

Hi Everyone,

First of all a very big *Thank You* to Bessel for a wonderful presentation last Tuesday. He is clearly a pioneer and recognized leader in trauma research and treatment. The major part of his talk was oriented around his paper, demonstrating that the efficacy of EMDR was **substantially greater** than Fluoxetine in eight weekly sessions with a six-month follow-up with PTSD (adult onset) patients who had access to the memory of their trauma.

In this discussion I will focus on dissociation and memory when patients can't remember the trauma. Here are some of my thoughts/questions. Please respond with your own. Bessel will also try to help us sort out some of these issues.

Empirical Foundation

Psyche theory requires the kind of empirical foundation that Bessel's research creates. This becomes the infrastructure for understanding the subjective phenomenological experience in which the analyst/patient dyad immerses itself with the hope of fostering change. From this perspective every long-term analysis is experimental. Analysts don't have statistically relevant data. We have anecdotes but very powerful ones built up over many years.

Current Treatments based upon Focused Attention and Available Memory

EMDR, mindfulness treatments, and hypnosis all center on creating a state of *focused attention in conscious awareness*. They seem to activate trauma recall when *memory* of the trauma *exists*, even in diffuse, fragmented form. Here there is little suppression or dissociation of the memory. My sense is that all dissociative capacities require *focused attention*. This is a very different way of thinking about "forgetting." However, forgetting, for which extinction provides a model, can also be an active process.

I am using dissociation as the UHR defense mechanism from which other defense mechanisms evolve during childhood development. For example, repression involves the cortex and may make the relationship ambivalent but allows it to continue.

Dissociation is the most general category for all defense mechanisms that remove traumatic memory from *conscious awareness*.

However, dissociation as protection against severe trauma becomes so intense that it even moves us beyond fear/rage into complete isolation. In trauma, dissociation works by focusing attention on everything but the memory. The cost of such self-protection is loss of the relational connection.

The Dissociative Spectrum

I think that the dissociation spectrum does not just apply to mind/brain defense mechanisms but includes the very positive experience gained from mindfulness, yoga,

etc. All dissociative capacities, including the positive, healing ones require *focused attention*. Treatments like EMDR help the person to exit from a state of fear/rage driven by the sympathetic N.S. and enter into a relaxed, calm, even peaceful state driven by the parasympathetic N.S. The diaphragm seems to be the body center of the tension and relaxation experience. The focused state may include self-awareness/narrative self or move beyond it into the “nirvana state.” Here self-awareness or the “I” perspective is actually relinquished.

Memory

Bessel et al., write that “EMDR targeted memories associated with primary trauma identified during pretreatment evaluations (p.40).” What is important here is that patients had memories or memory fragments.

Severe Childhood Dissociation

Bessel also notes that subjects who had been sexually abused as children (over 10% of the population, mainly female) **did poorly** in the clinical trials. This correlates with analytic clinical experience, especially in cases of extended incest. Here the person feels discarded by the family, chronically fearful, and even too fearful to be rageful. The fear is managed thru dissociation from the body (proprioceptive; insula, Craig), from feelings, and from visual, auditory, and olfactory sensations. The experience of isolation is devastating. “When I look in the mirror, I don’t recognize myself.”

Fragmented Memory and Childhood Memory

I find the Script Drive Imagery Scale very useful. Bessel and others suggest that traumatic memory, especially in childhood, is stored as fragments of sensory experience, a neurological phenomenon mediated at the first gateway, the thalamus, “the core consciousness temporal binding gateway station.” In these cases, trauma is first reexperienced as isolated, implicit, sensory and affective “images”. If we try to remember our own life at age eight or five or if we try to remember our dreams, we will use similar catalysts.

Formation of Enduring Associative Memory using Time –dependent Coordinated Hippocampal-cortical Interactions

The same holds true for dream recall. Bob Stickgold’s laboratory has shown that consolidation of motoric memories occurs during particular sleep phases. This seems also to be true of narrative memory. The patient I quoted had virtually **no dream recall** for many decades of her life; hence no consolidation or reconsolidation. In psa we say that if the memory is frozen (a metaphor), there is no recontextualization. Bob also theorizes that the efficacy of EMDR results from the bilateral brain stimulation which allows fragments of memory to be consolidated into narrative memory.

Narrative Memory

Let's keep in mind that autobiographical or narrative memory develops slowly in the second year of life and is not fully mature until age five or so. It is also the beginning of the associational system called the default brain network, which continues to mature until our mid-twenties. Narrative memory allows the child to report a story from the first person "I" perspective. This makes it a narration. (Before recall memory the child has largely recognition memory.) The parents practice with the child by going over memories in great detail at the end of the day. This helps the child gain affective self-control, greater perspective, and autonomy. An abused child has no such containment, guidance, and love. When memory returns to the adult who was abused as a child, it will be fragmented and overwhelming.

I heard Bessel saying that EMDR helped patients who could create a first-person narrative of their experience. First-person reporting implies perspective; a distance from the memory, an observer's point of view. This stands in contrast to field memory. In trauma, field memory means being totally in the experience and overwhelmed by it. All treatments, including psychoanalysis, try to help patients experience trauma from the "observer" perspective where they learn not to be overwhelmed by it.