Chronic Suicidal Thoughts and Implicit Memory

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Overview

- Memory systems and their developmental trajectory
- Management of emotional pain
- Suicidal thoughts and memory
- Anxiety and the therapeutic space
- Managing chronic suicidal thoughts
- Changing implicit memory

Review of memory systems

Two systems

1/ Implicit

2/ Explicit (or declarative, or autobiographical)

- Semantic
- Episodic

Neuroanatomy

- Explicit: hippocampus, parahippocampus, fronto-basal areas, rhinal and perirhinal
- Implicit: not fully worked out, but amygdala seems to be involved in the emotional organization of implicit memory. Basal ganglia also involved, and the cerebellum plays a role in the experience of fear. Indirect evidence suggests posterior temporal-occipital-parietal area of right hemisphere
- Reference: Mancia 2006

Implicit Memory: Procedural

- Fully activated at birth (prob last trimester)
- Sensory: Remembers basic arousal, satiety, safety in first two months
- Movement: Body in space, intentional location, fine and gross motor actions
- Interactional (both emotions and actions): how others are with you, and how you relate to others

Implicit continued

- Acquired slowly, with practice
- Precise and inflexible (specific to specific situations)
- Cannot be recalled, but always experienced
- Later on it becomes reality (right parietal stroke, with neglect syndrome)
- Most robust: “never forget how to ride a bicycle”, Alzheimer’s

Implicit continued

- Imprints action and feeling (no language or meaning)
- Reading: mother ignores child's affection : page 846, para 3-4, The Foundational Level of Psychodynamic Meaning, Boston Change Process Study Group, 2007
- Expressed through action and sound initially, but later with language through emotion, syntax, pauses, and the way that the story is told (the rhythm and feeling of the language, the "music", rather than the content)

Semantic memory (Explicit)

- Starts in second year of life, fully activated around 18 months, elaborated with language
- Coincides with language acquisition
- Also “reality”, what you know about things stored as facts
- Capital of France
- No memory of when or how these facts are acquired, but “fact” is available to consciousness

Episodic memory

- Starts around 3-4 years old
- Memory of events/episodes (one trial learning)
- When it happened, who with, and how it felt, as well as some details of the story, are remembered = story (first plane trip)
- Less robust (more easily updated, forgotten, re-created, lost): dementia
- False memories (playground experiment)
- Based on action, feeling, language, and meaning (implicit memory is interwoven)

Memory systems and emotional distress

- When upset, who responded, in what way, how much
- Located in implicit and semantic memory
- Experienced as “fact” or reality
- No memory of when the experiences happened, why, or who it involved
- Cannot bring rational thought to modify
- Difficult to describe in language, as mostly done through action throughout the lifespan, but can be trained to in therapy (discussed later how)

Managing Emotional Pain

4 ways:

- Try and stop it
- Try and manage it (work with it, accommodate it etc.)
- Hope that it will go with time: wait
- Get help from someone else

Origin of Chronic Suicidal thoughts

- Why want to die?
- Because: **overwhelming emotional pain**

- no escape (can't do anything to stop it)
- Unbearable (cant manage it with usual strategies)
- Never-ending (timeless)
- Others can't help

Suicidal thoughts and implicit memory

- No studies
- **Speculation: what phase of life is pain**:

- Inescapable
- Forever
- Unmanageable

?

Very early experience!

Babies are unable to escape pain

- Cannot use mental strategies to diminish or contextualize pain
- Here and now is only experience, no past or future (painful experience is never-ending)
- Totally dependent on caregiver to relieve pain

Caregiver **regularly** unable to relieve pain?

- Then, implicit memory stores pain as:
- Unbearable
- Endless
- **Nobody there to help**

- Therefore: any experience that mimics the original experience will activate implicit memory, **but is felt as current and real**

Function of chronic suicidal thoughts

Function: (Ultimate) escape from the pain that is

1. Overwhelming
2. Never-ending
3. No one can help

Problem with the chronically suicidal patient (BPD)

- Experience traumatic memory system in suicidal thoughts
- No awareness of memory
- Fundamental belief that nobody can help (“you cant help”), and that suffering will go on forever
- Create bi-directional field of despair and anxiety
- Therapist struggles to hold reflective space (collapsed by own anxiety)

Problem with suicidal patient continued

- Extra anxiety from
- patient's family or friends
- Our colleagues
- Hospitals, mental health teams etc.
- Medicolegal
- Supervision (internalised and real)

Enactments vs anxiety

Shut down reflective space =

1. Suicidal threat: all anxious
2. enactment: mutually interacting trauma system (me: overwhelming pain, failure)

- Combination of both

What doesn't work

- Explaining, cognitive understanding, reassuring, "you have so much to live for", "what would happen to your children" etc.
- Above appropriate for later memory systems (bad experiences for older children/adults)
- Ineffective for implicitly coded experiences that lead to chronic suicidal thoughts

General management of chronic suicidal thoughts

- Recognise value of suicidal thoughts
- Acknowledge, explore and understand "suicidal self" (feelings, thoughts and actions) – hard to do, counterintuitive
- Later, look for, explore and expand "other selves" – initially stunted or hidden
- Beware of patient's actions to shut down therapeutic conversation (deliberate self harm, not turning up etc.)

Our Anxiety

- Acknowledge: must feel it
- Watch for tempting action/solutions that reduce therapeutic space: “slow response”
- Taking over control
- Suicide contracts
- Hospitalization
- Medication

Triggering implicit memory and suicidal thoughts in session

- "disjunction" = therapist is experienced as emotionally unavailable)
- Implicit memory of original caregiver failure is triggered
- **Not aware of memory**, experience is with therapist, but with the power of implicit memory
- Patient feels despair and hopelessness, with suicide the only solution, and therapist "not there"

Repair of disjunction

- If suicidal thoughts come up in session, look for disjunction
- Together, acknowledge that something has gone wrong
- Try and “re-find” patients experience that was missed
- Later on, possibility of understanding what was triggered, and how

Access Implicit Memory?

Disjunction (suicidal thoughts), but also:

- Unusual, incongruous feelings
- Enactments
- Extreme behaviours between sessions
- Unusual behaviour in session – theirs and ours = frame changes

Importance of the frame

- “Frame” = Behavioural rules that make therapy run smoothly, effectively and safely
- Some verbalised, many assumed
- Many patient (and therapist) actions arise out of implicit memory systems
- Therefore, discuss any frame changes = avenue to implicit memory understanding
- Example, open window

Restructuring implicit memory

- Long-term therapy?
- Many times learning new implicit memory
- Because of the function of suicidal thoughts as “the only escape”, hard to shift
- Therapist fear and despair should not be underestimated – supervision
- Crucial: forged in rel, changed in rel

How does implicit change occur?

- Who Knows?
- Something different is experienced in therapeutic rel. Mediated by:

Words

Syntax

Non verbal communication

Affective sharing

Cross modal communication (another talk)

But I Prefer….

My (hoped for) way of doing psychotherapy

- Listening deeply
- Giving value to all pt experience (esp suicidal)
- Allowing not knowing (take time to puzzle together)
- Understanding together
- Being moved profoundly

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