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Different Types of Traumatic Memory

(K.D. Lehman MD, first released 7/18/2008, last revised 3/16/2025)

I. Introduction: As discussed at length in Part III, the first and most important distinction is between non-traumatic memories and traumatic memories. When an experience completes it's 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
- •Easy to access
- •Associated learning easier to modify

Traumatic memories:
- •Experiences that have *not* successfully completed their journey through the processing pathway
- •Contain unresolved, toxic content
- •Difficult to access
- •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 people with the particular clinical picture of lung cancer,[1] 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

[1] 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).

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.[2] 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 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

[2] 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.

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*[3] early childhood trauma. These studies gather data that clearly describe the pre-hippocampal, pre-autobiographical memory phenomena discussed in Part III; and as described in this earlier 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 access and difficult to modify.

A. 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 occurring in mid childhood (3-5 years old) or later.
- •Difficult to access (in comparison to non-traumatic memories), but still available to conscious awareness as autobiographical memory.
- •Difficult to modify (in comparison to non-traumatic memories)

B. 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).
- •More difficult to access, but still available to conscious awareness as autobiographical memory. 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.
- •Difficult to modify (in comparison to non-traumatic memories)

C. 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

[3] 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.

- •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.
- •More difficult to access. Not available to conscious awareness *as autobiographical memory*, but rather comes forward as implicit memory fragments. Can be activated by many common triggers, but often/usually not recognized as memory.
- •Difficult to modify (in comparison to non-traumatic memories)

D. 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. *Not normally available to conscious awareness*. Can only be accessed under conditions that resolve, navigate around, or temporarily overcome the level 2 involuntary dissociative barriers.
- •Difficult to modify (in comparison to non-traumatic memories)

E. 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. *Not normally available to conscious awareness*. 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 barrier **unknown**
- •Difficult to modify (in comparison to non-traumatic memories)

IV. 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.[4] 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 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

[4] The strategic search function can be hindered by psychological defenses and spiritual opposition, as discussed in Part III, but these blockages are usually much easier to resolve than the level 2 involuntary dissociative barriers.

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**

V. 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***.[5]

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*

[5] 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.

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***.[6] 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 it's 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 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,[7] 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.

[6] 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.

[7] 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."

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.[8]

VI. 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 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,[9] 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.

VII. Dissociative phenomena include *Both* free will choice *and* involuntary neurology: One

[8] 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.

[9] 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.

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. SLIDE 43.2 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 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*.