Psychological dynamics affecting traumatic memories: Implications in psychotherapy

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The search to understand response to trauma has turned to the contribution of personality factors. The way people process the stressor event is critical in determining whether a trauma will be configured or not. Neuroscience shows that the brain does not store memories, but traces of information that are later used to create memories, which do not always express a completely factual picture of the past experience. Whenever an event is retrieved, it may undergo a cognitive and emotional change. Psychological dynamics – emotional interpretative tendency that affects the internal dialogue related to a meaningful event – may influence the development of positive or negative outcomes after stressor events. We postulate that therapists must see beyond the traumatic event itself and work with the internal dialogues that maintain the pathological relationship with the past episode. Thus, they may better treat traumatized patients by therapeutically rebuilding the memory. A brief clinical case is presented to show how exposure-based and cognitive restructuring therapy may help trauma victims experience psychological growth from their negative experiences, by fostering healthy psychological dynamics.

Exposure to a wide variety of life-threatening and violent events occurs with relative frequency across a broad spectrum of the population. The lifetime prevalence rates for the occurrence of at least one traumatic event were estimated to be 51.2% for women and 60.7% for men (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Certain experiences

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are so overwhelming that they seem to cause symptoms in most people (Cahill, Llewelyn, & Pearson, 1991). However, traumatic events *per se* do not determine the development of psychiatric disorders. Potentially intense and devastating experiences have also variable effects (Chertoff, 1998; McFarlane & Yehuda, 1996). Studies show a marked degree of inter-individual variability in the processing of memory of life-events and basic emotions (Eugene *et al.*, 2003), resulting in no single human response to the same stressor events, thus weakening the concept of ‘universal reaction to trauma’ (Hull, 2002; Jones *et al.*, 2005). There are countless variations of behavioural expression caused by traumas. Researchers have shown a strong relationship between psychological trauma and development of post-traumatic stress disorder (PTSD; Leskin, Kaloupek, & Keane, 1998), simple phobia and social phobia (Magee, Eaton, Wittchen, McGonagle, & Kessler, 1996), borderline personality disorder (van der Kolk, Hostetler, Herron, & Fisler, 1994), somatoform disorder (Lamprecht & Sack, 2002), dissociative disorders (Ross *et al.*, 1991), eating disorders (Tobin, Molteni, & Elin, 1995), self-mutilation, suicide, high-risk behaviours, substance abuse (Marshall *et al.*, 2001; Schinagle, 2002), and major depression (Neria, Bromet, & Marshall, 2002). Even though traumatic memories are referred to in greater number in literature associated with PTSD, there is a larger group of traumatized people that do not meet the DSM-IV criteria for PTSD and other psychiatric disorders. The prevalence of PTSD in the general population is about 9% (Breslau, Davis, Andreski, & Peterson, 1991); sub-threshold PTSD is estimated to be approximately 30% (Weiss *et al.*, 1992). A longitudinal study suggests that individuals with sub-threshold PTSD require the same level of care as individuals with PTSD (Carlier & Gersons, 1995). However, many people are exposed to loss or potentially traumatic events at some point in their lives, and yet they continue to have positive emotional experiences and show only minor and transient disruptions in their ability to function (Bonanno, 2004). The same stressor event can be absorbed and processed in very distinct manners (Breslau, 2001). Veterans of the Vietnam War submitted to the same stressor events did not develop the same behavioural responses in the medium and long term (Jones *et al.*, 2003; van der Kolk, McFarlane, & Van Der Hart, 1996). Part of them developed PTSD, specific phobias, and somatoform disorders, while other veterans were able to reassume their lives with satisfactory quality. Many victims of trauma look for professional support, literature, supervision, consultancy, and friendship, while others emphasize collapse or victimization (Spouse, 1999). A number of battered women report physical and psychological distress, whereas others are able to respond to adverse sequelae with less severe outcomes (Humphreys, 2003). Most samples of rescue and recovery workers showed remarkable resilience in most reviews (Norris *et al.*, 2002). Nevertheless, not only rare individuals with exceptional emotional strength (e.g. Castella & Motta, 1990) are capable of resilience. In the face of loss or potential trauma, resilience is more common than is often believed (Bonanno, 2004), being the rule rather than the exception in the aftermath of major disasters (Shalev, Tuval-Mashiach, & Hadar, 2004). Massive stressful events have increased with recent world occurrences (Yehuda, 2004), and mental health efforts must continue to improve diagnosis, treatment, and
prevention of trauma disorders. Although, there are significant qualitative differences in how traumatized and non-traumatized people process and categorize their experiences (McFarlane, Yehuda, & Clark, 2002), crucial questions remain: what makes individuals submitted to the same stressor events develop pathologies while others do not? What predicts the development of positive outcomes? Could these factors be helpful for treating sufferers of psychological trauma? To partially answer these questions, this article will discuss the relationship between individual psychological dynamics and the way traumatic events are processed. We intend to shed light on psychotherapeutic perspectives to better treat PTSD patients by working with the internal dialogues established with the stressor event.

**Neuroscience contributions**

‘Biologically, physiologically, we are not very different from each other; historically, with narratives, each one of us is unique.’ (Sacks, 1998, p. 11).

Functional and structural neuro-imaging findings suggest that the difficulty in synthesizing, categorizing, and integrating the traumatic memory into a narrative may be related to the decreased volume of the hippocampus, the relative decrease in activation of the left hemisphere, and the decrease in activity of prefrontal cortex, anterior cingulated gyrus, and Broca’s area (Bremner, 2002; Hull, 2002). Neuroendocrine changes, such as lower cortisol levels, may also influence traumatic memory formation and processing and may be associated with the underlying pathology of PTSD (Yehuda, 2004). Nevertheless, it is of interest to understand why certain individuals may develop PTSD after traumatic exposure and others appear to be more resilient to the effects of trauma.

The perception and memory processes are intimately connected to generation of adaptive behaviours. Perception is also an inference process and may be biased by unconscious strategies that were functional and adaptive in the past (Nisbett & Masuda, 2003). Hence, past experiences affect current behaviour patterns by the predictions of the future that are biased by memory storage. However, the reconstruction of emotional and traumatic memories is continuous and dynamic. Neuroscience findings have shown that the brain does not actually store memories, but stores traces of information that are later used to create memories, which do not always factually represent what was experienced in the past. To perform this process, different parts of the brain act as important nodes of the neural network that encode, store, and retrieve the information that will be used to create memories (Baddeley et al., 2000; Gonsalves & Paller, 2002). Hence, whenever a traumatic or emotional event is retrieved, it may undergo a cognitive and emotional change. Loftus (Loftus, 1996; Loftus & Polage, 1999) observed imprecision of the remembrance process, demonstrating the phenomenon of false memories. DelMonte (2000) pointed out that there is no reliable way of distinguishing between true and false memories. Both can be held with equal conviction and vividness. Additionally, Leichtman, Wang, and Davies (2000) and Gonsalves and Paller (2002)
revealed that the similarities between false and true memories are deeper than researchers had previously thought and McNally (2003) reported that responses to traumas are also guided by emotional beliefs, regardless of their accuracy. Beckman (2003) drew attention to the compatible neurophysiological responses observed in PTSD patients with memories of events that could never have possibly happened. Modern trauma research and psychotherapy face a crucial issue. Even though an emotional memory does not always provide a completely factual picture of the past experience, the emotional content, configured as a memory, is an absolutely genuine representation of the internal references and their corresponding psychological dynamics. The natural human process of mixing and falsifying memories cannot be denied or avoided by psychotherapists. On the contrary, it must be used effectively to promote psychological health. When professionals dismiss patients' retrieved memories as falsehoods or fantasies, they may be greatly adding to their burden (DelMonte, 2000).

Even though human memories come from experiences, new memories are constructed and evoked from millions of memories and memory fragments found in the brain. In addition, multiple memory systems are activated simultaneously and may interact on various occasions (Poldrack & Packard, 2003; Wieser & Wieser, 2003). Thus, declarative memories aligned with resilient attitudes, such as positive learning from experiences, self-esteem, self-confidence and tranquillity to deal with difficulties may be part of this immense repertoire and, consequently, may participate in the memory rebuilding process. The retrieval of an emotionally charged memory is influenced by the particular interpretation of the event. Izquierdo (2002) states that ‘. . . we are what we remember. Without our memories, we would be nobody, and without evoking them, mixing them and falsifying them, we could not live’ (p. 9).

Moreover, neuroscience findings have shown that the most important regulators and modulators in the acquisition, formation, and evocation of memories are the emotions and the level of consciousness (Baddeley et al., 2000; Dolan, 2002). The retrieval of traumatic memories, whether spontaneous or provoked, occurs in an altered state of consciousness with important emotional expression. Once the state of consciousness shifts, the perception of the same event also changes (Dietrich, 2003) and, consequently, there is a new interaction and relationship with the difficult context which the sufferer of the trauma is dealing with. Therefore, therapists of individuals who are victims of trauma must be well-qualified to work with emotions and altered states of consciousness which directly modulate memory formation. We postulate that the neurophysiological faculty of reinterpreting and reconstructing emotionally charged memories can also be used with efficiency in psychotherapy.

**Personality causing consequences**

‘We don’t see things as they are, we see them as we are.’ (Nin, 1969, p. 220).

The search to understand response to trauma has turned to the contribution of personality and environmental factors. Studies suggest that previous exposure to trauma
and intensity of the response to acute trauma may affect the development of PTSD (Yehuda, 2004). Results indicate that individuals with feelings of insecurity, lack of personal control, and alienation from others are more likely to experience higher levels of depression and post-traumatic stress symptoms subsequent to exposure to traumatic events on the job (Regehr, Hill, & Glancy, 2000). Individuals who are unable to trust others, are sensitive to rejection, are easily hurt by others, and experience difficulty making friends, are more likely to experience higher levels of distress following a critical event (Regehr, Hemsworth, & Hill, 2001). Another study revealed that personality was the strongest factor differentiating individuals who took mental health stress (MHS) leave from those who did not. Although there was no significant difference in group means on the impact event scale, those in the group who had taken MHS leave in the past continued to report traumatic stress symptom levels in the high or severe range significantly more frequently than did their colleagues who had not taken leave. People with personality patterns characterized by suspiciousness, hostility, and isolation, and having a tendency toward demanding, controlling, and manipulative behaviour in relationships were more likely to have taken an MHS leave (Regehr, Goldberg, Glancy, & Knott, 2002). Meta-analytical studies have consistently revealed several clear predictors of PTSD reactions, including lack of social support, low intelligence and lack of education, family background, prior psychiatric history, and aspects of the trauma response itself, such as dissociative reactions (Brewin, Andrews, & Valentine, 2000; Ozer, Best, Lipsey, & Weiss, 2003).

On the other hand, what factors predict resilient functioning or efficient recovery? The term recovery connotes a trajectory in which normal functioning temporarily gives way to threshold or sub-threshold psychopathology - for at least several months - and then gradually returns to pre-event levels. By contrast, resilience reflects the ability to maintain a stable equilibrium (Bonanno, 2004). Developmental theorists have argued that resilience to aversive childhood situations results from a cumulative and interactive mix of genetic (e.g. disposition), personal (e.g. family interaction), and environmental (e.g. community support systems) risk and protective factors (Rutter, 1999; Werner, 1995).

Evidence suggests that the personality trait of hardiness (Kobasa, Maddi, & Kahn, 1982) helps to buffer exposure to extreme stress. Hardiness consists of three dimensions: being committed to finding meaningful purpose in life, the belief that one can influence one’s surroundings and the outcome of events, and the belief that one can learn and grow from both positive and negative life experiences. Hardy individuals are also more confident and better able to use active coping and social support, thus helping them deal with the distress they do experience (e.g. Florian, Mikulincer, & Taubman, 1995). The dispositional resilience implicit in hardiness has protected family assistance workers from the effects of disaster-related bereavement (Bartone, Ursano, Wright, & Ingraham, 1989).

A study of individuals who were in or near the September 11th attacks showed that self-enhancers reported better adjustment and more active social networks and were rated more positively and better adjusted by their close friends. Further, self-enhancers'
salivary cortisol levels exhibited a profile suggestive of minimal stress response (Bonanno, Rennicke, Dekel, & Rosen, 2003). Links between personality measures of resilience and adjustment following mass stressor events were mediated by the experience of positive emotions, such as solidarity, gratitude, interest, and love (Fredrickson, Tugade, Waugh, & Larkin, 2003).

The sense of belonging also seems to positively influence trauma recovery. Political commitment, social support in exile, prior knowledge of and preparedness for confinement, and torture in the imprisoned cohort served to foster resilience against psychological sequelae. The contribution of Buddhist spirituality plays an active role in the development of protective coping mechanisms among Tibetan refugees (Holtz, 1998). Nearly 850 studies have examined the relationship between religious involvement and some indicator of mental health in patients that experienced severe medical illness. Religious and spiritual coping behaviours were strongly related to patients being able to experience greater psychological growth from these stressful health problems, less anxiety and depression, and lower rates of substance abuse. Subjective confidence manifested by the belief in an all-powerful, loving, and responsive God may have brought to patients greater purpose and meaning in life and greater hope and optimism, which influenced how individuals coped with adversities (Koenig, 2001).

Early intervention in communities suffering massive trauma consists of general support and first improving the recovery environment rather than psychological treatment (Shalev, Tuval-Mashiach, & Hadar, 2004). The sense of responsibility among others, compassion, and a goal to achieve, foster the development of positive outcomes. After the strongest earthquake ever recorded in Mexico City, survivors of trauma demonstrated resilience and strength in dealing with the physical and psychosocial aspects of the disaster. Most residents continued to function in spite of the trauma (Gavalya, 1987).

Findings are consistent regarding the benefits of beliefs about the ability to cope, as reflected in such constructs as coping self-efficacy, mastery, self-esteem, optimism, and hope. What matters, apparently, is not how individuals actually cope, but rather how they perceive their capacities to cope and control outcomes. The perception that one is capable of managing specific demands related to a disaster is strongly predictive of good psychological outcomes (Benight, Ironson, & Durham, 1999). Lower distress has also been linked to higher self-efficacy (not disaster specific), perceived control, self-esteem, hopefulness, future temporal orientation, and optimism.

The ability of people to ‘spring back’ in the face of adversity may be related to the internal dialogue and self-interpretation of the event. Internal dialogues of self-pity, helplessness, being a victim of injustice, and self-deprecation may enhance negative emotions related to the traumatic memory and keep fostering psychological suffering. People who cultivate psychological dynamics with internal dialogues that accept faults, face the present and try to positively change it, set long-term goal and work with motivation and solidarity, more easily overcome psychological traumas.
Trauma and psychological dynamics

'I have done that, says my memory. I cannot have done that, says my pride. At last my memory yields.' (Nietzsche, 1886, p. 80).

Trauma, in its Greek etymological root, means lesion caused by an external agent. This concept migrated to the psychological field and, therefore, it is often assumed that a trauma occurs once the natural psychological defences have been trespassed. Freud (1962) stated that psychic trauma is a result of excessive excitement related to an individual's tolerance and capacity to integrate and psychically elaborate the stimulus. Our clinical observation reveals that there is more to this issue. The way people process the stressor event after the occurrence is critical for a trauma to be configured or not. The characterization of an event as traumatic not only depends on the stressor stimulus, but also on the tendency of the perceptive processing and on the representation patterns of reality present in the individual. The uniqueness repertoire of each individual seems to be related to the particular psychological dynamics involved in the processing of daily information and stimuli. Confirming our findings, theorists and researchers in the area of trauma are pointing to the importance of individual differences in resilience and vulnerability as key determinants of the intensity and duration of trauma-related symptoms (Bonanno, 2004; Chertoff, 1998; McFarlane & Yehuda, 1996).

Psychological dynamics can be understood as an emotional interpretative tendency that affects the internal dialogue related to a meaningful event. Just as two people in the same environment can experience and perceive two different situations and also observe corresponding aspects, emotional memories under the same conditions may be similar but never identical. The internal dialogue of an individual's psychological dynamics, based on self-experience processes, will affect the external relationship with the event. If a psychotherapist gives the same elements to two patients to tell a story, with or without emotional content, the story will have different psychological circumstances and incidents that make the story peculiar to each story teller. The experience reconstructed as a memory that triggers sadness or any other emotion must be respected as an undeniably subjective process. Narration of the traumatic memory is biased because the particular life repertory may bring interpretation patterns. Therefore, we believe that psychotherapists should look beyond emotional or traumatic episodes and perceive the psychological dynamics arising from the memory content. Once they understand the relationship between the emotionally-charged script that maintains the psychological suffering, they will be better able to treat the patient.

Freud wrote that if a person does not remember a trauma, it will probably be re-enacted: 'The trauma is reproduced not as a memory, but as an action, a behavior.' Freud emphasized that the individual would repeat some behaviours without being aware that the trauma was being repeated or re-enacted and believed that 'this was how the trauma was remembered' (Freud 1896/1962, p. 150). DelMonte (1998, 2000) also observed that certain traumatic memories may be acted out behaviourally by
a compulsion to repeat the abusive experience or engage in other self-destructive
dehaviours, such as substance abuse and self-mutilation, with what appears to be
masochistic gratification, but which may also be an attempt to master it. In fact, we have
observed that in general the patient is not aware of the psychological dynamics behind
the current behaviour. Curiously, these dynamics were generally repeated in the past
with less intensity. It is important to consider that significant past episodes also reveal
the functioning of the patient’s psychological dynamics and that these dynamics may be
repeated on various occasions. Thus, the therapist can help the patient become
conscious of the common ‘place’ occupied in different past emotional stories.
Traumatic memories are associated with the individual interpretation and belief systems
that may trigger behaviour patterns (Lamprecht & Sack, 2002). Therefore, we consider it
therapeutically important, when the traumatic memory with sensory fragments has
been linguistically encoded (DelMonte, 2000), that psychotherapists perceive
psychological dynamics arising from the memory content.

When specific dynamics, such as victim of injustice or self-pity scripts are repeated in
the patient’s speech, the therapist can ask whether the same script is present in the
narrative of the traumatic memory. If one specific place is occupied in several past
emotional stories, then the same dynamics may be occurring in the patient’s current
difficulty. Awareness of the psychological dynamics is a valuable therapeutic tool
and allows choices about which dynamics it would be better to cultivate in the
present. Psychotherapy can thus bring previously unconscious behaviour patterns
to the consciousness. Cognitive re-decisions based on a self-resilient repertoire
may promote the construction of new healthier internal dialogues, feelings, and
behaviours.

**Implications for psychotherapy**

‘The mind is its own place, and it itself can make heaven of Hell, a hell of Heaven.’ (Milton,
1996, p. 44)

The purpose of psychotherapy is to gradually attribute new emotional meaning to a
past traumatic experience that no longer occurs (van der Kolk et al., 1996). Psychological
science has been giving greater attention to exposure-based therapies for the cognitive
restructuring of past events under a new perspective of understanding and learning
(Leskin et al., 1998; Marks, Lovell, Noshirvani, Livanou, & Thrasher, 1998). The essential
component of exposure treatment involves repeated confrontations with memories of
the traumatic stressor (imaginal exposure). On the other hand, confrontation with
traumatic memories through debriefing has been shown to be ineffective when treating
individuals with PTSD (Lewis, 2003). Therefore, the therapeutic effect does not occur
only through confrontation, but in how the memories are confronted. The therapeutic
principle of repeated confrontations is aligned with predictors of positive outcomes,
such as facing adversities instead of avoiding difficulties.
We have observed that psychological dynamics permeate reconstruction of the memory and influence interpretation of the traumatic event and, consequently, the relationship with that event. We will briefly describe the three main phases that are necessary to therapeutically rebuild the memory process according to our exposure-based procedure. The first phase occurs during anamnesis when positive emotional memories related to resilient attitudes in which self-esteem, self-confidence, and a positive self-interpretation are retrieved and strengthened. Interpretations of the stressor event occur through internal dialogues and in how the individual remembers the trauma. Therefore, during the second phase, the individual evokes and narrates the traumatic memories to understand, with the help of the therapist, the emotions and states of consciousness that modulate the memory and corresponding perception, interpretation, and relationship with the stressor event. The patient becomes aware of the psychological dynamics and corresponding interpretations that maintain the psychological suffering. Since multiple memory systems are activated simultaneously and may interact on various occasions (Poldrack & Packard, 2003; Wieser & Wieser, 2003), therapeutic rebuilding of the traumatic memory is directly related to interface with the previously reinforced resilient memory bank. The third phase promotes dislocation of internal dialogues aligned to the resilient memory bank in order to generate new interpretations that will facilitate therapeutic reconstruction of the traumatic memory. The possibility of neural circuitry interaction is a crucial aspect for the development of a psychotherapy approach which could favour the search for a resilient integrative translation of the traumatic memory.

Since the psychological dynamics may maintain the dysfunctional behavioural pattern, the therapist will be able to better treat the patient once the relationship between the emotionally-charged memories and the psychological suffering brought to psychotherapy has been understood. We have observed that the manner in which the individual perceives, interprets, and relates to the stressor event through memory can be therapeutically modified. Our clinical experience shows that with this understanding the patient can consciously drive the choice to construct healthier psychological predictors of positive outcomes.

Clinical case report: fostering healthy predictors

‘Life is a mirror and will reflect back to the thinker what he thinks into it.’ (Holmes, 1997, p. 322).

All of the treatments that include cognitive interventions have exposure as one of their key elements (Brewin, Dalgleish, & Joseph, 1996). Exposure and cognitive restructuring, singly or combined, improved PTSD markedly and results continued to be stable (Marks et al., 1998). According to the Expert Consensus Guideline Series for treatment of PTSD (1999), exposure-based therapy was indicated as a psychological treatment of choice for flashbacks, intrusive thoughts, trauma-related fears, and avoidance.
A clinical case treated at our Institute is presented to exemplify how our exposure-based and cognitive restructuring therapy called reenactment restructuring therapy, may help trauma victims experience psychological growth from their negative experiences, by fostering healthy psychological dynamics.

A patient with PTSD and depression co-morbidity was diagnosed according to DSM-IV criteria. Her main complaints were that she had stopped her daily activities and isolated herself at home and had suffered from flashbacks and intrusive thoughts due to a kidnapping 8 months prior to starting therapy. The patient Ms. M., 36 years old, married, and the mother of two girls, underwent 16 sessions (one per week) in approximately 4 months. The Clinician administered PTSD scale (CAPS; Blake et al., 1990), the structured clinical interview for DSM-IV (SCID; First, Spitzer, Gibbon, & Williams, 1995), the Impact of event scale (IES; Horowitz, Wilner, & Alvarez, 1979), the beck depression inventory (BDI; Beck & Steer, 1987), and the beck anxiety inventory (BAI; Beck et al., 1988) were applied four times: (1) before psychotherapy, (2) after psychotherapy, (3) 5 months after psychotherapy (follow-up), and (4) 12 months after psychotherapy (follow-up; Table 1).

<table>
<thead>
<tr>
<th>Instruments</th>
<th>Pre-RRT</th>
<th>Post-RRT</th>
<th>5-Month follow-up</th>
<th>12-Month follow-up</th>
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<tbody>
<tr>
<td>BAI</td>
<td>32</td>
<td>12</td>
<td>10</td>
<td>11</td>
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<tr>
<td>BDI</td>
<td>14</td>
<td>5</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>IES</td>
<td>42</td>
<td>21</td>
<td>18</td>
<td>19</td>
</tr>
<tr>
<td>CAPS</td>
<td>54</td>
<td>26</td>
<td>22</td>
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Note. The higher the score, the worse the measured quality. At pre-psychotherapy, post-psychotherapy, 5-month follow-up and 12-month follow-up. RRT = reenactment restructuring therapy; BAI = beck anxiety inventory; BDI = beck depression inventory; IES = impact event scale; CAPS = clinician administered PTSD scale.

During anamnesis, the therapist investigated how Ms. M. dealt with past adversities, not related to the current trauma. Ms. M. described various situations where she felt vulnerable, fragile, and unable to change childhood situations that caused suffering. As an adult even when right, Ms. M. did not argue with authority figures, such as older brothers, teachers, and bosses because she felt unable to defend herself. The emotionally impacting situations brought the reoccurring statement, 'I felt very little, rejected and unable to do anything'. She considered the episodes unfair, presenting self-pity and then manifesting significant anger. During anamnesis, the therapist helped Ms. M. select some positive memories from episodes in which she had faced and overcome her fear of the dark at the age of 11, overcome her fear of travelling without her parents at 16 and enjoyed herself, at the age of 18, defended her younger cousin when she was beaten up by an older boy, and at 29, argued with her son's doctor.
because of lack of attention, thus obtaining the correct treatment. These and other resilient memories created security, self-confidence, and a good self image.

The exposure-based and cognitive restructuring therapy gradually helped Ms. M. realize how strong the anger was and that actually, she had survived important adversities and, if she had not been a strong person, this would not have happened. Throughout narration of the traumatic events, Ms. M. became aware of the reoccurring dynamics related to self-pity and her refusal to believe that she could deal with adversities. The internal dialogue, ‘I just cannot do it’ was verified several times during the narration of her negative emotional memories. Ms. M. realized that the same psychological dynamics of fragility, helplessness, and lack of ability occurred in her present life as she retrieved and reinterpreted the traumatic memories of a kidnapping that had occurred 8 months before starting psychotherapy. Ms. M. was surprised to realize that the same expression, ‘I felt very small and unable to do anything’ was repeated when she retrieved the still sensorial fragmented and narratively disorganized memory of the kidnapping. Ms. M. became aware of the unconscious pattern in a satisfactory manner. In a calm relaxed state, the patient contacted the previously reinforced resilient memory bank in order to generate new interpretations that would facilitate therapeutic reconstruction of the traumatic memory. Questions such as, ‘How can your resilient experiences help you now?’ ‘What learning can be gained from this experience so you can lead a better life in the present?’ ‘How do you want to use the awareness you’re acquiring in your daily life?’, were asked at appropriate moments.

After becoming aware of these unconscious behaviour patterns, Ms. M chose a new place to occupy in her current moment life. Ms. M. elaborated cognitive re-decisions that created new psychological dynamics based on her strength and ability to face adversities, such as, ‘I am an adult who can control my life and feel good. I respect my strength and can face difficulties calmly and confidently’, and ‘I can resume my daily activities and be secure and happy’. Healthy psychological dynamics, predictors of a positive outcome, occurred at the behavioural level by putting the re-decisions into practice. Gradually, Ms. M. resumed her daily activities, the flashbacks and intrusive thoughts decreased, and sleep patterns returned to normal as of the sixth week. Afterwards, Ms. M. narrated her memories in a more cognitively organized manner and applied a new therapeutically biased narration that modified the valence of the preceding traumatic memory. We believe that a sensory fragmented memory – probably non-hippocampally dependent – was translated into a declarative (emotional) memory – hippocampally dependent (Brewin, 2001; Brewin et al., 1996). The beck anxiety inventory (Beck & Steer, 1987), the beck depression inventory (Beck et al., 1988), the Impact of event scale (Horowitz et al., 1979), and the Clinician administered PTSD scale (Blake et al., 1990) scores decreased satisfactorily after 4 months of psychotherapy (Table 1). Ms. M. was clinically monitored for 12 months after the psychotherapy (Table 1). Gains continued to be stable, Ms. M. maintained healthy dynamics and there was no reoccurrence or shifting of symptoms.
Final considerations

'The past is malleable and flexible, changing as our recollection interprets and re-explains what has happened.' (Berger, 1963, p. 57).

The outcomes of trauma survivors can vary according to the severity of exposure and personal characteristics (Norris et al., 2002). Several studies discuss the meaning and implications of the factors predicting resilience and vulnerability. Irrespective of the nature and magnitude of trauma, the most outstanding predictor of future positive adjustment and resilience is a healthy outlook based on knowledge of one’s capacity to face and overcome difficulties – looking forward instead of recreating suffering. When people become traumatized it is often to look for a new sense of meaning and purpose in their life. Psychotherapy appears to enable sufferers of psychological trauma to cope better and experience psychological growth from their negative experiences, rather than be defeated or overcome by them. Intervention programs for trauma must be prepared to address underlying patterns of interpersonal relating, as well as immediate symptoms of distress (Regehr et al., 2001).

Emotionally-charged memories are subjective representations of an event, often distorted and distant from the original episode, but even so, the meaning to the individual is absolutely true. Although there is a marked degree of inter-individual variability in how memory of life-events and basic emotions are processed (Eugene et al., 2003), the neural ability to reconstruct emotional and traumatic memories can also be used efficiently in psychotherapy. The level of consciousness and emotions modulates memory formation (Baddeley et al., 2000; Dolan, 2002) and multiple memory systems are activated simultaneously and may interact (Poldrack & Packard, 2003; Wieser & Wieser, 2003). Considering neuroscience findings, a key factor for therapeutically reconstructing traumatic memories is to correctly deal with states of consciousness and emotions, since the shift of both may enable people to alter memory modulation and, consequently, the way they process and perceive the past event. In addition, the psychological dynamics attached to emotional memories may be mutable, especially when the unconscious process of interpreting events becomes conscious.

We postulate that psychotherapy of trauma victims must go beyond the episode itself, reconstructed as a memory, so the patient can observe the psychological characteristics that permeate interpretation of the event. However, it is not an interpretative psychotherapeutic process since the patient is given the tools to understand the relationships between the emotional content retrieved as a memory and the place occupied in the story according to the particular psychological dynamics.

Determining the relative influence of individual psychological dynamics is important for the further development of theoretical models for understanding trauma responses and for subsequent development of intervention strategies that are sensitive to individual differences. The belief that one can learn and grow from both positive and negative life experiences, and the perception of having capacities to cope and control outcomes, are crucial aspects to be worked with in psychotherapy. However, therapists
do not have to tell the patient ‘how to do it’, but rather facilitate the self-understanding about the psychological dynamics to be chosen to develop new self-growing interpretations and behaviours.

The intention of this article is to shed light on the value of psychotherapeutic work with internal dialogues that may unconsciously keep the patient attached to the suffering. The clinical case presented summarizes our clinical experience. Once there was awareness of the psychological dynamics, the patient was able to choose a healthy internal dialogue and, consequently, a new relationship with the past traumatic event. Changing the internal dialogue related to the past seems to be easier than changing the past traumatic memory. Nevertheless, the self-growing dialogue triggered the construction of a resilient behaviour that fostered a new emotional valence for the previous memory. Elucidating an unconscious behavioural pattern may allow a person to better choose dynamics aligned to a healthy present.

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