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Reconsolidating Traumatic Memories for Healing

by Carol Farthing, Ph.D.

Over the past few decades, trauma has become increasingly understood to cause or contribute to emotional and behavioral disorders. The Adverse Childhood Experiences (ACE) study[1] documents the relationship between ten adverse childhood events and problematic outcomes. The more adverse events a child has, the greater the probability of serious problems later. The extensive literature on child abuse and neglect also reflects the long-term results of such exploitation or maltreatment.

Many psychological symptoms, including anxiety, depression, and nightmares, may reflect unresolved trauma. Some traumas, such as a car accident, may relate to a single incident while others may reflect an ongoing and inescapable set of conditions in which a child is raised. The latter are referred to as "developmental" trauma. Many of our clients have both developmental and single incident trauma, making treatment complex and challenging.

> ". . . our nervous system enacts . . . survival strategies . . ."

Fight, Flight, or Freeze

At an individual level, trauma occurs when an event exceeds a person's capacity to respond. That capacity depends on factors such as age, developmental level, external support, and personal strengths. Under threat, our nervous system takes over and enacts biological survival strategies, such as fight, flight, or freeze. If one of these strategies is successful, the individual is less likely to experience trauma's aftermath.

Children are vulnerable to trauma because their survival strategies are often blocked. If freezing and submitting are a child's best option for survival when fighting or fleeing are not possible, the nervous system "learns" that freezing is the way to go. The nervous system's learned preference for freezing can persist into adulthood when the individual might otherwise be physically able to fight or flee. For example, an adult might freeze when a threatening individual approaches rather than run away and then report confusion or shame at freezing in situations when he or she could have acted. The nervous system does not "know" that the person is an adult with greater abilities. Part of therapy is to restore blocked strategies so the adult can employ the full range of survival options under threat.

Research Leads to New Methods for Treatment

Prior to major advances in neurobiology and treatment methods, the standard approach to treating trauma was to have the client tell the trauma story to a validating and supportive therapist who would help the client put the experience into perspective. While this approach was sometimes helpful, often the client was retraumatized by reliving the traumatic experience. Talk therapy often led to an intellectual understanding: "I know where my intense reactions come from, but that doesn't help me not have the reaction or manage it when it comes."

We have since made progress in our understanding of brain functioning. Threat responses are managed by the brain stem, while the cortex handles thinking and the limbic system processes emotions. Under threat, survival reactions are instant, and the cortex is temporarily shut down, since taking time to reason out the best option could well lead to death. The traumatic emotions and physical sensations are stored in the limbic system and the body, often as fragments of experience.[2]

This "sequestering" of the traumatic material allows the individual to continue functioning in day-to-day life. For some individuals, the full impact of the trauma may stay buried; for others it eventually emerges. Individuals may consciously recall the traumatic event but usually not with its full experiential impact, including mental pictures, emotions, physical sensations, meaning, and movement. Some trauma survivors

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Case Study|**Sister Joan**

Sister Joan was referred to SLI for severe depression following a car accident eight months earlier. During evaluation, she was diagnosed with Major Depressive Disorder. Her history included harsh treatment by her father and the diagnosis of History of Psychological Abuse in Childhood was indicated. Strong compulsive traits were noted in her tendency to be perfectionistic and avoid mistakes.

Individuals come to SLI with many presenting issues that may initially seem unrelated to trauma. Typically, these include alcohol, depression, anger, and poor relationships.

Increasingly, the mental health field understands many presenting problems of adults as adaptations to an unsafe environment or attempted solution to troubles experienced as children. Survival by adaptation is prioritized over the developmental learning of play, emotional regulation, and relating to others. Addictions can be understood as attempts to self-soothe when relationships are absent or punishing. Depression and anxiety disorders often have a basis in early experiences of terror, rage, and helplessness.

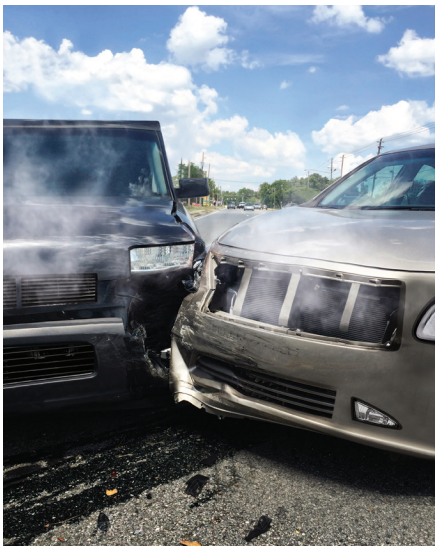
Early in treatment, Sister Joan met with our psychiatrist for a medication evaluation; she started a recommended medication and found this helpful. In therapy groups she seemed very sensitive to criticism and appeared hurt when given feedback, that made giving her feedback very challenging.

Staff noted that Sister Joan related to others easily and was very compassionate, but she had great difficulty tolerating her own mistakes. In exploring her referral issues, the car accident loomed large. She was fearful of driving and had avoided driving since the accident. Her self-esteem seemed very vulnerable, which was why hearing feedback was so difficult for her.

Given the trauma of the car accident and possible earlier developmental trauma related to verbal abuse by her father, Sister Joan was referred for EMDR therapy. The therapy started with psychoeducation about trauma and the brain to build on what she already learned in the treatment program. After assessing her readiness for trauma work and strengthening coping resources, work began on the car accident. It became clear Sister Joan blamed herself for the accident, which undermined her already fragile confidence. In the EMDR processing, her accident-related distress lessened, but remained significant, pointing to earlier contributing experiences.

Sometimes clients recognize that early painful experiences have been traumatic. Often, a child experiences their environment as "normal" no matter how violent and chaotic, and the adult might not identify their background as having lasting influence on them. Psychoeducation helps individuals understand how past events contribute to current problems. The emphasis in trauma therapy is not on the events that happened, but on the implicit learning that came from the events, such as whether the world is a safe place or not and whether relationships will be helpful or hurtful. This unconscious learning is the basis for the individual's approach to life and relationships.

In exploring earlier times when Sister Joan felt a lack of confidence, she recalled her father's negative comments when he taught her to drive. "You're never going to get this right," and "I'm wasting my time with you" were typical. She also recalled multiple times as



a younger child when his criticism stung, and she tried very hard to avoid mistakes. At times she eschewed an activity she wanted to do, like roller skating, to escape his negative judgment.

In the EMDR processing of early memories with her father, Sister Joan was able to comfort her younger self with her adult self's compassion. She experienced that it was her father's lack of patience and judgmental style that was the problem and not some defect of hers. This process is different from blaming her father, as her adult self could understand the stresses he carried. What had been missing was understanding and compassion for her younger self.

Going back to the accident after working on the earlier memories, Sister Joan realized there was nothing she could have done to avoid the accident and gradually recovered her confidence as a driver. Work on her difficulty with feedback and making mistakes remained challenging, but with the emotional understanding of why this was hard for her, she was able to accept that mistakes

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Sister Joan *continued*

are a normal part of new learning. Her progress was supported by her therapists and community peers, who connected with her more deeply as she became less defensive.

Regardless of their presenting problems, clients at SLI have a great opportunity to develop their ability to manage emotions and to improve relationship skills. These skills are often underdeveloped, since as children dealing with trauma, they had to prioritize survival over learning about themselves. Progress in healing is realized as individuals become less emotionally reactive to present triggers, less defensive, and more open to feedback.

For confidentiality, reasons, names, identifying data, and other details of treatment have been altered.

Reconsolidating *continued*

sound like detached reporters when they describe traumatic events, while others avoid any mention of the trauma to avoid being emotionally overwhelmed.

Several newer therapies, usually called "somatic" or "limbic system" therapies, access the parts of the brain where the traumatic material is stored so it can be reworked, resolved, and integrated into the person's narrative understanding of their history. These therapies enable neural connections to be made between the older (brain stem and limbic system) and newer (cortex) parts of the brain. These approaches share the view that humans have a built-in capacity to heal unless trauma cuts off the brain's processing.

Unpacking the Healing Process

Treatment usually begins with education about trauma. Comprehending the brain processes involved in handling trauma relieves shame and alleviates the sense that "there is something wrong with me and it is my fault." The fragmented nature of trauma recall makes it possible to function in the world without constantly feeling overwhelmed, but this also prevents updating the traumatic memory with the understanding and increased coping resources of the adult.

Understanding and compassion are often needed to heal childhood trauma; however, when trauma is triggered, these resources are not immediately available. Ironically, the needed help may be literally inches away in the brain, made inaccessible by the lack of sufficient neural connections between the stored trauma and adult coping skills.

Eye Movement Desensitization and Reprocessing

Eye Movement Desensitization and Reprocessing (EMDR), formulated by Francine Shapiro in the late 1980s and greatly enhanced by research and innovations since then, facilitates access to trauma material in the emotional brain and strengthens neural pathways connecting the emotional brain to adult resources from the frontal lobes of the brain. A trauma resolved is experienced as something that happened in the past without the previous emotional pain. Dr. Shapiro found that stimulation of the brain through eye movement, listening to alternating tones or holding tappers that buzz in each hand alternatively, enhances processing of the traumatic material.

EMDR therapy is a modality SLI therapists have been using since the late 1990s. Through it, traumatic material is brought into working memory, and processing that got stuck years ago is reactivated, with careful titration so the client is not overwhelmed. In working memory, new material, such as the adult's compassionate perspective, can be accessed and integrated with the old material into a new configuration. The memory is then "reconsolidated" with the new material and no longer feels as though it is happening in the present. The individual knows that the event happened in the past and no longer feels hijacked by experiencing it as though it is happening now.[3] A client once described an upsetting traumatic incident when resolved as "a closed book to put on the shelf."

Endnotes

[1]The Adverse Childhood Experiences (ACE) Study. Am J Prev Med. 1998 May;14(4):245-58.

[2]MacLean, Paul D. (1990). The triune brain in evolution: role in paleocerebral functions. New York: Plenum Press.

[3]Shapiro, Francine. (1995). *Eye Movement Desensitization and Reprocessing.* New York: The Guilford Press.

Carol Farthing, Ph.D., has been a Clinical Psychologist at Saint Luke Institute since 1989, serving for many years in clinical leadership. Since her retirement from full-time work in 2014, Dr. Farthing has offered EMDR therapy to SLI residents and outpatients.

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