A step backward in the recovered memory debate

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A Step Backward in the Recovered Memory Debate

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Space constraints force us to address only the most crucial issues raised by Karon and Widener's (1998) discussion of the memories of World War II (WWII) veterans.

1. Karon and Widener (1998) asserted that we and other critics of their article "suggest[ed] that the WWII patients who suffered trauma and repression were all malingerers" (p. 482). Yet, in our article (Lilienfeld & Loftus, 1998), we stated that "*It is possible* [italics added], for example, that his [the patient's] symptom represented malingering" (p. 474) and discussed several other explanations for the patient's reported symptoms. Moreover, nowhere did we suggest that the symptoms of other WWII veterans represented malingering. We find it difficult to understand what would motivate Karon and Widener to mischaracterize our statements in such a wholesale manner.

2. Although Karon and Widener (1998) claimed that we "talk[ed] about issues never raised in our article: hypnosis as a truth-seeking procedure" (p. 484), this denial is categorically false. In their original article, they asserted that during WWII "there were experimental uses of hypnosis and sodium penthathol interviews to undo the repression and recover the memories in brief therapy" (pp. 338–339).

3. We are at a loss to respond to Karon and Widener's (1998) assertion that the *Consumer Reports* study (Seligman, 1995), which revealed that most individuals who receive therapy report benefits, provides evidence that the lifting of repressions is therapeutically effective. Most forms of psychotherapy do not rely on removing repressions, and Karon and Widener's contention that "any psychotherapy that permits patients to remember more of their life" (p. 484) depends on the concept of repression renders this concept essentially indistinguishable from other forms of forgetting.

4. Karon and Widener (1998) concluded that we "create[d] a catch-22: If there is *no* corroborating evidence, the patient's memory is false; if there *is* corroborating evidence, then the patient must have known about it through the evidence and not through memory" (p. 485). This statement vastly oversimplifies the key issues involved in the repressed memory debate. Two crucial points, which Karon and Widener sidestepped, are that (a) *repression,* which is traditionally defined as the unconscious motivated forgetting of unpleasant material (Holmes, 1990), is only *one* potential mechanism for failures to report memories; and (b) a variety of other factors (e.g., childhood amnesia, ordinary forgetting, reluctance to disclose painful information) can account for such failures. Karon and Widener effectively equate repression with all forms of nonreporting and again deprive this term of all surplus meaning beyond other forms of forgetting.

5. Karon and Widener (1998), apparently unable to refute a single criticism of either the case study that took up half of their original article or numerous other cases to which they referred (Karon & Widener, 1997), instead resorted to referring to our arguments as "deceptive" (p. 485) and as constituting "blatant misdirection" (p. 484), and to suggesting (incorrectly, in the case of the first author, who is a clinical psychologist) that "psychologists who dispute the conclusive evidence of repression do not do therapy" (p. 486). Such ad hominem remarks do not advance the recovered memory debate and are particularly unfortunate in a journal devoted partly to psychologists' professional conduct.

By treating the lifting of repressions as synonymous with all forms of remembering and repression as synonymous with all forms of nonreporting, Karon and Widener (1998) render the concept of repression so broad as to be virtually meaningless. Their article thus represents a major step backward in the complex debate concerning the existence of repressed and recovered memories of wartime trauma.

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Smearing in the Name of Scholarship

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Karon and Widener (1998) responded to my critique (Pendergrast, 1998) of their earlier claims by attempting to deflect my scholarship through personal smears, misstatements, and distortion of my research and writing.

It is certainly true that I have lost all contact with my two adult daughters because they went to recovered memory therapists and apparently came to believe that I sexually abused them as children. I did not. I love my children deeply and was, all things considered, a good, loving father. If readers have children, perhaps they can begin to understand the misery I feel and the worry over how my children are, living with such a profound and disturbing delusion. Karon and Widener (1998) asserted that that my children "feel that he [Pendergrast] is a liar" (p. 485). My children have never called me a liar—only

Karon and Widener have done so by implication.

My personal tragedy has little to do with the debate at hand, however. I was a scholar and investigative journalist long before losing my children, and I brought those skills to *Victims of Memory,* my book-length examination of recovered memory therapy (Pendergrast, 1996). Yes, I am personally involved, but that just gave me initial motivation. Would Karon and Widener also suggest that Elie Wiesel should not be allowed to write about the Holocaust, or Kay Jamison Redfield about manic depression, because they were personally involved?

Karon and Widener (1998) quoted my private correspondence with Karon out of context, insinuating that I condone the sexual abuse of children because, in some cases, "mild" sexual abuse such as fondling is not perceived as abusive or traumatic at the time it occurs. (Karon & Widener, 1998, p. 485; Kilpatrick, 1992; Lindsay, in press; Pendergrast, 1996; Rind, Tromovitch, & Bauserman, 1998 p. 545–550). I do not condone *any* form of adult sexual activity with children. I was simply supporting my theory that when real sexual abuse is forgotten and then recalled—which does sometimes happen—it is because it did not make a significant impression at the time. As I wrote to Karon,

> I did find some corroborated cases in which people forgot limited abuse and then recalled it. But in all of those cases, the abuse was not originally perceived to be traumatic, or it occurred near the period of infantile amnesia. I have yet to find a convincing case of massive repression. (Pendergrast, personal communication, 1997–1998)

Then Karon and Widener asserted that my book, *Victims of Memory,* contains "many half-truths and misquotes." (1998, p. 485). To my knowledge, there is not a single misquotation in the book, whereas Karon and Widener are the masters of half-truths and distortion. I did not cite anyone, for instance, as "proof that repression does not exist" (Karon & Widener, 1998, p. 485); I have repeatedly stated that no one can ever prove that, because no one can prove a negative. (Pendergrast, 1996, p. 71–117, 535–540). My recommendations for therapy, which they dismissed without quoting, are in fact quite reasonable and not "hurtful if you care whether the patient gets help," as they wrote (Karon & Widener, 1998, p. 485; Pendergrast, 1996, p. 528–535).

Karon and Widener asserted that I "misquoted Diven's research" (1998, p. 485). Not so. As I wrote, Diven's research offers no proof for repression. I invite readers to read the 1937 Diven article and judge for themselves. Karon and Widener unfairly twitted me for "avoiding" Earnest Haggard's 1953 article. (1998, p. 486). As I wrote in my original article, I had mistakenly photocopied another article out of that collection, which I obtained on interlibrary loan (1998, p. 479). Now, I have the Haggard (1953) article in front of me. It does not prove repression, though I do not have the space for a detailed critique. In both the Diven (1937) and Haggard (1953) experiments, participants were given electrical shocks. None of them "repressed" the traumatic memory that they were shocked.

Citing *Massive Psychic Trauma,* a 1968 book edited by Henry Krystal, Karon and Widener (1998) asserted that "concentration camp victims do repress memories" (p. 486). The Krystal book concluded, "Many memories of persecution have become hypermnesic, at the same time occurring with such clarity and being so threatening that the patient cannot be sure that the old horrors have not, in fact, reappeared." Most Holocaust survivors have "indelible memories." However, Krystal (1968) also claimed to observe "far-reaching memory defects with total or partial amnesia for various traumatic events, marked vagueness of the capacity to recollect, and the emergence of acute episodes of confusion and anxiety when urged . . . to remember what the events were." (p. 329)

I submit that Krystal (1968) and his colleagues, who presumed the existence of repression, confused *repression,* or *amnesia,* with an unwillingness to talk about the horrors of the past, or an inability to recall specific episodes in a flood of horror. Certainly, no Holocaust survivors have ever forgotten the trauma they endured, as a totality. In personal correspondence with three Holocaust scholars—Elie Wiesel, Lawrence Langer, and Raul Hilberg—I asked whether they had come across any cases of massive repression, in which Holocaust survivors had completely forgotten terrible trauma. All three denied knowing of any such instances without organic brain damage. A few years ago, I conducted an interview with a woman in her 70s who spoke in moving detail about her time in the camps. She told me that I was the first person to whom she had ever recounted those memories—including her own children. She found them too painful.

Karon and Widener (1998) stated that I suggested that veterans with psychological problems were "all malingerers," a typical example of their deliberate distortion of the written record (p. 482). Instead, I originally wrote:

> Examining the memories of war veterans poses special problems. Many of the memory losses may well be attributable to organic brain damage. Others may involve faked memory loss in order to avoid active duty. Finally, although many of these veterans clearly suffered from very real trauma and PTSD [posttraumatic stress disorder], it is not clear that they repressed and then recalled traumatic memories. (Pendergrast, 1998, p. 481)

Then, Karon and Widener (1998) claimed that "in World War II cases . . . hypnosis and pentathol were used to produce rapid remission of the symptoms so that the patient could return to active duty" (p. 482). I urge readers to watch *The Battle of the Bulge,* a 1994 documentary that includes an interview with Ben Kimmelman, a military dental officer who had to administer barbiturates to traumatized soldiers and send them back to war.

> [We] put them through a kind of a very quick and dirty process in which they were given sodium amytal or one of these other—it's a sort of a truth serum thing. . . . And this would give them . . . almost a trance-like sleep for 24, sometimes or 48 hours.

After a long, drug-induced sleep and "abreaction," the soldiers would be roused.

> They'd be walking around, completely numb. Sometimes they would be slipping and falling. That took a few more hours. And then they would be given a shower, new clothes and a pep talk and the attempt was made to send them back. . . . The thing that repelled me so badly was that you were talking to men who weren't quite yet still in charge of themselves and you were sort of shepherding them back to the front. (*Battle of the Bulge* transcript, 1994, p. 9–10).

Such is the treatment that Karon and Widener (1998) praised, and such is their proof for the reality of repressed memories.

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Repressed Memories: Just the Facts

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The evidence is clear: Repression exists. Patients describe it, if they are given a chance to talk. Dynamic psychotherapists and psychoanalysts see it daily in their clinical work. The clinical literature is very clear.

The experimental literature is less clear, in part, because it would be unethical to intentionally traumatize people. We have already described several important pieces of research (Diven, 1937; Haggard, 1943; Shevrin, Bond, Brakel, Hertel, & Williams, 1996), which should be read by the interested reader, not Lilienfeld & Loftus's (or other secondary sources') characterizations of them. We do not address point by point the newest comments about what we did or did not say earlier (Lilienfeld & Loftus, 1999; Pendergrast, 1999). Obviously, we find the recent remarks distorting; however, we doubt that more "they said we said, but we actually said" dialogue will add much. Instead, we invite interested readers to actually *read* Karon and Widener (1997) and Karon and Widener (1998).

Repression refers to the psychological process of keeping something out of awareness because of unpleasant affect connected with it. The "something" may be a memory (or part of a memory), a fantasy, a thought, an idea, a feeling, a wish, an impulse, a connection, and so forth.

Those arguing in the repressed–recovered memories debate have questioned the existence of repression. Our original article (Karon & Widener, 1997) was intended to call attention to the hundreds of documented cases from World War II. These cases were well-known to professionals in the 1940s and 1950s, and they were discussed in standard textbooks of the 1950s and 1960s, but apparently have been forgotten in recent years. These battlefield neuroses patients had repressed battlefield traumas and developed neurotic symptoms (particularly conversion hysteria). The symptoms were alleviated when the battlefield trauma and its associated affects were consciously remembered. We illustrated these cases with one specific example. (Recently, Van der Hart, Brown, & Graafland, 1999, published a similar historical article reminding us of the data concerning World War I battlefield neuroses and their treatment.)

However, the facts regarding the existence of repressed–recovered memories are far more compelling than even we had indicated (e.g., Courtois, 1999; Loftus, Polonsky, & Fullilove, 1994). In addition, there is a Web page, the Recovered Memory Archive, set up by Professor Ross Cheit of Brown University, which annotates 66 cases of recovered and validated memories of abuse, 22 relevant experimental studies, and 24 studies relevant to traumatic amnesia in concentration camp survivors. In reaction to statements that there were no validated cases of repressed memories which were recovered, Cheit set an undergraduate research assistant to work, using information in the public domain. In just a few hours, 6 clearly validated cases were found. Cheit noted of all 66 cases now listed, "The cases are annotated and all have corroboration, including medical evidence, confessions, multiple victims, or even eyewitness testimony" (Cheit, in press). All of this data may be reviewed at www.brown.edu/Departments/Taubman_Center/Recovmem/Archive.html

The phenomena of repressed–recovered (or, more theoretically neutral, "lost and remembered") memories exist. Nor, according to Elliott's (1997) survey data on traumatic memories, are they confined to people in therapy. There is a wide range of lost and remembered memories reported including suicides and murders of family members as well as sexual and battlefield traumas. However, fully understanding their mechanisms is a different issue. Multiple processes may be involved. There are, of course, organic amnesias as well.

The conditions under which memories (or parts of memories) of traumas are lost or become intrusive have never been satisfactorily explained, nor the conditions under which lost memories return, although there are psychodynamic (e.g., Fenichel, 1945; A. Freud, 1966; S. Freud, 1940/1968; Thoma & Kachele, 1988), cognitive (e.g., Christianson, 1992; Nyberg & Tulving, 1996; Tomkins, 1992), and neurological theories (e.g., Joseph, 1998; Schore, 1994), all of which require further research and confirmation. Nevertheless, a lack of an entirely satisfactory explanation of phenomenona does not mean a lack of existence of the phenomena.

Normal people report memories they know could not have happened as well as accurate memories, some of the details of which are distorted. Normal people and people in therapy report memories of real events (some of which were previously repressed); they also report fantasies that

are not objectively accurate but are always meaningful—usually, a metaphor or analog to some emotionally meaningful situation or conflict. For example, B. P. Karon (1996) has described one possible basis for memories (not literally true) of alien abduction.

Repression may be massive. B. P. Karon treated a patient (as previously mentioned, Karon & Widener, 1998) who, on entering treatment, could not remember anything before the middle of high school. He had very serious symptoms. These symptoms remitted during the course of dynamic therapy in which he remembered the earlier years of his life, many details of which were validated by others. (Usually, psychotherapy patients attempt to check out their recovered memories if it seems possible and safe to do so.)

On the other hand, repression may be specific, as it was in the patient (of B. P. Karon) who sought therapy for irrational violence: "I hurt people and I don't want to." He described beating up a girlfriend for no reason. The only conscious reason he could give was because she had performed fellatio on him without his asking. Associations led to her being a "bad woman" and that his mother, who "was like the bible, she always knows what's right," had warned him that there would be "bad women like that" and had showed him what they would do (performed fellatio on him). The anger about the sexual molestation was repressed and displaced toward other women because it conflicted with his need to have an idealized image of his mother. He remembered the child abuse simply as moral instruction. Awareness of his previously repressed anger connected with this child molestation led to a permanent disappearance of violent assaults against women.

Repression is one of the coping mechanisms people use to survive. It is not the only coping mechanism (for a detailed discussion of defense mechanisms, see A. Freud, 1966). But we must include in our clinical understanding the dynamics of repression (or at least the phenomena that are described by that concept), if we are to be aware clinicians and scientists.

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