Long Ago and Far Away:
New Approaches to Treating Traumatic Memory

Dr Janina Fisher

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events@delphicentre.com.au

Long Ago and Far Away: New Approaches to the Treatment of Traumatic Memory

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Janina Fisher, Ph.D.

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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. . . .*** *We must [also] mention another 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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"The [traumatic] past is not dead and buried. In fact, it isn't even past."

William Faulkner

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The nature of memory

- **When we talk about 'memory,' we generally mean 'explicit memory,'** conscious verbal memory, including:
  - Declarative memory: verbal description, stories
  - Autobiographical memories: the narrative of personal experience
  - Fund of knowledge: vocabulary, multiplication tables, politics and current events
  - Working memory: holding ideas in mind, problem-solving, learning from experience
- **Explicit memories are voluntarily retrievable:** we can choose to recall them or not recall them.

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The nature of memory, cont.

- **Implicit memories are "state specific."** We cannot choose to retrieve them, but they are stimulated by associated stimuli. Implicit memories can be any of the following:
  - Emotional memory: feelings, emotions
  - Visceral memory: internal body sensation
  - Perceptual: olfactory, visual, auditory, tactile
  - Muscle memory: posture, tension, movement, skills
  - Autonomic: sympathetic-parasympathetic responses
  - Vestibular: balance
  - Procedural: memory for habit and function

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Many brain "departments" for different memories

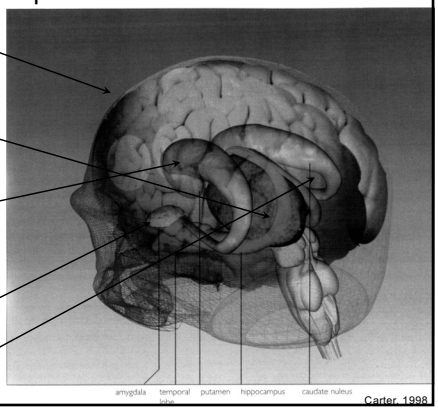
Frontal cortex: 'the story' and beliefs attached to it

Hippocampus: the brain's "filing cabinet:" organizes, contextualizes, sequences

Putamen: procedural memories, what to do, how to react

Amygdala: implicit and emotional memory

Caudate nucleus: instinctual responses (fight/flight/freeze)



Carter, 1998

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Do we suffer from traumatic events or from traumatic environments?

- **Although historically trauma treatment has focused on specific traumatic events, those events most often occur in unsafe environments:**
  - Abusive families
  - Intimate partner relationships
  - War
  - Environments of neglect
- **Our clients rarely suffer from the single events alone! They suffer from the effects of traumatic environments in which they are never safe even when nothing is happening**

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Memory for childhood experience

- In child development, **implicit memory formation begins long before children have the ability to encode explicit chronological 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 verbal memory is encouraged**
- Parents who support early acquisition of narrative memory ability are described as affirming children when they report recent experiences, prompting their recall, respecting their autonomy, and supporting what they describe (Larkina and Bauer, 2010; Svane et al, 2021)

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Memory for childhood, cont.

- **Implicit memory is also dominant during the first two years of life** and when negative relationships with parents figures inhibit memory function (Vanderbrouke et al, 2017), and when adaptation requires that the child be silent
- Because implicit memory "primes" the body to respond to danger automatically, **implicit memory is more adaptive in unsafe environments than explicit memory**
- **Childhood trauma survivors, therefore, are more likely to remember traumatic experiences implicitly and to have fewer explicit memories.** This also means they may have greater vulnerability to being triggered by even subtle stimuli

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Implicit Memory System

- **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**.
- **Since implicit memories feel like feelings, they affect our actions and reactions without our awareness.** When they are stimulated by verbal recall, visual, sensory and emotional cues, or by people, we react implicitly
- **"[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)*

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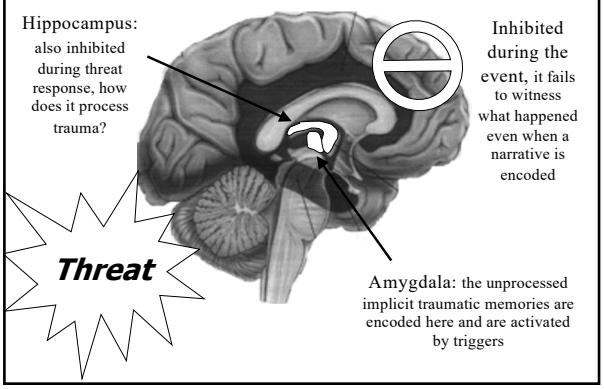
How we remember trauma

Van der Kolk et al, 2001



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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 . . . ."*

Van der Kolk, Hopper & Osterman, 2001

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Sensory elements without words = implicit memory

- **The survivor is left with a host of overwhelming implicit memories:** automatic emotional, physical, and somato-sensory responses—**disconnected from the event**
- These implicit memories do not "carry with them the internal sensation that something is being recalled. . . . **[Instead] we act, feel, and imagine without recognition of the influence of past experience** on present reality." (Siegel, 1999)
- **Verbal recall activates implicit memory networks** "[and may be] indirect means of perturbing those behaviors [associated with the memory]" (Grigsby & Stevens, 1999, p. 361)

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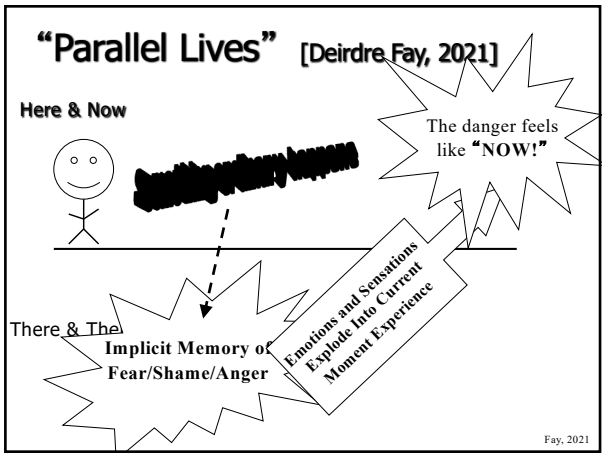

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"[Implicit state-specific] memory converts the past into an expectation of the future without our awareness*, and that is both a blessing and a curse. It is a blessing because we rely daily on emotional implicit memory to navigate us . . . Yet [it]is 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 **anticipation** 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 usually 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"

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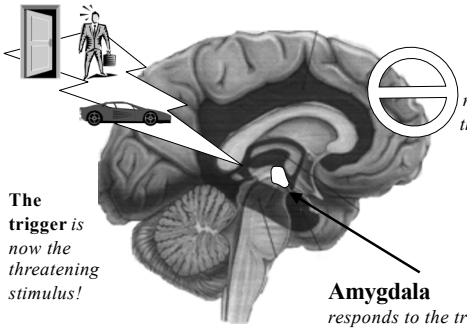
Triggering supports a sense of threat



An inhibited prefrontal cortex can't reality test: is there danger? Or am I just triggered?

The trigger *is now the threatening stimulus!*

Amygdala
responds to the trigger by activating emergency stress response

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"[T]raumatic memories are an alternative cognitive entity that deviates from memory per se. . ."

Perl et al, 2023, p. 2226

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*". . . traumatic memories are not experienced as memories . . . Rather, these are **fragments of prior events**, subjugating the present moment to evade the [sense] of belonging to the past."*

Perl et al, 2023, p. 2235

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Why would the brain evade the past?

- **The advantage** of experiencing the trauma as something current instead of over is that we will remain on guard, still on high alert for the next threat. Once we accept traumatic experiences as past events, we become more vulnerable
- While explicit memories validate that clients have been harmed by others, **implicit memories are usually interpreted as signs of failure or lack of safety.**
- **Also, trauma-related triggers repeatedly re-evoke the implicit memories,** confirming the sense of threat and sensitizing clients to signs of danger

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Implicit Memories are Autonomically Driven

Sympathetic Nervous System-Related Symptoms:
High activation resulting in impulsivity, risk-taking, self-injurious behavior
Chronic hypervigilance, post-traumatic paranoia, chronic dread
Intrusive emotions and images, flashbacks, nightmares, racing thoughts
Obsessive thoughts and behavior, cognitive schemas focused on danger and dread

Sympathetic Hyperarousal

"Window of Tolerance"*

Parasympathetic Hypoarousal

Hypoarousal-Related Symptoms:
Flat affect, numb, feels dead or empty, "not there"
Cognitively dissociated, slowed thinking process
Cognitive schemas focused on hopelessness
Disabled defensive responses, victim identity

Ogden (2021);
*Siegel (1999)

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Non-verbal 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
- **Thoughts**, especially when intrusive or contradictory, predict threat or failure, or are ruminative
- **Dreams, nightmares, flashbacks**, images
- **Impulses:** to run, to hurt the body, hide under the bed or in the closet, avoid going out
- **Voices** or 'noise' in the head, loss of hearing or vision
- **Somatic sensations:** spinning, dizziness, pain, heaviness, floating, tingling, numbing

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The struggle to find a relationship to traumatic memories

- Brewin et al (1996) observed three types of relationship to memory in trauma patients:
  - **Completed, successful resolution:** client may get triggered but recognizes it and re-regulates
  - **Chronic incomplete emotional processing:** client ruminates about the past, is emotionally flooded, preoccupied with the trauma, cannot focus on normal life
  - **Sustained and automatic suppression and avoidance:** client avoids talking about the past, minimizes or is disinterested in it Fisher, 2009

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Traumatic memory is terrifying. . .

- "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 [Holocaust] 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)

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Addressing declarative memory doesn't resolve implicit memory

"[It] is in the very nature of traumatic memory to be dissociated, and to be initially stored as sensory fragments without a coherent semantic component. The ***persistence of intrusive sensations related to the trauma [even] after the construction of a narrative*** *contradicts the notion that learning to put the traumatic experiences into words will reliably help to abolish the occurrence of flashbacks."*

van der Kolk & Fisler, 1995

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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, unlovable without recognition of these states as their memories of childhood neglect, abandonment, and trauma

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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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Methods that address implicit memory, not just event memory

- Sensorimotor Psychotherapy [Ogden]
- EMDR: Eye Movement Desensitization and Reprocessing [Shapiro]
- Somatic Experiencing Therapy [Levine]
- Internal Family Systems [Schwartz]
- Coherence Therapy [Ecker]
- Energy Therapies

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Treating implicit memory requires focused attention

- **Encouraging clients' interest and curiosity** about their trauma-related states as "body memories" or "feeling flashbacks"

Noticing patterns as implicit memory: repeated emotional reactions, changes in activation, self-concept, impulsive behavior

- **Interrupting procedural learning** by drawing attention to it as interesting or meaningful, empathically reframing impulsive acting out as another kind of memory, increasing curiosity
- **Encouraging client mindfulness** of 'body memories,' and patterns, appreciating both "survival strategies" and "resources"
- Patiently but stubbornly insisting on **differentiating feeling memory from present reality**

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Addressing triggering first

- **Survivors seek treatment because they have been triggered:** the "living legacy" has been stimulated, evoking anxiety, intrusive memories, overwhelming emotions, depression, and/or increased chemical dependency
- **The first goal of trauma treatment is to recognize the role of triggering:** to provide psychoeducation about triggering, make connections between trauma responses or symptoms and their triggers. *"Well, of course you were scared—you were triggered!" "It's hard when you're triggered . . . "*
- **Without awareness of triggered states, our clients are left to conclude that "now" is just as bad as "then"**

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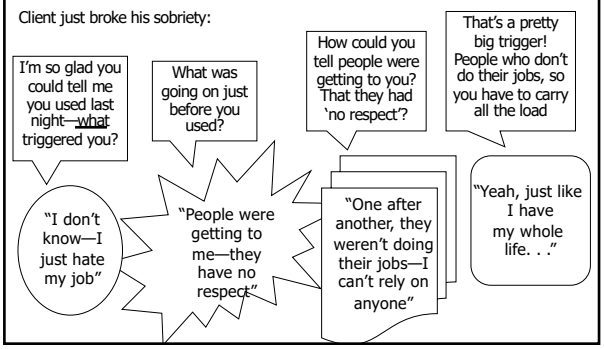
Mindfully tracking connections between symptoms and triggers



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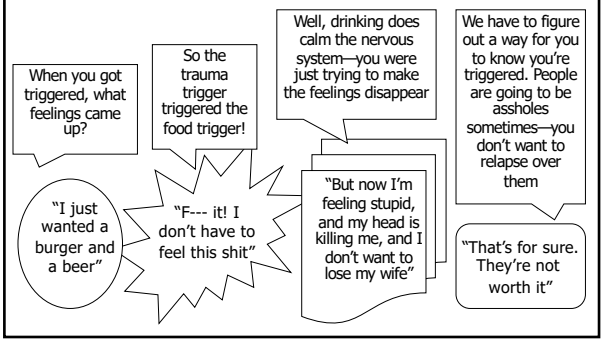
Connecting symptoms to triggers, cont.



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Acknowledging triggering

- **Triggers are best acknowledged by referencing the traumatic past without exploring it.** Trying to connect triggered responses to a specific event is less helpful. Instead, connect them to clients' unsafe environments
- **The goal is recognition that the body or emotions are remembering the past**—things are not as bad as they seem when the client is triggered
- When they relate to triggering by remembering specific events, clients can actually exacerbate their symptoms. **When they relate to triggering as just a symptom, its power is reduced!**

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Finding a new language

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

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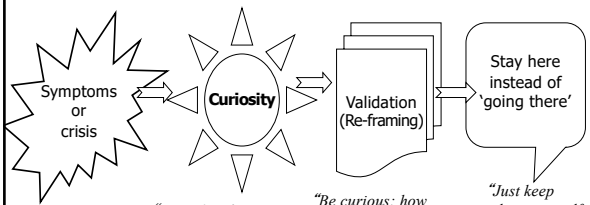
Trying to stay here, not 'go there'



"I can't handle this anymore—I give up!"

"I wonder if you're triggered—there must have been a trigger for you to get so freaked out…"

"Be curious: how could wanting to give up have helped me survive in an unsafe world? How was that smart?"

"Just keep reminding yourself, 'It's just body memory—just triggering—it doesn't mean I have to do anything."

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The treatment of implicit memory as "memory"

- When clients are avoidant of event memories or have little access to them, **the ability to identify implicit memories and process them becomes crucial.**
- **"Transformation" = changing our relationship to a memory.** It feels further away, less overwhelming, more settled and in the past. We feel safer inside
- In Sensorimotor Psychotherapy, **implicit memories that arise spontaneously in the therapy session are noticed as "just body sensations."** Uncoupled from the memory of the event, they are no longer frightening.

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The treatment of implicit memory as "memory," p. 2

- **An implicit memory can also be processed by connecting the "feeling or body memory" to a child part.** "Where does this feeling of shame fit in your childhood past?" "What does this feeling tell you about this young part's experience?"
- **Can the client connect to this part who is feeling so scared?** So ashamed? So hurt? Compassion for self and part is a powerful healing agent.
- Or an **implicit memory can be transformed by a change in procedural learning:** by helping the client change her actions and reactions in response to the fear or shame.

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"Long-lasting responses to trauma result *not simply from the experience of fear and helplessness but* ***from how our bodies interpret those experiences."***

Yehuda, 2004

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Sensorimotor Psychotherapy

Sensorimotor Psychotherapy is a body-oriented talking therapy developed in the 1980s by Pat Ogden, Ph.D. and enriched by contributions from Alan Schore, Bessel van der Kolk, Daniel Siegel, and Steven Porges.

Sensorimotor work combines traditional talking therapy techniques with body-centered interventions that transform the neurobiological effects of trauma.

By using the narrative of the event as a vehicle to evoke trauma-related somatic responses, we attend first to how the body has "remembered" the trauma and then later to cognitive and emotional meaning-making

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Transforming bodily responses into explicit and implicit memory

- **"Uncoupling" body sensations and emotions** from the narrative so that it is no longer overwhelming to tell
- **Increasing the client's sense of mastery** over bodily states of dread, terror, panic, rage, and grief by noticing instead of reacting to them
- **Expanding the capacity to feel safe in the body:** the capacity to set boundaries, leave or flee, cry for help
- **Expanding the capacity to tolerate states of calm,** peacefulness, well-being, and joy

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Uncoupling 'over-associated' sensations and dysregulation

- **Because the intense sensations**, movement impulses and autonomic activation that accompany trauma-related responses **are not easily recognizable as "memory," they are experienced as dangerous and out of control.**
- The client feels frightened and powerless, and the prefrontal cortex shuts down
- In order for clients to feel a sense of mastery over their symptoms, **it is essential for teach them to "uncouple" or disconnect the physical experiences from the traumatic content, to uncouple past and present**

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*"[M]emory research has established that **learnings accompanied by strong emotion form neural circuits . . .that are exceptionally durable**, normally lasting a lifetime. **The brain is working as evolution apparently shaped it to do** when, decades [later], this tacit knowledge is triggered in response to current perceptual cues [stimulating] behaviors and emotions according to the original adaptive learning."*

Ecker et al, 2012, p. 8

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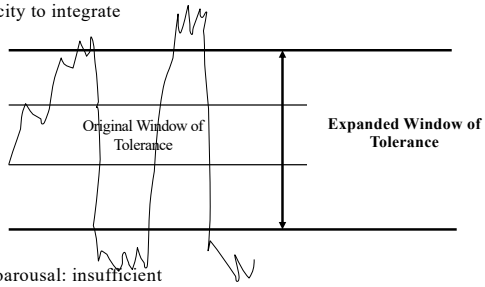
Transformation depends upon an expanded Window of Tolerance

Hyperarousal: activation exceeds capacity to integrate



Hypoarousal: insufficient activation to integrate

Ogden and Minton (2000)

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And on the ability to take in and process new information

- **Through the body:** "Can you see the door you are afraid to open? What home does it belong to? Next, bring to mind the image of the door you want to open now—what happens when you see your front door?"
- **Through exposure to "living knowledge that is fundamentally incompatible** with the [old] model of reality" (Ecker et al, 2012), knowledge that we can feel , not just know intellectually
- **Through holding the felt sense of both past and present** in mind or oscillating back and forth between the experiences of them

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A Transformation Model for Trauma Work

•If the issue in trauma is the legacy of implicit memories and autonomic dysregulation, **how does that change our approach to working with memory?**

•**The legacy of trauma is a separate issue from traumatic events**, no matter how horrific they were. The 'damage' or legacy is **the ongoing day-to-day effect of the 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

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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 prioritizes 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"** even when triggered and overwhelmed.

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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 them as "body memories" or "feeling flashbacks," **interpreting implicit memories as information about how the client survived** gives them gtreater 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 the arm is a sign of wanting 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 clients 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

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"Telling the story to ourselves is more important than telling it to someone else."

van der Kolk, 2009

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Re-thinking the role of 'witness'

- **A cornerstone of trauma treatment has been the telling of the story to a "witness."** But telling someone "what happened" is not just a drive to be "witnessed"
- In the context of safety, children tell adults when they are frightened, distressed, angry, hurt, lonely, or bored because they want someone to **"do something"** to shift their state
- The animal defense response of "cry for help" is an instinctive response reflecting powerlessness and vulnerability. The intense **"wanting to be heard"** often encountered in the treatment of trauma **is an implicit memory of the desperate longing to be helped,** not just a longing to be acknowledged

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Transformative witnessing

•**Witnessing in a therapy session of an adult's story cannot resolve the implicit memory of a child's past experience** of no one hearing, no one doing anything to protect,, no one seeming to care

•**Telling the story also activates the implicit memories associated with it**, often causing clients to automatically disconnect emotionally and default to a dissociated state. **The therapist is present but not the client**

•For those who need witnessing, **we need to use transformative techniques that allow clients to stay present** and experience a 'felt sense' of being witnessed

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Transformative witnessing, p. 2

•**Set the stage:** "Today, you are going to tell me about what happened when you were 6—no one was there to listen then, so it's very important that 6-year-old feels both of us listening very carefully today. As you tell the story, I'm going to pause you every so often to make sure you and she both know that someone is here, listening . . ."

•**Slow the pace:** don't let the client tell the story detail by detail or very quickly. Detail activates more of the implicit memories; the fast pace leads to disconnection. **Don't be afraid to "empathically interrupt" to regulate pacing:** the interruptions are necessary to the experience of keeping the client in the room to feel witnessed!

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Transformative witnessing, p. 3

•**Bring the client's attention to what's happening:** "Notice that as you are speaking, I am listening. I'm right here with you. Can you feel me here?"

•**Bring client's attention to what's different**: "It's really different, huh? Back then, that 6 year old had no one to listen, no one to help her, and right here, right now, we're both here. Can she notice the difference?"

•**Try to evoke a felt sense that can be remembered as a new experience:** "What's that like for her? Is it emotional? Or more calming and reassuring? How do you feel different inside when you can see and feel that now someone is here with you?"

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Safely Accessing Event Memory

- **In Sensorimotor Psychotherapy, we start just BEFORE the traumatic event occurred.** As the client 'accesses' that moment, the therapist asks:
  - "What happens inside when you remember that moment just before things went bad? What do you notice?"
  - "How can you tell you are afraid? How is your body telling you that? If that fear had words, what would it say?"
  - "Is there an image or memory that goes with those words? What happens when that image comes up?"

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Safely accessing memory, cont.

- **Note the slow pacing and attention to each aspect of experience as different and separate.**
  - Body sensation, activation, felt sense
  - Emotions
  - Thoughts
  - Images
  - Impulses or movements
- **Also notice that the client is kept focused and mindful to keep the medial prefrontal cortex online**

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Safely accessing memory, p. 2

- **To increase dual awareness, the implicit memories can be connected to the young child we once were.** We can transform the pain of the past by observing the memories compassionately as those of the child
- **Processing the emotional and body memories of child parts creates a greater sense of internal safety:** there is a felt sense of the present being different than the past that is the essence of transformation
- In these ways, **we facilitate 'missing experiences' unavailable at the time:** the experience of safety, compassion, being heard or seen, protection, someone there, being welcomed

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Safely accessing memory, p. 3

- If a memory or image causes dissociation or loss of mindfulness, the therapist shifts the focus back to staying present, grounded, orienting to 'right here, right now'
- If the client can remain mindful, then the therapist might work with the implicit memory activated by the story: **"What happens when you just notice the activation as 'body memory'?** Really appreciate how dissociation and disconnection saved you then from overwhelm. . . It's so automatic to just go away, huh?"
- **The key in memory work is have no other goal than helping the client to have a different, reparative experience**. That is transformation.

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"The biggest change in our understanding of trauma treatment is its goal. *What is important is not the story of the terrible things that happened but* ***developing a healing narrative*** *with which the survivor can live now. . ."*

Donald Meichenbaum, 2014

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A Complication: Trauma ⟹ Alienation from One's Self

- **To survive, human beings need psychological distance from overwhelming events.** The sense of self must be kept separate from the ongoing trauma
- **Disowning "the bad child"** (the child who submitted to the abuse and humiliation) **is a survival response**: it preserves self-esteem, motivates us to be the "good child," to please and comply
- **Disowning as "bad" any reaction, emotion or need that increases danger is a survival response**. Disowning attachment-seeking or neediness and caretaking attachment figures also can increase safety

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"Repairing" Internal Attachments

•**While yearning to 'like' ourselves, the disowning** of vulnerable, ashamed, angry, or depressed parts **results in a profound alienation from self:** *'I don't know myself, but I know I don't like myself'*

•This sets up a dilemma that profoundly affects the therapy: the internal experience is: ***"I don't want to know this person*** *that I don't like—I can't be kind to them."* But self-judgment increases emotional pain and alienation

•**The ability to be compassionate or comforting or curious with others is not matched by the ability to offer ourselves the same.** So it feels believable that those others deserve or belong or are worth more

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Establishing relationships between client and parts

•**The relationship between the client and traumatized child parts begins with mindful curiosity** about the parts' feelings, thoughts, and impulses.

•**Curiosity about who these parts really are** naturally **enhances empathy:** *"How old might this part be? Very young? Middle-sized? A teenager?"* The therapist's curiosity has to be a role model for the patient

•As curiosity challenges the automatic animosity toward parts and they come to be better understood, the therapist can ask an Internal Family Systems (Schwartz, 2001) question: ***"And how do you feel toward that part now?"***

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Befriending one's selves

•**We can't integrate that which we disown, despise, or deny.** But most clients need to be actively encouraged to 'befriend' their parts, to change these habits of self-hatred

•During this phase of the work, **clients need us to hold empathy for all parts and challenge their resistance to befriending them:** "*What do you imagine would happen if you really knew them and got close to them?" "If you befriended them, what are afraid would happen?"*

•Typically, when we encourage befriending, we hear: "But I hate them," "I wish they'd go away," "I wish they would just grow up!" **These statements must always be re-framed as another part:** "a part that hates the other parts" or a "part that wants to disown" them.

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Providing the "missing experience" of help or safety

- Once child parts have communicated their fears or longings, then **we can help clients offer them the compassion and support now that was not available when the parts were young and/or in danger**
- Since **traumatic attachment and fragmentation will complicate the interpretation of what we offer,** it is important that the client be the "rescuer," not the therapist
- Child parts often believe that we are the "magical stranger" for whom they have been waiting for rescue—or the mothers they never had. **Dependence on our care means they cannot truly be safe.**

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Disconfirming the Past

- **The idea of 'disconfirming the past' as a way of repairing traumatic memory comes from the work of Bruce Ecker,** the developer of memory reconsolidation treatment (2024).
- "New learning always creates new neural circuits, **but it is only when new learning also unwires old learning that transformational change occurs. . .**
- **The process fulfills the brain's requirements for allowing new learning to rewrite and erase an old unwanted learning . . ."** (Ecker et al, 2012, p. 4)

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Steps to reconsolidating implicit memory (Ecker et al, 2012)

1. Identify the implicit memory to be reconsolidated.
2. Evoke the memory in the here-and-now: "still frame" it rather than talking about it.
3. Identify a disconfirming experience: "living knowledge that is fundamentally incompatible with the [old] model of reality." The client doesn't have to endorse it: it just has to be "fundamentally incompatible" with the old learning.
4. Then go back to the implicit memory again
5. Re-activate the disconfirming experience in the here-and-now and help client feel both simultaneously
6. Repeat the pairing of old and disconfirming experiences again several times

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Types of discomfirming experiences

- **Body:** calm, free of fear, warm, connected, solid, strong, grounded, chin held high, feeling of the child being held
- **Emotional:** the "grief of relief," happiness, safe and energizing anger, pleasure, pride
- **Cognitive:** new beliefs, such as "I can stand tall," "I am not alone," "I' m safe now," "Someone is with me," "Someone understands," "I' m safe"
- **Five-sense perception:** soothing voice, safe touch, smiling eyes, calm face, beautiful images, soothing smells and sounds, balance, rocking

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*"**The therapist's empathy** is not in itself curative of attachment problems, but rather it **serves to create new experiences that disconfirm and dissolve troubled [traumatic] schemas**. . . (p. 108)."*

The therapeutic power of the therapist's empathy resides not so much in the client's agreeable feeling of it, but in how the agreeable experience very specifically disconfirms the client's particular, problematic models of self, relationship, and the world."

Ecker et al, 2012, pp. 108-109

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"No matter what modality we use, the goal of trauma treatment is finally to be 'here' and not 'there.'"

van der Kolk, 2001

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For further information, please contact:

Janina Fisher, Ph.D.
511 Mississippi Street
San Francisco, California 94107
DrJJFisher@aol.com
www.janinafisher.com

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