Treating Trauma Master Series

How to Work with Traumatic Memory That Is Embedded in the Nervous System

the Main Session with
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Treating Trauma Master Series: Main Session #3

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How to Help Clients Unlearn the Nervous System's Response to Trauma

> "Trauma treatment is not about telling stories about the past. As long as you can tolerate what's going on right now, there's no need for any further treatment."

Dr. Ogden: Honestly, I feel like we don't need the content of the trauma at all because the effects of the trauma are living in the client at the present time – in the way they move, in the way they talk, the prosody, the way they think. It's all right there.

Dr. van der Kolk: You look at people's reactions. Everything happens in the present. Trauma treatment is not about telling stories about the past. Trauma treatment is about helping people to be here *now,* to tolerate what they feel right in the present. As long as you can tolerate what's going on right now, there's no need for any further treatment.

Dr. Buczynski: How do we work with a client's traumatic memory when it gets wired into their nervous system?

> "Once you've learned it, it stays with you until you find the way to unlearn it."

Dr. Levine: Trauma, that is to say, survival responses, are also learned motor behaviors –but they're much, much deeper. The thing is once you've learned it, it stays with you until you find the way to unlearn it. The way to unlearn it, at least in somatic experiencing, is to be able to complete those responses so that they then go back into neutral and then we're not driven by those.

Dr. Buczynski: That's a way of thinking about what we're going to talk about: how we might help clients UN-learn the nervous system's response to trauma.

But to do so, we're also going to take a deeper look into one of the most crucial parts of treating trauma: how to help our clients learn to tolerate and integrate traumatic memory.

You see, when we help our clients heal from trauma, it changes not only their lives, but the lives of their family, their friends and their community as well.

And for that reason, I would say that when you help someone heal from trauma, you change the world.

Coming up, we'll look at the specific way a traumatic experience can trap the mind. We'll look at how trauma can impact the four different types of memory and how it can trick the brain into sustaining a traumatic memory's power.

Then we'll get into the body. We'll focus on how traumatic memory can bind itself to the nervous system and alter a person's physiology. We'll look at how to release procedural memory that gets corrupted and reestablished as painful physical patterns.

Lastly, we'll look at some practical strategies to help clients tolerate the expression of traumatic memory and how to build up powerful inner resources to prevent overstimulation and shutdown.

We'll be taking a 360-degree view of the way traumatic memory can hold our clients back from healing and how to reverse the way it leaves its deep tracing on the nervous system.

But right now, let's get into why traumatic memory is so powerful.

How Trauma Affects the Four Types of Memory

Dr. van der Kolk: The nature of trauma is that it's still overwhelming for your mind and brain to know what's going on. So, what happens is that you feel like things are happening here. You have intense feelings. You have intense reactions. The memory comes at the end of treatment. A coherent memory about an event comes when it's all over.

So asking people, "Tell me your trauma story" – which I hear people do – is really a very naive notion about trauma because trauma is overwhelming.

Dr. Buczynski: Dr. Bessel van der Kolk is the world's leading expert in the treatment of trauma.

What Bessel is reminding us is that trauma affects the way our clients process memory. And this can lead to emotions and sensations that make the traumatic memory feel like it's happening right now, in the present.

And that's exactly why traumatic memory can hold so much power over our clients. One way to think about it is that it's a kind of "processing breakdown." It's that inability to distinguish between what's happened in

the past and what's happening now. That's key to understanding trauma.

So exactly how does trauma do this? To get a better understanding, let's look at the specific memory types that are most vulnerable to a traumatic experience.

Dr. Levine: I think trauma affects every kind of memory. There's the classical work that was done on the hippocampus where when you're in a traumatic state, the hippocampus gets inhibited. If it's chronic, it actually shrinks. That's about short term memory, so a person who's traumatized generally has trouble with short term memory. When you're talking to a person and you start to notice that, then you're very likely to suspect that there's trauma.

It affects emotional memory by giving triggers to these adverse emotions and it affects episodic memory, autobiographical memory by kind of shutting it out. By shutting it out, taking away this direction in our lives.

Dr. Buczynski: Dr. Peter Levine is the developer of Somatic Experiencing and the author of *Trauma and Memory: Brain and Body in a Search for the Living Past*.

We just got a quick overview of a few of the memory types that can be affected by trauma.
But let's unpack this a little more. In order to fully realize how trauma affects memory, we first need to review the four basic memory types and how we process each of them.

Now, as I know you know, memories can be broadly divided into two categories - explicit and implicit.
And in each of those categories, there are two subsets of memory. Two for explicit, and two for implicit. That gives us four total.

Let's start with explicit – the more conscious category of memory.

Real quick – we sometimes refer to **explicit memory** as ***declarative memory***. We can recall or "declare" these memories, which helps us in every area of life. So the first subset of explicit memory is semantic. This is memory of general facts and knowledge, like – what is 5 times 5, what's the capital of Poland, and what do you do with an exercise bike?

Now, the second subset of explicit memory is known as ***autobiographical*** or ***episodic memory***. This is memory of specific experiences and events in time. They contain more context and can often have an emotional charge attached.

Now, episodic memories are interesting because they can sometimes get triggered by one of our senses.

Dr. Levine: So, the classic example of this is in Marcel Proust's *Remembrance of Things Past* where the protagonist has a cup of tea and he dips in one of these little pastries, these madeleines.

All of a sudden, he's taken back to the streets of his childhood in Dublin. The smells, the textures, the taste, the lighting. That just seems to come out of the blue, but again, we're able to reflect on it and go back to a memory like that.

I had a memory of my fifth-grade teacher, which at the time was tremendously scary, but now I realize that it really gave a direction to my life in terms of learning and studying. I can reflect on that fondly even though it was pretty scary at the time. So, when you can access episodic memories, they can be very important to help the person find their purpose, their direction in life. That's a very important thing that sometimes is neglected in therapy. Because I believe everyone has their own destiny.

"By nurturing the ideals and values that might be connected to past experiences, it can help clients to continue with their healing and find meaning in life."

Dr. Buczynski: I really appreciate Peter's sentiment, and I feel that last part bears repeating.

By nurturing the ideals and values that might be connected to past experiences, it can help clients to continue with their healing and find meaning in life.

So, just take a moment to reflect - How might you nurture a client's episodic memory to help them find resources from a past experience?

Ok, getting back to those two broad memory categories – Explicit and implicit. We just went over the two subsets of explicit memory: semantic and episodic.

Now let's look at that second category - **implicit memory**. This is memory that is unconscious and lives deeper within our nervous system.

The first subset of implicit memory is what is sometimes referred to as ***emotional memory***.

Dr. Levine: Out of the blue, you're introduced to somebody at a party and all of a sudden, you feel a wave of fear. Well, that's coming from an emotional memory. We're not thinking about that consciously, we're not remembering it consciously, and probably we're not going to remember when we're being introduced to that person. We just experience fear,

"Emotional memory is very different than episodic memory because it just grabs you."

or anger, or shame, just out of the blue.

So, something about them triggers this emotional memory. It's very different than episodic memory because it just grabs you.

Dr. Buczynski: For some people, emotional memory can feel exactly like that – it grabs you.

Emotional memory can be incredibly powerful, both in its intensity and also in the way it presents itself. A memory can come on suddenly and leave a distressing amount of pain and agony in its wake.

So that's the first type of implicit memory.

Now, the second type of implicit memory is known as ***procedural memory***. This kind of memory allows us to perform common tasks without thinking about them - like using a fork or driving a car.

We're going to go much deeper into this type of memory later in the session.

But just to tie this part up, many of our different memory types – both explicit and implicit - can be heavily impacted by trauma.

And one of the things you have to think about in the treatment of trauma is whether the traumatic experience affected and possibly impaired any of these types of memory. It could be some. It could be all.

And here's why this is so important. The mind is constantly building upon all our memories to create an internal sense of reality. That's how we make meaning out of our experience or out of our lives. It's the essence of not only how we see ourselves but how we see the world.
When trauma enters the picture, this entire process can get corrupted.

Dr. van der Kolk: In fact, trauma interferes with the construction of a new reality.

If you get traumatized, you see that same thing over and over again. You hear the same thing over again. And you get pieces, fragments of the past that keep coming back. You may not know that these are fragments of the past.
You may see a piece of wallpaper or you may smell the smell of a drunken person, or you may feel awful sensations in your body, and you may not know the context of it. Traumatic memories are imprints of the past that keep coming back that you may or may not know are related to the past.

A traumatic memory is fundamentally a breakdown of the ordinary memory system. An ordinary memory

system is to sort of let things go and integrate it with everything else that you know already and to mess up what you see in the context of your existing reality. Trauma doesn't fit in. Trauma cannot be integrated and lives on as an isolated piece of the past that keeps coming back

Dr. Buczynski: That's the heart of it right there. Because when you experience something in such a way that you're reliving it, it's reminding you of something from the past. But you don't have the context for it.

You see, the mind can get tricked into replaying the very memory that created so much pain and suffering.

Now sometimes this can lead to a common phenomenon we call a flashback.

How the Nervous System Gets Tricked into Thinking Trauma is Happening in the Present

Dr. Levine: A flashback is when the person's nervous system is either hyperaroused or is hypoaroused shutdown. That's what their nervous system, their body is doing.

The nervous system cannot really differentiate between this kind of state and the original trauma. They're both basically the same. So, in a flashback, what's happening is you're having the same sensations and emotions that you had at the time of the trauma. Therefore, you are having the trauma again because the nervous system and the body can't tell the difference.

> "In a flashback, you're having the same sensations and emotions that you had at the time of the trauma. You are having the trauma again because the nervous system and the body can't tell the difference."

Dr. Buczynski: So let's look at how a flashback can trap our clients in this painful cycle.

First – sometimes traumatic memories don't get integrated;

Second – a triggering event or image or smell can send the person into either hyperarousal or hypoarousal;

Third – and this doesn't always happen. But sometimes the nervous system reacts as if the trauma is happening in the present. And that can sustain the traumatic memory.

As an example, let's consider a war veteran who hears a bus backfire.

If the person has integrated the traumatic memory, they'll be able to think *oh, this is reminding me of Iraq or Vietnam.*

If the person has not integrated the memory, they'll be thinking *Oh no, where can I hide and how can I return fire.*

That's because they haven't integrated the context. And what we just described, the unintegrated context, another word for that is *flashback*.

The important points to remember are:

Number one - a lot of this is happening in the nervous system faster than the pre-frontal cortex (PFC), the thinking mind, is able to process.

And number two – without context, the person is unable to differentiate between *is this happening now?* or *am I remembering something?*

And that one factor – that inability to differentiate –is what makes traumatic memory so overwhelming.

And this can also lead to some difficult changes in the brain.

"Anything is bearable as long as you know that it's going to come to an end."

Dr. van der Kolk: Everyone thinks that what happens when you get traumatized is that the time-keeping part of your brain, the dorsolateral prefrontal cortex, shuts down so you'll feel like this is forever. This is unbearable because there's no end to it. Anything is bearable as long as you know that it's going to come to an end.

Dr. Buczynski: And that's the key. A person experiencing trauma, especially in a state of terror, loses that sense of timing – particularly the sense that *this bad feeling is going to end.*

Now, before we move on, I just want to quickly review how trauma can affect the different memory types.

One – short term memory can be damaged;

Two – it can shut down episodic memory, taking away our client's sense of purpose and direction and fragment the sequencing of experiences and events;

Three – it can alter emotional memory, and trigger painful emotions and sensations oftentimes without

context.

And this can be useful when we look at how a particular client presents the after-effects of a traumatic experience. By focusing on the different memory types, it can help us better target our treatment.

Now, we'll get to some approaches to treatment in just a bit. But first, I felt it might be helpful to quickly touch on the pacing of our interventions.

How to Avoid Triggering a Client's Reactive or Protective Response when Working with Trauma

Dr. Buczynski: While we do want to help our clients integrate their traumatic memory, we might want to approach it gradually, in a slower more titrated way.

> "If a person is in a dissociated state, you need to bring together the different sensations and feelings and images and behaviors and meanings, ***gradually***."

Dr. Levine: If you bring them all together at once, *boom*, it explodes.

If a person is in a dissociated state, you need to bring together the different sensations and feelings and images and behaviors and meanings, *gradually*. Again, if you do it too quickly, they'll just dissociate again.

The key is because the trauma is so close to what you're experiencing in the present, there is no present. There is no *now*. There's only the *past* playing over and over and over in the present time, but keeping that from becoming a *now* moment.

So, again, we don't want flashbacks. We want touching in. We want bringing one element of the experience together with another element, with the map which I call SIBAM , so that you gradually start putting the pieces of a jigsaw puzzle together little by little. Each time you put a little piece together, there's a release of that energy and then that energy can become assimilated. Then another piece, and another piece, and another piece. Piece by piece by piece. Slow always wins.

Dr. Buczynski: This can be a helpful perspective to keep in mind. By taking a more measured approach, we can hopefully avoid triggering a reactive or protective response in the client's nervous system.

Now, I just want to circle back for a second to Peter's mentioning of "SIBAM". Peter's SIBAM model is how he

breaks down the 5 different ways we typically gather, process and store information.

SIBAM stands for **Somatic**, **Images**, **Behavior**, **Affect** and **Meaning-making**.

Let's shift our focus to the first of those elements - somatic - and let's look at why it plays such an important role in our interventions.

How Trauma Can Affect Procedural Memory and Create Maladaptive Patterns

Dr. van der Kolk: You need to learn to manage to feel whatever that awful feeling in your belly is as you think about your dad and to say, *Okay. That's the feeling I have. This has something to do with the past. I'm going to take a deep breath. I can feel my butt in the chair.*

And say, "Okay." And then they can really think about what happened to that little kid back then and how awful it was for that kid to be exposed to that terrible guy.

You allow people to, in the present, safely visit the past.

So you need to really help people to feel safe to feel what they feel in their bodies, and to manage the housekeeping of their bodies.

> "You allow people to, ***in the present,*** safely visit the past."

Dr. Buczynski: As we've said, traumatic memory can wire itself into the nervous system and get expressed implicitly as sensations.

So let's run with this now and get a little deeper into that second subset of implicit memory known as *procedural memory.*

Dr. Levine: Procedural memories are what are sometimes called motor learning memories. So, these are learning skills. Skills like riding a bike or skiing, making love.

Dr. Ogden: When we learn to ride a bike, we have to focus. We're unsteady. We don't have the coordination of our feet doing the pedals and steering with our hands and maintaining our balance. Once we learn that, we don't have to think about it anymore. It's just automatic, which is riding along, and we don't even think about our balance or our feet or anything. It has to do with when you repeat things over and over

> "When you repeat things over and over and over, it becomes procedural."

and over, it becomes procedural.

Dr. Levine: Once you learn how to ride a bike, as the saying goes, you never forget.

Dr. Buczynski: So procedural memory is how we're able to function in the world. We don't think about our posture, how we walk. We don't think about how to drive a car or the steps to brushing our teeth.

Procedural memory is embedded.

And what trauma does - trauma can create new procedural memories that actually extend the painful aftermath of the trauma.

So how can this inform our work with clients?

> "Procedural memory is embedded. And trauma can create new procedural memories."

Dr. Ogden: We're looking for any habit in any pattern. And these could be habits of posture and structure. Like, somebody who this is the way they go through the world. Their shoulders are up. They're rigid. They don't have a lot of flexibility or differentiation.

Those are all procedural habits that reflect and sustain working models, emotional patterns, and past responses to trauma and attachment. And I want to emphasize, again, it's very important to remember that these procedural habits are salubrious responses to the past.

The child grows up in an environment where the parents expect them to be tough and strong. He might develop a body which is adaptive in that environment, but later on, when he gets married, his wife wants to go to couple's therapy because he can't soften.

So we look at habits and we train ourselves to notice the physical habits.

Dr. Buczynski: Dr. Pat Ogden is the founder of the Sensorimotor Psychotherapy Institute.

And what Pat just described is how trauma can affect procedural memory.

But I quickly want to underline an important point she made – Even though this kind of nervous system response can be considered maladaptive, at one time it was vital for the client's safety.

Dr. Ogden: If you grow up in a frightening atmosphere, you might have a particular posture because you're frightened. And after a while, your body maintains this procedural tendency –which, we have to remember, is very adaptive in a frightening environment. You want to be on guard. You want to be looking around. But

then, later on, when you're safe, you're still doing it. You're still in your procedural learning.

So procedural learning is a habit, and it's usually not conscious. It's that saying that was attributed to Einstein. "The fish will be the last to discover water." That's how I think of procedural learning.

Dr. Buczynski: That fish and water quote is such a great way to think about it.

So what was once an attempt to protect the client becomes embedded as a procedural memory.

Now, the important takeaway here is that this is usually happening at the unconscious level. And this is why a procedural memory can be challenging for clients to work with.

Dr. Ogden: But see, this also happens in our thoughts and our emotions. We have patterns of thinking.

One exercise that I often do with my students is have them just mindfully, for five or ten minutes, list all their thoughts in one column of a paper. And then in the next column, start to list and describe the functions of that thought.

> "That's the procedural element of thinking – it's not what we're thinking; it's the patterns."

Like, *I'm judging myself. I'm planning for the future. I'm ruminating over my mistakes.*

Because that's the procedural element of thinking – it's not *what* we're thinking; it's the *patterns*.

Dr. Buczynski: That was a helpful point about procedural memory. This kind of memory can affect both the mind and body.

And Pat's mindful strategy can help isolate areas where traumatic memory not only exists, but has also become self-sustaining.

But I want to continue focusing on the body.

In certain traumatic situations, procedural memory can severely impair a client's physiology.

Dr. Levine: I give this a subcategory of procedural memories, and these are procedural memories that have to do with survival based responses. So, if we're fighting or fleeing, or if we retract, or if we twist, or if we collapse. These are all procedural memories and they are extremely powerful.

Dr. Buczynski: This can be especially difficult for clients when their adaptive response goes into overdrive, revving up to protect them from potential threats.

And this can be a problem. See, these procedural memories often can't complete themselves. And when that happens, it can have a rippling effect through the client's nervous system.

What Can Happen When a Procedural Memory Becomes "Stuck"

Dr. Levine: So, if a procedural memory is in a stuck place, we're going to have a stuck emotion. We're going to not have access to our episodic memories and we're going to have to rely entirely on our explicit declarative memories. People do that, you can do that. It's a compensation, but they cut themselves off from the wealth of inner experience.

> "If a procedural memory is in a stuck place, we're going to have a stuck emotion."

The key here is in knowing how to work with procedural memories – particularly those that have to do with things that the body does to defend and protect itself.

Dr. Buczynski: So when we're looking at procedural memory, especially procedural memory that gets stuck in the body, this is a vital piece of the puzzle.

Procedural memory that's left unprocessed can "reflect upwards" and affect other kinds of memory as well.

So procedural memory can have a profound impact on our clients, beyond just what's happening in their body.

Now there's one more wrinkle to this kind of survival-based memory. The client can show the symptoms, but they might not remember the actual trauma.

Dr. Levine: I was teaching a class in Jerusalem, before the intifada so we were able to have Israeli and Palestinian people together in the class.

Dr. Buczynski: Peter Levine was at a trauma conference in the Middle East when someone in the audience asked a question: Is it possible to work with a trauma if you don't know what it is?

So, Peter threw the question back and asked if anyone in the audience had a particular symptom that they would like to explore.

One man raised his hand. It was Haim Dasburg. He just happened to be an expert in the field of treating

trauma.

Dr. Levine: He was the leading person on pioneering psychoanalytic treatment for a Holocaust survivor. He came up and said that he had severe back pain for 30 years. Non-remitting back pain.

Dr. Buczynski: So next, Peter did a pain assessment with Haim. Haim turned out to be a nine on a ten-point scale. That's pretty harsh pain.

What Peter did next was draw attention to the area of pain in Haim's back. He asked him to notice any muscle tension that might be lying underneath the pain.

Dr. Levine: So, he took a few moments, and he said "Ah, yes. I feel the tension, I feel a lot of tension in my back."

Then I said something like, "Is the tension equal on both sides?"

Again, he went in to explore. He said, "No, it's more on the right."

Then, I said, "OK, if you feel that tension and you allow that tension to just slowly move your body, in what way might it move your body?"

Then he feels himself moving and orienting towards the right side. Then, all of a sudden, he starts breaking out in sweat, autonomic memory. Emotional autonomic memory.

He said, "I'm afraid I'm falling."

I came up and put my hand behind his head to make sure he has support and then just waves of sweating, of terror.

Dr. Buczynski: Peter began sensing two things.

Number one – he thought Haim might be working through an implicit memory;

And number two – Peter sensed that Haim was getting stuck in an incomplete response.

This memory was triggering a lot of pain and confusion, and it was about to come to the surface.

Dr. Levine: He then had the memory, an image – he was an army doctor and the truck that he was in was ambushed and he fell out into a ditch on his back. Everyone else was killed except for him because they

didn't see him. It was just a horrific sight.

Then at the end, we reoriented and looked around the room and I asked him about the pain level. He said, "One or two. Oh, I barely feel it."

So, that was working with that particular symptom.

> "You absolutely do not need to have a declarative memory, because again, every moment of every day we have that memory ***constantly***."

So, you absolutely do not need to have a memory or a declarative memory, because again, remember, every moment of every day for Haim, and for many people, we have that memory *constantly*.

Dr. Buczynski: That's a helpful framing of the issue when we're talking about traumatic memory. The memory can often live on in the physical patterns *and* the cognitive patterns that a client might develop after a traumatic experience.

> "The memory can often live on in the physical patterns ***and*** the cognitive patterns."

This can become a painful paradox – because the very response that kept our client from harm can now be keeping them from healing.

So how do we work with this? How do we work with these patterns in our clients – and they can be very subtle movements - how can we effectively work with them to help our clients find relief?

One approach is to put a spotlight on the pattern itself.

Dr. Ogden: So somebody might come into the office saying things like, "Whenever my wife talks about the way I raise the kids, she's so critical." And you'll see that pattern exacerbated a little bit.

So then you can say, "Right there. Did you notice when you said that, how your shoulders tightened up a little bit?"

Dr. Buczynski: Now, the client might not notice these physical responses. The movements can be so quick or so ingrained that the client simply doesn't see what you're seeing.

But after you've brought their attention to the pattern, and after they've agreed to work with it, what do you do next?

Here are two ways to approach it.

Two Ways to Approach Procedural Memory That Gets Expressed Through the Body

Dr. Ogden: One – you can stay with that pattern, maybe even exaggerate it a little bit and find out about it. Let it speak to you using mindfulness. *What does it feel like? What happens to your breathing? Are there emotions that go with it? Are there memories that go with it? Maybe thoughts that go with it?* So that's one choice; stay with the pattern.

The other option is what we would call to *resource the pattern*, to help him learn to take a breath and let his shoulders drop.

So those are your two basic options. But I want to caution against just shifting the body and leaving the part of the client that is frightened or hiding themselves, leaving that in the dust.

If we resource the pattern, we probably want to go back to this part and have these two parts start to communicate, so there can be integration.

> "We don't want to resource the pattern at the expense of having the client explore the pattern more deeply."

Dr. Buczynski: That's an important caution that I think bears repeating. We don't want to resource the pattern at the expense of having the client explore the pattern more deeply.

You see, these memories often get grooved into the nervous system. So if we don't address the part of the client that is triggering the response, it can keep them from being more attuned to their present existence.

Now, we just heard two ways to work with a client's procedural memory when it's expressed through the body.

Number one – exaggerate the pattern and help the client to stay with it, to increase their awareness of it. And to get them to know all about it.

And number two – resource the pattern.

But now the question becomes – how do we know *when* to use which approach?

Dr. Ogden: Many traumatized clients need a resource to help them stabilize before we can go into a pattern, especially if the trauma has to do with attachment.

So, if this client is highly traumatized and his wife is critical, and he's going to get super dysregulated and dissociated, we're not going to go under that pattern any more. We're going to find a way to help him stabilize, self-regulate first.

Dr. Buczynski: That's a significant point to consider when we're working with traumatic memory. And it directly connects to what we discussed earlier, about the importance of taking a measured approach to the integration of memory.

Dr. Levine: If you bring them all together at once, boom, it explodes.

Dr. Buczynski: Now, Pat mentioned the need to help clients stabilize before addressing these patterns. In just a bit, we're going to look at four specific ways to resource clients to help them both stabilize and also tolerate traumatic memory.

But first I want to quickly shift and take a look at another issue that can come up with procedural memory.

How to Work with a Traumatic Memory That Has Formed at the Preverbal Level

Dr. Buczynski: Throughout the series, we've been talking about unprocessed traumatic memory. But what happens when the memory is both unprocessed and inaccessible?

Now, I don't mean inaccessible because the memory is stuck, like in Haim Dasburg's case.

I'm more talking about cases where the trauma happened when the client was preverbal.

Dr. Levine: Generally, if you look at the emotional effect on the hippocampus, so if the amygdala is activated, that tends to shut down the hippocampus which tends to shut down declarative memory formation and recollection. So, I would say in general, anything before the age of three, you really have to assume that declarative memory is limited.

Dr. Buczynski: We know that areas of the brain are still developing at this young age. And this can interfere with the forming of explicit memories.

Again, it's the *explicit* memory that doesn't really form. But when we're talking about *implicit* memory – as in an emotional memory – this kind of memory is different.

You see, an emotional memory follows a different path when it's being laid down.

And it can encode itself in the mind even if the person isn't old enough to cognitively process it.

Dr. Levine: It's encoded in two ways. As emotions, use the hot emotions.

Well, you can have early emotional memories of joy – I mean, we do. Children do, but the ones that tend to last, well, that *do* last and that are intrusive, are the *negative* emotional memories. So, you get those without those without any declarative memory. It's just like, again, they're hot and they just burst like a volcano when the person may be least expecting.

Dr. Buczynski: So this brings up a challenging question. How do we work with a traumatic memory that's happened in a preverbal context?

Dr. Ogden: Well for one thing, it's not accessible most of the time. And second, this has to do with procedural memory, because it's not the event itself, it's what happens to us, the patterns that we start to develop during and after a trauma. So if it's a preverbal trauma, there will be an effect on the body and the emotions that, if you're working with the implicit self, you will be able to track and work with.

Dr. Buczynski: So even in the case of preverbal trauma, we can track the effects of traumatic memory by looking at several things in particular.

One - the client's movement;

Two – their vocal patterns and tone of voice;

Three - their breathing patterns;

Four – the coloring in their face;

And five – their thought processes.

And this links back to something we talked about at the top of this program.

Dr. van der Kolk: You look at people's reactions. So everything happens in the present.

Dr. Buczynski: With preverbal trauma, these patterns, these emotions, these thoughts – these can all be seen as part of the client's experience.

> "We can start to work with procedural tendencies in the present time. You really don't need history at all."

And when we have these pieces to work with, we might not even need the content of the trauma.

Dr. Ogden: Our focus in sensorimotor psychotherapy is on how a person organizes their experience, not their history. Clients often want to tell their history, and it can be helpful because as they're describing their history, their body will start to shift and then we can start to work with procedural tendencies in the present time. But you really don't need history at all.

Dr. Levine: The person is never going to declaratively remember it. It's probably not going to be an episodic or an autobiographical memory of it. But, their body is remembering it all the time. So, the only way that they can access it is through sensation and inner movement. These are not voluntary movements, but these are primarily involuntary movements.

So, the memory exists all the time as a procedural memory playing out in the present time. But, it's not something that you can just say, "OK, I want to remember this."

No, that's the nature of preverbal trauma.

Dr. Buczynski: Now, earlier we touched on the need to help clients stabilize before working with traumatic memory.

And I want to explore this further. Let's look now at four specific ways to help your client tolerate and integrate traumatic memory.

Four Strategies to Help Clients Tolerate and Integrate Traumatic Memory

Dr. Buczynski: The first strategy is to build up the resources that the client is already using.

Pat Ogden had a client who was dealing with some difficult areas of her life.

In the session, Pat's client started to become hyperaroused and dysregulated.

But while Pat was helping her client to regulate, she started to focus on one particular affect.

Dr. Ogden: She was talking about all these emotions, and she has all this anger and this rage at different

people in her life. And while she's talking, she's making certain motions.

We always want to track how the person is already trying to resource themselves. So this motion is a containing motion. It tightens your arms and your back, and it contains, which she needed. She needed containment.

So our first resource was to say, "Interestingly, your body is already doing that... Let's play with that. Can we stay with that a little bit?"

And then I do it with her, and we practice this action. And that was her first resource that helped her feel a bit more settled.

So one thing we do is that we watch the body – see what the person is already doing to help themselves calm down. We can capitalize on that.

Dr. Buczynski: The big takeaway here is that clients will sometimes show you how they're trying to resource themselves. Once you identify that, you've created an opportunity to begin healing.

Had Pat not been tuned into her client's experience at a bodily level, it's possible that treatment might have taken much longer.

So that's one strategy. Let's go on to the second of these four strategies. And that is to help retrain the way clients approach stimuli. Here, we're talking about both external and internal.

Dr. Ogden: Something I've found to be very effective is to help clients be aware of what they're orienting to, both outside in the environment and inside in themselves, because clients who are traumatized start to orient toward threat cues. And they start to orient toward those cues of dysregulation inside themselves.

Dr. Buczynski: One method that Pat uses to help clients change this way of orienting is by having them look around the room during a session. She'll move their focus to things that are visually appealing, like a painting or maybe a plant.

Dr. Ogden: I might give homework. "Go for a walk around the block and just seek out things that bring you pleasure in the environment — colors, the sky, maybe birds, it could be even sounds." You're helping retrain their orienting habits.

And then you do the same thing internally – ask them if they can remember a time where they felt good (or

at least less bad), whether it's a relationship or an experience in nature. And then that becomes a new focal point of orienting.

> "If you orient towards pleasurable things in the world, your body starts to respond."

What's nice about both of these is that if you orient towards pleasurable things in the world or pleasurable things inside, your body starts to respond. So we'll help a client be aware of that.

Dr. Buczynski: So there are two ways to help retrain the way a client might orient to things.

You can: A – bring their focus of attention to pleasurable things in their environment;

And: B – bring their focus of attention to pleasurable feelings or experiences that they recall from their past.

Not only does this approach help clients shift their awareness, but it can have a calming effect on their nervous system. They can begin to breathe deeper and feel more settled inside.

The third strategy is to focus on the client's survival skills.

Dr. Ogden: I like to spend time with clients on appreciating their strengths – being able to articulate the things that they are competent in, because every single client is. And this is a wonderful, wonderful way to start to transform memory.

If somebody survived a trauma, they had resources. Whatever they were, they had resources. Even if they dissociated, that's what we would call survival resources.

> "When we work with memory, we'll go back into that memory, searching for all the ways that someone handled it that were indicative of a strength."

So when we work with memory, we'll go back into that memory, searching for all the things – the skills, the relationships – the ways they handled it that were indicative of a strength.

And once a client realizes that, that memory is never, ever the same. And that's what I think is so wonderful.

Dr. Buczynski: So, articulating the client's strengths can be a very effective approach. What this does is, rather than focusing on the client's pain or pathology, you shift their focus to the efficacy that they've exhibited in their lives.

Pat used this approach to help one client overcome feelings of victimhood after a car accident.

Dr. Ogden: He was thrown from the car. And the thing that he remembered was that somehow he knew to lie perfectly still. And that probably saved his life. He could have moved, but he said, "I know I had to be perfectly still."

So as he remembered that, that started to shift that victimization and started to resource him, that he actually had a resource that he used in that horrible trauma.

Dr. Buczynski: Now, admittedly, some clients struggle when it comes to identifying actual strengths, especially when they've experienced early life trauma. And in these cases, you can call on the fourth strategy of building resources – using the power of imagination.

Dr. van der Kolk: Well, imagination is a central human capacity that allows us to get to new places. In some ways, imagination is everything. As long as you cannot imagine anything other than what is, you have nowhere to go. Opening up people's imagination is a critical part of trauma treatment.

Dr. Buczynski: Bessel uses several practices to help clients create this area of imagination - from theater groups to hypnosis to psychodrama. The important part is to help clients develop more resources.

Dr. van der Kolk: If you have people imagine alternative ways of what can happen – *what would have happened if you would have walked in this room the way you are right now and would have seen what your uncle was doing to this little kid? What would you do today for that little kid?* – a whole new imagination pops in and says, "Oh, my god, if I saw this happen to a kid, I would do the following."

But when you're a kid, you do none of these things.

And so you juxtapose the two new realities for people.

Dr. Buczynski: So just to review, we've looked at four different ways to help clients both stabilize and build up resources to tolerate traumatic memory.

Number one – accentuate the way that they're already resourcing themselves;

Number two – help them to retrain the way they orient to things and bring their awareness to their environment;

Number three – focus on the skills they used to survive the trauma;

And number four – use an approach that works with their imagination, like theater or hypnosis.

About NICABM . . .

Ruth Buczynski, PhD has been combining her commitment to mind/body medicine with a savvy business model since 1989. As the founder and president of the *National Institute for the Clinical Application of Behavioral Medicine*, she's been a leader in bringing innovative training and professional development programs to thousands of health and mental health care practitioners throughout the world.

Ruth has successfully sponsored distance-learning programs, teleseminars, and annual conferences for over 20 years. Now she's expanded into the 'cloud,' where she's developed intelligent and thoughtfully researched webinars that continue to grow exponentially.

The National Institute for the Clinical Application of Behavioral Medicine is a pioneer and leader in the field of mind-body-spirit medicine. As a provider of continuing education for health and mental health care professionals for over 20 years, NICABM is at the forefront of developing and delivering programs with "take home" ideas, immediately adaptable for practitioners to use with their patients.