

# The Living Legacy of Traumatic Experience

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*"At first sight it seems extraordinary that events experienced so long ago should continue to operate so intensely—that their recollection should not be liable to the wearing away process to which we see all memories succumb. . . . [A]nother remarkable fact: . . . these memories, unlike the memories of their lives, are not at the patient's disposal. On the contrary, these experiences are completely absent from the patient's memory when they are in a normal psychical state or are only present in a highly summary form. . . ."*

*Breuer & Freud, 1893, P. 7-11*

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## Phobia of Traumatic Memory

- "It's too dangerous for me to put these things into words. I am afraid they might become gigantic and I be no longer able to master them."

■ E.M. Remarque (1929/82, p. 165)

- "The moment any memory or shred of a memory was about to float upwards, we would fight against it as though against evil spirits."

■ A. Appelfeld (1993, 1994, p. 18)

Sensorimotor Psychotherapy Institute

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*“The [traumatic]  
past is not dead and  
buried. In fact, it  
isn’t even past.”*

*William Faulkner*

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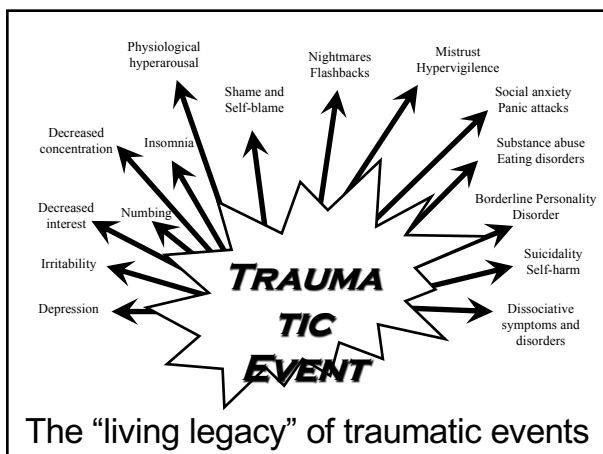
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### What do we mean by “memory”?

- Explicit:** conscious, verbal
  - Declarative: verbal description, information, facts
  - Autobiographical: narrative of personal experience
- Implicit:** non-verbal
  - Emotional memory: feelings, emotions
  - Visceral: involving internal sensation
  - Perceptual: images, smells, taste, touch
  - Muscle memory: movements, physical reactions
  - Autonomic: sympathetic-parasympathetic patterns
  - Procedural: memory for habit and function

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## Implicit Memory

•The implicit nonverbal memory system is a more powerful influence on our behavior than verbal memory because implicit memories are not recognizable as memory: **they are states, not narratives.**

•Implicit memories cannot be recalled voluntarily. They are evoked by stimuli directly or indirectly related to the event, including verbal recall, visual/perceptual/sensory reminders, emotional cues, interpersonal stimuli.

•“[I]mplicit-only memories continue to shape the subjective feeling we have of our here-and-now realities, the sense of who we are moment to moment. . . .” (Siegel, 2010, p. 154)

Fisher, 2017

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## Traumatic “memory:” the return of the past

*“Under conditions of extreme stress, there is failure of hippocampal memory processing, which results in an inability to integrate incoming input into a coherent autobiographical narrative, leaving the sensory elements of the experience unintegrated and unattached. These sensory elements are then prone to return . . . .”*

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## Sensory elements without words = implicit memory

•Traumatized individuals are left with overwhelming implicit memories: automatic emotional, physical, and somatosensory responses—all disconnected from the event

•These implicit memories do not “carry with them the internal sensation that something is being recalled. . . . [We] act, feel, and imagine without recognition of the influence of past experience on present reality.” (Siegel, 1999)

•The meaning of these “sensory elements” can only be interpreted correctly with an understanding of trauma and dissociation.

Fisher, 2017

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***“[Implicit] memory converts the past into an expectation of the future without our awareness, and that is both a blessing and a curse. It is a blessing because we rely daily on emotional implicit memory to navigate us . . . Yet [it] is also a curse because it makes the worst experiences in our past persist as felt emotional realities in the present and in our present sense of the future.”***

*Ecker et al, 2012, p. 6*

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### **“Triggers:” stimulants of implicit memory**

- The human body doesn’t just react to events: it also reacts to the **possibility** of something bad happening.
- The body automatically responds to all danger signals it has known before:** times of day or year, particular kinds of people and places, colors, smells or sounds, weather, tone of voice, body language, misattunements
- “Triggers” do not evoke explicit memories.** Triggers activate **implicit** feelings, sensations, and impulses, **re-creating the experience of danger. The feeling is “I AM in danger,”** not “I am remembering danger” Fisher, 2014

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### **Remembering in childhood**

- In childhood, **implicit memory formation precedes the ability to encode explicit declarative memories**
- Research demonstrates that the ability to formulate declarative or autobiographical memory is ‘experience-dependent,’ i.e., **we remember narratives earlier and more consistently when remembering is encouraged**
- Parents who support early acquisition of narrative memory ability** are described as reminding children of recent experiences and recounting them for the child, re-stating the events multiple times, and communicating positive feelings about these events Fisher, 2013

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## Remembering in childhood, cont.

- **Implicit memory is dominant during the first two years of life**, especially when parents do not encourage narrative remembering or when adaptation requires animal defense survival responses, not verbal responses
- Because nonverbal memory “primes” or conditions the body to respond to danger automatically, **it is more adaptive in survival situations than explicit memory**
- **Childhood trauma survivors are likely to remember traumatic experiences implicitly and to have fewer explicit memories.** But this also means **they may have greater vulnerability to being triggered** even by very subtle stimuli

Fisher, 2014

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## ‘Modalities of memory’ associated with trauma

In their 2001 study of traumatized adult patients who had woken from anesthesia in the middle of surgery, Van der Kolk et al (2001) found that, **even after recalling a narrative, the subjects reported re-experiencing** the traumatic event via the following additional “channels”:

Visual  
Affective  
Tactile  
Olfactory  
Auditory

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## Implicit memories don’t feel like memory—they feel like “me”

*“When the images and sensations of experience remain in ‘implicit-only’ form . . . , they remain in unassembled neural disarray, not tagged as representations derived from the past . . . **Such implicit-only memories continue the shape the subjective feeling we have of our here-and-now realities, the sense of who we are moment to moment.** . . .”*

Siegel, 2010, p. 154

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### Implicit memories take many different forms

- **Intrusive emotions** disproportional to the stimulus: fear, anger, shame, dread
- **Fearful or shame-producing thoughts**, especially when intrusive, contradictory, or obsessive
- **Intrusive images**, dreams, nightmares, flashbacks
- **Impulses**: to run, to hurt the body, drink or drug, hide under the bed, avoid going out
- **Voices or 'noise' in the head**, loss of hearing or vision
- **Somatic sensations**: spinning, dizziness, pain, heaviness, floating, tingling, numbing

Fisher, 2013

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### How do we differentiate implicit memory vs. 'regular' emotion?

- 'Regular' spontaneous emotional responses to present moment experience may differ person-to-person but are rarely over- or under-reactions
- They 'fit' the situation
- While implicit emotional memories are intrusive and sudden, 'regular' emotions tend to build to a crescendo and then subside. Implicit emotions do not subside or resolve
- 'Regular' emotions can evolve and transform; emotional memories repeat over and over

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### Voices: are they memories? Or hallucinations?

- In a 2014 study by Pearse et al, **one half of subjects diagnosed with Borderline Personality** reported 'auditory hallucinations:'
- Voices talking in the 2<sup>nd</sup> person ("You are stupid," "You don't deserve to live")
- Voices talking in the 3<sup>rd</sup> person ("She is stupid").
- Thirteen per cent had tactile 'hallucinations,' 10% olfactory, and 30% visual intrusions
- But were these hallucinations? **Or were they implicit memories for which the subjects had no event memory?**

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## Psychosis and Trauma

[Ellason & Ross, 1995]

“A substantial number of patients with dissociative identity disorder have had previous diagnoses of schizophrenia, due to the presence of positive symptoms of schizophrenia: [i.e., hallucinations and delusions].”

“[In this study,] **the positive symptom and general psychopathology scores were significantly more severe in the [DID] group** than the norms for schizophrenia, while the negative symptoms were significantly more severe in schizophrenia. **[Patients] with dissociative identity disorder report more positive symptoms of schizophrenia than do schizophrenics**, while schizophrenics report more negative symptoms . . .”

Fisher, 2017

## Voices: Psychosis or Dissociation?

•In Martin Dorahy’s study comparing ‘voices’ in schizophrenics with and without trauma histories vs. DID patients, the **DID patients report more voices and frequent intrusion of voices** (often a ‘running commentary’ all day) **than did the schizophrenics**. Also, the voices in the DID patients were of different genders or ages and more likely to be focused on the individual’s faults and weaknesses. **“Command hallucinations” were more frequent in DID**

•**Schizophrenics had fewer intrusive voices**, and those focused on external threats, rather than internal failings. There was no difference in ‘location:’ both groups reported voices coming from the inside and the outside

Fisher, 2009

## Dissociation: each part is driven by animal defenses and implicit memories

[Van der Hart, Nijenhuis & Steele, 2006]

‘Better not to know too much

“Going on with Normal Life”

Part was able to go to school, socialize, develop skills

Traumatized Parts were able to mobilize self-protective efforts in secrecy

**Fight:**  
Self-Protection

Anger, sense of unfairness, impulse to fight

**Flight:**  
Self-Protection

‘Going away’ is safer than fighting

**Freeze:**  
Terror

Fear, panic, dread, paralysis

**Submit:**  
Collapse, Go Numb

Compliance, depression, shame

**Attach:**  
Cry for Help

Separation anxiety, fear of abandonment

### Diagnostic Confusion

- After the birth of her son, “Annie” began “seeing” images of a priest and feeling terror each time she saw him. She assumed she was going crazy until her sister reassured her that she was remembering the priest who had abused them both
- “Laura” had a diagnosis of paranoid schizophrenia, and when she reported seeing images of her father outside her window telling her to come with him, she assumed she was hallucinating. So did the doctors. The voices that told her to kill herself were the only other symptoms of schizophrenia she had, and she could get relief only by reminding herself they were “just voices”

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### Equal Opportunity

- Historically, **the psychotherapy world has focused on event** or explicit autobiographical memory **without recognition or acknowledgement of implicit memory**
- Since implicit memory comprises the majority of traumatic memory and is less easily identifiable, **it falls to us to make sure that we give implicit memory credibility**
- If our clients do not learn to recognize their implicit responses as “memory,” they will continue to feel lost, fraudulent, disoriented, ashamed, shut out, and terrified without recognition of these states as their memories of childhood neglect, abandonment, and trauma** Fisher, 2014

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### A Transformation Model for Trauma Work

- If the issue in trauma is not the EVENT but the living legacy of implicit memory, **how does that change our approach to working with memory?**
- The ‘legacy’ of trauma is a separate issue from the traumatic events, no matter how horrific they were. The damage done is **the ongoing day-to-day effect of implicit memories on the client’s sense of safety in the world**
- A transformation model emphasizes **repairing the damage**: ie, on transforming the ability to feel safe, to regulate emotion and arousal, to feel comfortable in close relationships, to feel proud instead of ashamed Fisher, 2014

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## A Transformation Model, cont

•A transformation model assumes that **our interventions should begin with the present, not the past.** Since we can't change what happened then, **we have to change what happens 'now.'**

•**The treatment prioritizing facilitating opportunities to have new or "missing experiences"** than on processing past experiences. **We acknowledge the past but focus on ameliorating it:** celebrating survival, creating a new ending, bringing the past to an end

•The goal is to **"stay here"** instead of **"going there"**

Fisher, 2014

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## Why work on 'now,' not then?

*"The past is stable. What happened, happened. No matter what we do in therapy . . . , no one can change history. **How it is remembered, how it is reported, how it is felt or interpreted, how we regard it, and different viewpoints [towards it] can all change, but the facts of the past are permanent.** . . . no matter how hard we try or how good our tools. **The good news is, though, we can change the effect the past continues to have on . . . our clients now and in the future.** That is really the aim of trauma recovery . . ."*

Rothschild, 2017

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## The treatment of implicit memory as "memory"

•Whether clients remember everything or nothing, **the ability to identify implicit memories and process them is crucial to correct diagnosis and treatment**

•**"Transformation" = changing our relationship to a memory.** It feels further away, less overwhelming, more settled and in the past. We feel safer inside

•**To change the relationship to implicit memory, we first make a connection to a past event:** "Where does this feeling of shame fit in your childhood past?" "What does this feeling tell you about this young part's experience?"

Fisher, 2013

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### Finding a new language for symptoms

• **It is our job to translate descriptions of triggered implicit memories** into a language that changes the client's relationship to their trauma-related responses

• **"Body memory"** helps to capture the 'whole body' aspect of implicit memory, the constellation of cognitive, emotional and bodily reactions

• **"Feeling flashback"** is a term that capitalizes on a familiar term and expands it from visual to emotional

• **"Thought memory"** for negative cognitions changes their believability, while **"long, slow flashback"** helps put words to traumatic states that last hours or days

Fisher, 2013

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### A way to safely navigate traumatic memory: address the implicit

*"[Successful treatment of traumatic memory] consists of **helping patients to overcome the traumatic imprints that dominate their lives: the sensations, emotions, and actions that are not relevant to the demands of the present but are triggered by current events that keep reactivating old, trauma-based states of mind.**"*

van der Kolk, 1996

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### Assuming health brings out the best in all of us . . .

*"If I accept you as you are, I will make you worse; **if I treat you as though you are what you are capable of becoming**, I help you become that."*

--Johann Wolfgang von Goethe

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### Re-framing aids acceptance of implicit memory

- **Implicit memories are a potent contributor to the trauma survivor's fears that s/he is crazy, defective, or "losing it."** Overwhelming emotions, involuntary shaking, moans, or movements feel "out of control"
- Although it is helpful to observe and name them as "body memories" or "feeling flashbacks," **interpreting implicit memories as information about how the client survived** gives them new meaning and purpose
- **The sudden sensation of fear or dread was once a warning signal of real danger**, not a false alarm. The twitch in her arm is a sign she wanted to fight back

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### Re-framing aids acceptance of implicit memory, cont.

- **Re-framing also draws a clear distinction between the past and the present:** *"It helped you survive then to mistrust all human beings over the age of 25, and now, it makes it harder to be in the world. . ."*
- **Often, clients have failed to encode their stories past the trauma:** new, safe, pleasurable or honorable experiences have been interpreted negatively, not owned as real
- If we want them to 'own' the story of what happened after the trauma, re-framing will aid in their seeing how even rocky periods, unsafe behavior, or self-hatred were ways of surviving the aftermath of what happened

Fisher, 2014

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### "Integration requires both differentiation and linkage"

[Siegel, 2010]

- We cannot integrate aspects of ourselves that we have not observed, acknowledged, and "owned" as part of "me"
- Integration approaches in which the fragmented client is treated "as if" s/he were one integrated person always fail.
- The parts must first be noticed and identified, then connected or linked so they become essential aspects of one system that is adaptive and "flows." As Siegel (2010) says, **"Failure of integration leads to chaos, rigidity or both."**

Fisher, 2010

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### Cultivating curiosity as an alternative to rigidity or chaos

- To make educated distinctions between psychotic, dissociative, and trauma-related implicit memories requires curiosity and the ability to tolerate “not knowing” what diagnosis we are working with
- We must help our colleagues to **avoid narrow assumptions that either psychosis does not exist OR dissociation does not exist**
- **Curiosity assumes that we keep an open mind** as we observe traumatized individuals over time and help them to notice their thoughts, feelings and bodies

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### Cultivating curiosity as an alternative to rigidity or chaos, cont.

- **We must help patients to be curious**, too, rather than assuming they are either crazy or “OK.” They can learn to observe their different responses, different voices, images, and beliefs and label them as memory
- **We might even entertain a very radical thought: perhaps we don’t have to eliminate patient symptoms.** Perhaps we simply have to help our patients **change their relationship to the symptoms** so that they are no longer evidence of defectiveness. They are evidence of how each survived traumatic experience.

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*“When those aspects [of ourselves] that have been unconsciously refused are returned, when they are made conscious, accepted, tolerated or integrated, the self can then be at one, the need to maintain the self-conscious edifice disappears, and the force of compassion [is] automatically unleashed.”*

*Epstein, 1995, p. 19*

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