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EMOTION RELEASING PROCESS AS A NEW APPROACH TO EASE UNCOMFORTABLE EMOTION: A CASE SERIES

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CASE REPORT **OPEN ACCESS**

ABSTRACT

Introduction – This paper explores the potential of the Emotion Releasing Process (ERP) as a therapeutic approach for individuals suffering from anxiety and depression, often stemming from traumatic memories. This case series aims to describe two cases using ERP as a therapeutic approach for individuals dealing with anxiety and depression.
Methods – The study investigates the effectiveness of ERP through case series analyses of two individuals experiencing significant emotional distress.
Results – Both cases demonstrated substantial reductions in anxiety and depression symptoms (56.25% and 93.75% decrease in HSCL scores) following a single ERP session. The paper highlights the unique strengths of ERP compared to traditional methods like CBT and psychodynamics, emphasizing its focus on directly addressing emotional sensations in the body rather than cognitive restructuring or storytelling.
Discuss – Traumatic memories are different from ordinary memories in several ways. The emotional impact of traumatic memories can be significant. In addition to the emotional impact of traumatic memories, they can also have physical effects on the body.
Conclusion – This approach, bypassing the need for detailed memory recall, holds promise for individuals struggling to verbalize or confront traumatic experiences. Further research is encouraged to explore the broader applications of ERP across various diagnoses and specific trauma types such as PTSD or complex trauma.

Keywords: ERP, emotion, trauma, psychotherapy

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INTRODUCTION

The prevalence of anxiety disorders and depression is a significant global burden. According to the World Health Organization, about a third of the adult worldwide population suffers from a mental disorder such as depression, anxiety, and schizophrenia. These disorders, together with neurological disorders, account for 13% of the global disease burden, surpassing both cardiovascular diseases and cancer. Trauma-related mental health disorders are a leading cause of global disability burden, with nearly 75% of individuals reported to have experienced one or more traumatic events worldwide. Exposure to wars, natural and human-caused disasters, and other traumatic events can cause or worsen anxiety, depression, and posttraumatic stress disorder (PTSD).[1–3]
The impact of trauma on the development of anxiety and depression is significant. A significant number of individuals exposed to traumatic events will develop PTSD along with depression, anxiety, and substance use disorders. Trauma survivors often experience symptoms of avoidance and hyperarousal, which can affect their engagement with mental health interventions. The family burden due to traumatic conditions such as epidermolysis bullosa is very high, independent of the disease type or subtype, and is associated with the probable presence of depression and anxiety among caregivers.[4]
Anxiety disorders and depression are a global burden, with trauma-related mental health disorders being a leading cause of disability burden. The impact of trauma on the development of anxiety and depression is significant, emphasizing the need for effective mental health interventions and support for trauma survivors.
Current therapeutic processes, namely Cognitive Behavioral Therapy (CBT), pharmacotherapy, and psychodynamics, have their respective shortcomings, here are the shortcomings of each approach. In CBT there is limited engagement with technology-based interventions, leading to limited participation and high attrition rates, especially for trauma survivors who often experience symptoms of avoidance and hyperarousal.[1] CBT may not address the underlying causes of anxiety and depression, such as trauma, which could lead to the recurrence of symptoms. Pharmacotherapy may not be effective for all individuals, as the response to medications can vary significantly. It has side effects that may negatively

impact the patient's overall well-being. Psychodynamics can be time-consuming and may require extensive therapy sessions, which may not be accessible to all individuals in need of help. It can be challenging to engage patients in the therapeutic process, especially for those experiencing symptoms of avoidance and hyperarousal.

Despite these shortcomings, each of these therapeutic approaches can be beneficial for certain individuals and in specific situations. However, it is essential to consider the limitations of each approach and tailor treatment plans to address the unique needs and experiences of each patient. Additionally, we need a new approach to help people with their emotions so they can feel better and contribute more to society. This paper wants to provide a new method to reduce the emotional burden of depression and anxiety symptoms.

METHOD

In this research, we employ a case series analysis as a methodological approach to investigate the effectiveness of the "Emotion Releasing Process" intervention in alleviating symptoms of anxiety and depression. A case series design offers an insightful exploration into the outcomes of individual cases, allowing for a nuanced understanding of the intervention's impact.

CASE SERIES

First Case

The first case presented with a 25-year-old male participant who presented with notable symptoms of anxiety and depression, and he didn't want to take any antidepressants. He is on low energy and has difficulty thinking, concentrating, and doing activities.

Step 1: Preparation

The chief complaints felt by patients are loss of energy and motivation in carrying out tasks, low mood, anxiety about the future and further studies, fear of disappointing other people, feeling lonely and alone, and not having a support system.

A catastrophizing thought process was found, namely the patient felt he had to be ideal in achieving his targets. The patient believes that if he does not meet the target, other people will be disappointed, and this becomes the way the patient views himself. The patient compares himself with himself in the past who was an achiever (this part is a memory that has an emotional content) but now feels inadequate.

When the patient was asked to imagine a memory about himself being an achiever, at that time sad emotions appeared dominant and the patient sobbed. Here it is decided that this memory is the one that is processed with step 4.

It was also found that other thought processes burdened patients, namely feelings of loneliness and aloneness. The patient's sexual orientation is homosexual, but the patient is also a religious person. So these two things make the patient feel restless throughout the day because it seems like they are going in two different directions.

One of the memories that the patient imagines is when he was with his partner and felt happy, excited, able to tell stories and be understood. So the patient feels the need to have moments like this again, which makes the patient feel lonely. This memory is also decided as the second memory which will be processed in step 4.

Step 2: Re-education

In this step, we bring up a discussion about traumatic memories, which are characterized by enduring emotions. Each memory brings forth intense emotions that linger. It's important to acknowledge and address these emotions to facilitate healing.

In this theme, we also teach patient to acknowledge their negative emotions, because negative emotions often serve as a defense mechanism to protect oneself. It's essential to recognize that not all negative emotions need to be suppressed or opposed. Nevertheless, it's crucial to assess whether these emotions align with your current goals or if they contribute to unnecessary suffering.

By engaging in this re-education process, individuals can gain insight into the dynamics of their emotions, paving the way for a more intentional and healing emotional experience.

Step 3: Motivation Enhancement

This step is designed to increase motivation by providing a clear contrast between the current emotional state and the potential positive outcomes of letting go. It aims to inspire a conscious decision to release emotions that may no longer serve a constructive purpose in the individual's life.

Step 4: Emotion Release

Because the patient feels tired due to several emotions from several memories, the release process is carried out one by one. The first memory that is released is the memory of hope to be like before, able to be productive and work well. This hope of being able to be productive as before creates an emotional burden for the patient, in the form of self-judgment, feelings of shame, laziness, and low self-esteem.

The second memory that is released is a memory about a partner in the past. Where in the past, when they had a partner, patients could talk, and be close and attached, so that in difficult moments the patient was not alone. However, this also conflicts with the patient's religious beliefs, making the emotional burden even heavier. The emotions that arise regarding this are calm, happy, and close, but also conflicting emotions such as sinful, guilty, and deserving of punishment.

The part of emotional release begins with setting the intention to release the residual emotions during the breathing process. Incorporate "encore breathing" by repeating the process. As they exhale, we bring suggestions verbally and repeat the name of the emotion, expressing the intention to release it. This reinforces the act of letting go with each breath.

This systematic approach to emotion release combines mindfulness, breathwork, and cognitive processing to effectively address and release deeply held emotions associated with traumatic memories.

Second Case

Continuing our exploration, the second case is a 39-year-old female patient. The patient complains of feeling sad, depressed, helpless, and angry if they remember or imagine the abuse that occurred as a child. This patient also feels nauseous at the start of the session. The patient cannot tell the story of the abuse incident, describing speechless terror. This case offers valuable insights into the potential effectiveness of the intervention in addressing symptoms of anxiety and depression.

Step 1: Preparation

This stage begins by collecting data about symptoms, thought processes, and beliefs that inhibit the patient, as well as memories that arise and have an emotional content for the patient. The main complaints felt by patients are low mood, feeling on the edge, anxiety, and memory of sexual abuse that occurred as a child.

At the first meeting, the patient could not say the word “pelecehan” (a terms in Bahasa, that means abuse), until the second time in the ERP session the patient still could not say the words or tell the story. The emotion associated with the memory was anger, sadness, hopelessness, and fear. The are no thought processes that can hinder releasing emotion. The patient is aware of her own emotions and wants to let go of the emotions. Here it is decided that this memory is the one that is processed with step 4. Steps 2 and 3 are similar for every case so we don’t write it down for this case.

Step 4. Releasing Emotion

We are doing emotional release by intentionally recalling memories associated with the targeted emotions. The goal is to bring these memories to the forefront for processing. And having the individual become aware of which side of their body the emotion is predominantly felt. This awareness helps in directing focused attention to the specific area. By knowing the sensation and the name of the emotion, this process helps people not to attach to the memories themselves.

RESULT

For both patients, the Emotion Releasing Process method was carried out which consists of four stages. Step 1 as preparation begins with collecting data about symptoms, thought processes, and beliefs that inhibit the patient, as well as memories that arise and have an emotional content for the patient. Step 2 is re-education to understand the nature of emotions and their connection to traumatic memories. Some important things to learn such as emotions are experienced as sensations within the body. Recognizing this physical aspect is crucial to understanding the essence of emotions. Some people believe that emotions are the same as thoughts, thereby confusing strategies for processing emotions. Because even though telling stories is a relief, part of it uses the mind. To process emotions, a person needs to be able to connect with the body, not just with the mind.

Step 3 as the motivation enhancement part focuses on enhancing motivation to let go of emotions by connecting with the present feelings and related memories. In this step, we are inviting awareness of current emotions and associated memories. After doing that we are doing motivational interviewing tools to enhance their motivation, willingness, and readiness to release and let go of their emotions. Step 4 is emotion release by intentionally recalling memories associated with the targeted emotions. The goal is to bring these memories to the forefront for processing. And having the individual become aware of which side of their body the emotion is predominantly felt. This awareness helps in directing focused attention to the specific area. By knowing the sensation and the name of the emotion, this process helps people not to attach to the memories themselves.

For the first case, when we continue the process of breathing, naming, and rating until the intensity of the emotion reaches 0, at this point, the individual should experience a significant release of the targeted emotion. After reaching 0 intensity, we try to confirm that there is no emotion left in the body, so we try to recall the memories associated with the emotion. If the intensity remains at 0, the process is complete. If any residual emotion persists, repeat the encore breathing until full release is achieved. Baseline assessments were conducted using the Hopkins Symptom Checklist (HSCL) to quantify the severity of anxiety and depression. The participant's HSCL scores for anxiety and depression were recorded at 2.6 and 1.46, respectively, resulting in a total score of 1.92. These scores provided a comprehensive snapshot of the individual's mental health status at the first meeting of the study. Immediately one day after the session the anxiety and depression scores in HSCL were recorded at 1.3 and 0.53, resulting in a total score of 0.84. Therefore, the treatment resulted in a 56.25% decrease in the HSCL score, indicating a significant improvement in the patient's symptoms.

For the second case, after reaching 0 intensity, we try to confirm that there is no emotion left in the body, so we try to recall the memories associated with the emotion. The patients can tell the whole story of the abuse, without feeling any emotion. The patient never told anyone before about this story, because she cannot verbalize the memories. This is the first time the patient can tell the story with no emotion attached to it. The patient did not tell us about the detail of the story, because she is having “speechless terror”. And this is the uniqueness of ERP, the therapist doesn’t have to know the detail of the story. We just need to know the emotion, how intense the emotions, where it felt in the body, and what is the name of the emotion.

In the first encore breathing, patients seem to have more intense emotions. This is very common when doing ERP, because of the nature of the flowing of emotions, it needs to be felt as a whole felt sense, then we can let go of the sensations. After three encore breathing patients felt relief and not feeling nauseous sensation. After 6 encore breathing, the patient’s emotional intensity reaches 0. At the commencement of the study, the participant's HSCL scores were indicative of a total symptom burden, registering at 1.92. Further breakdown revealed an anxiety score of 1.9 and a depression score of 1.93, signaling a moderate level of distress. The participant's total HSCL score plummeted to 0.12 after one session, reflecting a substantial improvement. The anxiety score decreased to 0.1, and the depression score decreased to 0.13, both reaching a remarkably low level. This represents a 93.75% decrease in the score, which is a substantial improvement.

DISCUSS

According to Gendlin in focusing on psychotherapy and Hakomi Mindfulness, emotion has a quality of "felt sense".[5,6.] This means that emotions are not just cognitive processes, but also involve bodily sensations. Furthermore, a study on valence-related bodily sensation maps of emotions found that happiness feels light and sadness feels heavy, indicating a deep interrelation between emotion and bodily sensation.[7] So, this is the limitation of CBT and psychodynamic approaches, because sensations in the body are often difficult to explain. Therefore, the author created a module to reduce the emotions felt in the body, but not through storytelling or cognitive intervention.

This method focuses on traumatic memories and the patient’s belief system. Traumatic memories are those that are

associated with a traumatic event, such as a natural disaster, a car accident, or an act of violence. These memories are often accompanied by intense emotions, such as fear, anger, or sadness, and can be very disturbing in daily life.

Traumatic memories are different from ordinary memories in several ways. First, they are often more vivid and detailed than other memories, as the brain tends to encode traumatic events more deeply. Second, they are often associated with strong emotions, which can make them more difficult to forget or ignore. Finally, traumatic memories can be triggered by a variety of stimuli, such as sights, sounds, or smells, which can make them difficult to avoid.[8]

The emotional impact of traumatic memories can be significant. Individuals who have experienced trauma may experience a range of emotions, including fear, anger, sadness, guilt, and shame. These emotions can be intense and overwhelming and can interfere with daily life. For example, a person who has experienced a car accident may feel anxious or fearful every time they get behind the wheel, making it difficult to drive or even ride in a car.

In addition to the emotional impact of traumatic memories, they can also have physical effects on the body. For example, individuals who have experienced trauma may experience symptoms such as headaches, stomachaches, or muscle tension. These physical symptoms can be distressing and can further interfere with daily life.

Until today traumatic memories usually help by exposing it deliberately and frequently in prolonged exposure, which for some people can be overwhelming. Or we help people by changing the cognitive process with CBT, which for some people could help, but for others, people can feel invalidated or being dismissed.[9,10] At this point we need other tools that can help people with trauma deal with their emotions in another way. This is what ERP does, we try to reduce or eliminate disturbing emotions from memories.

There are some body-based and emotion-based approaches such as Somatic Experiencing, Somatosensory Psychotherapy, Mindfulness, Hakomi Method, and some other modalities. This modality has its uniqueness and limitations. ERP has the same approach to meeting emotion directly in the body but with different intentions and interventions compared to other approaches. With ERP the intention is to reduce and if possible, eliminate emotion in traumatic memories. In these two cases, it is illustrated that emotions in traumatic memories can be processed until they are neutral and no longer disturbing. So, this then becomes a consideration for further research to look at the function and effectiveness of ERP in other forms. What if it is used in certain diagnoses, and/or specific trauma, for example, PTSD or complex trauma.

Limitations of the study

While the case studies presented offer promising insights into the potential of ERP, it's important to acknowledge some limitations of the study:

1. Sample size: The study relies on only two case studies, which limits the generalizability of the findings. A larger and more diverse sample is needed to confirm the effectiveness of ERP across different individuals and trauma types.
2. Selection bias: The participants in the study may not be representative of the broader population of individuals suffering from anxiety and depression. They may have specific characteristics or motivations that make them more responsive to ERP than others.
3. Single-session design: The study only investigated the effects of ERP after a single session. Long-term follow-up studies are needed to assess the sustained impact of the intervention and explore the need for additional sessions.
4. Subjectivity of outcome measures: The study relies on self-reported measures (HSCL scores) to assess symptom reduction. These measures can be subjective and influenced by various factors, potentially limiting the accuracy of the results.
5. Lack of control group: The study does not include a control group, making it difficult to isolate the specific effects of ERP and rule out potential placebo effects or other contributing factors.

By acknowledging these limitations and addressing them in future research, the potential of ERP as a valuable tool for emotional healing can be further explored and validated.

CONCLUSION

The presented case studies suggest that ERP holds the potential as a valuable tool for alleviating anxiety and depression symptoms associated with traumatic memories. Its focus on directly releasing emotional sensations in the body offers a distinct advantage compared to traditional therapeutic approaches. Further research is crucial to validate these findings and explore the broader effectiveness of ERP across different diagnoses and trauma types. Integrating ERP with existing therapeutic modalities could potentially lead to more comprehensive and effective interventions for individuals struggling with emotional burdens due to trauma.

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