Repressed Memory Syndrome

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Transcript of the Panel Discussion
(As recorded in the Audiotape)

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DR. SANDRA L. BLOOM: I'm Sandy Bloom, Executive Director of the Sanctuary at Friends Hospital and currently President of the International Society for Traumatic Stress Studies.

DR. DAVID SPIEGEL: I'm David Spiegel, Professor and Associate Chair of Psychiatry and Behavioral Sciences at Stanford University School of Medicine.

1. DR. FINK: Today, we're here to talk about memory, repressed memory, false memory, and the difficulties that are currently occurring in our society around this subject that could have long-term implications for the mental health professions, particularly around the area of psychotherapy. We're going to try to get to a deeper understanding of this problem so that we can figure out how to deal with what is a growing difficulty among those of us who do psychotherapy in this country. Dave, you've written an important article on memory, and I'd like to start with you to talk a little bit about the scientific basis of our problem.

2. DR. SPIEGEL: I agree with you. I think this issue is very important for our patients, their families, and for the process of psychotherapy. I think a false dichotomy has been set up between the notion of repression and the influence of suggestion on memory, so I'd like to start out examining that.

There's been an assertion that there's no such thing as repression, that people can't repress memories of traumatic events, and that, on its face, is just plain nonsense. In fact, everything we know about human information processing is that the vast majority of information we handle, which is immense, we handle outside of consciousness. We couldn't function if we didn't process most information outside of consciousness, and, while it is true that unusual or extreme events are often strongly encoded, we also know that ways in which we regulate our emotion may regulate our access to the content of that information. So the idea that we can't repress anything and the idea that we can't repress memories at times of traumatic events is just flat-out wrong.

As a matter of fact, to the extent that suggestion, suggestive questioning in a legal context or in therapy, can influence memory, it seems to me, it's a matter of logic that it can influence memory in either direction. So if you can have a false memory that your father sexually abused you when you didn't, you can also have a false memory that he did not abuse you when he did. I think dissociation in a way is the other side of the so-called false memory syndrome. We need to be careful and there is no proof that any report with or without memory enhancement techniques, with or without leading questioning is true without external corroboration of that memory. We don't have the luxury of saying that any memory that's reported about abuse is categorically true or not true. It's a matter of clinical judgment and using it in the context of helping people get better, work through their problems, and get on with their lives. So, it's a complex issue, but I think the research makes it clear that these phenomena are robust and they need clinical attention.

3. DR. FINK: Sandy, you are a clinician. You run a program that deals with these kinds of traumatic issues. What do you think about the problem?

4. DR. SPIEGEL: Well, it's been interesting to kind of watch this problem unfold and look at the political ramifications of it and the legal ramifications that seem to be obfuscating what we understand both clinically and scientifically, a lot around the use of words, words like repression and dissociation and recovered memory and repressed memory therapy. There's been a lot of confusion about what is repression and what we're referring to, and the false memory advocates have chosen to use specific words that I think are designed to be somewhat inflammatory and have talked about repressed memory therapy as if it were some discrete kind of therapy that thousands of people out there are practicing to the harm of their patient. It's been very difficult for me to figure out what the difference is between repressed memory therapy and things like taking a history from a patient, which is part of normal medical practice. That is not well defined in the literature that we're having to contend with. So, I think there's a lot of semantic confusion, much of which is fairly deliberate.

5. DR. FINK: I never thought of it quite that way. I've been doing so-called repressed memory therapy for 35 years now, and, obviously, my interest is in trying to find out what's going on inside the patient and, I agree with David that if we had everything we've ever learned conscious, we would all be psychotic or overloaded to the point where our computers would not be working. But, it's interesting your saying that about the semantics because they have tried to oversimplify everything. One of the oversimplifications is to call repressed memory therapy something different than dynamic therapy, something different than psychoanalytic therapy, something different than having a conscious or unconscious psychology.

6. DR. SPIEGEL: Well, there've been a lot of straw men set up. Another one is the so-called robust repression straw man, that there's no evidence for robust repression. Which means that all of the literature on repression and dissociation for the last 100 years is, from that point of view, irrelevant, and so I think it is a way of kind of creating a cartoon-like idea of what goes on in therapy and then attacking that rather than dealing with the reality of therapy. None of us are in favor of bad therapy and there are people who make assumptions or impose assumptions on patients, and none of us, I think, are in favor of doing that.

On the other hand, I fear we're at a point where people are afraid to even ask about a trauma history for fear that they will be accused of somehow implanting a memory of it, and that's bad for our patients. It's good clinical history-taking, as you mentioned, Sandy, to inquire about a history of trauma. Sometimes, there'll be one and sometimes there won't, and more rarely there may be one, but people can't remember it. There are people who say, "Well, if you remember it, it happened; if you can't remember it, it also happened." That's clearly bad, too, but I think there are errors
on both sides and what we need to do is find that sensible middle ground that allows us to take the best care of our patients.

1 **DR. BLOOM:** I absolutely agree. I think what often gets missed from the discussion about this is that part of this whole discourse is being informed not by the clinical or scientific system but by the legal system. From what I understand, the reason why we have to focus in this argument on repression and not on the massive amount of real scientific data about dissociation is because of changes in the laws that occurred through the '70s and the '80s in every state, that addressed delayed recovery, that allowed people who had been abused as children and later remembered the abuse after a period of having forgotten it to then prosecute their alleged offenders. The laws are built around the word repression. Therefore, if you want to undo that legislation, you really have to focus the argument on repression and try to ignore the information that we have and data about other mechanisms of forgetting like dissociation.

2 **DR. FINK:** If we were asked to prove the unconscious, it’s one of those terrible dilemmas. We know from our clinical experience and the work that we’ve done and the kind of research that you’ve been doing, David, that the unconscious exists. We have known for 150, 200 years. What has happened is that this pseudoscientific idea that we have to prove that there’s an unconscious puts us in the defensive position. It’s not the issue of repression because repression is a product of the unconscious as we understand it. Putting something out of consciousness is a good idea. If we were all overwhelmed with the idea of being annihilated by nuclear bombs and that was all that we could keep in our minds, the world essentially would stop and so we do have things out of consciousness. I know that we can’t prove that there’s an unconscious and I always use the analogy in physics of Brownian movement. You can’t see the atoms colliding. You can only see the result of the atoms colliding. That was 40 years ago, when I took physics. Now, I guess you could say that there must be the technology to actually see the atoms colliding and, maybe, at some point, we’ll have the technical capability and the skill to prove that there’s an unconscious mind, but the reality is, this effort to oversimplify and say that repression is the bad thing and that psychotherapy itself is dangerous and we need to get informed consent for psychotherapy puts us in the position of trying to fight a straw man.

3 Yesterday, one of my colleagues said to me, “Well, you’re not going to come out and say you’re against informed consent?” I certainly am, because I cannot say to a patient, “Now these are the dangers of psychotherapy. You’re going to fall in love with me. That’s a danger. You’re going to get angry with me. You’re going to have feelings for me. You may get worse. If you get worse, you may try to kill yourself.” I’m not going to say that to patients and expect them to come to my therapeutic office day after day or week after week, pay me a lot of money with the idea that they may get worse and kill themselves. I’m just not going to do that. If it becomes the law of the land, which is what they’re trying to do, then I think they have essentially stopped us from doing what we have been trained to do, what we know how to do, and so people with no background and training, but people who want to protect themselves from the allegation of having hurt their children are addressing us in this fashion.

**4. DR. SPIEGEL:** I take a slightly different position on this issue of proving the unconscious. I think it’s a stupid question. It is so obvious that we process most information outside of consciousness that it’s not even worth asking the question. Of course, we do unconscious mental processing. There is a substantial literature that some people choose to ignore, that shows that people dissociate ordinary things, but that under traumatic situations, a substantial minority of people have difficulty retrieving memories of the event even immediately after the time it happened. They feel detached from their bodies or their surroundings and the people who do that are significantly more likely to develop post-traumatic stress disorder. That’s been shown in combat veterans, in earthquake victims, in victims of shootings. We have data at Stanford. There’s data from Charlie Marner’s group at UCSF. Doug Bremner’s group at Yale. It’s not like one of these “maybe” things. There is evidence from multiple excellent centers that show that these processes are set in motion in a substantial minority of people who undergo traumatic experiences. You have the Linda Williams study that shows that 38% of women who were brought to emergency rooms for treatment of sexual and physical abuse could not recall the index episode 17 years later.

5 Now, how much more evidence do you need that not only is there unconscious mental processing but that these particular kinds of defenses sometimes get mobilized in the aftermath of trauma and they’re particularly associated with people who are having difficulty processing traumatic information, which is what we’re there to help them with. I don’t even think it’s an interesting question, but if you pose it that way, you make it sound impossible to answer.

6 **DR. FINK:** But how do we address very well regarded psychiatrists who say that it’s us who are creating the multiples and the dissociative reactions? It’s the psychiatrists who are causing people to think of themselves as dissociating.

7 **DR. SPIEGEL:** I’d say, where’s the evidence that in fact psychiatrists do it? Where are the studies that show that you can make a perfectly normal, happy, highly educated functional person into a very impaired dissociative identity disorder patient? I don’t see any evidence that that can happen, and I put it this way: If we have such power to induce pathology by asking questions about history, don’t families and other people have equal or greater power to suggest that there’s no problem at all when in fact there is one? You can’t have it both ways. If suggestion is so powerful, then it’s got to work both ways, and there are indeed situations in which patients with dissociative disorders have met physicians who say to them, you don’t have any problems, just straighten up and fly right. Does that make the disorder go away? I don’t think so. And families will in fact exert tremendous pressure on people not to discuss issues of abuse when in fact they occur. So, if a suggestion works, it works both ways.

8 **DR. BLOOM:** I can certainly understand why physicians would have difficulty with this material. The whole issue of multiplicity and lesser forms of dissociative disor-
ders gives us a lot of difficulty about the model of the mind that we've been working with up until this time. I mean, what does it mean if someone can have several different personalities that may show different kinds of physiological responses under certain conditions? I mean, what does that mean for our model of the mind and much of what we have been taught? This material about trauma and what it does to people and what it does to the brain is paradigm shaking. It really puts up to question a lot of what we have learned and a lot of what is kind of existing tenets of psychiatric practice, and, for many people, that's threatening. That's scary. I understand that from my own experience of coming to terms with the reality of the degree of trauma that has always existed in my patients, but being at the point in time back in the '80s, when I suddenly saw it, it wasn't that it suddenly appeared. It was that I began to have a cognitive framework to understand it. It had always been there, and, as far as my patients were concerned, they were surprised that it was a new revelation to me. So, I think that we have to look at it in a broader understanding of how scientific knowledge progresses and changes over time and we're in the middle of an enormous change, and what we're seeing, I think, is a backlash that always occurs when established knowledge is challenged.

1. DR. SPIEGEL: An illustration of what you're talking about, Sandy, one has to do with our diagnostic category; the other with the biology we're beginning to understand. Diagnostically, the change we produced in the DSM-IV about this disorder was to rename it, to call it dissociative identity disorder, rather than multiple personality disorder, the reason being to emphasize the fact that the problems was not that there were really 12 people in that patient, but the failure of integration of different aspects of identity, memory, and consciousness, to help people understand that it was the difficulty in integrating that was really the issue. It's sort of like not believing the delusions of a schizophrenic.

2. We don't say that their view of the world is correct, but we describe the phenomenology of their delusions in the same way we don't believe there are really 12 people there. We realize that they have difficulty integrating aspects of experience. Now, is that so implausible?

3. Well, there are now two MRI studies showing hippocampal atrophy, one in Vietnam combat vets with PTSD and another in victims of childhood sexual abuse. The hippocampus is what helps us store and retrieve memories. It helps us assess context in the world, so it's not surprising that people who apparently have — and more work needs to be done — smaller hippocampi may have difficulty assessing the contextual meaning of various environmental cues and its effects on their identity. We still have a long way to go in the research, but there is reason to believe that people's ability to impose context on events may be damaged by a history of traumatic stress.

4. DR. FINK: That's what I was talking about when I said that there may be a time when we will have biological, physiological evidence of the kinds of things that we know are true and have assumed to be true as psychotherapists. The failure of integration, we know, is related to the trauma. The recent study with obsessive-compulsive disorders demonstrating that you can see brain changes as a result of psychotherapy or medication, same brain changes, and the recent studies that say that kids who witness trauma begin to have brain changes within 72 hours. All evidence that what happens in the brain is becoming clearer. What it means in terms of retaining memory, losing memory, holding onto traumas, repeating the traumas, we don't know yet. We're in the middle of a scientific revolution essentially. That's what's happening.

5. DR. SPIEGEL: Well, there is some more evidence accumulating. Cahill and McGaugh did a very interesting study in which they exposed people to a film with different interpretations that were either very traumatic or not. They found that emotional arousal increased the amount of retention they had of the details of the film. If they gave them propranolol, a beta-adrenergic blocker, to block the arousal, they also reduced the increase in content recall that came with the normal emotional arousal, so the point there is that when we do things to block our own emotional arousal to detach ourselves from a traumatic event, we should also be affecting the content of our ability to retrieve that kind of information.

6. Cheryl Roopman in my lab and Catherine Classen looked at people in the Oakland-Berkeley firestorm several years ago and found a very interesting thing, that the people who tended to dissociate to detach themselves during the firestorm and immediately after actually endangered themselves more. That is, when people numb themselves to the consequences of trauma, they may actually expose themselves to more traumatic events. These people would cross police lines to get a closer look at the fire. They'd make lunch instead of pack up and get out as the fire was approaching. So, there's evidence that these processes may have a defensive purpose to regulate affect, but they may have some maladaptive effects as well, and that's what we see as clinicians in people who have patterns of revictimization.

7. DR. FINK: I want to talk about the whole question of the complexity of this, which is clear from our discussion thus far, and the efforts at oversimplification by what I'm going to call bad therapists. Several years ago, I met with the people from the False Memory Syndrome Foundation and said, let's not attack psychotherapy and repression. Let's try to cleanse the field of therapists who have oversimplified the system and who use this cookbook methodology of psychotherapy, which says, it's clear, if you have bulimia, you must have had sex with your father. Those kinds of horrible oversimplifications by psychiatrists, psychologists, social workers have been really a tremendous problem for us. We've never been good at cleansing the field from bad therapists. So, we're now stuck with a situation in which the problem is over here and the attempt to solve it is over here by getting rid of psychotherapy essentially or proving that repression doesn't exist or forcing us to prove that it does exist. That's the complication that I think we need to address because lots and lots of people are still doing this kind of cookbook therapy.

8. DR. BLOOM: Yes, I assume they are, but we really don't know how many people are doing it and there are many people, respectable people, in the field who are being accused and who are being sued for doing
therapeutic activities that I think we would all find perfectly acceptable. So, I think again, it's so difficult. We do need to set practice standards. We always need to set practice standards consistently and there are things that are not appropriate to do, that are disrespectful of the patient, that are just bad practice. Suggesting, as David referred to earlier, that someone has had a trauma when they haven't is wrong and suggesting that they haven't when they have is just as wrong. So that is a separate area, the whole issue of therapeutic influence and how much we can influence people and under what circumstances and what kinds of therapy. It needs to be studied and it has not adequately been studied at this point in time.

Just as important is the obfuscation around this whole discourse, some of which we've already touched on, but what we haven't touched on is the issue of different kinds of memory, that different kinds of memory do exist. One is implicit and one is explicit. That's one of the terms for it. Implicit memories, which are largely nonverbally coded memories, appear to be pretty fundamentally important in traumatic experiences at the peak moments of hyperarousal when the information systems are not functioning as properly as they do under normal circumstances. At least that's the hypothesis and there's a great deal of support for that from studies that have been done, but in the conversations and in the material that's written about false memory, you don't read much about all of the data that does surround traumatic memories and how different we think the processing is under conditions of extreme stress from normal information processing.

DR. SPIEGEL: That's a good point, Sandy. The whole literature on implicit memory is a good example of overwhelming evidence of unconscious mental processing. That is, implicit memories are for anything from the impact of traumatic events, which is unusual, to knowing how to type and to ride a bicycle. You can't remember explicit episodes of how exactly where you learned to do the keyboard on a typewriter or how to ride a bicycle, but you sure know how to do it. So we function all the time on the basis of information that we don't have exact details of how it got there and what the episodes were, but that's how we function.

You're right that traumatic information can also have effects that go beyond just the immediate memory of a given event and may influence people's role relationship models, what they expect from people they interact with, and can have profound influences that we can think be helped with appropriate psychotherapy, helping them to sort out how they may have had a traumatic experience imposed on them and then impose the reflection of that experience on much of the other relationships that go on in their lives.

DR. FINK: I think the issue for me as a clinician is, how am I supposed to explain what I do, if I have to? What are the standards of treatment? I know that part of my training was, you don't make suggestions to patients about what to do. We know that there are reports that therapists say, "Break off relations with your father. We know what he did to you. Break off relations. Accuse him. Tell him and then just leave him and never see him again." From my point of view as a therapist, that's outrageous. Instead of saying, let's solve the problem. Let's see if it occurred or it didn't occur. Let's see how much evidence we can put together to really determine the effect of this. I'm not saying it didn't happen, but I want to be sure that it did happen, and I want to know how you're going to handle this and what you'd like to do. I'm more delicate and reasonable and nondemand approach to the patient, so that, ultimately, the patient understands that you're allies in this, but you're going to try to figure out, as best you can, what happened and what to do with it. This idea that there's this directive instruction I find very complicated because it's not my style. I know that there are directive therapies. Not everything is an indirect therapeutic process. That's another issue. What are these standards of treatment? One of them I think is, don't do harm and don't instruct, and that I think we know as a possibility, but what are some of the others?

DR. BLOOM: I think don't do harm is a good way of thinking about it, and, of course, you have to take into account the situation and the level of danger that is involved. So, if we're talking about a child, talking about in the present being actively abused by someone, then the standard of care is going to vary dramatically than is an adult who is recalling experiences that go back 30 or 40 years and they are presently in no danger. So, the reality element is really important to consider.

It's also important to respect attachment relationships and when you instruct someone that they should break off an important attachment relationship, you're really meddling in dangerous waters. You may certainly do a lot more harm than good. Giving someone instructions for how to take better care of themselves and not engage in self-destructive behavior is different from giving them instructions about what they should do in their other relationships in the rest of their life. Those are two very different kinds of instructions, and that's not our job. The patient, it's their life. They have to decide what to do. We can give them information. We can help provide the context within which information and narrative about their previous experience can unfold, but it is not our job to run their life.

DR. SPIEGEL: I think we have the sort of procrastinate bed problem. I think we have bad therapy either way. If either people sort of start out with a mental imprint that all mental health problems are due to abuse so I've got to convince you you were abused so I can make you better, which is clearly wrong, or you start out with the opposite assumption, which is you're just whining and looking for some excuse not to get on with your life and it probably didn't happen anyway so don't tell me about it. I think either of those, kind of rigid, I don't care what the patient has to say points of view, I know what's happened, is clearly wrong and is not good clinically. You need to be open to learning from your patient what their life situation is.

I agree with Sandy, there are occasions where actually we do have an obligation. If someone is being physically abused, we have an obligation to do what we can to keep them from being further abused. How active I would be depends in part on what external information I have, medical reports, E.R. visits, other things than just what the patient tells me, although I'm interested in that.
I do think some therapists have been much too quick to promote confrontations with abusive families, which I frankly, just from a clinical point of view, don’t find very useful. What good is going to come out of a nose-to-nose confrontation with an abusive father even if you’re certain that he was. If he’s willing to abuse a child, he’s probably willing to lie about it or deny it, and suppose he says, “Yeah, I did it and I’m terribly sorry.” You know, you have someone whose life has been very badly damaged by being abused by a caretaker, are they just supposed to say, “Oh, well, thanks dad. Everything’s fine now.” You know, that doesn’t work out very well either. So, I think it’s partly also a matter of respecting the kind of boundaries of what goes on in psychotherapy and being very cautious before what you’re doing in the office gets extended to what’s going on out there in the patient’s life.

DR. FINK: Let me pick up on your word corroboration. There is a movement to insist that we use outside corroboration of events in psychotherapy. I’m not a couple therapist. I’m not a family therapist. I’m an individual therapist. My corroboration comes from the accumulation of data over time. I really want both of your opinions about this issue of corroboration. How much do we have to go out, or do we tell our residents and our psychiatrists, you really have to corroborate this by talking to the mother, talking to the wife, talking to the police? How much do we do?

DR. BLOOM: Those suggestions are simply absurd and dangerous. It’s an infringement on privacy. It’s a breach of confidentiality, to say the least. I think we have to remember that the vast majority of memories of abuse have never been forgotten. It’s not a question of dissociation or repression. People have always remembered, in most cases, their experiences of abuse.

Linda Williams has done a study in which she has looked at the differences between people who have always remembered the past history of abuse and people who have forgotten and then remembered and did not seem to be any difference in the degree of discrepancies in the stories. Well, if that’s the case, why should we be any more suspicious than we would be about any other information we get from our patients? Now, do we encourage them to validate it? Well, that’s a useful thing to do. If people don’t remember parts of their past and you’re working with them and talking about the past and they’ve just remembered something, then part of what they often want to do is get some sense of “Well, could this be real?” So, encouraging them to do it may be entirely appropriate. Having us do it goes way outside the bounds of our medical and legal responsibilities and is very inappropriate and very intrusive.

DR. SPIEGEL: The need for corroboration has a lot to do with the purpose to which that information is to be put. I certainly would feel, if a patient is talking with me about confrontations with family members or legal action, which is not something I recommend to them, but if they discuss it with me, I would say, for sure, before you raise any kind of public issue or legal issue, you better have plenty of corroboration because continuous or repressed anything else, people will challenge your report of what happened. For what goes on inside the therapy, though, I think that’s a rather different matter. I think we can’t function like district attorneys. We can’t send out an investigator every time a patient reports information and find out that that’s really true; that would violate the trust and confidentiality that patients expect of us.

I have, at times, interviewed family members of patients and found it very interesting to get their point of view about what happened, and not infrequently family members may not admit that they don’t deny some of the allegations of the patient and it’s an interesting experience for the patient and me to kind of watch the parents say, well, yeah, but I did try to protect you when your father held your head under the water in the sink, that kind of thing. I find that useful because obviously any psychotherapist has to be doing a mental calculus of their own about how likely it is that these things happen, and, clearly, we’re not doing our patients a service if we’re operating on one premise and it turns out the premise is wrong. So, I like to get more information if I can, but I think the idea that we have to be as certain as a jury would be about whether or not these events happen to do psychotherapy is ridiculous.

DR. FINK: I agree with that and I think that this whole issue of corroboration is another red herring. It’s another problem, but they use as a rationalization the fact that now most therapy is short term and the opportunity to have the information evolve, like in the work I do as a long-term therapist or a psychoanalyst, is not available, because, after all, they only have seven sessions or they only have three sessions. I think that’s a rationalization.

I’m reminded of a case that I saw where the information evolved over a period of time. A man married with two children in his 40s, who had been continually self-destructive over a long period of time, never quite making it and everytime he was close to making it, doing something to screw things up, began to have some strange images. One piece of historical information is that every once in a while he would go to a gay bookstore and have someone perform fellatio on him. That was a kind of piece of information that was out there. It wasn’t meaningful or integrated into anything, but he knew that he had this kind of wish every once in a while and would act out. His first evidence of a problem was that he would be overcome with a black color in the back of his mind and it became a piece of black cloth and evolved ultimately into a memory of having been, as an 8-year-old, put under the cassock of the priest and forced to do fellatio. So, in his behaviors in the bookstores, he was turning it around, but that was isolated until we got this information and it evolved in a very, very slow and deliberative process with a lot of trouble from him and a lot of effort to unpress. I think of that case when I hear these ridiculous oversimplifications that we’ve been talking about.

DR. BLOOM: That’s a really good example of the complexity of working with victims who have the previous history of trauma, that you do have to let the story unfold and we have to think about, what are the goals of treatment? A person comes to us with a variety of symptoms that may range from what your patient came to depression, suicide, self-mutilation, substance abuse, you name it. That may be the presenting symptom. Our goal of treatment is not to grill them to remember what happened to them. As the memories un-
fold, as this material comes out and you begin to ask questions about, well, why do you go to the bookstore and have this experience? Do you have any idea what that’s linked to? You don’t have to suggest what it may be linked to, even though in your mind you may be developing a hypothesis, you may not. You don’t have to suggest anything. The material, given time and given the context within which it’s safe to unfold, will unfold.

1 The purpose isn’t to just drag up memories. The purpose is what we talked about earlier. It’s integration. It’s to integrate the memories and the affect into a coherent narrative that makes sense, that does ultimately alleviate symptoms. But it’s very complex because when we’re talking about early childhood trauma, we’re talking about experiences that have affected every level of the person’s development. They develop problems with interpersonal relationships, with self-concept, with the way they perceive the perpetrator, with the way they manage their emotions that then intertwine with each other, so that there is no simple solution.

2 It’s not like lancing an abscess and you let all the memory pus drain out and then somebody’s going to be healed. It is contextual. Healing occurs by forming a narrative in the context of a safe relationship over time. That safe relationship may be with a therapist. It may be a relationship with someone who has with themselves when they keep their journal. A lot of people do a lot of work outside of the context of therapy, but it’s very complex. The disturbing part, I think, about this whole false memory issue, as you’ve alluded to, is that they keep trying to oversimplify a process that is more like art than many times like the process of investigating science.

3 DR. SPIEGEL: I agree with that, but, at the same time, I think your case history, Paul, illustrates a number of important issues in psychotherapy and in how memory works. First of all, he was able to deal with this information in the context of a trusting relationship with you. I’m sure there’re all kinds of transference and countertransference issues about what he was doing, how he was endangering himself, whether you were going to be helpful or abusive to him in the course of the therapy, which is a standard part of therapy, and why a lot of these barriers, like consent forms, are so complex. People who have been traumatized bring a traumatic transference to the therapy in which they expect that you will be as abusive to them as the people who abused them when they were younger and so you have to constantly work to gain their trust.

4 At the same time, the way memories are encoded, stored, and retrieved has to do with associational networks. That’s how we bring material into consciousness when we search for it; everything from looking for somebody’s name to the fact that he had some behavior that he was engaged in that led him over time in a trusting relationship with you to access information that he had kept out of consciousness.

Now, is it so weird that that information was out of consciousness? No.

5 You know, we all have a lot of happy events in our life that we may not have thought of for a decade. You go back to some place that you’d been, where you went to college or something. Suddenly you have a flood of memories of great things you did that you hadn’t thought of. Was it repressed? Well, it hadn’t been in your consciousness for 20 years or whatever, and you go back and an associational network is set up that stimulates retrieval.

Another example is the cognitive theory of depression. Depressed people have great difficulty accessing memory of positive events in their life. It’s not trauma. It’s they can’t think of anything good. They don’t even hear good things that are said to them, and the cognitive therapy is about getting them to access memory stores that would not tend to just make them more depressed. So, there’s plenty of evidence that we do that and that psychotherapy is helpful in correcting these distortions and allowing a more balanced access to memory.

6 DR. BLOOM: David brings up a good point about how people do present in therapy, what triggers off the traumatic memories, what starts it going. Is it usually in the process of therapy, because that’s another thing that we hear in this argument is that therapists are implanting these so-called false memories of abuse. Well, we don’t have any evidence that therapists are able to implant false memories of traumatic experiences. There’s a wide body of information about the effects of suggestion and that you can convince people that things that did happen didn’t and vice versa, but you cannot generalize from the studies on normal memory processing to the experiences of having a traumatic event occur to you. It is not the same to watch a car accident on a screen as it is to watch your child being killed in the seat next to you in a car crash. Those are not comparable experiences.

7 Most traumatic memories do not begin to emerge in the context of therapy. They begin to emerge for the person in all different ways. It may be things like the perpetrator dies or the patient’s child reaches the age they were when they were first sexually abused, or there is some reminder, as David was talking about, for pleasant events. There’s some reminder of a past event that triggers off that neural net, that whole sequence of associations, and then symptoms begin to emerge in someone who may have been relatively asymptomatic before. Then they may indeed go see a therapist who begins to explore where this material is coming from because that’s what the patient is there to talk about, but it’s again very complex. There’s no simple way that these things present, but the majority is not through the exchange with the therapist.

8 DR. SPIEGEL: One thing to add, Sandy, about the literature and I agree with you that you can’t extrapolate from what happens in an experiment with college students to the meaning of a suggested memory that something terrible happened in one’s life, but even in those experiments, there are two things about them. By and large, what they show is that about one fourth of subjects in these experiments can have their memory contaminated, and people don’t point out that the overwhelming majority of people subjected to these suggestive influences don’t respond and incorporate to suggestion. Most of them don’t, and again the direction of the suggestion can go either way and that’s the other thing that’s overlooked. If you are suggested, you know, did you see the stop sign instead of a stop sign? So instead of seeing a yield sign you see a stop sign, what happened to the memory of the yield sign? That memory was repressed and you substituted another memory, which is that you saw a
stop sign, so to the extent that this minority of people who are vulnerable to suggestion in a controlled setting are, it can be in either direction.

1 DR. FINK: We’re talking about the repression of events. We also have to understand that there is a tremendous amount of repression of affect. That hasn’t even been dealt with by these people, thank goodness, but we all have cases where the affect is released by events, in the same way that you pointed out that the memories of events can be released by new events, by things that happen.

I want to talk about the false memory syndrome, their success in court and their success in the public eye. The recent article in The New Yorker, in which psychotherapy was treated very badly and these simple-minded things that we’ve been talking about were discussed. That used to be almost a psychoanalytic journal and now it’s been turned around. The fact that the case in California was reversed, where the woman had the memory of her father killing a friend. The guy was convicted and then the people who went to court on behalf of that daughter were people whom we respect very highly as good researchers and good psychiatrists and now this oversimplification issue is being translated into the courts and into the public press. That, I think, is a major problem because we can’t make what’s been going on here in this last 40 minutes simple. So, we really are faced with a dilemma that’s a political dilemma, but a real dilemma for us as we try to think about the preservation of psychotherapy as we know it.

3 DR. SPIEGEL: Well, I agree. I think it has generalized to an attack on psychotherapy. A couple of specific comments. There were statements in that New Yorker article, which I thought of more as a New Yorker cartoon without the humor than an article, that, for example, that there’s no evidence of a link between trauma and dissociative disorders and that just is flat-out wrong. You can not like the evidence. You can disagree with it, but you can’t say it doesn’t exist. She kind of repressed the memory of all this literature. I know that because she interviewed me and she ignored all the information I gave her about it.

4 The case you raise, the Franklin case, I can only say so much because I was an expert witness for the defense in that case. It’s being touted as sort of rejecting repressed memories. The grounds on which that case was properly overturned by the appeals court judge were actually constitutional grounds. It had to do with the way the judge handled the case itself. His daughter tried to get him to confess in a situation in which he was being recorded in prison. He pointed to a sign that said all things are being recorded and didn’t say anything. The prosecution was allowed to argue that that meant he was guilty. The appeals court judge said, if I’ve ever seen a flagrant violation of the constitutional protection against self-incrimination this was it. So, the grounds on which the case were reversed really did not have to do with repressed memory. It had to do with some appropriate legal issues about the way the case was conducted.

5 DR. FINK: I really appreciate your saying that, because I’m a student of this and I didn’t know that, and the reason I didn’t know that is because the advertisement about it is that it was a rejection of repressed memory. It’s good to know that. It would be good for the field to know that because I think, in a sense, it justifies our belief that and our knowledge that it is possible for someone, as you suggested, to remember something when your daughter gets to the same age and to begin to have these shards of memory come back and congeal into a real memory of an event, which how it was described by that woman who accused her father. So, your information is really quite important.

6 DR. SPIEGEL: The other issue I might mention that came up in the review that’s more salient to this and is worth keeping in mind is the defense was not allowed to present to the jury the fact that the witness had a complete file of news clippings that her husband had assembled about all the events, so nothing that she reported in court was necessarily only available to her because she had been a witness, and that was information that was not presented to the jury, which they felt was prejudicial to the defense, the appeals court did, but it gets to that issue of the need for corroboration when you’re in a legal setting. The standard that must be far higher than it should be in a psychotherapy setting.

7 DR. FINK: I don’t want to belabor this because I think that it’s interesting, but it’s tangential to the problem. The problem we have is how to establish clearly what we know is true and that is the value of psychotherapy and the reality of repression as a part of psychotherapy and the whole question of finding memories, recalling memories, thinking about memories. It’s the context. You said contextual. It’s the connections between the memories and the behavior at this point. It’s the integration that is shattered by the trauma. It’s those things that I think we’re going to have to go on a publicity campaign about what psychotherapy is.

8 DR. BLOOM: This whole issue has pointed out to me an area of my medical training that was woefully lacking, which was the uses of information and the misuse to which information can be put, the uses of propaganda, and how important it is as a physician to really try to find the best sources of information that are giving us the whole story rather than just settling with public accounts of these kinds of issues that end up being very controversial.

9 That’s difficult for most of us in practice because our time becomes more and more demanding and we want information in the shortest form possible, but, in reality, these issues are complex and the information is out there, but we have not done a very good publicity campaign.

10 We have not had the motivation perhaps behind us to want to justify what, for us, is perfectly evident. I mean it’s hard to listen to some of this information that comes through the press and the media and not go, how in the world can this be happening when there is so much contradictory data? How can it happen that a major news source, as The New Yorker magazine, prints a story that is so biased and one-sided without even having a disclaimer for that? How can that happen, and that’s a tremendous naivety on my side, but I think may be part of a tremendous naivety that is out there in our entire profession, at least where does information come from and what is the motivation of the people providing the information for us.

11 DR. SPIEGEL: What I really worry about is our being hampered in our ability to do our best for our patients. There’s a kind of an absurdity been floated. It would be
stunning indeed if people who were in fact sexually abused or physically abused as children did not have lasting aftereffects. I just find that mind-boggling. There are recent studies, too, that show tremendous increase in the incidence of psychiatric and medical disorders in people who have been sexually abused and it would be mind-boggling if a corrective, intensive experience with a therapist could not be helpful. The literature on psychotherapy for rape victims, for example, makes it very clear that almost all of them suffered serious emotional consequences and that the majority of them can be helped by structured psychotherapy. So, these are things that we just know. We get focused on these bizarre cases or allegations of a false memory here or there and we lose the big picture, which is that there are a lot of people who are harmed by trauma and who need help dealing with it, and I don’t want us to be impaired in our ability to help them.

D.R. FINK: Well, I think the issue of the whole question of the complexity of psychotherapy is something that we’ve dealt with. You mentioned before the word transference, which is another unconscious activity that occurs, universally and ubiquitously. It is an essential for psychotherapy. In cases where I’ve been involved with therapists who have used the cry for help as their guide, they have not been therapists in the sense that they have been clear about the transference and dealt with the transference in a good way. They’d been charismatic cult leaders in the couple of cases I’ve dealt with. So, the transference can be misused also.

It’s clear that educating psychiatrists about the use of psychotherapy and how it works, getting people to understand how transference operates and that it is a matter of unconscious activity that takes a person from childhood to adulthood, it’s one of the bridges, it’s so important. We are specialists, spent a lot of years getting here and the effort to oversimplify and subdivide psychotherapy into little bits, this is a whole world of sound bites. Mentioning just little pieces of the psychotherapeutic process and dividing it off and calling that a different kind of therapy, it’s totally senseless. I don’t know what we’re going to do about that.

D.R. SPIEGEL: Well, I think you’re right. I think the relational aspects of psychiatry, of psychotherapy, and the power of the relationship to heal is not something that can be compartmentalized into a couple of visits that some insurance company clone decides whether or not to authorize. We do have enough experience to know that the way our patients are helped is in part through this complex relationship that Harry Stack Sullivan used to call participant observation. You have a real enough relationship that you participate in it, but you can always step back and observe and say, what’s going on here? That has great therapeutic power and we’ve known that for centuries and we need to continue to develop our ability to use it.

I agree with you, there are people who oversimplify, who view it all as just a cognitive process of figuring out how your current symptoms map onto your trauma and ignore the most important power in the relationship, which is that you can be an intelligent, caring individual who can hear this, who can still care about the patient, even though you know all these things about them and their own inappropriate guilt and conflict and ambivalence about people who have hurt them and you can help guide them through it. That’s a complex process, and it’s not one that yields to simple formulas and it can be abused along the way as well.

D.R. BLOOM: I think when we look at trying to define what bad practice is, what shouldn’t be done, we can probably group most of it under a formulation of boundary violations. That’s a very important topic of discussion because patients who have been abused as kids by definition have had their boundaries violated. That will come up inevitably in the therapeutic relationship. Therapists, even good therapists, often make the error of being pulled into repeating the past and violating those boundaries again and again. A key thing, I think, for a therapist out there in practice to be thinking about is, when they go to do any maneuver that is questionable or outside of the realm of what they usually do, is this a violation of an otherwise healthy boundary?

D.R. FINK: I’m glad you said that, because in our discussion we’ve been talking about trust and the trusting relationship. We’ve been talking about safety and a safe relationship and certainly whether you call it a misuse of the trusting relationship or a misuse or misunderstanding of the transference or a boundary violation, no matter what you call it, it’s bad therapy, and it’s that kind of bad therapy that undermines our ability to defend psychotherapy and talk about psychotherapy in the context of a skill. We’ve been talking today about this as a skill. It’s something that we do after years and years of working it out and figuring out, making mistakes, trying to help patients do better and get better and feel better, and you said an art. Certainly, it’s an art, but I see it as an artful skill, because it has certain tenets that we have to keep in mind and we have talked about some of them during this session.

The one that is most critical is the transference. Years ago, I wrote a paper called “Every Resident Should Have a Transference Experience with a Patient Before They Get Out of the Residency.” Otherwise, they will never understand what psychotherapy is in the context that we’re talking about. I don’t think it’s bad for people to do other kinds of therapy: cognitive therapy, behavioral therapy, family, group, individual, dynamic, rapid dynamic, and so forth, but the basic idea of the transference is there no matter what kind of therapy you do. The idea of the doctor replacing himself with a tape recorder and walking out to get lunch just doesn’t work. That was also in The New Yorker, and so there is the human interactional thing. I think your work, Sandy, with trauma demonstrates that people don’t feel safe very easily with people who try like a therapist to make the person feel comfortable and safe. That has to be learned in the therapeutic situation. It is a complicated skill.

D.R. BLOOM: Absolutely. People who have been traumatized have to learn, often the experience with trauma, particularly if it’s in the context of early childhood family trauma, is that being abused sexually, physically, emotionally is normative. That’s what is normal. That’s what they come to expect. David used the word expectations before and they come to expect that that’s what’s going to happen to them, and will often engage in reenactment behavior. We call it traumatic reenactment, which will kind of compel their environment to get back to their normative experience. It is difficult in individual therapy, it is difficult in the kind of milieu
that we create, to not give into that impulse to violate boundaries, to do bad things, to be abusive, or to be the one that is being abused. That’s a part that’s not talked about a lot is that the transference with us can be quite hostile and negative and sometimes even dangerous, which people are doing the kind of work that is coming out of experiences from the past.

The other thing we have to remember about this whole false memory controversy is that there is very little said about childhood physical abuse, childhood emotional abuse, childhood other forms of trauma and their connection with repression, amnesia, dissociation, for all of which there is evidence. What this discourse focuses on is sexual abuse and we have to remember that that may have something to do with not just having anything to do with psychiatry but to do with larger sociological issues like our whole social perspective around sexuality and our puritanical beliefs and values that have been challenged for the last 30 years, but it’s sexual abuse that has really been the target for this argument.

DR. FINK: Sandy, your point about different kinds of abuse is also a critically important issue. We know that there are somewhere around two million reported cases of sexual abuse in this country and that half of them are corroborated. A million kids who are sexually abused is a lot. What we don’t know is, how many never come to the surface or we don’t hear about? We know that 95% of children are hit by their parents and 52% of kids continue to be hit into adolescence. There’s a lot of physical misuse of children. Then we wonder why they hit people. We know a lot about the realities. We’re not talking now about repression. We’re talking about the realities of memorable events. I have a patient who says to me, “I was hit and beaten every day of my life.” He’s a guy who can’t relate to anybody and is always looking over his shoulder to see who’s going to hit him. This is not out of context. The reality is that we have a tremendous amount of misuse of people, and trauma, kids who see and hear people being shot on the street, go to sleep at night and in their ghetto homes live with bullies whizzing by.

I’ll tell you an anecdote. I go into a school of sixth graders. We’re talking about the bullets on the street. It’s an all-African-American school. I said to this little girl who was sitting there, “Well, what happens when you hear the bullets?” And, she said, “I get scared.” And I said, “For reasons I can’t understand, I said, “Well, what do you do when you get scared?” thinking like my children, she would run into the arms of her parents and get safe. She looked up at me and she said, “I cry,” and I felt terrible because it was the reality that she didn’t have any sense of safety at home, on the street, in the school, and this is a sixth grader. We’re not talking about the adults that we’re trying to uncover repressed memories on. All of this trauma gets stored up and gets turned into characterological distortions, and we’re not even talking, as you say, about that. We’re just talking about the sexual abused child and the rare one that doesn’t remember. It’s the rare one that doesn’t remember and then what do they do with those repressed memories and how it comes out in the course of treatment.

DR. SPIEGEL: It’s a good point you’re making. One other issue about memory, Susan Pezdek has done some very interesting work looking at how people do make distortions in memory, who are the old and what kind of distortions, and they’re rarely completely incongruous, out-of-the-blue distortions. It’s more like somebody who was abused in one way may have a mistaken belief that they were abused in some other way because there’s a kind of pattern recognition and people will sometimes fill in the blanks. So again, we’ve got to get away from this all-or-none idea that either it’s fantasy or it’s completely true and recognize that distortions may have to do more with previous experience.

DR. BLOOM: I’m glad you brought that up, David. The case that got me into studying trauma was a case of false memory. A young woman accused a man on her college campus of having raped her and the police investigated and found out that he had an alibi. It had not happened. Years later, she began to remember the experience of incest at a much younger age, when she was little, that was corroborated by her mother and her mother wasn’t there at the time, but her mother did remember the surrounding circumstances and that made it very consistent with the entire clinical picture that had emerged over those many years. When she began to recall all that and that the father was already dead and worked the memories through, she became asymptomatic.

DR. FINK: Well, hopefully, people who have listened to us will understand the complexity and we want to try to deal with integration, the contextual relationship of memory to life and the connections between childhood and adulthood.

List of Supplementary Reading Materials

To help you obtain more details regarding this program’s subject, the following supplementary reading materials are recommended:


Answers to Pretest Questions

1. True
2. False
3. True
4. True
5. False
6. False
7. True