology at Rosemead School of Psychology, Biola University, has written two articles systematically critiquing Dr. Ed Smith and Theophostic® ministry. In these articles he states, "It is troubling that TPM is being used to treat serious and diverse disorders absent any published empirical research on TP supporting its efficacy across such applications," and clearly implies in his additional discussion that practitioners should wait for published empirical research before using a new treatment tool, and that it is irresponsible, unsafe, unprofessional, and unethical to include a new healing method such as the Immanuel Approach in the treatment of a serious mental health concern before empirical research has been published supporting the use of these new approaches for the specific clinical disorder in question. David N. Entwistle, "Shedding Light on Theophostic® Ministry 1: Practical Issues." *Journal of Psychology and Theology*. 2004, Vol 32, No. 1, pp 26-34, and David N. Entwistle, "Shedding Light on Theophostic® Ministry 2: Ethical and Legal Issues." *Journal of Psychology and Theology*. 2004, Vol. 32, No. 1, pp 35-42, specific quote on page 39.

disorders, attachment disorders, personality disorders, and every form of addiction.[3]

I. Initial empirical research support: As of January 2026, Dr. Emily Hervey, licensed clinical psychologist and Adjunct Professor at Regent University, has published two quantitative studies supporting the effectiveness of the Immanuel Approach.[4] Furthermore, Dr. Kristine Bresser completed a quantitative study supporting the effectiveness of the Immanuel Approach as her doctoral dissertation at Regent,[5] and Dr. Mark Hattendorf completed a qualitative study of the Immanuel Approach for his doctoral dissertation at Regent.[6] Which is all very encouraging. However, these are only a small handful of studies, the Immanuel Approach was included as part of a larger faith-based treatment program in each of these studies (as opposed to being studied as a stand-alone intervention), and these studies focused on treatment for only PTSD.

Fortunately, there are also other sources of support for using the Immanuel Approach in addition to this initial empirical research. With respect to direct support, we also have carefully documented case studies that show consistent, strong positive results. Furthermore, there is *indirect* support for the effectiveness of the Immanuel Approach based on similarities between the Immanuel Approach and psychotherapy modalities that *have* been verified as effective by empirical research, and there is more indirect support based on theoretical considerations.

II. Case study evidence supporting efficacy: It is a very common practice, in all branches of medicine, in mental health care, and in emotional healing ministry, for care providers to use a new treatment method on the basis of positive case study results, even though the treatment method is not yet supported by published empirical research. There are usually many years between the case study description of a new treatment method and confirmation of the new method in published empirical research. In fact, empirical research, such as blinded, controlled

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[3]This list of clinical disorders is not intended to be comprehensive. For example, as noted in footnote #1, I have also used the Immanuel Approach as part of the treatment plan for patients with bipolar disorder, schizophrenia, and schizoaffective disorder. However, with certain clinical conditions, such as the three just mentioned, it is important to be especially careful that work with psychological trauma does not precipitate decompensation.

[4]Emily G. Hervey, "Spiritually Oriented Trauma Healing in Nigeria: A Program Evaluation to Assess Trauma-Symptom Reduction and Spiritual Growth," *Journal of Psychology and Theology*, Feb 2023, Vol. 0, Num 0, https://doi.org/10.1177/00916471221150402; and Emily G. Hervey, "The Effects of a Spiritually Integrated Trauma Healing Program on PTSD Symptoms and Spiritual Well-Being in Nigeria," *Spirituality in Clinical Practice*, 2024, Advance online publication. https://doi.org/10.1037/scp0000386. Note: The abstracts for Dr. Hervey's studies do not mention the Immanuel Approach, but the full articles clearly describe including the Immanuel Approach as the primary intervention for the treatment of trauma.

[5]Kristine Bresser, *A quantitative study of a faith-based trauma healing intervention among Kenyans*. [Doctoral dissertation, Regent University]. (Ann Arbor, MI: ProQuest Dissertations Publishing, 2022.) https://www.proquest.com/dissertationstheses/quantitative-study-faith-based-trauma-healing/docview/2645791129/se-2.

[6]Mark Elliott Hattendorf, *Immanuel: Narrative Case Studies Exploring Inner Healing in Clinical Settings* [Doctoral dissertation, Regent University]. (Ann Arbor, MI: ProQuest Dissertation Publishing, 2014).

studies, is usually undertaken only after many practitioners have begun to use a new treatment on the basis of case study reports, and enough patients report positive results to justify embarking on more systematic research (which is tedious, time-consuming, and very expensive). Millions of patients have been effectively treated with new, innovative interventions on the basis of positive case study results, even though the new interventions were not yet supported by published empirical research.

For example, several years ago I read a case study in one of my professional journals describing a patient with treatment-resistant rapid-cycling bipolar disorder. The patient described in the case study had improved dramatically with the addition of a certain kind of thyroid medication to her previous medication regimen. I had a patient whose clinical picture was very similar, and so tried the medication combination described in the case study. The thyroid medication was *not* FDA approved for rapid-cycling bipolar, and had *not* been confirmed as effective for rapid-cycling bipolar in any kind of empirical research study; however, I tried the proposed treatment plan on the strength of the carefully described case study. My patient experienced dramatic and lasting improvement, for which she is profoundly grateful.

Furthermore, many practitioners in the real world of actual medical and mental health care make treatment decisions on the basis of informal case studies described by respected and trusted colleagues. It is VERY common for a medical or mental health professional to get together with several of her colleagues, and ask "I have a patient with the following clinical picture....(fill in the blank). I have already tried....(fill in the blank – usually the established treatments that have already been supported by published empirical research), but they have not been effective in this case. Have any of you found something that worked in a case like this?" The others present then offer stories about discoveries they have made in the context of their personal practices. And if one of her colleagues – someone she knows, respects, and trusts – reports discovering a medication and/or method that seemed effective in a similar situation, she will usually begin to test this treatment option in her own practice.

The material presented on our Immanuel Approach website, in my Live Ministry Series (LMS) sessions, and in the big lion book provide a number of carefully described case studies of Immanuel Approach principles and techniques being used in the effective treatment of various serious mental health conditions.[7] And I have received reports from many colleagues who have been seeing similar results with Immanuel Approach principles and techniques in their practices.[8]

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[7]See, for example, the bulimia case study presented on the "Case Studies" page of our web site www.immanuelapproach.com, the narcolepsy case study presented in Live Ministry Series (LMS) session #4, the phobia case study presented in LMS session #5, the addictive-eating case study presented in LMS session #7 and Chapter 1 of the big lion book, the attachment trauma case studies presented in LMS session #34 and Chapter 30 of the big lion book, the crack-addiction case study presented in Chapter 7 of the big lion book, the phobia case study presented in Chapter 9 of the big lion book, the many PTSD case studies presented in Chapters 2, 17b, and 38 in the big lion book, and the major depression, panic disorder, and obsessive compulsive disorder case studies described briefly in Karl Lehman, *Mind and Brain: Separate but Integrated* (Evanston, IL: Immanuel Publishing, 2024).

[8]See, for example, the case study included at the end of Wendy Hayes, "The Immanuel Approach," Counseling Connections Across Australia, Vol. 11 (November 2019), pages 52-59. See also informal case studies posted on websites, shared in podcasts, and shared in newsletters for ministries such as Life Model Works with Jim Wilder, Immanuel: A Practicum with Patti Velotta, THRIVE with Chris and Jen Coursey, Face to Face with Cathy Little and Melinda Wilson, Alive and Well with Margaret Webb, and

III. Indirect research support for the Immanuel Approach (shared principles and techniques with research-supported psychotherapies): As of this writing (May 2023), extensive medical and psychological research shows that EMDR (Eye Movement Desensitization and Reprocessing), exposure therapy, and cognitive-behavioral therapy significantly reduce the signs and symptoms of a number of mental illnesses, including Post Traumatic Stress Disorder (PTSD), Obsessive Compulsive Disorder (OCD), and panic disorder.[9] The shared principles and techniques between the Immanuel Approach and these other mainstream psychotherapy modalities are discussed in much greater detail in "Cognitive Therapy and the Immanuel Approach," "The Immanuel Approach & EMDR: F.A.Q.'s and Common Misunderstandings," "Exposure Therapy and the Immanuel Approach,"[10] and Dr. Mark Hattendorf's doctoral thesis, *Narrative Case Studies Exploring Inner Healing in Clinical Settings*,[11] but here is my short summary regarding several of the most obvious shared principles and techniques:

- Now, with the new iterations of cognitive-behavioral therapy and exposure therapy specifically developed for PTSD, cognitive-behavioral therapy, exposure therapy, EMDR, and the Immanuel Approach all recognize the importance of traumatic memories. And they all explicitly, deliberately work to help the recipient resolve the traumatic memories as a central part of the therapeutic process.

- With the new iterations specifically developed for PTSD, cognitive-behavioral therapy, exposure therapy, EMDR, and the Immanuel Approach all recognize the importance of distorted, false negative cognitions (lies), they all recognize that the distorted, false negative cognitions are anchored in root traumatic memories, and they all work very deliberately to resolve these erroneous negative cognitions.

- With the new exposure therapy iteration specifically developed for PTSD, exposure therapy, the Immanuel Approach, and EMDR all recognize the special power of *experiential* truth in resolving the 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.)

Healing Center International with Betsy Stalcup.

[9]See, for example, C. Sherman. "Two Modalities Rival Prolonged Exposure for PTSD." *Clinical Psychiatry News* April 2002, p. 40; Foa EB, Keane TM, Friedman MJ eds. *Effective Treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies.* (Guilford Press: New York, NY), 2000; J. Ballenger. "Current treatments of the anxiety disorders in adults" *Biol-Psychiatry*. 1999 Dec 1, Vol. 46, No. 11, pages 1579-94. See also "The Immanuel Approach & EMDR: F.A.Q.'s and Common Misunderstandings" in the "Special Subjects/Advanced Topics" section of the "Resources" page of www.immanuelapproach.com, pages 7-8 for careful discussion of the research regarding EMDR.

[10]These three essays provide careful discussions of both the similarities and differences between the Immanuel Approach and each of these psychotherapies, and they are all available as free downloads from the "Special Subjects/Advanced Topics" section of the "Resources" page of www.immanuelapproach.com.

[11]Mark Elliott Hattendorf, *Immanuel: Narrative Case Studies Exploring Inner Healing in Clinical Settings* (Ann Arbor, MI: ProQuest LLC, 2014).

- Establishing a "safe place" to go back to, as a psychotherapy safety net, is a technique that the Immanuel Approach shares with EMDR (and also with many other psychotherapy approaches that focus especially on resolving psychological trauma).

- And with the new exposure therapy iteration specifically developed for PTSD, exposure therapy, EMDR, and the Immanuel Approach all apply principles and interventions coming out of recent research regarding memory reconsolidation. (For a brief discussion of the principles and interventions coming out of recent memory-reconsolidation research, see section V below.)

So if these other psychotherapy techniques have strong research support for efficacy, and the Immanuel Approach includes many of the most important principles and techniques from these psychotherapies, then the empirical research demonstrating that these other psychotherapies are effective would predict that the Immanuel Approach will probably also be effective. The theoretical connections to research-supported psychotherapies therefore provide strong *indirect* research support for the efficacy of the Immanuel Approach.

Note that medical researchers frequently use this logic in developing new treatments. For example, if a certain medication is effective for a particular illness, then there is a good chance that similar chemical compounds will also be effective for this same illness. When medical researchers are looking for additional treatment options, they often start with these similar chemical compounds since they are "good bets."[12]

IV. Using the Immanuel Approach on the basis of theoretical considerations: Medical and mental health professionals often decide to include an intervention in the treatment plan based on theoretical considerations, even though there is not yet empirical research proving that the specific intervention in question is effective for the specific application in question. For example, there is strong case study support, strong indirect research support, and strong theoretical support for Immanuel Approach principles and techniques being effective for resolving the psychological effects of traumatic events. And there is also a lot of research and case-study evidence indicating that unresolved psychological trauma contributes to many mental illnesses, such as dysthymia, depression, eating disorders, anxiety disorders, addictions, somatization disorders, attachment disorders, personality disorders, and the obvious posttraumatic stress disorder (PTSD).[13] Putting these two pieces together – if unresolved psychological trauma contributes to these mental health problems, and Immanuel Approach principles and techniques are thought to be effective for resolving psychological trauma, then it is reasonable to include the Immanuel Approach in the overall treatment plan for people with these mental health concerns.

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[12]See Gladys L Hobby. *Penicillin: Meeting the Challenge*. (Binghamton, NY: Vail-Ballou Press) 1985, especially "New Penicillins Introduced," Chapter 11, pages 213-231, for a well documented historical account of this pattern of investigation with respect to the penicillin family of antibiotics.

[13]See Karl Lehman, *Mind and Brain: Separate but Integrated* (Evanston, IL: Immanuel Publishing, 2023), Chapter 12, for a brief summary of the extensive evidence indicating that unresolved psychological trauma contributes to these many mental health problems. And see Allan N. Schore, *Affect Dysregulation and Disorders of the Self* (New York, NY: W.W. Norton & Company, 2003) for an exhaustive discussion of the many neurophysiological ways in which psychological trauma contributes to mental illnesses.

This approach is a long established and widely accepted practice in medicine and mental health care, and it has resulted in good outcomes in many individual cases, as well as leading to many important discoveries. For example, the cure for malaria was discovered when Jesuit priests at missions in the foothills of the Andes mountains observed that the Native Americans drank powdered cinchona bark in hot water to calm their trembling muscles when they were shivering from cold exposure. It occurred to the priests that cinchona might therefore also be helpful for the intense shivering that is associated with malaria, and they tested the powdered bark on several patients suffering from malarial fever. They were pleased when this treatment proved helpful in controlling the shivering, but much more excited to discover that it also cured the underlying illness![14]

Dr. Paul Brand trying a new surgical technique for preventing blindness in leprosy patients provides another example.[15] After his ophthalmologist wife discovered that many people with leprosy go blind because their corneas no longer prompt adequate blinking,[16] they first tried many behavioral interventions, in hopes that their patients could just learn to blink frequently enough to provide the needed corneal protection. Unfortunately, it's really, really hard to remember to blink every ten to fifteen seconds all day every day, and all of their behavioral interventions failed. So Dr. Brand did some searching, and found a surgical technique that had been developed to help with a very similar blinking problem experienced by people with facial paralysis due to Bell's palsy. This intervention is a bit strange, but extremely clever – the surgeon takes a small strand of the chewing muscle from the side of the face, tunnels it under the skin to the corner of the eye, and then attaches it to the eye lid, so that the patient will now blink every time they chew.

This procedure had never previously been used for this purpose. So there was *zero* empirical research supporting the way in which the Brands wanted to employ this intervention to help prevent blindness in leprosy patients. But *it made complete sense based on theoretical considerations*. And the results proved that the theoretical considerations were valid. When combined with the habit of gum-chewing, this intervention quickly and dramatically increased blinking protection for the patient's eyes.[17]

Published case studies provide a large supply of additional examples, since many of the case studies that appear in medical and psychological journals are examples of treatment plans *that do*

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[14]Rocco, Fiammetta. *The Miraculous Fever-Tree* (New York, NY: HarperCollins, 2003), pages 60-63.

[15]Paul Brand and Philip Yancey. *Pain: The Gift Nobody Wants* (New York, NY: HarperCollins, 1993), pages 143-147.

[16]The cornea is normally exquisitely sensitive to the slightest irritation. Even the tiniest dust particles, that we don't even notice consciously, will cause enough irritation to prompt blinking. The result is that we blink many times each minute, all day every day, and this blinking both moisturizes the cornea and removes irritants. As leprosy deadens the sensitivity of the cornea the person blinks less and less, and the resulting lack of moisture and lack of irritant removal cause progressive corneal damage, which eventually leads to blindness.

[17]If the professional medical community had delayed this treatment for years, waiting for published empirical research on animals before allowing the procedure to be tried with people, the thousands of leprosy patients who went blind as a result of this delay would not have thanked them.

not yet have published empirical research support, but rather are based on theoretical considerations, and that have been chosen for publication because they appear to have resulted in good outcomes.[18]

An article about treatment for psychological trauma in a February 2005 mainstream medical journal provides still more evidence that it is common practice to make treatment decisions based on theoretical considerations in situations where there is not yet published empirical research. The author summarizes a series of interventions "recommended by expert panelists," and then simply states, without any apology or apparent embarrassment, that these recommended interventions "have not been tested empirically."[19]

I have used this approach of making treatment decisions on the basis of theoretical considerations in my own psychiatric practice, with respect to both psychotherapy tools and psychiatric medications, and have seen great benefit with minimal difficulty.

V. Recent research regarding memory reconsolidation: The strongest theoretical support for the Immanuel Approach comes from recent research regarding memory reconsolidation. In discussing this important new research, let me start with summarizing several long-established brain-science phenomena that provide context:

A. Learning that occurs in the presence of intense emotions is rapid, strong, and easy to demonstrate. For example, you can take a guinea pig, a monkey, or an undergraduate trying to make some extra spending money by participating in a psychology research project, and run them through a handful of training trials in which you play a specific audio tone and then administer a painful electric shock. And then a day later, a month later, or a year later, you can demonstrate that the experimental subjects remember the learned association by playing the audio tone and observing that they immediately experience distress – the college student will actually describe feeling anxiety/fear, all of the experimental subjects will display behavior indicative of anxiety/fear, and they will all manifest bio-indicators of anxiety/fear (such as increased respiration, increased pulse rate, increased blood pressure, and increased sweating).

B. Even learning associated with intense emotions can be completely, permanently erased by interventions that block new synapse formation. For example, if you take your guinea pig or monkey[20] and run them through the training trials in which they hear a specific audio tone and then receive a painful electric shock, but then you inject them with a neurotoxin that blocks the formation of new synapses, *they will not show evidence of any learning associated with the painful electric shocks.* If you play the audio tone even mere hours after the training trials, the usual behaviors and bio-indicators associated with distress *will be completely absent*. Again,

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[18]See, for example, Taylor F., Cahill L., "Propanolol for reemergent posttraumatic stress disorder following an event of retraumatization: a case study," *J Trauma Stress*. 2002; Vol 15, pages 433-437. MANY similar examples can be obtained by even a cursory review of mainstream medical and mental health journals.

[19]Watson, Patricia J., Shalev, Arieh Y., "Assessment and Treatment of Adult Acute Responses to Traumatic Stress Following Mass Traumatic Events," *CNS Spectrums*, February 2005, Vol. 10, No. 2, pages 123-131, specific quotes on page 127.

[20]Thankfully, college students are not included in these studies that require injecting neurotoxins.

the experimental subjects will not show any evidence of fear or anxiety in association with the tone.

C. Learning associated with intense emotions can be completely, permanently erased only during the five hour window before it is consolidated into long-term memory. That is, the interventions[21] that block new-synapse formation no longer have any effect on learning or memory once the new synapses are stable and learning has been consolidated into long term memory. For example, if you take your guinea pig or monkey and run them through the training trials, but then wait for five hours (or more) before injecting the neurotoxin, *the neurotoxin will have no effect* – a day later, a month later, or a year later, you can demonstrate that the experimental subjects remember the learned association by playing the audio tone and observing that they immediately display all of the usual indicators of anxiety/fear.

D. Once this learning associated with pain and intense emotions has been consolidated into long-term memory, it can be managed, and even completely suppressed (temporarily), but it can no longer be truly, permanently resolved, erased, or replaced. This conclusion has been based on extensive research on a phenomenon called extinction. Now, extinction is the process of eliminating a learned response by running the experimental subjects through a new set of training trials that carry the *opposite* meaning from the initial trials. (For example, extinction training for our guinea pig, monkey, and college student would be to run them through repeated trials in which they hear the audio tone, but then *do not* receive an electric shock.) And a very significant, very consistent finding from the many, many studies examining extinction is that extinction training *does not actually erase or replace the initial learning*, but rather only temporarily suppresses it. Even though the initial learned response would seem to completely disappear in response to repeated extinction training trials, it would always eventually return (unless regular refresher extinction trials were continued indefinitely).[22]

Furthermore, research studying learning that occurs in the context of intense emotions[23] reveals that this kind of learning is stored in specialized implicit memory circuits that are exceptionally durable.[24] And studies examining extinction also show that the learning from extinction training is actually carried in the prefrontal cortex, a completely different part of the brain from

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[21]There are actually a number of different interventions that will block new synapse formation. For example, shocking the brain, hypothermia, and a number of different neurotoxins will all produce the same effect of blocking new learning by blocking new synapse formation.

[22]For a review of the research regarding memory consolidation, and how it "proves" the "impossibility" of reprocessing, replacing, or erasing emotional learning once it has been consolidated, see James L. McGaugh, "Memory–A Century of Consolidation," *Science* Vol. 287 (Jan 14, 2000): pages 248-251.

[23]Note that "learning that occurs in the context of intense emotions" would include the erroneous negative cognitions that are included in the toxic content associated with traumatic memories. Also, to the extent that learning includes any new memory content associated with a new experience, "learning that occurs in the context of intense emotions" would include ***all*** toxic content associated with traumatic memories.

[24]James L. McGaugh, "Making Lasting Memories: Remembering the Significant," *Proceedings of the National Academy of Sciences of the United States of America*, Vol. 110, Suppl 2 (June 18, 2013): pages 10402-7.

the learning that it is trying to manage/suppress.[25] So if a person has distorted, erroneous negative interpretations associated with a traumatic memory, extinction training will teach a different part of the brain how to manage/moderate/suppress the toxic content associated with the trauma, but it will not rewrite, replace, or resolve the memory files actually carrying the toxic content.

Based on the huge collection of research studies thoroughly establishing these four points, the official position of mainstream neuroscientists and psychologists for many years has been that the toxic content carried in traumatic memories was unchangeable and permanent once the new-learning synapses stabilized and the experience was consolidated into long-term memory. The mainstream, established belief was that we could train other parts of the brain to manage, moderate, and suppress the toxic content carried in traumatic memories, but that there was no way to truly, permanently resolve it. When a therapist or emotional healing minister occasionally claimed that a client/recipient seemed to experience true, complete, permanent healing for a traumatic memory, the neuroscience and psychology authorities would simple state, "That can't happen, doesn't happen, and didn't happen – we have proven that it is impossible."

And then, beginning in 2004, new research has been discovering and clarifying details regarding a psychological/neurological phenomenon called memory reconsolidation. To make a long story short, this new research demonstrates that we can truly, permanently modify and resolve even traumatic content that has been consolidated into long-term memory *if we establish certain very specific conditions and include a very specific intervention*.

One of the necessary conditions is that *the traumatic content must first be activated*. When a therapy client/ministry recipient is trying to permanently reprocess and resolve traumatic content, they must be connected to the memory to the point that they can feel the emotions associated with the original experience (at least to some extent) – they must be working *inside* of the activated traumatic memory, as opposed to just thinking about it and talking about it from the outside. And a second necessary condition is that their experience of being inside of the activated traumatic memory must now contain something significantly different.[26]

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[25]See, for example, Mohammed R. Milad and Gregory J. Quirk, "Neurons in medial prefrontal cortex signal memory for fear extinction," *Nature* Vol. 420 (Nov 7, 2002): pages 70-74; Brenda Milner, Larry. R. Squire, and Eric R. Kandel, "Cognitive Neuroscience and the Study of Memory," *Neuron* Vol. 20, No. 3 (March 1998): pages 445-468; Elizabeth A. Phelps, Mauricio. R. Delgado, Kathering L. Nearing, and Joseph E. LeDoux, "Extinction Learning in Humans: Role of the Amygdala and vmPFC," *Neuron* Vol. 43, No. 6 (Sept 16, 2004): pages 897-905; Gregory J. Quirk, Ekaterina Likhtik, Joe Guillaume Pelletier, and Denis Paré, "Stimulation of Medial Prefrontal Cortex Decreases Responsiveness of Central Amygdala Output Neurons," *The Journal of Neuroscience* Vol. 23 No. 25 (Sep 24, 2003): pages 8800-8807; and Edwin Santini, Hong Ge, Kegin Ren, Sandra Pena de Ortiz, and Gregory J. Quirk, "Consolidation of Fear Extinction Requires Protein Synthesis in the Medial Prefrontal Cortex," *The Journal of Neuroscience* Vol. 24, No. 25 (June 2004): pages 5704-5710.

[26]One proposed explanation regarding this second necessary condition is that metabolic resources are required to open the circuits back up, and the brain needs to have a good reason to invest these resources. If everything just looks the same, the brain thinks, "Why invest resources to open up the circuits if we are just going to relearn the same lesson?" In contrast, if something is significantly different, the brain concludes that it is worth the investment to make space for the possibility of new learning that might be adaptive in some way. See page 7 of Bruce Ecker, "Memory Reconsolidation Understood and Misunderstood." *International Journal of Neuropsychotherapy* Vol. 3, No. 1 (2015): pages 2-46.

The very specific necessary intervention is for the client/recipient to have a corrective experience while connected to, or "inside of," the activated traumatic memory. That is, while they are connected to the traumatic memory, they must have a corrective *experience* that carries the *opposite meaning* from the toxic learning produced by the original trauma.[27]

A striking aspect of the new memory reconsolidation research is that it easily and compellingly demonstrates this necessary intervention and these necessary conditions. For example, if we take a guinea pig and monkey that have learned to associate the audio tone with an electric shock, and the memories for this learning have been allowed to consolidate so that they are no longer affected by the neurotoxin, *but then we activate the memories for the learning trials and deliberately include something different,* the memory circuits will open back up and an injection of the neurotoxin will once again be able to permanently erase the learning. Furthermore, if we take a guinea pig, monkey, and college student that have learned to associate the audio tone with an electric shock, and the memories for this learning have been allowed to consolidate so that they are no longer affected by the neurotoxin, but then we activate the memories for the learning trials and deliberately include something different, the memory circuits will open back up and be receptive to new learning ***that can truly reprocess/re-write/replace the original training memories.*** So if we run our experimental subjects through extinction learning trials that would normally just train another part of the brain to temporarily suppress the learned fear reaction, *but with the necessary conditions for memory reconsolidation now in place*, the experiential opposite meaning in the extinction trials will now *permanently replace, and thereby permanently resolve*, the learned fear response.

And when those studying memory reconsolidation carefully observe trauma-therapy sessions, with these principles in mind, they find the exact same results. For example, if a person has a traumatic car accident, she develops a phobic fear of driving as a result of the accident, and months have gone by so that the trauma is consolidated into long term memory, traditional extinction training as part of traditional exposure therapy will only produce temporary suppression of the phobic reaction – exactly as predicted by all of the research on extinction. *However*, if we first activate the traumatic memory (for example, by coaching the client to focus on it until she feels connected to the toxic content), and if we also deliberately include something different (such as the presence of an attuning ally *with her* as she is "inside" the memory), then the same traditional extinction training that would otherwise just produce temporary suppression will instead *permanently resolve* the toxic learning from the trauma – the opposite meaning in the extinction training corrective experience ***will actually replace, and thereby permanently resolve***, the toxic learning produced by the trauma.[28]

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[27]Note that "toxic learning produced by trauma" can include more than just level V erroneous cognitive interpretations regarding the meaning of the experience. For example, the Level III loss-of-relational-circuits component of trauma can be framed as an *experiential meaning* along the lines of, "I am alone – God and my community are not with me here," which would be a form of toxic learning produced by trauma. Similarly, the Level IV unable-to-navigate-the-situation-in-a-satisfying-way component of trauma can be framed as an *experiential meaning* along the lines of, "I am inadequate and have failed – I don't have the knowledge, strength, and skill necessary to be able to handle this situation." Note also that this wider formulation of "toxic learning" would enable memory reconsolidation research to more fully synchronize with the Immanuel Approach and our pain processing pathway model.

[28]For a much more detailed discussion of recent research regarding memory reconsolidation, and the implications of this research for psychotherapy, see Bruce Ecker, Robin Ticic, and Laurel Hulley,*Unlocking the Emotional Brain: Eliminating Symptoms at Their Roots Using Memory*

Finally, lets come back to the Immanuel Approach. This new research regarding memory reconsolidation provides support for the Immanuel Approach because it clearly, compellingly demonstrates that fully consolidated memories can be opened back up for reprocessing, and then permanently reprocessed/re-written before being reconsolidated back into stable long-term memory – just as we see with Immanuel Approach emotional healing. Furthermore, the new research regarding memory reconsolidation clearly identifies a specific intervention and two specific conditions that are necessary for truly, permanently resolving traumatic memories, ***and the Immanuel Approach emotional healing process clearly includes this specific intervention and these necessary conditions***. To summarize the specifics regarding this last point:

* The IA healing process always includes activation of the traumatic memory – the recipient always focuses on and talks about the traumatic memory until they can feel (at least to some extent) the toxic content carried in the memory. That is, the IA healing process always includes activation of the traumatic memory *so that the recipient is connected to, and working **inside** of the memory, as they are reprocessing the toxic content.*

*The IA healing process always includes a piece that is profoundly different from the original traumatic experience – the recipient always experiences the living, tangible, interactive, attuning, loving presence of Jesus *with them* inside of the traumatic memory.

*And the IA healing process always includes a corrective experience with opposite meaning from the toxic content produced by the original traumatic experience – Jesus seems to be fully aware of this important necessary intervention, and always makes sure to provide it in one way or another.

Another way to summarize the strategic importance of this new memory reconsolidation research is that the new discoveries being established by this rigorous, compelling research validate, support, and are totally consistent with many of the key principles and process components of the Immanuel Approach.

VI. Most psychotherapy approaches lack robust empirical support: Somewhere in the middle of my psychiatric residency training, I briefly reviewed a book that summarized the different psychotherapies available in the United States at that time. This book listed ***almost six hundred*** different psychotherapy approaches, and I'm sure a number of new psychotherapies have been developed in the 35+ years since this book was published. As far as I am aware, there is published empirical research support for only a handful of psychotherapies – cognitive behavioral therapy, exposure therapy, eye movement desensitization and reprocessing (EMDR), and biofeedback. Furthermore, these few, select psychotherapy modalities have empirical research demonstrating efficacy for *certain, specific* mental health problems, but they are also often used for other mental health concerns – specific applications for which there is *not yet research support*.[29] What this means is that the overwhelming majority of specific psychotherapy

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Reconsolidation (New York: Routledge, 2012), especially chapters 1 & 2; and see also Bruce Ecker, "Memory Reconsolidation Understood and Misunderstood." *International Journal of Neuropsychotherapy* Vol. 3, No. 1 (2015): pages 2-46.

[29]Over the last 35+ years, I have noticed that case studies and other articles in the professional literature often describe these psychotherapy modalities being used for applications that do *not* yet have research support. I have also observed this same pattern in the practices of most of my mental health

applications are currently *not* supported by published empirical research.

It is good to keep working towards empirical research support, but in the mean time, it does not seem reasonable to demand that the Immanuel Approach abide by standards that are *not* met by the vast majority of other psychotherapies.

VII. Informed consent: A simple and important part of addressing the current lack of stronger published empirical research support is to clearly acknowledge this in the informed consent process. Throughout the field of mental health care, this is the accepted way to deal with the humbling reality that *most* psychotherapy tools do not have published empirical research demonstrating efficacy for many of the specific clinical problems to which they are applied. When I present the Immanuel Approach as a possible treatment option for patients in my psychiatric practice, I explain the reasons why I think the Immanuel Approach would be helpful, I summarize the evidence described above that I perceive to support the efficacy of the Immanuel Approach, and I also inform them that there are currently only three empirical research studies demonstrating efficacy.[30] If the patient then chooses to include the Immanuel Approach as a part of the treatment plan, it is not inappropriate, unprofessional, irresponsible, or unethical to go ahead and honor their informed decision.[31]

VIII. Conclusion: In conclusion, I agree with those, such as Dr. Entwistle, who believe that the Christian mental health and emotional healing community should work towards more robust empirical research support for the efficacy of the Immanuel Approach. However, pending more empirical research, I think it is appropriate to use the Immanuel Approach in the care of various mental health concerns, including some major mental illnesses, on the basis of the case-study evidence, indirect research support, and theoretical considerations discussed above. My assessment is that all of these sources of support indicate that the Immanuel Approach can be helpful for any mental health concern where unresolved traumatic memories are contributing to the overall clinical picture. And the current absence of robust *direct* empirical research support can be addressed in a simple and straightforward way via adequate informed consent.

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professional colleagues, and in my own private practice. As described elsewhere in this essay, most mental health professionals apply logic regarding theoretical considerations, use their best clinical judgment regarding what would be helpful, and then address the lack of empirical research support by including adequate informed consent.

[30]One easy way to go through this initial conversation and informed-consent process with a client is to refer them to the Getting Started page of the IA website (https://www.immanuelapproach.com/getting-started/) for introductory information, and then once they have had a chance to educate themselves regarding the Immanuel Approach, discuss the option of including it in their care and go through the sample informed-consent form together. For additional discussion regarding informed consent, and for a sample informed-consent form, see "Informed Consent: General Comments and Sample Form for Immanuel Approach Emotional Healing" in the "Special Subjects/Advanced Topics" section of the "Resources" page of www.immanuelapproach.com.

[31]For additional discussion of informed consent, and for a sample informed consent form, see "Informed Consent: General Comments and Sample Form for Immanuel Approach Emotional Healing" in the "Special Subjects/Advanced Topics" section of the "Resources" page of www.immanuelapproach.com.

Addendum: Is it appropriate to bill insurance for Immanuel Approach sessions? First of all, in light of the reasons just discussed above, it should be clear that it is appropriate to include the Immanuel Approach as part of the treatment plan for a wide variety of clinical mental illnesses.

Secondly, mental health professionals will be providing the Immanuel Approach in the wider context of a psychotherapy practice, and this wider context includes resources that will be important and valuable for whatever specific psychotherapy principles and techniques that might be applied. For example, mental health professionals receive training regarding boundaries and ethical practices, and they practice under the supervision and regulation of professional boards. This provides important protection for vulnerable recipients. Mental health professionals also receive training regarding basic therapy principles, tools, and techniques, such as listening skills, mindsight, mindfulness, attunement, relaxation techniques, and other tools for finding and resolving trauma-anchored blockages (very important for recipients who are not yet able to perceive or connect with Jesus). In this wider context of a psychotherapy practice, I think it is appropriate for mental health professionals to consider Immanuel Approach work as a form of psychotherapy.

Thirdly, my understanding with respect to therapists in the United States is that if you are a licensed mental health professional authorized to bill insurance, all you have to specify is "psychotherapy." That is, you don't have to specify which of the many forms of psychotherapy you are using when you fill out the insurance-billing paperwork. And, as discussed above, there are literally hundreds of different approaches to psychotherapy currently being used by mental health professionals, most of which have less case study support, less indirect research support, and less theoretical support than the Immanuel Approach. Mental health professionals bill insurance for all of these other forms of psychotherapy. I think it is at least as legitimate to bill insurance for Immanuel Approach emotional healing work.

Therefore, as a licensed mental health professional (physician, specialty of psychiatry), I bill Immanuel Approach sessions as psychotherapy; and in the chart notes I label the session as "Psychotherapy with components of EMDR, exposure therapy, and cognitive-behavioral therapy, with the explicit goal of memory reconsolidation, and with faith-based components at the patient's request."[32] If someone asked me to defend this policy of billing for Immanuel Approach work, I would point out that my Immanuel Approach work is provided in the wider context of the many psychotherapy resources I bring to the table, I would point out that the faith-based components of the Immanuel Approach are included *at the patient's request and with the patient's informed consent*, and I would point out that the Immanuel Approach incorporates many of the key principles and techniques from mainstream psychotherapies, including those that are most strongly supported by empirical research (such as cognitive-behavioral therapy, exposure therapy, Eye Movement Desensitization and Reprocessing (EMDR), and coherence therapy).[33]

Second addendum – caveat regarding the book, *Unlocking the Emotional Brain:*

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[32]I present the Immanuel Approach as an option, and then we include it if the patient says, "Yes, I would like to include that as part of my care."

[33]Coherence therapy is the psychotherapy that most deliberately and systematically incorporates the discoveries from memory-reconsolidation research.

***Eliminating Symptoms at Their Roots Using Memory Reconsolidation*:** The authors of this book 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 into long-term storage (reconsolidated) as a new, modified, resolved memory that is no longer traumatic. And this 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 opposite-meaning, corrective 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 our theoretical explanation to explicitly recognize the whole processing pathway.

An alternate way in which to synchronize the Immanuel Approach and our pain-processing-pathway model with the formulation put forward by these authors would be for "toxic learning produced by trauma" to include more than just level V toxic, erroneous *cognitive interpretations* regarding the meaning of the experience. For example, we would frame the Level III loss-of-relational-circuits component of trauma as an *experiential meaning* along the lines of, "I am alone – God and my community are not with me here." And correspondingly, the Immanuel Approach corrective experience with *opposite meaning* would be for the recipient to experience the living presence of Jesus *with her* inside of the traumatic memory. Similarly, we would frame the Level IV unable-to-navigate-the-situation-in-a-satisfying-way component of trauma as an *experiential meaning* along the lines of, "I am inadequate and have failed – I don't have the knowledge, strength, and skill necessary to be able to handle this situation." And correspondingly, the Immanuel Approach corrective experience with *opposite meaning* would be some clever therapeutic interaction with Jesus, such as the Lord saying, "The next time you encounter a situation like that, you could try this," and then modeling a simple, elegant, life-giving response that the person feels like they could actually pull off."