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Different Types of Traumatic Memory

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I. Introduction: As discussed at length in “Brain Science, Psychological Trauma, and The God Who is With Us, Part III: Traumatic Memories vs Non-Traumatic Memories,”¹ the first and most important distinction is between non-traumatic memories and traumatic memories. When an experience completes its journey through the processing pathway, and all processing tasks are successfully completed, it is stored as a non-traumatic memory. In contrast to a traumatic memory, it will not contain any unresolved, toxic content, it will be easy to access, and any learning associated with it will be much easier to modify.

Non-traumatic memories:

- Experiences that have been completely and successfully processed
- Do not contain any unresolved, toxic content
- Easily available to voluntary conscious recall
- Associated learning easier to modify

Traumatic memories:

- Experiences that have *not* successfully completed their journey through the processing pathway
- Contain unresolved, toxic content
- *Not* easily available to voluntary conscious recall²
- Difficult to modify

Just as it is important to recognize that non-traumatic memories are different from traumatic memories, it is also important to recognize that there are different kinds of traumatic memories. And just as with non-traumatic memories vs traumatic memories, *the different kinds of traumatic memories display qualitative differences – they feel subjectively different and behave differently in ways that are consistent and important.*

II. Importance of recognizing and understanding different kinds of traumatic memories: A medical analogy can help us perceive the importance of recognizing and understanding the different kinds of traumatic memories. Consider what would happen if doctors lumped all people with breathing difficulties into one group, so that people with lung cancer, asthma, and pneumonia were all simply diagnosed as dyspnea (the fancy medical term for difficulty breathing). One group of physicians might develop special skill in recognizing and treating

¹ Available as a free download from the Special Subjects/Advanced Topics section of the Resources page of www.immanuelapproach.com.

² For most mild-to-moderate non-dissociated trauma occurring in mid-childhood or later, *explicit autobiographical* components of the memories are actually easily available to voluntary conscious recall. In contrast, the toxic, traumatic implicit-memory content in all categories of traumatic memories is almost always difficult to access. (The exception being PTSD with intrusive traumatic content.)

people with the particular clinical picture of lung cancer,³ and this team would eventually gather more and more patients with lung cancer. Another group of physicians might develop special skill in recognizing and treating people with the particular clinical picture of asthma, and this team would eventually gather more and more patients with asthma. A third group might develop special skill in recognizing and treating people with the particular clinical picture of pneumonia, and this team would eventually gather more and more patients with pneumonia.

Once this pattern had been established, what would happen if the three groups started doing research on the patients in their respective clinics, and then met to discuss their discoveries? An amazing amount of misunderstanding, confusion, and conflict would quickly ensue. The research team working with the first group would describe carefully conducted studies “proving” that dyspnea was a frighteningly serious disease, and that surgery and chemotherapy must be aggressively applied as soon as possible to provide any hope of survival. They would also describe studies showing that antihistamines, allergy shots, and antibiotics are completely ineffective, and they might even imply that doctors prescribing these treatments are incompetent.

The research team working with the second group would then come forward and describe carefully conducted studies “proving” that dyspnea was mostly a nuisance, and that it could almost always be adequately managed with antihistamines and allergy shots. They would also describe studies showing that surgery and chemotherapy are dangerous and unnecessary, and that antibiotics are mostly harmless but also worthless. They might even suggest that doctors applying these other interventions were just waiting for malpractice suits.

Finally, the research team working with the third group would come forward and describe carefully conducted studies “proving” that dyspnea could be very dangerous if not properly managed, but that it usually resolved quickly when treated with the appropriate antibiotic. They would describe studies supporting group number two's assessment regarding the unnecessary danger of surgery and chemotherapy, but then would also present studies clearly demonstrating that it was antihistamines and allergy shots, not antibiotics, that were “harmless but worthless.” And having been nettled by earlier comments, they would comment that the only incompetent doctors waiting for malpractice suits were those who used treatments other than antibiotics.

What a mess! Not to mention the dire consequences should some poor patient with asthma find his way into the clinic that saw every case of dyspnea as lung cancer (or vice-versa).

Sadly, this hypothetical medical analogy is not far from the truth when it comes to working with traumatic memories, in that most discussions of traumatic memory have not made any distinction between dissociated traumatic memories and traumatic memories that are not dissociated. For example, the majority of research psychologists studying traumatic memories work with non-dissociated autobiographical memories for mildly to moderately traumatic experiences.⁴ Most of the remaining research psychologists studying traumatic memories work with non-dissociated memories for mildly to moderately traumatic events that occurred during early childhood, before

³ Even though the “official,” accepted formulation was “all patients with breathing difficulty have the same illness,” doctors with good right hemisphere skills would *intuitively* recognize that certain “dyspnea” patients had a particular clinical picture, and they would *intuitively* recognize that patients with this particular picture did much better with certain treatments (any treatments that would be effective for an underlying lung cancer).

⁴ For example, they might have subjects watch disturbing video footage as a way to induce very mild trauma in the laboratory, and then study the memories for these traumatic experiences; or they might question study subjects regarding past traumatic experiences that are accessible to their conscious awareness as autobiographical memories.

the hippocampus and the autobiographical memory system are on line. Both of these groups of research psychologists then apply the data and conclusions from these studies to discussions regarding “traumatic memories,” without making a distinction between traumatic memories that are dissociated and traumatic memories that are not dissociated.

Not surprisingly, this has often resulted in misunderstanding, confusion, and conflict. One of the most significant places this has happened has been in the false memory/recovered memory debate, where research results from studies of non-dissociated traumatic memories are used to argue that the amnesia and recovery seen with dissociated memories do not exist. For example, studies with autobiographical memories for mildly to moderately traumatic experiences have shown that traumatic experiences will be remembered *more* intensely and persistently than non-traumatic experiences, and some authors have used these findings to argue that there is no such thing as dissociative amnesia that could cause a person to “forget” an intensely traumatic experience immediately after it occurs. Another example is provided by people working with non-dissociated memories from *mild to moderate*⁵ early childhood trauma. These studies gather data that clearly describe the pre-hippocampal, pre-autobiographical memory phenomena discussed in Part III.⁶ And as described in this Part III discussion, these memories are not even accessible as coherent autobiographical narratives, and they certainly never come forward as vivid, detailed experiences of “reliving” the original events. Some authors then use this data to argue against the existence of level 2 dissociative amnesia, and then later “flashback” recovery, for early childhood trauma.

III. Overview of different kinds of traumatic memories: Note that *all* traumatic memories contain unresolved, toxic content from painful experiences that have not successfully completed their journey through the processing pathway, and that *all* traumatic memories are difficult to access⁷ and difficult to modify.⁸

A. “Normal” explicit autobiographical traumatic memories:

- Contain unresolved, toxic content from painful experiences that have not successfully completed their journey through the processing pathway
- Memories for traumatic events occurring after librarian function for filing and retrieving autobiographical memories is in place (hippocampus is fully myelinated – three to five years old or older).
- Explicit⁹ autobiographical components of memory are available to voluntary conscious

⁵ The point with respect to “mild to moderate” is that the content is *not* dissociated, and therefore does not display the vivid flashback recall associated with severe traumatic content that *is* dissociated.

⁶ “Part III” refers to the essay, “Brain Science, Psychological Trauma, and The God Who is With Us, Part III: Traumatic Memories vs Non-Traumatic Memories.”

⁷ Again, the explicit autobiographical components of some traumatic memories can be easily accessed just like non-traumatic explicit autobiographical content. And with the exception of intrusive PTSD trauma content, all traumatic memories have *toxic traumatic implicit-memory content* that is difficult to access.

⁸ The toxic traumatic implicit-memory content of traumatic memories can only be permanently modified and resolved through the memory reconsolidation process, as discussed in “The Place of the Immanuel Approach In the Treatment of Clinical Disorders,” available as a free download from the Special Subjects/Advanced Topics section of www.immanuelapproach.com.

⁹ If you are not already familiar with the important differences between explicit implicit memory, see the first four pages of chapter two in *Outsmarting Yourself* or section IV. Implicit Memory Vs Explicit Memory in “Brain Science, Psychological Trauma, and The God Who is With Us, Part III: Traumatic Memories vs Non-Traumatic

recall just like explicit autobiographical content from any other memory. In fact, the explicit autobiographical components are especially available to voluntary recall because mild to moderate trauma that is not sufficiently intense to trigger suppression and/or repression and/or dissociation produces especially strong explicit autobiographical memory traces.

- Toxic traumatic implicit-memory content is *not* available to voluntary conscious recall. When trauma content is activated in associated with recalling/describing the explicit autobiographical components, the trauma content is often/sometimes recognized as memory. However, the trauma content usually comes forward as implicit memory when activated by triggers that resemble one or more aspects of the original experience, and in these scenarios it is usually *not* recognized as memory.
- Difficult to modify. (Toxic traumatic content can only be modified/resolved through the memory reconsolidation process.)¹⁰

B. Non-dissociative traumatic memories, with most explicit autobiographical content lost through prolonged suppression/avoidance:

- Contain unresolved, toxic content from painful experiences that have not successfully completed their journey through the processing pathway
- Memories for traumatic events occurring after librarian function for filing and retrieving autobiographical memories is in place (hippocampus is fully myelinated – three to five years old or older).
- Explicit autobiographical components of memory have mostly been lost, so that memory for the experience is no longer available to voluntary conscious recall as normal explicit autobiographical memory. Even with extensive emotional healing work, only scattered fragments of autobiographical content are ever recovered.
- Toxic traumatic implicit-memory content is not available to voluntary conscious recall, but rather comes forward when activated by triggers that resemble one or more aspects of the original experience. This toxic implicit-memory content is usually *not* recognized as memory.
- Difficult to modify. (Toxic traumatic content can only be modified/resolved through the memory reconsolidation process.)

C. Non-dissociative traumatic memories, with most/all autobiographical content buried through repression:

- Contain unresolved, toxic content from painful experiences that have not successfully completed their journey through the processing pathway
- Memories for traumatic events occurring after librarian function for filing and retrieving autobiographical memories is in place (hippocampus is fully myelinated – three to five years old or older).
- Explicit autobiographical components of memory have mostly/completely buried through repression, so that they are not available to voluntary conscious recall (as long as the repression remains in place). However, much of the autobiographical content can often be recovered with emotional healing work.
- Toxic traumatic implicit-memory content is not available to voluntary conscious recall, but rather comes forward when activated by triggers that resemble one or more aspects of the

Memories,”

¹⁰ Again, toxic traumatic implicit-memory content can only be permanently modified and resolved through the memory reconsolidation process.

original experience. This toxic implicit-memory content is usually *not* recognized as memory.

- Difficult to modify. (Toxic traumatic content can only be modified/resolved through the memory reconsolidation process.)

D. Impaired-hippocampus non-dissociative traumatic memories:

- Contain unresolved, toxic content from painful experiences that have not successfully completed their journey through the processing pathway
- Memories for traumatic events that occur *during the time when the hippocampus is coming on line but is still immature* (between 3 and 5 years of age), or for later traumatic events that are severe enough to impair the hippocampus (but not totally disable it).
- Explicit autobiographical components of memory are more difficult to access, but still available to voluntary conscious recall. However, when the hippocampus is *impaired-but-not-totally-disabled* it does a poor job of mapping how the different components of the experience fit together, so that when the memory is recalled the different components of the experience come forward in a disorganized jumble instead of being coordinated into a coherent autobiographical story. If you ask the person to describe the traumatic event, he will have trouble remembering how the visual images, auditory memories, cognitions, and emotions all fit together, and will tell a story that is disorganized and confusing.
- Toxic traumatic implicit-memory content is not available to voluntary conscious recall, but rather comes forward when activated by triggers that resemble one or more aspects of the original experience. This toxic implicit-memory content is usually *not* recognized as memory.
- Difficult to modify. (Toxic traumatic content can only be modified through the memory reconsolidation process.)

E. Pre-hippocampus/pre-autobiographical non-dissociative traumatic memories:

- Contain unresolved, toxic content from painful experiences that have not successfully completed their journey through the processing pathway
- Memories for traumatic events that occur *before the hippocampus is neurologically “on line”* (before 3 to 5 years of age), or for later events that are so traumatic that the hippocampus is totally knocked off line by extreme stress and cortisol.
- Autobiographical components are not available to voluntary conscious recall as explicit memory, but rather come forward as implicit memory fragments in response to triggers. These implicit-memory autobiographical fragments are often/usually not recognized as memory.
- Toxic traumatic content is not available to voluntary conscious recall, but rather comes forward as implicit memory in response to triggers that resemble one or more aspects of the original experience. This toxic implicit-memory content is usually *not* recognized as memory.
- Difficult to modify. (Toxic traumatic content can only be modified through the memory reconsolidation process.)

F. Traumatic memories dissociated at level 2:

- Contain unresolved, toxic content from painful experiences that have not successfully completed their journey through the processing pathway.
- Memories for traumatic events that exceed involuntary capacity limit, and are therefore disconnected at level 2.
- Much more difficult to access. Neither autobiographical components or toxic traumatic

content are available to voluntary conscious recall. Can only be accessed under conditions that resolve, navigate around, or temporarily overcome the level 2 involuntary dissociative barriers.

- Difficult to modify. (Toxic traumatic content can only be modified through the memory reconsolidation process.)

G. Traumatic memories dissociated by internal parts:

- Contain unresolved, toxic content from painful experiences that have not successfully completed their journey through the processing pathway.
- Each of the other categories can be “dissociated” into amnesia by internal parts who employ mind/spirit *free will choice* to place the content behind amnesic barriers.
- Much more difficult to access. Just as with memories dissociated at level 2, neither autobiographical components or toxic traumatic content are available to voluntary conscious recall. Can only be accessed under conditions that resolve, navigate around, or temporarily overcome the internal part’s voluntary dissociative barriers.
- Neurological mechanisms** for creating these amnesic barriers **unknown**.
- Difficult to modify. (Toxic traumatic content can only be modified through the memory reconsolidation process.)

H. **Should have a section for traumatic memories carried in the mind/spirit**

(See *Mind and Brain: Separate but Integrated* for discussion of memories that seem to be carried in the non-physical mind/spirit, in that they would be totally impossible in the context of what we know about memory and the biological brain.)

IV. Additional discussion regarding explicit autobiographical memories:

Especially in the professional mental health community, we can get so focused on pre-autobiographical memories, trauma-distorted memories, dissociated memories, recovered memories, and memories with autobiographical details lost through suppression/avoidance that we forget most traumatic experiences are carried as just plain old “normal” memories – explicit autobiographical memories that are easily accessible to the recipient’s conscious mind with simple voluntary recall. For example, if, at any point in my life, you had asked me about my experiences of being bullied on the playground, I could have easily reached into my hippocampal-librarian filing system and retrieved these events as conscious, explicit, autobiographical memories.¹¹

In the most common emotional healing scenario, the underlying trauma is just a plain old explicit autobiographical memory. The recipient starts with focusing on a trigger in the present, she asks Jesus for guidance and help regarding the underlying source of the triggered reaction, and then she recalls a traumatic event that has always been available to her voluntary conscious recall. For example, I focused on my exaggerated anxiety when approaching an important project in my adult work environment, and the associated spontaneous thoughts along the lines of, “I’m afraid I’ll mess up and everybody will laugh at me.” I asked Jesus for guidance and help regarding the underlying source of the triggered reaction. And then a memory came forward in which I was playing baseball with my friends on the playground after school, and I kept dropping the ball followed by everybody laughing and making fun of me (a memory that I had always been able to recall as a conscious, explicit autobiographical memory).

¹¹ This is true for almost all of the mild-to-moderate trauma I describe as part of my own examples in the “Memory-Anchored Distortions, Hindrances, and Blockages” supplementary chapter (available as a free download in the “Immanuel Approach Book (Draft Version)” section of the Resources page of www.immanuelapproach.com).

V. Additional discussion regarding non-dissociative traumatic memories with most explicit autobiographical content lost through prolonged suppression¹²/avoidance: Most people know about repression and dissociation as psychological phenomena that can cause a person to “lose” memories for traumatic events. However, many do *not* know about prolonged suppression/avoidance as a subtle, quiet phenomena that can cause people to lose the conscious, explicit autobiographical content for traumatic memories.

Recalling, thinking about, and talking about an experience will strengthen the neurological connections that carry the conscious, explicit autobiographical memory content. For example, the memories from my childhood that are still clear and strong even after fifty to sixty years are for events that occurred during family vacations, memories from Christmas mornings, and other events from childhood that I and my family have frequently remembered and talked about. In contrast, when we do *not* recall, think about, or talk about an experience, the neurological connections that carry the conscious autobiographical content are *not* activated, refreshed, and strengthened, and the memory progressively weakens and fades. For example, one of my siblings will occasionally tell a story about something that happened to all of us during a childhood family vacation – an event that was just as striking/interesting/entertaining as other events, *from the same vacation*, that I still remember clearly – but I have no memory of what they are describing. And it always turns out that these are experiences that they have repeatedly recalled, thought about, and talked about with their friends and kids, but that I have *not* activated, refreshed, and strengthened.¹³

Looking at my original session notes for thirty-to-forty-year-old case-study stories provides another example. With some of these stories, my spontaneous internal response as I start reading is, “Oh yes – I remember that!” and, “Ah, yes, that was so amazing. It was an honor to be in the middle of that session.” And these turn out to be stories that I have repeatedly activated, refreshed, and strengthened over the years as I have thought about, written about, and talked about emotional healing. In contrast, there are other stories that I have almost completely forgotten. With these stories, when I first find them I cannot recall *any* of the details. And even after carefully reading through my own detailed written account, I can remember only a few faint scraps. These always turn out to be stories that I have *not* activated, refreshed, and strengthened.

The most dramatic example of this forgetting caused by lack of activating, refreshing, and strengthening occurs when we deliberately, repeatedly “look away” from the painful memories for small-t traumatic experiences. With this variation of forgetting, it’s not just that we don’t recall, think about, and talk about certain memories because some reminder or need does not repeatedly bring them to mind, but rather that we *deliberately* avoid recalling them, thinking about them, or talking about them because reconnecting with these memories is painful and we don’t know what else to do with them. And when we continue this suppression/avoidance for a long time, most of the explicit autobiographical content from these small-t trauma experiences is permanently lost.

¹² “Psychological suppression is the conscious, deliberate act of pushing unwanted thoughts, feelings, or impulses out of your awareness.” (Google AI overview 8/5/26).

¹³ This is also what happens to thousands and thousands of minor autobiographical memory events and details, such as the experience of going shopping for groceries on October 23rd of 2007, or the details of what you had for lunch on May 16th of 2011.

Initially the autobiographical content from these memories is available to our voluntary conscious recall. For example, if you talked to a person a few days after a painful experience that they were suppressing, and offered a large reward if they could describe the details, they could choose to press through their suppression/avoidance and recall all of the autobiographical details. However, under normal circumstances we subtly-but-persistently avoid recalling, thinking about, or talking about these memories, and the explicit autobiographical content increasingly fades due to straight-forward neurology.¹⁴

My perception is that most of us have a lot of small-t trauma for which most/all of the explicit autobiographical content has been lost through this “looking away,” suppression/avoidance forgetting process.

Traumatic experiential learning content remains: It is really important to note that even when almost all of the explicit autobiographical content has been permanently lost, the implicit-memory traumatic experiential learning content, including distorted, erroneous beliefs (lies) and their associated emotions, will still remain and can be triggered.

Small-t traumatic memories: This suppression/avoidance forgetting can only occur with small-t trauma, with original autobiographical memories that are comparatively weaker due to their comparatively lower intensity. In contrast, with most large-T trauma the autobiographical details are remembered with unusual clarity because of the unusual intensity of the experience. (I cannot think of any examples of Large-T trauma for which most autobiographical details have been forgotten due to prolonged suppression/avoidance.) And with severe/extreme large-T trauma, the too-intense experiences get dissociated.

Research demonstrating forgetting from suppression/avoidance: Research studying suppression-induced forgetting (which is also sometimes referred to as “motivated forgetting,” “intentional forgetting,” or “directed forgetting,” clearly demonstrates the existence of an *active forgetting process* that looks a lot like the suppression/avoidance that I describe in this essay. These research results show that we can *choose* to “look away” from selected memory content, and that this voluntary looking away impairs later attempts to recall the selected material.¹⁵

Suppression/avoidance forgetting looks and feels like pre-autobiographical trauma: This kind of traumatic memory will behave a lot like pre-autobiographical (early childhood) trauma. That is, the toxic traumatic implicit-memory content can be easily activated by triggers in the present, but when the recipient focuses on the triggered content and asks God to help find the underlying trauma she will not get normal explicit autobiographical memories. Rather, she will only find faint/vague scraps and pieces of autobiographical content, mixed together more of the toxic trauma content carried in the underlying memories. Even with thorough healing work to the point

¹⁴ The synapse connections carrying the actual autobiographical content, along with the hippocampal-librarian connections carrying the information regarding where to find the material and how to retrieve it, all progressively weaken since they are not being reinforced by repeated activation. In contrast to the autobiographical content, the implicit-memory toxic trauma content does not weaken/fade because it is reinforced every time it gets triggered.

¹⁵ See, for example, Anderson, M. C., Ochsner, Kevin N., et al. “Neural Systems Underlying the Suppression of Unwanted Memories.” *Science*. January 9, 2004, Vol. 303: pages 232-235.; Baddeley, A., Michael W. Eysenck, M.W., & Anderson, M.C., *Memory. Motivated Forgetting* (New York: Psychology Press, 2009). Pages 217-244; Johnson, H.M., “Processes of successful intentional forgetting”. *Psychological Bulletin*. 1994, Vol. 116, No. 2: pages 274–292.; MacLeod C.M., “Long-term recognition and recall following directed forgetting.” *Journal of Experimental Psychology: Human Learning and Memory*. 1975, Vol. 1, No. 3: pages 271–279.

that all toxic content is resolved, the recipient will only ever recover a handful of these faint/vague scraps and pieces.¹⁶ Another way to say this is that there is nothing wrong if the toxic content has been resolved but you still have only a few faint scraps of autobiographical content – there is no need to keep digging, or to worry that there must be an elaborate dissociative system that you need to uncover and work with.

Working with these memories is very similar to working with pre-autobiographical trauma: Working with suppression/avoidance forgetting memories is very similar to working with pre-autobiographical (early childhood) memories:

- Not being able to find underlying explicit autobiographical trauma memories makes it especially easy to conclude that the toxic content is really about the triggers, and to correspondingly get stuck fighting with the triggers instead of persisting with looking for the harder-to-recognize underlying trauma, that will present as just a mixture of toxic implicit-memory trauma content and faint/vague autobiographical fragments.
- Recipients need to be especially deliberate and persistent with “This _____ (details re traumatic content) is memory. It really, really feels like it’s about this trigger, but this is memory.” Recipients need to be especially deliberate and persistent with inviting and connecting with Jesus *inside* the toxic trauma content *as memory*. And recipients need to be especially deliberate and persistent to work with Jesus in looking at, thinking about, and re-processing the toxic trauma content *as memory*.
- Just as with pre-autobiographical memory, special access tools/resources can be very helpful.¹⁷

Practical considerations regarding forgetting caused by suppression/avoidance: There are a few practical benefits to knowing about this phenomenon. For example, if you realize that you are working with traumatic memories with suppression/avoidance forgetting, you can deliberately use the principles and tools that are especially helpful for working with pre-autobiographical and suppression/avoidance-forgetting trauma. And if observable, lasting positive changes confirm that you have resolved the trauma, you can trust the healing more easily if you realize that the lack of autobiographical details is simply due to suppression/avoidance forgetting. (That is, you don’t need to worry that you should keep searching for some elaborate dissociative system in order to explain the lack of autobiographical details.)

VI. Additional discussion regarding non-dissociative traumatic memories with most/all autobiographical content buried through repression: Some authors currently (as of 2026) claim that “science” has largely discredited the idea that traumatic memories can be repressed to the point that most/all of the autobiographical content is not available to voluntary conscious recall, and that these memories can then be recovered at some later time so that much/most of the autobiographical content is once again experienced as normal explicit autobiographical

¹⁶ My kindergarten and first grade memories of not being able to read due to dyslexia provide a good example. For detailed description and discussion of this example, see “Forgetting Caused by Suppression/Avoidance: ‘Where did kindergarten and first grade go?’” (available as free download from the “Case Studies” section of the Resources page of www.immanuelapproach.com).

¹⁷ For discussion of special memory access tools/resources that can be helpful for working with both pre-autobiographical memories and memories with autobiographical content that has been lost through prolonged suppression/avoidance, see “A Case Study in Additional and Special Memory Access Tools: Working With My Own 18 Month-Old Separation Trauma,” available as free download from the Kellehman.com Website Archives section of the Resources page of www.immanuelapproach.com.

memory.¹⁸ As I argue at length in “Discerning Truth in Memory,” this position is profoundly flawed, and there is compelling evidence to show that both repression, and recovery of repressed memories, are real, valid, important phenomena.

Compare/contrast to suppression/avoidance-forgetting: In contrast to suppression/avoidance-forgetting, with repression the autobiographical content is lost/buried over the course of hours, days, weeks, months, or a few years (as opposed to being forgotten over many years). Furthermore, much/most of the autobiographical content can usually be recovered with emotional healing work. In fact, a common scenario is for a survivor with many years of repression amnesia to experience many autobiographical details suddenly coming forward after she encounters a powerful activating trigger such as watching a movie that portrays a scenario similar to her trauma.¹⁹ And as described above, with suppression/avoidance-forgetting only a few faint scraps of autobiographical content can be recovered, even with healing work that is sufficiently thorough to resolve the trauma content.²⁰

Compare/contrast to dissociation: In contrast to dissociation, with repression the autobiographical content is lost/buried over the course of hours, days, weeks, months, or a few years (as opposed to lost/dissociated almost instantaneously – over the course of a few seconds).

Supporting research, corresponding brain function: As mentioned above, research on suppression-induced forgetting demonstrates that our brains can actively push away unwanted thoughts through a top-down inhibitory control network. And some authors are concluding that what has previously been called repression is just the same thing as this suppression-induced forgetting. However, there are important differences between suppression/avoidance-forgetting and repression (as just described), and this research demonstrates the slow forgetting and weak recovery seen with suppression/avoidance, but **not** the rapid forgetting and strong recovery seen with repression. Strong data points indicating that some kind of top-down inhibitory control contributes to repression are case studies where repressed trauma is suddenly, dramatically recovered after injury to the patient’s pre-frontal cortex.²¹

¹⁸ August 13, 2026 both Wikipedia and GOogle AI summary presented this view. Significantly, both of these sources almost entirely cited authors on only the false memory side of the false memory/recovered memory debate.

¹⁹ For an example of this kind of scenario, see case-study #5 on page 667 of Williams LM. “Recovered memories of abuse in women with documented child sexual victimization histories.” *Journal of Traumatic Stress*. 1995 October; Vol. 8, No. 4, pages 649-73. Also, the autobiographical details for repressed memories can sometimes initial be faint/vague, and can sometimes come forward slowly during the course of ongoing healing work. But even in these scenarios, many/most of the autobiographical details are eventually recovered.

²⁰ For a brief summary of some of the evidence supporting these points regarding repression and recovered repressed memories, see the section in “Discerning Truth in Memory” where I discuss Williams LM. “Recall of Childhood Trauma: A Prospective Study of Women’s Memories of Child Sexual Abuse,” *Journal of Consulting and Clinical Psychology*. 1994, Vol. 62, No. 6, pages 1167-1176; Williams LM. “What Does it Mean to Forget Child Sexual Abuse? A Reply to Loftus, Garry, and Feldman (1994),” *Journal of Consulting and Clinical Psychology*, 1994, Vol. 62, No. 6, pages 1182-1186; and Williams LM. “Recovered memories of abuse in women with documented child sexual victimization histories.” *Journal of Traumatic Stress*. 1995 October; Vol. 8, No. 4, pages 649-73.

²¹ For a very carefully document example of this kind of scenario, see the case-study about the young man who recovered traumatic memories after frontal-lobe injury, described under Sacks, Oliver in the “Research regarding the existence of repressed and dissociated memories, and/or the historical accuracy of recovered memories” section of “Discerning Truth in Memory.”

VII. Additional discussion regarding traumatic memories dissociated at level 2: There are a number of similarities between traumatic memories dissociated at level 2 and non-dissociated traumatic memories. For example, as with non-dissociated traumatic memories, level 2 dissociated traumatic memories contain unresolved, toxic content, they are difficult to access, and they are difficult to modify. Another important similarity is that dissociated traumatic memories use *some* of the same circuits as both non-traumatic memories and traumatic memories that are not dissociated.

However, there are also important differences between traumatic memories dissociated at level 2 and traumatic memories that are not dissociated. *Memories dissociated at level 2 are qualitatively different than non-dissociated traumatic memories – they feel subjectively different and they behave differently.*

A. Much more difficult to access: Memories for experiences dissociated at level 2 are not only more difficult to access than non-traumatic memories, but they are also more difficult to access than non-dissociated traumatic memories. Under normal circumstances, memories dissociated at level 2 are completely unavailable to conscious awareness. Non-dissociated autobiographical traumatic memories have been labeled by the hippocampus, and can therefore be accessed by the voluntary strategic search function.²² Non-dissociated traumatic memories that were processed with the hippocampus off line have not received the benefit of the hippocampus librarian labeling function, but the implicit memory fragments carried in these memories can still be accessed by triggering stimuli that resemble the implicit content. In contrast to these two types of non-dissociated traumatic memory, content dissociated at level 2 can only be accessed under conditions that resolve, navigate around, or temporarily overcome the level 2 involuntary dissociative barriers.

B. Feel subjectively different – “reliving” as opposed to “remembering”: As described in Part II, experiences that exceed a person’s involuntary capacity and are therefore dissociated at level 2 come back as flashbacks, that *feel, subjectively*, like **reliving** the original experience. For example, the combat veteran with flashbacks of battle will see the images, hear the sounds, smell the odors, perceive the thoughts, and feel the emotions just as he experienced them in the original traumatic event.

C. Flashback packages “play” differently than memories packaged by the hippocampus: One especially important observation is that traumatic memories dissociated at level 2 can come forward as an *organized package that includes all of the different pieces of the traumatic experience*, but the details of how the dissociated memory “plays” indicate that the pieces are being coordinated by neurological circuits *other than the usual hippocampal circuits*. For example, dissociated flashbacks always play back with the **exact same** sequence, the **exact same** content, and the **exact same** duration; whereas traumatic memories processed through the usual hippocampal circuits can play back with flexibility at many points – when a person recalls a memory that is being processed through the usual hippocampal circuits, she can choose to include or leave out certain details, she can change the emphasis and/or order of presentation as she describes the remembered event, and she can shorten or expand the telling of the story as appropriate to the situation. Furthermore, these details regarding the way in

²² The strategic search function can be hindered by psychological defenses and spiritual opposition, as discussed in “Brain Science, Psychological Trauma, and The God Who is With Us, Part III: Traumatic Memories vs Non-Traumatic Memories.” But these blockages are usually much easier to resolve than the level 2 involuntary dissociative barriers.

which people re-experience dissociated content in flashbacks cannot be explained by the hippocampus simply being offline, since this simply results in disconnected implicit memory fragments. With flashback memory packages, *something* is organizing the many components into a coherent replay of the original experience, and this “something” must be neurological circuits *other than the usual hippocampal circuits*.

D. Flashback packages formed when hippocampus “offline”: Another important data point indicating that experiences dissociated at level 2 are processed by something *other than the hippocampus* is that the components are mapped together into flashback packages at times when the hippocampus should be offline. The strongest examples are provided by severe trauma in early childhood, where the hippocampus is immature to start with, and should be totally disabled by even moderately stressful painful experiences. Never-the-less, some people with severe early childhood trauma have flashbacks for these experiences that come forward as organized, coherent packages. Others have obviously come to the same conclusion regarding the hippocampus being offline for these experiences, since a prominent argument in the false memory/recovered memory debate has been that flashbacks for early childhood trauma cannot be valid because the hippocampus is not yet available to map the different experiential components into such a coordinated, sequential, coherent package. Another example is provided by blackouts and flashbacks in adult life. In adult life, people have blackouts, with memory later returning as flashbacks, for only the most extreme traumatic experiences – the kind of overwhelmingly traumatic experiences that would be expected to severely impair or totally disable the hippocampus.

These differences regarding the subjective feel and observable behavior of dissociated content that returns as flashbacks indicates that traumatic memories dissociated at level 2 are stored, retrieved, and processed differently than non-dissociated traumatic memories. These additional differences indicate *one or both* of the following: 1) the *neurological circuits* that process traumatic memories dissociated at level 2 include additional important differences from both the circuits that process non-traumatic memories and the circuits that process traumatic memories that are not dissociated; and 2) traumatic memories dissociated at level 2 are processed as a *type of file* that includes additional important differences from both non-traumatic memories and traumatic memories that are not dissociated.

My current hypothesis is that when a painful experience exceeds our involuntary capacity, dissociative disconnection at level 2 shunts the traumatic content into an alternative set of neurological circuits that package and store the material as this particular kind of dissociated memory. This dissociated content therefore *misses all of the usual processing* at levels 3 through 5, and, instead, is *processed and stored in some different way by a different set of neurological circuits* that are *not* involved in the processing of non-dissociated experiences.

Returning to the diagrams in **figure **** regarding traumatic memories vs non-traumatic memories, we can add a third diagram representing the circuits involved in processing traumatic memories that are dissociated at level 2.

****figure comparing non-traumatic, non-dissociated traumatic, and dissociated traumatic**

VIII. Additional discussion regarding traumatic memories dissociated by internal parts:

One of the important points I want to make in this discussion of different kinds of traumatic memories is to distinguish between dissociation at level 2 and dissociative phenomena associated

with internal parts. Dissociation at level 2 is a totally involuntary neurological phenomena that occurs when an experience or memory exceeds a person's involuntary capacity, whereas dissociation associated with internal parts is much more complicated. *And dissociation associated with internal parts includes **mind/spirit** phenomena that involve **free will choice**.*²³

In my experience with dissociative phenomena associated with internal parts, I have often encountered internal parts who will talk very openly about their reasons for holding certain memories behind dissociative amnesia barriers. For example, a protector part might explain that she cannot allow the person to remember a certain event because she could not handle it: "...If I let her remember this, she will fall apart and lose her job...." And if the parts responsible for withholding certain memories connect with Jesus and work with Him to resolve their concerns, they report that they are now willing to release the previously amnesic experiences, and then the person is suddenly able to remember the experiences from her "normal" adult consciousness. My perception is that the internal parts are initially *choosing* to withhold the memories from normal conscious awareness, the parts have very clear reasons for making these choices, when their concerns are addressed they reverse their earlier decisions, and when they report *choosing* to release the memories, *the person promptly becomes able to access the memories from her normal conscious awareness.*

Furthermore, the memory content placed behind amnesic barriers is not restricted to flashback packages dissociated at level 2, *but rather can include **each of the categories of traumatic memory previously discussed**.*²⁴ For example, *many* memories disconnected by internal-parts choice look like hippocampal autobiographical memories – they are not accessible to the usual adult conscious awareness because internal parts are choosing to hold them behind amnesic barriers, but otherwise they look like autobiographical memories that have been processed through the hippocampus. People with DID provide some of the best illustrations of this point, such as when an adult with DID encounters an interpersonal conflict that is only *mildly* traumatic but still "switches" because there is a specific internal part that has been designated as the "expert" on handling interpersonal conflict. Since the person is an adult with a fully myelinated hippocampus and the conflict is only mildly traumatic, the hippocampus completes both its mapping and labeling functions, and the pain does *not* exceed the person's involuntary capacity so that the experience does *not* get disconnected at level 2. After the unpleasant experience is over, the person "switches" back to the host personality, and even though level 2 did *not* disconnect the experience and shunt it to the alternative circuits that produce flashbacks, memory for the conflict still "disappears" as the conflict-expert internal part returns to his usual place of invisibility behind dissociative amnesia barriers. Finally, at any point in the future that the conflict-expert internal part comes forward, he will be able to use the strategic search function to voluntarily access memory for the traumatic conflict and he will be able to describe the experience as an organized, coherent autobiographical narrative, *both of which are features that indicate the memory was indeed successfully processed through the hippocampus.*

In addition to using this choice-based dissociative phenomena with each of the categories of *traumatic* memory, internal parts will sometimes even apply this choice-based dissociative

²³ Dissociation associated with internal parts can get quite complex, and may *also* include involuntary neurological processes in certain situations, but the aspect of *free will choice* cannot be explained by involuntary neurological processes.

²⁴ I think this is an especially interesting and important insight regarding dissociated traumatic memories. In my experience, this key understanding explains many previously confusing observations regarding dissociative phenomena.

phenomena to experiences and memories *that are not in any way traumatic*. In the examples I can think of, the *point* is not to “forget” non-traumatic experiences, but dissociative amnesia for non-traumatic memories is rather a by-product, or side-effect, of other dynamics. For example, many people who have developed an internal parts system to cope with severe trauma have internal child parts who *live* behind dissociative amnesia barriers. The point is trauma-management, as opposed to keeping the internal child invisible, but one of the side-effect consequences is that the person is not allowed to be consciously aware of this child part’s existence, and this means she cannot be allowed to remember any events where the child part comes forward with executive control. If one of these invisible internal child parts decides that she has not been given enough time to play,²⁵ she might find a way to seize executive control for an hour. When this happens, the person comes to me and says: “I ‘lost’ another hour last night while I was working on my term paper, and then later I discovered my dolls all over the floor of my bedroom.” And when I use the direct eye-contact technique and ask: “Can I please speak to any parts that know about last night and the dolls?” a five year old child part comes out and explains how she was able to seize control for an hour, and then provides a detailed autobiographical description of the non-traumatic hour she spent taking her Barbie dolls on an imaginary camping trip.

Similar examples involving non-traumatic experiences, described by many therapists working with clients who have well developed internal parts systems, provide some of clearest case study examples demonstrating that memory content *other than flashback packages dissociated at level 2* can be held behind dissociative amnesia barriers.

To the best of my knowledge as of March 2025, the neurological mechanisms that internal parts use to implement their dissociative phenomena are undetermined. Some clues indicate that these neurological circuits are *not* identical to the circuits used for dissociative disconnection at level 2. For example, most of the experiences disconnected by the internal parts choice-based mechanisms are not shunted into the alternate pathway that produces flashback packages, and the *choice-based* dynamic cannot be produced by the involuntary circuits level 2 uses to implement the alternate pathway’s dissociative disconnection.²⁶

IX. Dissociation protects from greater damage: When working with extreme trauma, blackouts, flashbacks, and other dissociative phenomena, it often seems that dissociation makes the emotional healing process more complicated, and at times we can become frustrated or impatient with this additional difficulty. As mentioned in our earlier discussions of brain/mind/spirit capacity, when dealing with the difficulties caused by dissociation it is important to remember that dissociative phenomena protect us from greater damage.

Circuit breakers in our homes provide a good analogy. If I turn on the microwave without noticing that the air conditioner is running and that Charlotte is also using the vacuum cleaner, the circuit breaker pops, the lights go out, and everything shuts down. How frustrating! I have to stop what I’m doing, go down to the basement, and reset the circuit breaker. This is certainly a

²⁵ For example, the adult person might have been working on an important project for her graduate school program, and has therefore been non-consciously blocking internal child parts from coming out in the evenings for their usual “play time.”

²⁶ One of the data points regarding dissociation from internal parts involving neurological mechanisms other than cortisol blowing the hippocampus off line is that stress and cortisol disabling the hippocampus provides no place for mind/spirit choice, and internal parts dissociative phenomena clearly includes choice. Any model for internal parts phenomena must include a mind/spirit component to provide the free will choice.

hassle, and I might even be tempted to just pull those irritating circuit breakers right out of the system. But then I remember what happened before circuit breakers. Before circuit breakers,²⁷ when the electrical current exceeded the capacity of the wiring the wires just got hot. And then turned red. And then started to smoke. And then started fires inside the walls of your house.

So let's think about this for a minute: the lights go off and I have to run down to the basement to reset the circuit breaker, or my house burns down? I don't know....This is a really hard one....Could you give me some more time?

Okay, I take it back. Those little circuit breakers are a *wonderful* design feature, and I'll leave them right where they belong.

When dealing with the additional challenges caused by dissociation, it is important to remember that this fascinating phenomena prevents greater damage that would be caused by allowing the person to be totally overwhelmed by pain exceeding the involuntary capacity of his mind/brain/spirit system.

X. Dissociative phenomena include *Both* free will choice *and* involuntary neurology: One important implication of identifying dissociation at level 2 and dissociation by internal parts as two very different memory phenomena is to recognize that dissociation *sometimes* involves mind/spirit free will choice, and *at other times* is carried out by neurological processes that are totally involuntary.

When we think about experiences that are dissociated at level 2 it is important to remember our earlier discussion of *involuntary* capacity. As described in this earlier discussion, involuntary capacity primarily involves the physical limitations of the biological brain, and an important aspect of these biological brain limitations is that you are *not* consciously aware of them, and you do *not* make conscious, voluntary choices about what happens when you exceed your involuntary capacity. As you will probably remember, all of the level 2 neurological circuits are below the cortex, and this means that they are *involuntary* and *non-conscious*. These involuntary and non-conscious level 2 circuits also happen to be the neurological circuits that assess "Does this memory exceed the capacity limit?," the circuits that shunt the material to the alternative processing pathway, and the circuits that cause dissociative disconnection. Therefore, all of these processes will also be *involuntary* and *non-conscious*.

When we think about internal parts causing dissociative emotional disconnection or dissociative amnesia, it is helpful to remember our earlier discussion of *voluntary* capacity. As described in this earlier discussion, voluntary capacity primarily involves the mind and spirit, and has to do with limitations of strength for enduring pain and limitations of courage for facing fear. In contrast to involuntary brain capacity, when we are dealing with voluntary mind/spirit capacity we *are* consciously aware of the limitations of our capacity, and we *do* make conscious, voluntary choices about what happens when we exceed our capacity. For example, when you are in a ministry session working on a traumatic memory, you are consciously aware of feeling depleted as the (intensity of stress) x (duration) steadily accumulates, and you are consciously aware of the choice "Do I keep going, or is it time to quit?" If you are working on an intensely painful memory, and resolution is not coming quickly, you will be especially aware of the

²⁷ Actually, primitive devices called fuses came before circuit breakers, but many of the younger readers won't remember this. If we are going to be historically accurate, it was before *fuses* that electrical overload frequently resulted in house fires.

cumulative emotional burden, and you will be especially aware of how hard it is to stay with the memory.

If you eventually decide “I’ve had enough for today,” you will then end this particular attempt to process the memory by making conscious, voluntary choices to use various tools to shut the memory down. For example, you can move the focus of your attention onto something else by immersing yourself in some engaging task or by watching an engaging video. You can also use other tools, such as alcohol, street drugs, or other addictive behavior that will absorb your attention. And here’s where dissociative disconnection caused by internal parts comes in: once a person has developed a system of dissociated internal parts, causing dissociative emotional disconnection and/or moving content behind dissociative amnesia barriers often becomes one of the most commonly used tools to implement choices to disengage when a situation exceeds the person’s *voluntary* capacity.

Some working with dissociative phenomena emphasize that dissociation is not voluntary – that it is a completely non-conscious, involuntary neurological process that our brains employ to prevent greater damage. These people then also emphasize that we should not hold the person responsible for his dissociative phenomena or ask him to make choices with respect to his dissociative phenomena. And this position is valid with respect to involuntary capacity dissociation at level 2, where it is appropriate and important to remember the totally involuntary nature of the neurological processes involved. However, this perspective is *not* accurate with respect to many dissociative phenomena associated with internal parts. Failing to recognize the free will choice often involved when working with internal parts can preclude the use of some very effective interventions, and can also result in enabling dysfunctional behaviors.

Other’s working with dissociative phenomena emphasize choice: “Anything that’s happening is happening because, *at some level*, you are choosing it....If you can’t remember something, it’s because you’re choosing to not remember it.” And this position is valid with respect to many dissociative phenomena associated with internal parts. However, this perspective is *not* accurate with respect to involuntary capacity dissociation at level 2. Failing to recognize the totally involuntary nature of the neurological processes involved can result in the person feeling confused, inadequate, and guilty when they are asked (encouraged/exhorted/challenged) to make choices regarding processes that are not under her voluntary control.

When working with dissociative phenomena, it is important to remember that *some* dissociative processes involve *neurology that is totally involuntary*, and that *other* dissociative processes clearly involve *mind/spirit free will choice*.