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

Lisa: Childhood Surgery, Panic Attacks, and Abreaction – Explanatory Comments

(©Copyright 2004 K.D. Lehman MD & C.E.T. Lehman MDiv, New 5/29/2004, Revised 6/1/2012)

These notes provide explanatory comments for the video tape of the "Lisa: Childhood Surgery, Panic Attacks, and Abreaction" prayer for emotional healing session. Note: This session demonstrates **mostly basic**, and also **some intermediate** principles, techniques, and process. The intensity during the abreaction may cause intense triggering for some viewers.

Contents of Video Tape	Location on the tape	Length of the segment
Introductory Comments	Minute 0	1 minute
Prayer Session	Minute 1	58 minutes
Debriefing following session	Minute 59	3 minutes
Two-month follow-up	Minute 1:02	5 minutes
End comments	Minute 1:07	2 minutes

Session summary: In this 2003 session, Lisa initially focuses on the panic attacks she was experiencing as she anticipated having surgery (scheduled for the day after the session), and this leads to memories of a childhood surgery carrying the same thoughts and emotions as she had with her panic attacks. Lisa experiences a moderately intense abreaction (intense emotional release during recall and processing of traumatic memory) as she reconnects with the memories, and then Jesus helps her work through the trauma to accomplish healing. In the two-month follow-up interview, Lisa describes how this session resolved her surgery-related panic attacks. The day after this session, as she waited for *eight* hours in pre-op before her surgery, she was completely calm and sensing the Lord's presence instead of having panic attacks.

Abreaction and Physical Memory: This video provides good examples of both abreaction and physical memory – physical memory in the context of abreaction, and abreaction including physical memory (time on tape: abreaction starts at ~8 minutes, and then continues on and off until resolution at ~25 minutes).

Abreaction, definition: Intense emotional release experienced during recall and processing of painful memories that were previously not accessible to conscious awareness (previously completely repressed and/or dissociated).

Physical memory, definition: Any experience has many components, such as the autobiographical information (for example: "This is my eight-year-old birthday party, in our house in Brooklyn, and only two other kids came"), the interpretations you made in the experience (for example: "Nobody came because I'm a loser"), the emotions (for example: shame and sadness), and the various components of sensory information, such as sights, sounds, smells, tastes, and tactile body sensations. Most experiences are processed, at the time they occur, in such a way that when the experience is recalled the person has the subjective experience of "remembering" the event. Normal remembering of autobiographical events often includes the subjective

experience of "remembering" the different sensory aspects of the original events, but the person does not feel like he is re-living the original sensory perceptions. However, when a person experiences an especially traumatic event, the mind will often store the sensory information in a different way, where it seems to remain encapsulated in a very vivid, unprocessed form. "Physical memory" refers to the subjective experience of connecting with ("recalling") this vivid, unprocessed, "flashback," *re-experiencing* type of sensory memory, as opposed to "remembering" what was seen, heard, felt, etc. in the context of recalling a "normal" autobiographical memory. Physical memory can be very intense and vivid when the sensory memories connect fully (as in this session). However, physical memory can be subtle/much less intense if the sensory memories only come forward partially.

Note: Some people use the term "physical memory" to refer to any of the sensory components from this kind of encapsulated, vivid, unprocessed, flashback/re-experiencing memory, while others use the term to refer to only the body sensations (such as the subjective sensations of nausea and suffocation, and the tactile perception of being held down by hospital staff). I prefer to use "physical memory" for any of the sensory components, and "body memory" for the body sensations.

Many have asked about the relationship between abreaction and physical memory. Abreaction will often include various components of physical memory, but *can* be *only* intense emotions, without any physical memory component. Physical memory often occurs in the context of abreaction, but it is possible to have one or several isolated physical memory symptoms triggered forward without progressing to abreaction. For example, the person might feel some shortness of breath when a memory of suffocation is being partially triggered, but this piece of physical memory brought forward by the partial triggering will not always progress to full abreaction.

Co-conscious as opposed to switching between parts with amnestic barriers: Notice that Lisa never displays confusion or disoriented regarding "Where am I?" She is intensely blended with the child ego state from the memories as she goes through them, but her adult mind is co-conscious. One important clue indicating co-consciousness is how she makes comments from her adult mind that come smoothly and quickly, even in the middle of intense abreaction, with no indication of transition between separate, disconnected ego states. For example, at 15 minutes, she is clearly oriented to the fact that we are in an emotional healing ministry session, and prays from her adult mind with her adult voice, even though she is in the middle of abreacting through the childhood surgery memory. Also at 15 minutes, while still abreacting through the child memory, she makes a clear comment from her adult mind: "What came through my mind was 'I'm gonna die.' I don't know, if at five, I knew that." At 20 minutes, she makes a comment that is clearly from her adult mind: "I've had panic attacks every time they have put something over my face," even though she is abreacting from the blended child ego state less than one second before and less than one second after this comment.

Another clue that Lisa is co-conscious is that she does not become confused with respect to whether I am Dr. Lehman in 2004, or whether I am one of the hospital staff restraining her in the childhood memory. I am gripping her shoulder firmly (to try to provide an anchor to the present), but she does not fight me or display fear of me, even when she is abreacting through memories of fighting with and being scared of the hospital staff who are restraining her.

Core lies and corresponding truths: This tape provides good examples of core lies initially fueling intense negative emotions, and then the negative emotions resolving when the core lies

are replaced with truth. For example:

> Through the most intense parts of the abreaction, as Lisa is displaying panic, she keeps repeating "I'm gonna die," and "I can't breathe" (time on tape: first at ~16 minutes, and then repeated many times through the most intense parts of panic and abreaction). After the panic resolves, she eventually comments: "I'm okay now. It's okay, it's over. It's all right." (Time on tape: 35 minutes) "It's like I've been scared – this little girl...it's like, she's been in this panic mode for 45 years, and she's not any more...She's okay," and "It's okay. It's over. They didn't mean you any harm." (Time on tape: 36 minutes).
>
> Early in the session, as she is connected to the unresolved childhood trauma and experiencing intense negative emotions, she says: "Nobody cares" (time on tape: ~16 minutes). And then later in the session, after the intense negative emotions have resolved, she comments: "What came to me is that the people who were there care a lot about me," "The people in that room care," "...especially the nurse. There was a nurse that cared a lot," and "They tried to calm me down" (time on tape: 27 minutes).
>
> Early in the session, as Lisa is experiencing and displaying intense negative emotions, she makes multiple comments about being alone, feeling abandoned, and being afraid of being abandoned (time on tape: 10 – 12 minutes). And then later in the session, after the intense negative emotions have resolved, she comments "I wasn't alone," (time on tape: 27 minutes), and "It's like His [the Lord's] whole presence is there, like there's this whole light, in the whole room." (time on tape: 28 minutes).
>
> Later in the session, as Lisa is focusing on milder "splinters" of lingering negative emotions, she states: "If she [Mom] loved me, she'd be here," "My Mom doesn't love me. It must be because I'm a terrible person," and "I'm just a brat. If I wasn't a brat, she would love me." (Time on tape: 45 minutes). And then at the point that much of these lingering negative emotions resolve, she reports "He's picking me up and holding me," (time on tape: 46 minutes), and "It [my Mom doesn't love me because I'm a brat...etc] doesn't feel true at all." (Time on tape: 47 minutes).
>
> Towards the end of the session, as Lisa continues to focus on "splinters" of less intense, lingering negative emotions, she comments: "Maybe He [Jesus] won't be there [tomorrow in surgery]" (time on tape: 52 minutes). And then shortly after this, as more of her lingering negative emotions resolve, Lisa reports: "He [Jesus] is taking me to all the places, in all the Theophostic®[1] I've done, where He's shown up." (Time on tape: 53 minutes).

Delayed reporting: This session also provides good examples of a common phenomena that I call delayed reporting. For example, I'm sure that the lies "I can't breathe, I'm going to die" were resolved at the moment Lisa went from panic to calm (time on tape: 25 minutes). If we had stopped at that point in the session and asked her "Does it still feel true: 'I can't breathe, I'm going to die?'" I'm sure she would have said something along the lines of: "No. I'm not there any more. It's over." However, she didn't report "I'm okay now. It's okay, it's over. It's all right..., etc." until 35-36 minutes.

Dissociative amnesia: This session provides a good example of dissociative amnesia. A large

[1] Theophostic® Ministry is a trademark of Dr. Ed Smith and Alathia, Inc. of Campbellsville, KY.

block of the memory content that came forward during this session had never been consciously accessible to Lisa prior to the session. As Lisa comments (time on tape: 26-27 minutes), prior to this session she had no memory between leaving her mother in the waiting room and waking up in the recovery room. All the memory of being carried into the operating room, struggling with the staff, and feeling like she was dying as they put her under anesthesia had been "missing." This important memory content then came back suddenly during the session, associated with abreaction and physical memory. All of these observations are consistent with dissociative amnesia. Notice also that the dissociated memory content came back in steps/levels, which we have observed to be a common pattern. The main block of "missing" memory came forward first, but the recalled sequence was still stopping just before the scariest part of the memory – the part where Lisa felt like she was suffocating/dying after they put the anesthesia mask over her face. She did not consciously remember this deepest root of the panic until she deliberately focused on the memory of the mask being put over her face, with the specific question of whether this might be where the panic was anchored.

Working with guardian lies and "whole mind" choices, rather than working explicitly with internal parts: Note that in this session we did not work directly with internal parts, even though there was clear indication of dissociation (as discussed above). It was possible to resolve the dissociative disconnection just by working with guardian lies and "whole mind" choices, without having to work directly/explicitly with internal parts. Our experience is that in some situations, this approach is not only simpler and faster, but actually seems to work better than working explicitly and directly with internal parts. In other situations, it seems to be helpful (even necessary?) to explicitly acknowledge and work directly with internal parts.

Opening prayer, closing prayer: As you will notice, I tend to mumble. This is particularly noticeable for the opening prayer at the beginning of the session and the closing prayer at the end of the session. I use my own abbreviated version, but looking at the sample "Opening Prayer and Commands" and "Closing Prayer and Commands" on the Ministry Aids page of our website would probably still be helpful if you want to know what I said.

Deleted material: There were several sections of the session that contained information that we felt best to not include on the tape released to the public, and edits deleting this information are indicated by brief "Personal Details Deleted" messages. There are also other very small edits to delete things like coughs and other distractions. No significant content related to working with the panic and childhood surgery memory has been deleted.[2]

Dr. Ed Smith, Theophostic® Prayer Ministry: We strongly recommend that anyone involved in the field of emotional healing study the Theophostic® Prayer Ministry approach as developed by Dr. Ed Smith. We have greatly benefitted, both personally and vocationally, from studying Dr. Smith's training materials, and from watching Dr. Smith work at his apprenticeship training seminars. For further information on Theophostic® Prayer Ministry, and to buy Theophostic® training materials, go to www.theophostic.com.

---

[2] In case you are wondering why I bother to comment on material that has been deleted: When I view live sessions for education/training purposes (as opposed to viewing sessions for inspiration and encouragement), I want to know whether I am seeing the complete, unedited session, or whether material has been removed. If any material has been removed, I find it valuable to have at least summary information regarding what has been deleted.

Please note that we respect Dr. Smith tremendously, and value our friendship with him, however, neither we nor this tape are in any way officially connected with or endorsed by Dr. Smith or Theophostic® Prayer Ministries.

"Theophostic®-based" therapy/ministry: To describe the healing approach demonstrated in this session with Grace, we have developed the term "Theophostic®-based" therapy/ministry. We use the term "Theophostic®-based" to refer to therapies/ ministries, such as ours at the time of this session, that are built around a core of Theophostic® principles and techniques, but that are not exactly identical to, or limited to, Theophostic® Prayer Ministry as taught by Dr. Ed Smith. For example, a "Theophostic®-based" therapy/ministry might include dealing with curses, spiritual strongholds, generational problems, and suicide-related phenomena, and/or incorporate journaling, spiritual disciplines, community, and medical psychiatry – and these issues and techniques are not a part of what we understand Dr. Smith to define as Theophostic® Prayer Ministry.

More information: For more information from Karl Lehman M.D. and Charlotte Lehman M.Div, including our teaching about the Immanuel approach to emotional healing, our assessment and recommendations about Theophostic® Ministry, our teaching about how Christian emotional healing can fit into professional mental health care, and much more, please help yourself to the free information on our website, www.kclehman.com.