"RECOVERED" MEMORIES OF ABUSE - AN HISTORICAL REFLECTION

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I realize that whenever one writes about aspects of the history of psychiatry in an effort to illuminate some contemporary issue it is possible to be misunderstood. A review of experiences of the past, after all, is not science - it rests on things other than data. It is retrospective and selective. Most historical conclusions must be tentative. The past and the present are not the same. If, for example, I review, as I shall, past mistakes of medical thought such as the witch-craze of past eras when considering the issue of "repressed memories" of sex abuse, some might think that I believed that every contemporary claim of trauma or sex abuse in childhood was such a mistake. But witches do not exist and we all agree the sex abuse of children does.

One must emphasize that the study of psychiatry's history does not identify the causes or the nature of contemporary psychiatric issues. Those issues have to be addressed on their own merits with the instruments of today. Historical review, however, shows the collective experience of the psychiatric discipline and thus directs how we must practice today. It does not tell us what conclusions we must draw. It tells us how we must proceed so as to minimize error by demonstrating how past proceedings provoked it.

I plan here to review a set of historical events, each of which tells something about the pitfalls of practice. Knowledge of these pitfalls has always in the past and must now direct and justify how we evaluate a patient, how we consider alternatives,

how we employ information, how we collaborate with each other. We can then discern whether standard practices are being followed in managing repressed memories of sex abuse.

For all that the focus is on potential pitfalls, it is legitimate to propose a hypothetical schema from the historical record that might challenge the current epidemic of "recovered" memories. Such an hypothesis is helpful in that it provides an alternative, "null" hypothesis against which to compare other views of the nature of these memories and direct investigation to confirm or reject them.

Again, nothing that I am saying should be construed as denying that child abuse and incestuous acts occur. Nor am I denying that such abuse may have been underestimated. I have worked at Johns Hopkins for over a decade with a variety of sex abusers and with their victims. Victims exist and they deserve our concern and our help in rehabilitation.

My plan is to briefly describe three important past events and develop their implications for practice.

First: The witch-craze of the 16th and 17th centuries as an example of the invention of psychological entities out of a climate of social legend.

Second: The outbreak of hystero-epilepsy at the Salpetriere under the direction of J-M. Charcot as an example of professional induction of symptoms, the nature of hysteria, and its group support.

Third: The phenomena of flashbacks as studied in their first

appearance in World War I (WWI) as an example of psychological events that can be misinterpreted and their correct implications overlooked. I will employ these historical examples to make a basic point: doctors make mistakes and must modify their practices in their light, so as to avoid making similar ones in the future.

II

Witch-craze

During training every psychiatrist - at least in my generation - got lectures on the witch-craze. I remember how the Professor at the Maudsley Hospital in London, Sir Aubrey Lewis, spent two hours on the issue and how at first I thought he had chosen to do so because of the times - 1950s - and the political movement in the United States of the "Red Scare" which in newspapers was described as a witch hunt. When I mentioned this to him, wondering why he wanted to beat so hard on the open door of us liberal psychiatrists, Sir Aubrey became indignant. "Dr. McHugh, this has nothing whatsoever to do with Americans, the suspicions of the Soviet Union, Joseph McCarthy. I want psychiatrists to consider the witch-craze for purely professional reasons. It demonstrates the capacity of psychiatrists to invent false explanations for problematic behaviors and to create false images of the minds of others."

I took this rebuke to heart and its message that psychiatrists have the power to invent or imagine entities of mind, and therefore they are obligated to find ways to validate what they propose. The witch-craze, in fact, made clear that validation means somethin

much more than proposing ways - even consistent ways - to make a diagnosis.

The witch hunters received explicit "operational" ways of identifying witches. They taught each other and wrote their procedures and views in a large and influential book. This book entitled Malleus Maleficarum or the Hammer of Witches spelled out in exquisite detail the kinds of behaviors that characterize the witch and also identified the kinds of marks on the body that were of congress with devils, incubi and sucubi. The Malleus had as its epigraph: Haeresis est maxima opera maleficarum non credere ("to disbelieve in witchcraft is the greatest of heresies").

What was learned from this that might illuminate practices with "recovered" memories and the whole concept of "robust repression"? First: The fact that there is a manual telling how to recognize the manifestations of repressed memories does not confirm them. It is an exercise in creating a consistent approach to the diagnosis amongst therapists - a uniformity of diagnostic practice. It does not validate the presumed abusive experience. It is disrespectful to scripture to call The Courage to Heal the bible of the victim-self help movement. I believe The Courage to Heal could be viewed as a contemporary Malleus Maleficarum and, given the way it is quoted and employed, could carry a similar epigraph.

The issue for "recovered" memories is validation - and validation in every case when it appears. What that means is that the therapist must confirm the actual abuse before he or she launches into therapy. Some therapists will react strongly and

very negatively to the requirement that they must confirm an opinion when they wish to get on with therapy. However the effort at finding external confirmation of a diagnostic opinion is a standard practice with all psychiatric disorders and must be a emphasized when what is claimed is a serious, criminal offense by parents against children and a devastation to family unity.

It is not required that the therapist himself or herself carry out the diagnostic validation. This can be turned over to an open minded consultant who can press through hospital and school records, reach external informants,and assess all the parties involved in the charges. But to treat for repressed memories without <u>any</u> effort at external validation is malpractice pure and simple; malpractice on the basis of standards of care that have developed out of the history of psychiatric service - as with witches - and malpractice because a misdirection of therapy will injure the patient and the family. Such misdirection is the theme of the next section

III

Charcot and Hystero-epilepsy

The history of the practices of J-M. Charcot at the Salpetriere in 1880s taught many lessons about practice. Jean-Martin Charcot was the most distinguished neurologist and psychiatrist in France in the late 19th Century. Charcot - and the scientifically oriented psychiatrists of the time were interested in the neural control of the muscles and the body. He, for example, led the way in the development of a systematic

neurological examination; he discovered many diseases, as for example, Amyotrophic Lateral Sclerosis - Lou Gehrig's disease - and he had very distinguished pupils - including the great neurologists, Pierre Marie and Joseph Babinski, and the great psychiatrists, Sigmund Freud and Pierre Janet (who coined the terms, repression and dissociation after studying with Charcot).

At a crucial time in the mature years of his career, Charcot was presented with an intriguing situation. The Salpetriere Hospital, where he was the chief physician, was reorganized and the epileptic and hysterical patients - both with episodic conditions - were placed together in the same section. Gradually more and more of the hysterical patients began to show odd attacks - very similar to the epileptic, but sufficiently different to make Charcot believe that he had discovered a new entity - a new disorder at the interface between mind and brain, hystero-epilepsy. He began to study the manifestations of this condition with the same precision, exactitude and detail that he employed on all other neurologic patients. He watched every movement of the patient, recorded the similarities and distinctions in comparison with epileptics, tested ways to provoke and sustain the attacks and displayed his results to others.

Strangely, the patients became more and more disturbed, had more spells, and progressively more intriguing kinds of fits. What had at first been rather simple and quiet events emerged into dramatic provocative behaviors suitable to enthrall an audience of doctors and interested spectators from the intelligentsia of Paris.

Eventually quite wild group behavior involving many patients together surfaced at the hospital. For example, a group of women took to assuming a fixed posture and held themselves frozen in it whenever a bell was rung.

Charcot thought that hystero-epilepsy was a new disorder and that he had made another important discovery in neuropsychiatry. One of his students, Babinski, disagreed. Charcot had not discovered something, he had induced something out of his authority, his methods of study and investigation, his interest, and the hospital situation where real epileptics and pseudo-epileptics were grouped together. Babinski believed that suggestion started the behavior and social circumstances sustained it. He claimed that the patients would not improve unless Charcot changed his approach to them.

Gradually it became apparent that Babinski was right about the nature of this outbreak of hysterical behavior and its treatment gradually developed. In order to stop a patient from repeatedly displaying an imitation of epileptic seizures two practices were required - isolation and counter suggestion. Isolation meant separating epileptic from hysterical patients. Counter suggestion meant offering another idea to the patient than her view that she suffered from a disease very intriguing to Charcot. The doctors and other staff turned their and thus the patient's attention from the hysterical behavior and onto the life circumstances that had brought the patient into care originally, offering support and understanding to those issues. This was the beginnings of

psychotherapy.

How does this set of events relate to repressed memories? Charcot showed that just as there was epilepsy, it was also possible to create a pseudo-epilepsy. If one had a pseudo-epilepsy and focused on its counterfeit manifestations, they would worsen. If the patient remained amongst groups with both epilepsy and pseudo-epilepsy, she would not improve. The patient does improve when diagnostically distinguished from the actual epileptics and a relatively simple management then devised.

The resemblances to multiple personality and repressed memory are clear. The interest in how many personalities are to be found generates tens to hundreds of them. Also patients who were sexually abused and those with pseudo-memories of sex abuse are often placed together by therapists in "incest survival" groups. The patients with the pseudo-memories tend to develop progressively more complicated and even quite implausible memories of their abusive childhood. Particular ideas are induced from the mass media and spread throughout the group - such ideas as multiple personalities and satanic cult explanations for parental excesses are the most frequent.

The patients often do not get better. Months to years of therapy continue to keep many of these repressed memory patients angry at their fate and misinformed about their lives. The lesson from Paris to apply here is that it is crucial in practice to differentiate the incest injured from those with false memories. The treatments are as different for each of them as is the

treatment of epileptics and pseudo-seizure victims and are misdirected if differentiation is neglected.

IV

The Flashback Phenomenon

The so called flashback has emerged in this decade as a hallmark of the repressed memory of sex abuse and post-traumatic stress state. It is often employed to confirm a diagnosis of abuse in patients who without this phenomenon have no memory of it. Several questions emerge, but primarily the question is whether a flashback is actually a memory phenomenon, a vivid flash bulb reproduction of a life event? In other words, is it to be interpreted as evidence of what it displays? Much of this is for the scientists of memory to decide. But the historical record should provoke caution in reaching that conclusion.

First "flashbacks" are rather common phenomena - they are described accurately in the repressed memory literature. They do occur in frightened and traumatized people and are particularly prevalent in close temporal relationship to the fear or trauma. They appear in the drowsy hypnogogic state, but also as dreams, and occasionally when fully awake as vivid visualizations associated with feelings of terror.

All trauma patients have them - victims of crime, combat, accidents, civil unrest, war persecutions. Flashbacks are not cultural phenomena but rather universal human responses. For example, Cambodian refugees, including children who suffered horrible persecution have them. They can be mild and transient

after minor scares and trauma - perhaps only disturbing one night's sleep. Or they can be severe and long lasting after prolonged and terrifying traumas such as suffered by soldiers in continuing battle.

They were described in World War I in a classical book, entitled War Neuroses, by John MacCurdy. He studied the phenomenon carefully and made clear that these experiences reproduce some features of the setting where distressful events occurred - the subject remembers the trench, for example - but the event depicted in the "vision" as he called flashbacks was not a simple replication of an event, but the development from the experience of a "worst fear" scenario - the soldier visualizes that a hand grenade had fallen at his feet or that the enemy soldiers are appearing and overwhelming his comrades. Intense fear and other appropriate emotions accompany these experiences.

Thus, it was not that memory was jogged to replicate an experience in "the mind's eye", but rather that fear ran riot. The visions served a survival purpose by driving victims from combat and avoiding in the future circumstances that might generate experiences of the kinds imagined. They are mental phenomena with purpose behind them.

What have we learned with regard to flashbacks from this historical review - flashbacks are not so much reproductions of events as they are "worst fears" envisioned in settings where the patient could imagine even more traumatic consequences.

What should we say about appearance of such vivid

recollections in patients in therapy? By the flashback history, we are not entitled to presume that they are simply reproductions of the past. They are more likely expressions of worst fears generated out of the focus of therapy - and may represent not post-traumatic states from an abuse but a post-traumatic state generated by the reawakening of childhood fears and fantasies. Their temporal relationship to therapy in the sense that they follow its beginnings rather than precede it suggests this possibility. Flashbacks can not confirm abuse because they are not simply relivings of events. They are useful in confirming worst fears people share such as the frightening possibilities enwrapped in childhood's vulnerability.

V

Conclusion

Finally, what hypotheses might emerge from this historical review? Some alternatives are critical for the "recovered" memory field and should direct investigations to remove some of the heat of controversy from the subject. As long as it is assumed that the only alternatives when memories of sex abuse emerge in treatment are that the accusers are either telling the truth and any objection is an expression of denial or that the accusers are malicious liars with some peculiar ax to grind, then no productive investigations will emerge. With charges and countercharges practice will remain stuck within them. I believe that it is critical to state that child abuse does occur and perhaps is occasionally forgotten. However, there is evidence that false

memories of various kinds of abusive experiences also occur. This evidence includes alien abduction claims, retractions of previous claims of sex abuse, and now the emergence of wild satanic cult memories with no bit of objective evidence to confirm them. Our responsibility as psychiatrists is to find a way to differentiate the true from the pseudo-memories. To facilitate such a process some hypotheses about how a pseudo-memory could be generated can be helpful.

Pseudo-memories can be interpreted as phenomena of the hysterical kind - that is complaints by which the "sick role", or in its contemporary form the "victim role", is generated by social and self suggestion out of the misinterpretation of psychological states. A sequence that would explain hysterical pseudo-memories and place them in context with other hysterical phenomena is the social vortex into which patients are drawn permitting an epidemic of complaints of the pseudo-memory variety to emerge. What culture suggest, doctors develop. What doctors describe patients supply. What patients provide culture confirms.

This proposal can be better laid out in a graphic way as a cycle of interrelating psychosocial features that feed upon themselves and produce the energy for a social catastrophe. Entry into this cycle can be at any point - but usually comes with a patient suffering from some kinds of psychiatric symptoms for which she seeks both explanation and relief. These symptoms can be due to illnesses such as major depression, or to panic states, demoralization, etc. She is drawn into this cycle by being joined

with medical opinion that she harbors "a memory" and finds in the "sick role" a victim's view of the external sources of her psychological distress. The victim's role sweeps her into groups of like minded or actual victims and helps confirm her opinion. The schema as depicted speaks for itself and its social juggernaut quality is apparent. It places together - as this history suggests - the invention aspect (the mind can split, Satan exists, etc.) tied to cultural legend, the suggestive and inducing power of experts, the group contagion, and the misinterpretations of experience.

This alternative explanation for pseudo-memories encourages efforts to differentiate them from viridical memories of abuse. This is the essential first step in treatment. This differential diagnosis may not prove simple. But it demands a good faith effort to find objective evidence of the abuse and a careful scrutiny of the plausibility of the patient as a witness. Pediatric and school records must be investigated, family members who should have been witnessing an abusive home environment consulted, and eventually an approach to the accused that would give an opportunity for either confession or explanations of alternatives should be made.

Diagnosis will direct treatment and further management. For the sexually abused the treatments are rehabilitative and not different from other traumatized individuals who must be encouraged to move forward in their lives and begin to emphasize the assets rather than the liabilities in it.

The treatments for individuals with pseudo-memories include

isolation, counter suggestion, eventually explanation and reappraisal of the actual psychiatric problems that may in fact be major illnesses, situational problems etc. with their own specific treatments. Rehabilitative psychotherapy for both the individual and the family will always be necessary if a previous charge of sex abuse was levelled and quite complicated in itself if family injury has occurred.

Efforts at prevention of pseudo-memories and the termination of the contemporary epidemic are equally clear from the schema. This juggernaut can be interrupted at several points other than just the treatment of individual patients. The need is to report in the mass media the reality of false memories as well as real memories, to attack the legends in the culture particularly for example the existence of huge numbers of pathological abusive families and satanic cults, to insist on appropriate diagnostic practices by therapists with penalties eventually placed on their neglect.

These later exercises in prevention will not be easy. They may be twisted to sound like (1) not believing in sex abuse, (2) denying dynamic aspects of mental life. Neither of those ideas are true and nothing said here should imply them. It really is just following the standard rules of psychiatric practice derived from the history of this discipline and finding within them the means of progress. After all it still is true as Santayana said: "Those who cannot remember the past are condemned to fulfil it".

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