THE UNVEILING OF TRAUMATIC MEMORIES AND EMOTIONS THROUGH MINDFULNESS AND CONCENTRATION MEDITATION: CLINICAL IMPLICATIONS AND THREE CASE REPORTS

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INTRODUCTION

An impressive research literature exists describing the physical and psychological effects of meditation (Murphy & Donovan, 1988). Meditation has been used in the treatment of chronic pain (Kabat-Zinn *et al.*, 1985; Kabat-Zinn *et al.*, 1986), hypertension (Benson & Wallace, 1972), anxiety disorders (Kabat-Zinn *et al.*, 1992; Benson *et al.*, 1978; Goldberg, 1982; DelMonte, 1985), and as an adjunct to psychotherapy (Kutz *et al.*, 1985; Kutz, Borysenko & Benson, 1985). Meditation is commonly used as the main treatment intervention in stress reduction and relaxation programs (Fulton, 1990; Kabat-Zinn, 1990; Moyers, 1993; Noetic Science Institute Staff, 1993). As with any treatment intervention, there are possible side effects as well as contraindications to meditation practice. An overview of psychiatric complications of meditation practice has been previously described (Epstein & Lieff, 1986). This paper will explore the phenomenon of unveiling of previously repressed traumatic memories and painful emotions during the course of meditation practice. It will also raise the issue of an informed consent process for individuals referred to meditation-based stress reduction programs by health care providers.

concentration and mindfulness practices

Meditation is commonly divided into two sub-types: concentration and mindfulness practices. Often a meditator will use a combination of these two sub-types, either in a single meditation session, or during the course of their meditation practice. In concentration

meditation (CM) the instructions are to place the mind's attention on a single object, i.e., the breath, a *mantra,* a prayer, a candle flame, a visualized color, etc. Whenever the mind's attention wanders from that object, the meditator redirects his/her attention back to that object, allowing the distraction to move outside the sphere of the mind's attention. As concentration strengthens, it is often accompanied by states of calmness, relaxation, and equanimity. Common physiological changes include decreased heart rate, blood pressure, respiratory rate, and muscle tension (Murphy & Donovan, 1988). As the background "chatter" of the mind quiets, a common experience is the unveiling of past memories or their associated emotions that had long been forgotten, and in some cases totally repressed. If the unveiled memory/emotion is significant enough, it may not be possible to simply let it pass and return to the primary object. The unveiling of a past trauma which had been repressed can be quite overwhelming to the meditator (Goldstein, McDonald, Salzberg & Smith, 1993). As will be described below in a case report, it is possible to achieve advanced states of concentration without the unveiling of significant past traumas.

Mindfulness meditation (MM) can be viewed as developing a spotlight quality of consciousness, whereby any passing mind-object can become the object of the mind's attention. MM encourages a more experiential exploratory stance towards whatever mind-object presents itself in a given moment, with the intention of deepening one's understanding of the nature of the mind, and growing in wisdom towards eventual liberation from suffering. Kabat-Zinn defines MM as: "Paying attention, on purpose, in the present moment, in the service of self-understanding" (Kabat-Zinn, personal communication). The initial stages of this form of meditation usually involve practicing CM to develop a degree of stability of attention. Once grounded in moment-to-moment awareness of the primary object, the meditator then engages in a process of free attention, placing his/her attention on whatever mind-object is most prominent. The meditator is encouraged to investigate this mind-object from a stance of calmness and neutrality, free of judgment, self-involvement, and conclusions. Krishnamurti (1973) described this meditative stance as "choiceless awareness," and this aspect of MM is well described in the traditional Buddhist literature (Thera, 1962). As the meditator's mindfulness deepens, he/she is more able to embrace the present moment as it is, free of reflexive and habitual thoughts and behaviors which usually cloud present moment experience. The increasingly direct contact with the present moment often reduces stress, fear, anxiety, and dysphoria, as these mind states are often associated with some past experience which distorts the present moment reality.

grounded in moment-to-moment awareness of attention

Through the practice of MM, the meditator encounters a wide range of psychological states, both pleasant and unpleasant. Often unre-

solved or repressed material from the past surfaces with its original intensity. The instructions are to maintain a non-judgmental awareness of this material, and observe the process of the mind rather than the specific content (Kabat-Zinn, 1994; Levine, 1979). As mindfulness strengthens, the meditator is better able to face increasingly more difficult material with calmness and equanimity. Similar to what often happens during the process of psychotherapy, previously repressed material continues to arise as the meditator becomes more skillful at working with it.

CASE 1

E.K., a thirty-six-year-old, married, white woman from Africa with no prior psychiatric history, had been a practitioner of meditation for fourteen years. During the previous year she had been practicing intensive CM, and during an intensive CM retreat she experienced for the first time in her meditation practice the onset of a pressure sensation in her head, and neck pain. By maintaining her attention on the Jhanas (levels/states of absorption described in Buddhist and Hindu concentration meditation practices), as was the practice of this form of CM, these sensations were tolerable and remained in the background of her conscious awareness. Feeling she had made sufficient progress in her CM with the Jhanas, she chose to attend an intensive three-month-long silent MM retreat to balance out her meditation practice. She described the first three days of this retreat as "totally open . . . a part of nature." On the fourth day of the retreat she described the onset of a pressure sensation in her head, and back pain, described as, "like I was impaled on a wooden stick." The meditation teacher suggested that she "look at the pressure" rather than retreat away from it with a concentration practice. As she investigated the pressure sensation, she experienced "terror . . . cold terror," and then "hatred arose." As she continued to explore these sensations and emotions, she appeared to regress to her early childhood, of which she previously had a single unremarkable memory. She described how: "words started to arise . . . from childhood . . . Daddy . . . cot . . . people's names . . . (and then a) feeling of choking . . . dissatisfaction . . . clothing too tight . . . wanting food." As she continued with her MM practice, she began having intense flashbacks: "a man comes in my room and touches me sexually . . . I'm two years old . . . it's the gardener, a friend of the maids . . . he abuses me every afternoon . . . then there is another man, a frightening one, a friend of the gardener . . . he hurts me physically . . . I'm battered around . . . he takes me out in the afternoons in a car and it's like I'm a prostitute . . . he gives me to other men . . . they threaten to kill me with a knife if I don't do what they want . . . it comes up many times that there was sexual abuse . . . it's just too incredible . . . I'm nearly killed . . . something around my neck . . . choking me . . . (there

were at least) three other men in different scenarios." She was able to temporally place these events at age two; her parents divorced when she was two years old, and between the ages of two and three she was cared for during the day by maids while her mother worked full-time to support them. At age three her mother placed her in an orphanage during the week, and she remained there visiting with her mother only one day per week until age ten, when she returned to living with her mother. She appears to have dissociated frequently during episodes of sexual abuse. She stated how "it's like I'm going into this meditative state as a young child."

Remarkably, she continued with her MM practice throughout these flashbacks for a one-month period. She then became increasingly overwhelmed by fear, and began experiencing visual hallucinations as well as severe insomnia. She described how: "I did see a lot of dead bodies all over the place . . . like a flash in my mind . . . a mutilated body on the bed, in the closet, in the shower . . . fear, terrible fear that I had killed somebody, I had done something wrong . . . what had I done?" She offered: "So much came up, almost at once . . . I was sure I was going to die . . . I couldn't be with any of this stuff anymore." At this point she stopped her formal meditation practice, and a psychiatrist was consulted. She declined an antipsychotic medication, but responded well to low-dosage lorazepam, with improvement in her insomnia and anxiety. The visual hallucinations resolved when she stopped meditating.

"my whole life has changed"

Over the next several weeks she continued to be flooded with apparent flashbacks from her childhood abuse, as well as other grief issues from her childhood. She remained at the meditation center, but did not practice any formal meditation. She accepted this experience as a necessary one for her continued growth, and planned to continue her meditation practice at some future date. She concluded: "I just felt . . . that my whole life has changed."

CASE 2

K.L. is a forty-five-year-old, married, white mother of two who worked as an administrative assistant. She was referred to a MM-based Stress Reduction and Relaxation Program at a University Medical Center by her primary care physician who felt that her abdominal pain and diarrhea were stress related. She had no prior psychiatric history. She described herself as "frightened a lot" as a child, and "always felt alone." She had always remembered ongoing sexual abuse between the ages of five and nine by her male cousin, seven years her senior. Her father died of cancer when she was seven, and was frequently hospitalized prior to his death. Her mother would leave her under the care of the mother of this sexually abusive cousin while she visited her husband in the hospi-

tal. She recalled telling her mother on several occasions that this cousin was abusing her, between the ages of eight and nine, but "she [her mother] never did anything." During her adolescence and early adulthood, she described herself as "self-willed and strong willed . . . I became a real control freak. I would always act sure in social situations, but inside I was frightened."

She described the basic eight-week stress reduction program as successful, and offered "I felt better." However, she experienced difficulty relaxing, and chose to attend the Graduate Program which met monthly for four months and encouraged a daily practice of MM. As she began to relax, she noticed panic and anxiety arising. She experienced her first panic attack immediately following one of the graduate classes and was unable to drive herself home. As she continued to practice MM, she "became more uptight," and noticed "a feeling of fear, impending doom all the time," as well as the onset of daily panic attacks. She stopped practicing MM, but her anxiety symptoms progressed to the point where she became quite agoraphobic, and did not leave her home for a three-month period, necessitating a leave of absence from her job. She was referred to a psychiatrist, and the panic attacks significantly improved on a regimen of clonazepam and nortriptyline. She also began weekly individual psychotherapy, where, for the first time in her life, she felt she was able to develop a trusting relationship. During the course of her psychotherapy, she was able to open to and explore painful emotions from her childhood which had previously been repressed. After six months she was able to discontinue the nortriptyline, and the clonazepam was gradually tapered to an as-needed schedule which she used rarely. She continued in individual psychotherapy for two-and-one-half years, and offered: "I think I just grew. I don't think I'm an angry person anymore. I don't feel always on defense."

"I think I just grew"

She recently attended another eight-week MM-based stress reduction program offered at another hospital, and successfully completed it without any recurrence of her previous symptoms of anxiety. When asked if she would go through it all again if she had the choice, she offered: "definitely . . . I needed to go through it."

CASE 3

T.N. is a forty-three-year-old, twice divorced, white man with a history of chronic depression and anxiety. He abused alcohol regularly between the ages of twenty-one and twenty-eight, but has been alcohol-free since age twenty-eight. At age twenty-six he began practicing Transcendental Meditation (TM, a form of CM), and remained alcohol-free for a three-month period. He described feeling "peaceful" during this time, which he attributed to his

practice of TM. At the end of the three months, he became separated from his wife, stopped practicing TM, and relapsed with alcohol.

At age thirty-two, he began practicing TM again, but rather than experiencing peace of mind as was his earlier experience, he began to feel increasingly anxious. One year later he began individual psychotherapy to address his chronic depression and anxiety, and his therapist suggested he consider practicing MM. He had worked with this psychotherapist for nine years, and described how their work "helped give me a strength of character." He has practiced MM regularly since age thirty-three, with varying intensity.

At age thirty-five, he went on a ninety-day intensive MM silent retreat, during which he experienced the onset of strong feelings of "hatred and anger" which he directed at everyone at the retreat center. He described these as new emotions for him, and he was frightened by them. Following this retreat he began experiencing verbal outbursts of anger, which have continued to the present time. He described how: "I feel under attack or under siege. I don't see people as people. I will start boiling inside. I explode on someone and yell at them." Three years after this intensive MM retreat, while continuing in psychotherapy, he began having flashbacks of sexual abuse at age four by a thirty-year-old male neighbor; this abuse was ongoing for a six-month period. During his therapy sessions he would commonly dissociate when the abuse issues were explored. He also described dissociating whenever he experienced intense emotions.

practicing MM several times each day

At age forty-two, he joined the volunteer staff at a MM retreat center, and began practicing MM several times each day. After several months he had a recurrence of flashbacks of his sexual abuse, and described it as: "More of a feeling sense . . . down in my body . . . a lot of fear . . . a pressure cooker of anger." During the next six months, the anxiety and anger continued, and he became significantly depressed. He was referred to a psychiatrist who began him on antidepressant and antianxiety medication. Currently, he continues on these medications, attends weekly individual psychotherapy sessions, and continues to work at the MM retreat center where he practices varying amounts of MM.

DISCUSSION

These three case reports demonstrate the process of unveiling past, previously repressed traumas and emotions through meditation practice. Currently there is an active debate in the psychiatric and psychological communities regarding the accuracy of memories which were previously repressed (Grinfeld & Reisman, 1993). It is

possible that some unveiled memories should be viewed in the context of the total clinical picture, and corroborated whenever possible. Case 1 highlights the difference between CM and MM in regards to facilitating unveiling. E.K. had experienced neck pain and a pressure sensation in her head while practicing intensive CM, but she was able to keep these sensations in the background while she maintained her attention on the Jhanas, and she entered states of calmness and peacefulness. When these same sensations arose during the practice of MM and she was instructed to explore them with mindfulness, the neck pain and head pressure became a door to flashbacks of ongoing severe sexual abuse at age two. Her initial sensation of neck pain was at some level associated with her described past physical and sexual abuse by men who threatened her with "something around my neck . . . choking me." It is remarkable that she continued to practice intensive MM for one month after the initial unveiling of her abuse memories, and she only stopped practicing MM when she became psychotic, with visual hallucinations, insomnia and intense fear. Her psychosis resolved quickly once she stopped formal MM practice, and began on low-dosage antianxiety medication.

Case 2 demonstrates how meditation-based stress reduction can actually significantly increase the stress level for some individuals. K.L. was a routine referral to a MM-based Stress Reduction Clinic with the diagnosis of stress-related gastrointestinal symptoms. As she began to relax for the first time in her adult life, she experienced the onset of panic and anxiety which progressed to panic disorder with severe agoraphobia. The onset of these significant anxiety symptoms during meditation practice was likely related to her unveiling affective memories of her sexual abuse by her cousin, as well as unveiling the anger at her mother's inaction after being informed of this abuse. She had to stop her meditation practice and begin psychiatric treatment, which included both psychotherapy and psychopharmacology. After working through long-repressed emotions from her childhood associated with the sexual abuse by her cousin and her mother's inaction, including significant anger, her anxiety symptoms resolved, and she was able to discontinue her medication and terminate psychotherapy. She was then able to participate in another MM-based Stress Reduction Program without a recurrence of anxiety symptoms.

anxiety symptoms during meditation practice

Case 2 raises the issue of informed consent for prospective participants in clinical, meditation-based stress reduction programs. Stress reduction has found its way into mainstream medicine, and the growing field of Mind/Body medicine scientifically documents the significant role of stress in causing and exacerbating many medical conditions. As a result of this significant, evolving body of knowledge about the role of stress in health and illness, many hospitals, health practitioners, and managed-care organizations uti-

lize stress-reduction programs as part of their comprehensive treatment interventions. One study documented decreased health care utilization in a sub-population of members of a large insurance carrier who practiced Transcendental Meditation (Orme-Johnson, 1987). Although the anti-stress effects of meditation are well documented, there does exist a sub-population of individuals who will likely experience the onset of significant psychological symptoms through the practice of meditation. Prospective participants in meditation-based stress reduction programs should be informed of this risk, and a formal risk/benefit discussion should be part of any screening interview for stress-reduction programs.

Some stress reduction clinics and meditation retreat centers do have a pre-screening questionnaire (University of Massachusetts Medical Center, n.d.; Insight Meditation Society, n.d.) which attempts to identify individuals at risk for psychological distress from the practice of meditation. Populations of individuals at risk include: those with a history of psychosis, severe personality disorders, significant recent loss, severe depression, a history of physical or sexual abuse, and active substance abuse. Individuals at risk should not necessarily be excluded from meditation practice, but rather should be clearly informed of the likelihood that psychologically painful material will likely arise through meditation practice.

In all likelihood, a large percentage of prospective meditators will have at least one of the above described risk factors for the arising of psychological distress during meditation practice. Substance abuse is pervasive worldwide, and often serves the function of self-medication from painful psychological material. Childhood sexual abuse appears to be epidemic worldwide as well, and researchers commonly state that one in three women and one in five men were sexually abused during their childhood. Often the perpetrator is a relative or family friend. A recent study in New Zealand which surveyed three thousand women over the age of eighteen found that approximately one-third described sexual abuse before age sixteen (Anderson, Martin *et al.*, 1993), which supports the commonly quoted statistic.

meditation practice may indeed serve as the vehicle

For some of these individuals at risk for the surfacing of painful psychological material during meditation, their meditation practice may indeed serve as the vehicle to allow them to access, re-experience, integrate into their conscious awareness, and heal through past traumas. The memory of the trauma itself may have never been repressed, as in Case 2, but rather the associated affect and emotions were repressed or suppressed, and may surface during meditation practice. How the meditator relates to and works with difficult psychological material that arises will depend on many factors including: personality structure, psychological maturity, meditation experience, social supports, concurrent or past

psychotherapy, and relationship to the meditation practice. Some individuals will view the unveiling as a necessary part of their own personal journey of growth and healing, and may be able to tolerate intensely painful material through continued meditation with no other intervention. Others may view the process as undesirable, and stop meditation altogether, or begin psychotherapy to work on whatever material arose while postponing or simultaneously continuing with their meditation practice. A small percentage of individuals may become flooded with painful psychological material resulting in severe symptoms of anxiety, depression, anger or psychosis which would require acute psychiatric intervention.

The intensity of the meditation practice will impact on the unveiling process. Individuals participating in long-term silent meditation retreats, such as in Cases 1 and 3, are more likely to encounter difficult psychological material than individuals enrolled in time-limited meditation-based stress reduction clinics. Participants in stress reduction programs commonly practice meditation from fifteen to sixty minutes each day, while continuing with their usual day-to-day routine. In this setting, the meditator is more likely to experience calmness and relaxation as they take time out from their often demanding and activity-filled schedule. However, even in this setting, as Case 2 demonstrates, significant unveiling can occur.

It is significant that the individuals described in Cases 1 and 2 had no prior psychiatric treatment history. E.K. had no conscious memories of her severe childhood sexual abuse, and this is often the case. A recent article describes how "Researchers have estimated that as many as sixty-four percent of sexual abuse victims have been at least partially amnesic during some point in their lives" (Grinfeld & Reisman, 1993). Therefore, despite attempts at pre-screening individuals at risk, there will always remain a population of individuals where this is not possible. Rather, it is during the process of meditation practice that the risk factor for psychological distress surfaces. The informed consent process would at least alert prospective meditators to the possibility of the unveiling of emotionally painful memories.

the informed consent process

Case 3 describes an individual whose past history of chronic depression, anxiety and alcohol abuse provide indicators of significant internal pain and turmoil. During a ninety-day intensive MM silent retreat, T.N. experienced the unveiling of "hatred and anger," which he described as emotions that were previously unfamiliar to him. Exploration of these emotions became the theme of his ongoing work in individual psychotherapy following the MM retreat, and eventually he began having flashbacks of childhood sexual abuse. In this case his MM practice initially unveiled painful and intense emotions that were related to the sexual abuse, but it took an additional three years of psychotherapy before the actual abuse was

also unveiled. Four years following the recall of sexual abuse, he began experiencing somatic flashbacks of the abuse while again practicing intensive MM. This case highlights the process of recovery from a significant trauma, and the gradual unveiling over time that can occur.

All three of the above individuals described their experiences as a necessary part of their continued growth and healing. They expressed no regrets over the unveilings that occurred through their practice of meditation. Despite the emotional pain and intensity of their experiences, all three chose to continue to practice meditation.

The above case reports also demonstrate the potential role of meditation as an adjunct to psychotherapy, which has been previously described (Kutz *et al.*, 1985; Kutz, Borysenko & Benson, 1985). In the current health care climate of cost containment and managed care, meditation could be integrated with traditional insight-oriented psychotherapy in a model that would couple a regular meditation practice with less frequent psychotherapy sessions. This would reduce the cost of psychotherapy and very likely facilitate progress as unconscious material is unveiled through meditation. Of course, this model would not be appropriate for all individuals, especially those who are at high risk for significant psychological distress through meditation practice.

Another possible model would be to develop a weekly meditation/psychotherapy group, led by a therapist experienced in the meditative process. The first part of the group could be a period of silent MM, followed by a discussion/exploration of the group members' experiences during the meditation session. Another group approach would involve a daily meditation practice by group members, who would then meet on a weekly basis to discuss/explore their experiences with meditation.

meditation has found its way into mainstream medicine

In summary, meditation has found its way into mainstream medicine, with a growing number of clinical applications. Significant complications of meditation practice exist, including the unveiling of previously repressed memories of trauma as well as associated painful emotions. Health care providers who teach meditation or refer their clients to meditation-based treatment interventions should be aware of the possible complications and contraindications of meditation practice. Appropriate informed consent issues should be addressed with prospective meditators. Should a meditator experience the unveiling of traumatic memories or emotions during meditation practice, the appropriate intervention would depend upon many factors, most important of which is the individual's functioning and ability to consciously integrate the unveiled material. Interventions would include: continued meditation

practice, increased contact with the meditation teacher, decreased meditation practice, stopping meditation altogether, referral to psychotherapy, referral for psychopharmacology, and an acute psychiatric evaluation.

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