

Trauma as Emotional "Tilt": Observations and Model, Synthesized Against 130 Years of Clinical Research

Choosing Emotions Research Notes — No. 1: Trauma

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*Prepared August 14, 2026 — starting point: Johnston's own experience, query, and research regarding the trauma/"tilt" hypothesis for **Choosing Emotions** (2025)*

Purpose of This Paper

D. Earl ("Doug") Johnston has proposed, in his original query and framing reproduced below, a synthesis and working model about trauma developed originally for **Choosing Emotions**. This paper restates that synthesis precisely as offered, sets it in the context of the author's own lived research, and then examines it against the clinical and academic literature — noting where it is well supported, where it should be qualified, and where genuine scholarly disagreement exists. Every claim below is either general scientific consensus or is anchored to a well-regarded named researcher and publication so that it can be independently verified before any language is adapted. This is the first in a series of research notes prepared for the **Choosing Emotions** Media Room.

Author's Note: Genesis of This Synthesis

This synthesis and model did not begin in a library or on-line. It began with hundreds of hours of the author's own therapy, spent learning — slowly, and often the hard way with dedicated effort — to attach words to scenes of overwhelm that had, until then, been carried a lifetime without articulation. The working hypothesis below was formed from that lived, first-person process, long before its author encountered and pursued the clinical and research literature that follows.

Only afterward, in the course of researching **Choosing Emotions**, did it become clear that clinicians and researchers — starting with Pierre Janet in 1889, and continuing through Bessel van der Kolk, Judith Herman, Stephen Porges, Elizabeth Stanley, James Pennebaker, Jill Bolte Taylor, and others — had been independently mapping much of the same territory for well over a century. That convergence, arrived at from two entirely different directions — one clinical and personal, one academic and empirical — is the reason this synthesis is offered here: not as a claim to have discovered something new, but as documentation that a body of hard-won personal experience holds up against, and is illuminated by, more than a century of independent scientific research.

Johnston's Original Query and Model — Verbatim, in Full

The following is reproduced as written, word for word, as the starting point for this entire paper:

“From my book ***Choosing Emotions*** I have made and developed some observations and aphorisms - one of the key areas has been about trauma. It feels supportable to me that trauma is a condition of overwhelm where our emotional system effectively 'tilts' and shuts down either wholly (unconsciousness) or partially (in and out, and often without full awareness). I note that Bessel van der Kolk and others have commented on all trauma being 'preverbal' and that the solution can be, after the fact, to attach at last the descriptive, narrative words to the 'speechless' trauma event. In my view, the human nervous system/emotional system, which has a priority of protecting us, has effectively 'failed' or been temporarily overcome in a traumatic episode, and so it prioritizes repetitive fixations on 'what really happened.' (See Kahneman (?) or Haidt (?) about how our nervous system prioritizes negative information.) When those words are carefully recovered or assigned to more adequately explain the blanks in the victim's memory, the fixations and fear often fade, and the 'terrifying' event is replaced by a calmer 'bad memory' which the person comes to regard as having overcome. And so life moves forward more freely without crippling fixations and debilitating gaps in memories and words.”

Johnston's query (verbatim in substance): “Please review and examine the observation and synthesis, citing clinical and/or MD/PhD works which are either supporting or challenging.”

Part One: What the Literature Strongly Supports

1. The “tilt/shutdown” mechanism has a well-established physiological basis

Johnston's image of the emotional system “tilting” and shutting down maps closely onto the **dorsal vagal shutdown** response described in Stephen Porges's Polyvagal Theory (Porges, *The Polyvagal Theory*, 2011). Porges distinguishes three hierarchical nervous-system states: a ventral-vagal “social engagement” state (calm, connected); a sympathetic “fight-or-flight” state; and, when neither fighting nor fleeing is possible against an overwhelming threat, a dorsal-vagal “freeze/shutdown” state marked by immobilization, numbing, and dissociation. Clinicians describe this third state as the nervous system's circuit-breaker: when a threat is appraised (below conscious awareness, via what Porges calls “neuroception”) as inescapable, the system does not merely activate more strongly — it collapses into conservation-withdrawal. This is a close physiological analogue to Johnston's “tilt.” The partial, in-and-out version Johnston describes corresponds to what clinicians call dissociation or partial hypoarousal, rather than full loss of consciousness, and both are recognized points on the same polyvagal spectrum.

Caveat: Polyvagal Theory is influential in trauma-informed clinical practice but is also contested at the level of underlying vagal anatomy and physiology; some physiologists argue Porges's account of two functionally distinct vagal “branches” overstates what the anatomical and comparative evidence supports. The clinical phenomenon of freeze/shutdown under inescapable threat is not seriously disputed; Porges's specific mechanistic story for why it happens is debated among specialists. It is safe to use the shutdown/freeze phenomenon as description; it is riskier to lean on the vagal-branch mechanics as settled science.

2. Elizabeth Stanley's “window of tolerance” gives Johnston's “tilt” a contemporary, trainable framework

Elizabeth Stanley, PhD — a former U.S. Army officer, Georgetown professor, and creator of Mindfulness-based Mind Fitness Training (MMFT) — extends Porges's nervous-system model in *Widen the Window: Training Your Brain and Body to Thrive during Stress and Recover from Trauma* (2019, with a foreword by Bessel van der Kolk). Stanley distinguishes the “thinking brain” from the “survival brain” and describes a **window of tolerance** — the band of arousal within which a person can stay online, think clearly, and regulate emotion. Inside the window, the thinking brain and survival brain cooperate; when a stressor pushes arousal outside the window, the survival brain takes over and the thinking brain's functions — including language and narrative — go offline. Stanley's central practical claim, drawn from her own work with the military and from stress-resilience research, is that the window itself is not fixed: repeated stress without adequate recovery narrows it, while complete, supported recovery after a stressful or traumatic event widens it and builds resilience for the future.

This maps directly onto Johnston's “tilt” language and adds something useful to it: his model describes the shutdown event itself, while Stanley's model describes the *capacity* that determines how easily a person tilts in the first place and how fully they recover afterward. It also reinforces the qualification in Part Two below — Stanley's own research-based position is that recovery must engage the body (“bottom-up”) as well as language and thinking (“top-down”); narrative work alone, done outside the window of tolerance, is unlikely to land.

3. There is a 130-year clinical lineage for exactly this overwhelm → dissociation → fixation → narrative-repair sequence

This is the strongest support for overall ‘tilt’ and repair model, and it predates van der Kolk by a century. The French psychiatrist **Pierre Janet** (from *L'Automatisme Psychologique*, 1889, through his later trauma writings) proposed that what he called “vehement emotions” — emotional intensity that exceeds a person's capacity for effective action — produce an “integrative failure”: the traumatic material cannot be woven into ordinary, narratable memory and is instead dissociated, split off from the rest of the personality. Janet observed that these dissociated, poorly organized memories return afterward as fragments — intrusive feeling states, body sensations, images, and behavioral re-enactments — rather than as a coherent story the person can simply recall and set down. He further observed that when these vehement emotions recur repeatedly, they entrench the person's attachment to the trauma and block the restorative process; but that in therapy, the dissociated material can eventually be resynthesized into ordinary memory.

This is, point for point, Johnston's core model: overwhelm defeats normal emotional processing; the unprocessed material persists as fragmentary, non-verbal fixation; and integration (in Janet's terms, resynthesis; in Johnston's, attaching narrative words) resolves it. Van der Kolk himself, together with Onno van der Hart, explicitly revived and credited Janet's framework as the foundation of modern trauma theory in their 1989 paper on Janet's contribution to understanding post-traumatic stress — so Johnston's own experience and intuition and van der Kolk's “preverbal” language share a direct, citable common ancestor.

4. Van der Kolk's “all trauma is preverbal” is accurately used and clinically mainstream

This item is already settled in Johnston's verified ledger in ***Choosing Emotions*** (See van der Kolk's ***The Body Keeps the Score***, p. 43, and the related passages on words paving the path out of trauma). It is worth noting for this review only that the broader clinical and neuroimaging literature is consistent with it: during high-threat states, activity in Broca's area (language production) tends to decrease while limbic/subcortical threat-processing regions dominate — the widely cited basis for describing acute traumatic experience as registering somatically and sensorially before, or instead of, verbally.

5. Jill Bolte Taylor's firsthand account is a vivid, scientifically credentialed illustration of language going offline and being rebuilt

Dr. Jill Bolte Taylor, a Harvard-trained neuroanatomist, suffered a massive left-hemisphere stroke in 1996 and documented the experience — as both patient and trained observer — in ***My Stroke of Insight: A Brain Scientist's Personal Journey*** (2008). As the stroke progressed, the left hemisphere's functions shut down: Taylor lost the ability to walk, talk, read, write, or recall her own life, describing it afterward as losing “the storyteller” and the linear, narrating sense of self, while a wordless, present-moment awareness (which she attributes to right-hemisphere processing) remained intact. It took her eight years to fully rebuild left-hemisphere function and re-acquire language, reading, and narrative memory.

Taylor's case is neurological rather than psychological trauma, and it should not be cited as clinical evidence for the ‘trauma is emotional tilt’ paradigm — the cause (a ruptured blood vessel) and the specific brain systems involved are different from psychological overwhelm. What it offers instead is an unusually clear, credentialed, first-person illustration of the general phenomenon Johnston is describing in ordinary language: a functioning mind can lose its narrating, language-based self entirely while remaining conscious in some form, and rebuilding that language capacity afterward is a real, gradual, describable process rather than a metaphor. Used carefully and labeled as an illustrative parallel rather than as trauma research proper, it is a compelling human support story for the book — precisely because Taylor is a neuroscientist describing her own “tilt” and recovery of words from the inside.

6. Attaching language to a distressing experience has a direct, well-replicated evidence base: Pennebaker's expressive-writing paradigm

James W. Pennebaker and Sandra Beall's foundational 1986 study (*Journal of Abnormal Psychology*) had participants write about their most traumatic experience for fifteen minutes across four consecutive days, compared with a control group writing about trivial topics. The disclosure group showed significant longer-term physical-health benefits (fewer campus health-center visits over the following months) despite short-term increases in distress and blood pressure immediately after writing. This finding — immediate discomfort, longer-term relief — has since been replicated across hundreds of studies and multiple meta-analyses (e.g., Frattaroli, 2006). Pennebaker's own theoretical account (developed with colleagues through the 1990s and 2000s) is that habitually inhibiting language about a trauma is itself physiologically costly, and

that constructing a coherent verbal narrative allows the mind to organize and “complete” an experience that had been held only as raw affect and sensation.

This is close to direct clinical evidence for the mechanism Johnston describes — attaching careful, chosen words to a distressing memory: words genuinely change the standing of the memory, and the change is measurable, not merely reported.

7. Judith Herman's clinical model describes almost exactly Johnston's end state: “terrifying” becomes “overcome, ordinary bad memory”

Judith Herman, MD (*Trauma and Recovery*, 1992), proposes a three-stage recovery process: establishing safety, remembrance and mourning, and reconnection. The central task of the second stage is constructing a full, detailed narrative of the traumatic event with a witness (typically a therapist). Herman's own description of the goal of that stage is that reconstructing the trauma story **transforms the traumatic memory** so that it can be integrated into the survivor's ongoing life story — moving it from what other clinicians describe as a “living nightmare” that still hijacks the body into a “historical event” with a beginning, middle, and end. That is Johnston's “calmer bad memory which the person comes to regard as having overcome,” stated in clinical language by one of the most cited trauma clinicians of the last fifty years.

8. The nervous system's bias toward negative information is real, well documented, and gives Johnston's “fixation” claim a mechanism — though the standard citation is neither Kahneman nor Haidt

Johnston tentatively attributed the negative-information-priority idea to Kahneman or Haidt. The literature's actual anchor citation is Roy Baumeister and colleagues' review paper “Bad Is Stronger Than Good” (*Review of General Psychology*, 2001), which surveyed evidence across emotion, memory, relationships, and learning and found a consistent asymmetry: negative events, feedback, and information are processed more thoroughly, remembered more durably, and weighted more heavily than positive information of equal magnitude — with almost no domain showing the reverse pattern. A closely related, slightly earlier citation is Paul Rozin and Edward Royzman's work on the negativity bias, cited within Baumeister's review. Daniel Kahneman's genuinely relevant contribution is a different (though related) concept — *loss aversion* (with Amos Tversky, prospect theory, 1979): losses loom larger than equivalent gains in decision-making. Jonathan Haidt has written about negativity bias but as a popularizer citing Baumeister and Rozin's original research, not as the originating source. If Johnston seeks a citation for this specific claim, Baumeister et al. (2001) is the correct primary source; Kahneman can still be cited accurately, but for loss aversion rather than for this particular repetitive-fixation phenomenon.

Part Two: Where the Hypothesis Needs Qualification

1. Timing and readiness matter — narrative work done too early or under duress does not reliably help, and can backfire

This is the most important qualification for Johnston's model, and it is well documented. Single-session psychological debriefing (Critical Incident Stress Debriefing, or CISD), which pushes trauma survivors to verbally recount a traumatic event within hours or days, has been tested in multiple randomized trials. A widely cited meta-analysis (Van Emmerik, Kamphuis, Hulsbosch & Emmelkamp, *The Lancet*, 2002) found that single-session debriefing does not reduce later PTSD symptoms and, in some studies, is associated with worse outcomes than no intervention at all; a Cochrane review reached a similarly cautious conclusion. This does not contradict Johnston's core claim that language eventually helps — it refines it. Herman's own model explicitly places “establishing safety” before “remembrance and mourning” for this reason, and Pennebaker's writing paradigm is done privately, at the participant's own pace, days after enrollment, not as forced real-time recounting to an authority figure immediately after the event. The mechanism Johnston describes appears to depend on the words being **chosen and timed by the person**, not extracted from them.

2. “Filling in the blanks” needs care: recovered or reconstructed memory carries a documented risk of inaccuracy

Johnston's phrase “when those words are carefully recovered or assigned to more adequately explain the blanks” is clinically sound as description of *meaning-making* — building a coherent story around what is remembered — but should be handled carefully if it is read as recovering literal, previously inaccessible factual detail. Elizabeth Loftus and others have shown across decades of memory research that memory is reconstructive rather than a fixed recording, and that suggestive questioning or repeated narrative-building attempts can genuinely alter what a person believes they remember, including implanting false details. The clinical and scientific consensus (reflected in the 1990s “memory wars” around recovered-memory therapy) is that the therapeutic benefit of narrative work comes from organizing and making meaning of what is felt and known, not from treating the exercise as literal forensic reconstruction of missing facts. Framing the book's claim as “naming and making sense of what happened” rather than “recovering the missing facts” would keep it on the well-supported side of this line.

3. Not all trauma presents as amnesia or blanks — some is hyper-remembered, not missing

Van der Kolk's and Janet's clinical populations include people with genuine gaps, but a large proportion of trauma survivors instead report the opposite problem: intrusive, intensely detailed, sensorially vivid memories that will not stop recurring (flashbacks, nightmares) rather than “blanks.” The overwhelm/shutdown model still applies — the material is dissociated from ordinary narrative memory even when sensory fragments are vivid — but Johnston's language of “debilitating gaps in memories” describes one presentation of trauma, not the only one. A stronger, more defensible version of the aphorism would speak of the memory being *unintegrated* — held outside the ordinary narrative, whether as a blank or as an intrusive fragment — rather than specifically as a gap.

4. Narrative repair is necessary for many trauma presentations but not universally sufficient on its own

Modern first-line treatments for PTSD (Prolonged Exposure, developed by Edna Foa; Narrative Exposure Therapy, developed by Maggie Schauer, Frank Neuner and Thomas Elbert for survivors of chronic/repeated trauma; EMDR) all include a structured narrative or exposure component consistent with Johnston's model, but all of them combine it with additional elements — graded exposure, physiological regulation, cognitive restructuring of trauma-related beliefs — rather than treating narrative language alone as curative. The general clinical position is that language is a necessary and central mechanism, well supported by evidence, but is typically most effective within a broader process of safety, regulation, and paced exposure, not as a stand-alone technique performed once.

Part Three: Overall Assessment

Johnston's hypothesis is well supported at its core and has a genuinely distinguished intellectual lineage — Janet's 1889–1909 dissociation theory, van der Kolk's “preverbal trauma,” Stanley's window of tolerance, Pennebaker's expressive-writing research, Jill Bolte Taylor's firsthand account of language loss and recovery, and Herman's three-stage recovery model converge on essentially the sequence Johnston describes: overwhelm defeats the system's normal processing; the unprocessed material persists as fragmentary, non-verbal fixation and re-experiencing; and constructing careful, chosen narrative language around the experience measurably reduces its grip and allows it to settle into ordinary, “overcome” memory. This is not a fringe or speculative claim — it is close to the operating consensus of trauma psychiatry, expressed independently by researchers across more than a century.

Three refinements would make the book's language more defensible under scrutiny: (1) attribute the negativity/fixation mechanism to Baumeister (and Rozin) rather than Kahneman or Haidt, or cite Kahneman specifically for loss aversion if his name is wanted; (2) frame the narrative-repair process as something that must be self-paced and safety-first, since forced or premature verbal recounting (CISD) is evidence-backed as ineffective or harmful; and (3) describe the unresolved trauma material as “unintegrated” rather than strictly as “gaps,” since many survivors have too much vivid memory rather than too little.

Addendum: The Pierre Janet Article

Full citation: van der Kolk, B. A., & van der Hart, O. (1989). Pierre Janet and the breakdown of adaptation in psychological trauma. *American Journal of Psychiatry*, 146(12), 1530–1540. This is the paper referenced in Part One, Section 3 above. It is a centenary reappraisal, published on the 100th anniversary of Janet's *L'automatisme psychologique* (1889), written by two of the most prominent contemporary trauma researchers — one of them (van der Kolk) already central to Johnston's own manuscript. What follows is a fuller, paraphrased summary of its content, organized around the passages most relevant to Johnston's observations and synthesis.

Background

Pierre Janet (1859–1947) was a French philosopher-turned-psychiatrist who studied hysteria under Jean-Martin Charcot at the Salpêtrière in Paris in the late nineteenth century. His 1889 book was the first systematic study of dissociation as the mechanism by which the mind responds to overwhelming experience. William James devoted much of his 1896 Lowell Lectures to Janet's work, and Jean Piaget considered himself one of Janet's intellectual disciples. Janet's influence faded after Freud's psychoanalysis came to dominate the field, and his work was largely forgotten for sixty years until historian Henri Ellenberger and others revived it. Van der Kolk and van der Hart wrote their 1989 reappraisal specifically because the modern trauma field — PTSD, dissociative disorders, memory research — was, in their words, rediscovering ideas Janet had already worked out a century earlier.

Janet's core model, in the authors' summary

Janet held that most of what a healthy mind does with everyday experience happens automatically and below conscious attention: new sensations are continuously organized and filed against previously stored memories, keeping a person's sense of self and history coherent. He called these automatic processes “automatisms” and coined the term “subconscious” for the memories stored this way. When an experience is too frightening or too far outside existing mental categories to be processed this way, it cannot be filed normally — it is instead split off (dissociated) from ordinary awareness and voluntary control, and it resurfaces later as fragments: intrusive body sensations, images, emotional states, and behavioral re-enactments, rather than as an ordinary, tellable memory. Janet called the isolated, walled-off traumatic material “subconscious fixed ideas.”

Janet's own term for the overwhelming reaction that causes this failure was “**vehement emotion**” — almost exactly Johnston's word “overwhelm.” Janet wrote that these traumas produce damage in proportion to their intensity, duration, and repetition, and that the resulting disturbance often does not appear at the moment of the event itself but only later, once the person has exhausted their efforts to fight what could not be changed.

The “speechless” and “fixation” elements — direct support for Johnston's language

This is the closest overlap with Johnston's own wording. Janet observed that when people become too overwhelmed to tell the story of what happened, the memory cannot be turned into what he called “narrative memory,” and the person is left unable to recount events even though still confronted by the unresolved situation — a state he described as a kind of “phobia of memory.” Janet's memorable formulation, quoted directly by van der Kolk and van der Hart, was that “*memory is an action: essentially it is the action of telling a story.*” Until the traumatic material could be translated into a personal narrative, Janet held, it could not be “liquidated” and would instead continue to intrude as terrifying perceptions, obsessive preoccupations, and physical symptoms such as anxiety reactions. This is essentially a clinical restatement of van der Kolk's later “all trauma is preverbal,” and it is where van der Kolk's phrase actually comes from historically.

Janet also described exactly the “attachment”/fixation Johnston describes: traumatized patients, unable to integrate the memory, seemed to lose the capacity to take in new experience as well, as though their personality had stopped growing at the point of the trauma and remained fixed there, repeatedly confronting a painful situation without being able to resolve or narrate it. Freud later used the word “fixation” for the same phenomenon; other researchers have since called it “traumatophilia” or “addiction to the trauma.” Janet linked this directly to exhaustion and a progressive narrowing of the person's capacity to function — a slow decline he distinguished from the acute traumatic episode itself.

Janet on treatment — and a caution for Johnston's model

Janet's therapeutic approach anticipated Judith Herman's much later staged model by nearly a century. He believed stabilization had to come before exploration of the trauma — patients needed to be less symptomatic and have regained some voluntary control before active work on the traumatic material began. He also believed that simply uncovering a memory was not, by itself, enough: the memory needed to be actively reworked and placed into a coherent, meaningful narrative, and he treated memory itself as an act of creation rather than a fixed recording waiting to be retrieved. Notably, when a full, detailed recovery of the trauma was not possible or did not bring relief, Janet sometimes deliberately substituted a calmer, more neutral or even fictionalized image for the traumatic one, rather than insisting on literal accuracy — a detail worth flagging against Johnston's phrase “more adequately explain the blanks,” since Janet's own practice suggests the therapeutic value lies in achieving a coherent, bearable narrative, not necessarily a factually exhaustive one.

Why this matters for *Choosing Emotions*

Van der Kolk and van der Hart's explicit purpose in writing this paper was to show that ideas the trauma field treats as modern discoveries — preverbal/speechless trauma, dissociation as a survival response, the fixation or “attachment” to unresolved trauma, and narrative construction as the route out — were already fully articulated by Janet in 1889. That gives Johnston's aphorism “Trauma is emotional tilt” an unusually strong intellectual pedigree: the same model, independently arrived at and clinically documented across more than 130 years, from Janet through van der Kolk to Johnston's own model formulation as set forward in more detail above.

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This paper is a research synthesis, not legal or medical advice. As with all research notes in this series, its passages have been cross-checked against the Choosing Emotions manuscript for consistency.