Treating "Frozen" Latent Fantasies in Trauma Therapy

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"If our 'nows' are perpetually interrupted by intrusive memories, we're essentially stuck in a time warp formed by those stored perceptions. We can't problem-solve, we can't experience a daffodil or a sunset, we can't relate to other people, resolve old conflicts, or form new attachments. Only in the here and now can we directly experience, and move ahead with, our lives." – Scaer, 2014.

Trauma involves dissociation, and dissociation from the reality of the present moment can produce varieties of fantasies, such as a "revenge fantasy" that imagines a different outcome, or a denial fantasy that the traumatic event did not even occur. Such fantasies can become an integral aspect of the trauma itself, capable both of triggering posttraumatic symptoms, and interfering with treatment and healing.

These fantasies can lie anywhere on a spectrum of awareness in the client's consciousness, from fully conscious wishes and fantasies, to fully unconscious or subconscious ones. These are fantasies that may be related to what *did not* happen, or what *might have* happened, as opposed to what *did* happen. They are sometimes fantasies about what *should have* happened. For example, a child who was sexually abused by a parent might carry a latent fantasy of being rescued by the other parent or, at least, of having been defended by that parent. With trauma related to childhood neglect and abandonment, there is very likely a latent, or implicit, fantasy of a (non-existent) parent who was nurturing, present and loving.

Fantasies of this nature sometimes emerge explicitly in the treatment process, but they are usually implicitly buried in statements related to the material that emerges. When the client makes statements beginning with: "I wish that…" or, "If only…" or, "She (he) should have…" then he or she is expressing some degree of conflict between the fantasy of a desired reality, and the reality of their actual experience.

We can see these latent fantasies most clearly in the bereavement process. The bereavement process is one of coming to terms with a loss. This necessitates coming to a state of acceptance of the loss, and of any and all losses associated with the primary loss. This means letting go of the subconscious or conscious, mental and energetic constructs of the future that had been previously held. It is quite common among people who present as "stuck" in the bereavement process to find that they are stuck in letting go of how they had envisioned some aspect of their life, that is now no longer possible. There is an aspect of the loss which they are having difficulty accepting. In other words, they are holding on to what had been their expectations of the future, which is now a "frozen fantasy."

There is an aspect of trauma therapy which is virtually the same kind of process as bereavement: that of coming to terms with what happened, coming to full acceptance of that reality in order to be able to move on, and to be in the present, rather than to be reacting to the past. Here, again, when people are "stuck" we often find that what holds them back is difficulty accepting, and difficulty letting go – not only of what happened, but of what will now never be: an innocent childhood; a loving and protective parent; a sense of safety in the world; a close family; etc. I have found that these types of latent fantasies are invariably present in trauma resulting from childhood abuse because, invariably, the child was disappointed in his or her expectation (or fantasy) of being protected by the parent(s). There are many other possibilities of latent fantasies in these situations, but I have found that this is the most common, recurring one.

When we don't listen for such statements as *expressions of fantasy*, we may hear what is expressed as being "normal" thoughts and feelings, given the nature of the experience. But if these statements are heard as expressions of holding

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onto something, of not being able to completely accept the experience exactly as it was, of holding on to a different (feared, or wished-for) story of the events, we can hear them in the same vein as someone who is stuck in the bereavement process, having difficulty accepting a loss.

In discussing trauma-related dissociation, Scaer (2001) notes that while declarative memory, the form of memory that relates to the facts of an event, may be "notoriously inaccurate," it is also subject to decay. Cognitive therapy is therefore likely to be effective in addressing and/or correcting such conscious memories. *Procedural memory*, on the other hand, is more powerful and harder to change. It is involved in the development of emotional memories and associations, and in the storage of conditioned sensorimotor responses. "Procedural memory is unconscious, implicit and extremely resistant to decay, especially if it is linked to information of high emotional or threat-based content." (van der Kolk, 1994) Although declarative memory may account for much of the arousal-based cognitive symptoms of PTSD, procedural memory provides *the seemingly unbreakable conditioned link that perpetuates the neural cycle of trauma and dissociation.*"[My emphasis] (Scaer, 2001).

Trauma-related fantasy is not associated with declarative memory, but with procedural memory. It is not a conscious part of the event or experience, but represents a dissociative response to the event or experience that occurred subconsciously, that is implicit rather than explicit, and that is firmly linked in a cycle of dissociation related to unsuccessful attempts to be safe.

Fantasy is inherently present in all the ways that the traumatized person is *not in the present moment*. Fantasy therefore involves dissociation, and is an implicit and inescapable aspect of trauma that needs to be addressed in treatment. However, one of the most powerful fantasies that needs to be addressed in treatment is often neglected because the focus tends to be on what happened and, perhaps, on the ultimate victory of survival. The *imagined worst-case scenario* is a powerful fantasy that can continue to haunt or rather, continually retraumatize the victim, and interfere with resolution of the trauma. This fantasy is not always a conscious element of the process, but it can be critical to the success of treatment to identify it and resolve it (Mills, 1998).

If a child was abused sexually (or otherwise) and was threatened with a statement such as, "If you tell anybody I will kill you," then an immediate fantasy is formed of being killed by the perpetrator. This fantasy will become "frozen" in the psyche and can inhibit the therapy process. With victims of bullying, I have often found a "frozen" fantasy of the "worst-case scenario" continuing to affect the person's interpersonal and social functioning decades later.

With (adult) victims of childhood bullying I have also found a more subtle form of traumatic fantasy that seems to hold even greater power. Even if the individual was "only" actively bullied, say, once a week, every evening when he or she thought of going to school the next day, and every morning when going to school, that individual was either consciously or subconsciously playing out a fantasy of what *might* happen. This fantasy activates either fight or flight responses, regardless of the fact that bullying is not actually occurring in the present moment. But it also often activates a freeze response, a dissociative response, in the simple act of "pushing through" and forcing oneself to go to school - to walk straight "into the lion's den" with no means or hope of defending oneself. The freeze response is, of course, a trauma response. (Levine,1997; van der Kolk, 1994). It can persist well past the time that the traumatic event and the actual threats are over, and become a chronic pattern of response. These types of "frozen" responses become traumatic experiences in their own right.

For example, when the chronic physiological freeze response is activated, the physiological state and sensations themselves create an experience - including a perception - that the person is unsafe and under threat. At the minimum, it triggers a sense of not being in control of one's own body and mind, of one's own experience of the present moment. In this case, the chronic response itself triggers a re-experiencing of the original traumatic event, but as a *physiological* event. In PTSD, therefore, people may be continually re-traumatized by their psychological and physiological responses - not always to a memory, per se, but to a "frozen fantasy" that they may or may not be even conscious of.

If a distinguishing feature of unresolved trauma is "a sense that the trauma has not yet ended" (Rothschild, 2000, p 12) then an ongoing fantasy element perpetuates that aspect of the trauma experience and, therefore, the trauma itself. If we continue, for example, to fantasize about a worst-case scenario, then our brain continues to react either as if this may, indeed, occur or as if it is actually occurring, rather than processing the memory of the event as it was, and as something that

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is over. If we continue to fantasize (even subconsciously) about the ideal or desired reality that did not exist - such as a nurturing and protective parent - then our brain continues to suspend our full apprehension and acceptance of the reality of our experience. In both cases, there is dissociation from the reality of our experience, which not only prevents accepting and adjusting to the reality of the event as it occurred, but also prevents full realization that it has now passed and that the person is safe.

"The hippocampus...gives time and space context to an event, putting our memories into their proper perspective and place in our life's time line. Hippocampal processing gives events a beginning, a middle, and an end... It has been shown that the activity of the hippocampus often becomes suppressed during traumatic threat; its usual assistance in processing and storing an event is not available... When this occurs, the traumatic event is prevented from occupying its proper position in the individual's history and continues to invade the present." (Rothschild, 2000, p.12).

After having encountered this type of "frozen fantasy" among victims of bullying, I also became aware of it in treating military personnel with war trauma. One client of mine related how he arrived in Afghanistan and on his way to the compound saw a huge, burned-out, pile of sand. He was told the story of how four soldiers were trapped and died in their burning vehicle and sand was piled on the vehicle with a tractor to put the fire out. Arriving in the compound, he saw the burned-out shell of the vehicle. This immediately "imprinted" him. Beyond being vicariously traumatized, he now had a fantasy of this possibility happening to him, which was activated every time he went out in a motorized patrol. Another trauma involved watching a live video feed monitor, and witnessing some of his friends being gunned down in an ambush in a specific location. This also became a fantasy of what might happen to him. Every time he had to go to that location on patrol, he had a fantasy in his mind of what might happen, and found himself actively reacting to that fantasy.

These aspects of his trauma only surfaced through close questioning and listening, and by exploring beyond the usual definitions and expectations of what constitutes traumatic experiences. While they may have otherwise been seen and framed as either *vicarious trauma*, or as trauma resulting from the *perception* of a threat, addressing these occurrences in this way would not completely capture the meaning, the impact or the very nature of these traumatic triggers.

Specifically, it would not have captured the *active imagination* involved that resulted in physiological responses equivalent on some levels to actually being in those situations, and it would not have captured the *frozen* nature of the imagined trauma.

Treating Traumatic Fantasies

When I hear these fantasies being implicitly expressed or suggested by the client, and I verbalize them in the treatment process, there is often an instant, perceptible moment of recognition and of connection. The framing of these thoughts and feelings as a fantasy that keeps them locked in the past, is rarely something the client has thought of, but can sometimes be instantly recognizable to them. Sometimes, just reframing in these terms is enough to trigger an insight, that leads to a shift in both thoughts and feelings. I might explain how and why our minds would form such fantasies, and that it is normal and even predictable. I might use ways to talk about it, in words that vary according to the person, including talking about an aspect of the self that is "stuck back there" holding out for a different outcome, and recruit the person to help rescue that "part". Energy Psychology approaches are very effective in then resolving the "frozen energy" of the fantasy.

My preferred energy-focused approach is Logosynthesis, developed by Willem Lammers (Lammers, 2015) which I use consistently in my practice. Logosynthesis is a simple and elegant technique that combines aspects of mindfulness and somatic focusing, along with exposure and desensitization, and cognitive reframing. As I have described elsewhere (Isler, 2014), I have invariably found that this method is highly effective in facilitating the resolution of trauma (as well as many other types of issues.)

Logosynthesis involves guiding the client in making statements about retrieving energy, and removing energy. There is a very simple process of three sentences that is used, in this form: "I retrieve all my energy bound up in... I remove all non-me energy related to... I retrieve all my energy bound up in all my reactions to..." Between each sentence we allow time for processing. When I guide clients to use these sentences on the fantasy, usually one of the three sentences is key to releasing the fantasy, resulting in a clear "shift."

The very process of Logosynthesis facilitates the surfacing of latent fantasies, and I find that using this method to treat those fantasies invariably results in a significant, positive shift

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in the client's treatment process. Shifts result on a cognitive level as well as in feelings and symptoms. Memories are reframed, and the symptoms related to these memories - symptoms of re-experiencing, and of psychological and physiological reactivity - are reduced or resolved, as is reactivity to triggers related to that memory. ■

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