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Abstract
The history of the construct of psychological trauma is traced. This history begins with the often-misunderstood construct of repression and its complex relationship to trauma. In the 1800's, the metaphor of psychological trauma was a radical innovation to most writers. Military physicians, however, had been aware of psychological trauma and its effects centuries earlier. In the present century, changing ideas concerning trauma have been interwoven with contemporary military history. The varieties of experiences that are considered potentially traumatic have multiplied notably over the past few decades, as have the suspected sequelae of that trauma. Accompanying this has been a general trend in taking blame from the victim, and placing it on the traumatic experience. This expansion of cause and effect, and the removal of blame from the victim, has led to the modern phenomenon of 'victim-hood'. The relevance of current views on the subject to the forensic issue is discussed.
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To Angela K. McEachern

forty six forever
1 Introduction

One of the most pressing questions of Forensic Psychology is the issue of the effects of psychological trauma. It is, after all, a question especially relevant to the overlap between psychology and the law. Many traumatic events are criminal acts, thus those impacted by these events are often required to participate in the criminal justice process. And without doubt, the examination of emotional, cognitive, and social functioning is the province of psychology. The issue of the effects of psychological trauma is also a question that does not lend itself to simple answers. Thus this issue has been debated hotly, if intermittently, for over a hundred years. However, the scientific and social meanings of psychological trauma have changed greatly in that century. This change could be loosely described as a general expansion of both what constitutes psychological trauma and its effects. Scientific and clinical inquiries into the subject have vastly widened the scope of their subject matter. The varieties of experiences that are considered potentially traumatic have multiplied notably over the past few decades, as have the suspected sequelae of that trauma. The views of society at large have paralleled this expansion of both stimulus and response\(^1\).

As psychological trauma is a fundamental issue in Forensic Psychology, a tracing of the history of this, rather inconstant, construct is of some interest for its own sake. The history of ideas, while never supplying the clear, quantifiable answers available in the laboratory, does serve some very useful purposes. Even the most rigid of logical positivists would likely not argue that

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\(^1\) Paradoxically, this has often been coupled with a frequent insistence, on the part of the legal system, parts of the clinical and scientific communities, and much of society, that the question be phrased as "the effect of trauma" not the effects of trauma, leading to much acrimonious debate.
the pursuit of psychological knowledge has been a simple progression from ignorance to enlightenment. Psychology is seldom a cumulative discipline. Rather, it often absorbs the current *zeitgeist*, combining the implicit assumptions of society at large with scientific theory and data. These ‘temporal intrusions’ into psychological thought are frequently not evident at first glance\(^2\). They do often become readily apparent when the observer can gain some intellectual distance from the *zeitgeist* that inspired them in the first place. This can be accomplished by the simple passage of time. Psychological ideas that were heavily influenced by implicit assumptions that are no longer held by society often seem almost ludicrous. It can be likened to coming across an old Halloween costume you remember from your childhood. Your uncle may have terrified you as a child when he wore that monster costume, but upon your finding that same costume as an adult, long after your uncle has died, the costume seems merely tawdry, and empty. For example, for over a hundred years there have been attempts to support scientifically the idea that some ethnic groups are biologically disposed to criminal activity. However, society’s ideas concerning *which* ethnic groups are ‘born criminals’ have changed over the decades. Thus, when a late twentieth century reader is confronted with the extensive 19th century literature on the innate criminality of the Irish, the response is often one of astonished amusement. The same reader, when exposed to the contemporary research that levels the same charge at African-Americans, may be swayed by data and arguments no more sophisticated than those of the anti-Irish diatribes of the 1800s.

The above illustration can also be construed as an example of the other way of gaining intellectual distance; the study of the history of ideas. Taking into account the socio-cultural

\(^2\) The argument that complete objectivity is an *impossible* goal, of course, may have some merit. But even if this unfalsifiable assertion is true, it still does not follow logically that aspiring toward *more* complete objectivity is a hopeless, or self-deluding, task.
influences of the past can help make one more conscious of current socio-cultural influences. It may be likened to the vaccination process, i.e., an infection rehearsal. When a patient is vaccinated for a particular disease, she receives a weakened form of that disease. This leads her body to build an immune response to that disease that can protect her if she becomes infected with the full strength disease. To use the above example of 'criminal races', the knowledge of the arguments that were made against the Irish, a people that is no longer vilified (and therefore is a dose of the weakened disease), can serve to strengthen one’s cognitive resistance to similar arguments leveled against African-Americans, a group still the target of much calumny. Thus, it is of vital importance that any area of psychology explores the history of its cardinal issues.

This is not to be taken as an argument that all socio-cultural influence on psychological thought is pernicious, or even undesirable. It is neither possible nor efficacious to study people in a socio-cultural vacuum, to learn about people of a certain time and place, the socio-cultural context must be included because that context is part of its people. Paradoxically, however, taking into careful account such socio-cultural influence can help expose the more enduring, trans-cultural characteristics of humanity. If certain phenomena are found across different times and places, it is safe to suspect that these phenomena may be expressions of something more basic to humanity than cultural training. This is, again, another argument in favor of the careful historical exploration of our discipline’s constructs, one of the goals of the present paper.

The second goal of the present work is to explore how the current social and scientific views of psychological trauma may impact the forensic context. Over the last few decades, 'victim-hood' has gone from being a near meaningless term, through being a social stigma, to being an evocative, and all too often temptingly simplistic, origin myth, a way of explaining all manner of individual problems and incapacities. Accompanying this shift in societal views has been the
appearance of a phenomenon that will be referred to in this paper as "para-victims".

In recent years, a relatively small number of people have come forward claiming, or have thought to have been by others, to have been victims of crimes that could not have happened to them. However, many of these cases seem to combine truthful accounts of victimization with false accounts. The term "para-victims" is an admittedly unattractive neologism but it is also one that has the virtues of denoting neither conscious fraud nor unintentional error while connoting some similarity to that of 'real' victims, for many para-victims appear to experience a great deal of genuine suffering and indeed, many have been the victims of some sort of crime. However, the use of a single overarching term is not meant to imply a proposed unitary etiology. Many different possible factors may play a role in each case of a para-victim. For instance, much attention has been focused on cases of so called "False Memory Syndrome", the erroneous construction of a memory thought to have been repressed. Yet in some cases, the para-victims claim never to have forgotten their inaccurate accounts of victimization. In the present paper, the intentionally wide, and thus difficult to reify, term para-victims is simply meant as a descriptive label.

It is unknown whether the apparent rise of para-victims is a true increase or simply a matter of such cases getting farther along in the legal system or an increase in media attention to such cases, or a combination of any of the above. What is clear is that seemingly other wise undelusional people claim to have been gravely sexually violated, grievously physically assaulted, forced to participate in mass murder and cannibalism, ad astra, when there is no evidence to support their claims and much evidence to discredit their claims. This does not imply that some para-victims may not have been victims of crime but only that some, often central, aspects of their accounts, and perhaps their memories of their victimization, are
inaccurate.

This paper’s focus on this topic will be limited to speculation concerning cases where the para-victim seems to be the primary source of the inaccurate account of victimization. Current social and scientific views of psychological trauma and its effects may be most relevant to such cases. There are other cases, however, where the inaccurate accounts do not originate primarily from the para-victim. Inappropriate investigative techniques that might lead to such a situation are dealt with in the appendix.

In regards to these cases where the para-victim seems to be the primary source of the created, but perhaps sincerely believed, account, it will be argued that the changing meaning of psychological trauma, detailed in the first part of the paper, may allow the family of disorders once subsumed under the rubric of hysteria to manifest themselves in the Forensic context in a new and intriguing manner.

Any discussion on the effects of psychological trauma must address the issue of repression. The history of this often-controversial construct and its changing relevance to the topic of trauma will be traced. This will lead to an examination of the development of modern views of trauma from the perspectives of the laboratory and the clinic, as well as society at large. Finally, there will be an exploration of how these current views of trauma may affect the expressions of psychological disorders in the forensic context.
2 Pre-Freudian Repression

The effects of psychological trauma on both the victim's psychological health and the victim's memory have been intertwined with the question of repression for over a hundred years. Currently, few psychological constructs are discussed with as much rancor as repression (see Brown, Schefflin & Hammond, 1998, for a finely detailed and balanced account of the controversy). A large part of this incivility may be due to general confusion over the term. Often the various sides of the debate seem to be each discussing very different concepts of repression. For example, after reviewing six decades of laboratory research on repression, Holmes (1990) concludes that there is no controlled laboratory evidence supporting the construct of repression. Yet the studies cited by Holmes (differential recall of pleasant and unpleasant experiences, differential recall of completed and uncompleted tasks, changes in recall associated with the introduction and elimination of stress, and individual differences) seem to address a very different construct than the one that concerns clinicians. This is not simply a criticism that such studies only examine the possibility of repression of trivial material. There may be a great deal of merit in this criticism but the problem may not be just a discrepancy in degree, but a discrepancy of kind. Is an individual predilection to remember pleasant events over mildly unpleasant events equivalent to an involuntary lack of memory for a repeated trauma? Is a differential recall for a completed task over an uncompleted task equivalent to an unconscious pushing out of awareness of a disturbing instinctual desire? As is readily apparent from the preceding two questions, not only is there a confusion of terms between the laboratory and the clinic but there is also a confusion of terms within the laboratory and within the clinic; Is a differential recall for a completed task over an uncompleted task equivalent to an individual
predilection to remember pleasant events over mildly unpleasant events? Is an unconscious pushing out of awareness of a disturbing instinctual desire equivalent to an involuntary lack of memory for a repeated trauma? Such confusion of terms of reference can easily lead to discordant and interminable debate. This confusion is understandable, since the term repression (Verdrängung) was introduced by Johann Friedrich Herbart in the 19th century (Ellenberger, 1970) it has been used, sometimes retrospectively, to label a myriad of different ideas. For example, the editor of a relatively recent collection on the subject (Singer, 1990) found it necessary to include a chart indicating where each of the book’s contributors’ definition of repression lay on a variety of different dimensions (Singer & Sincoff, 1990).

Both the retrospective use of the term, ‘backdating’ the concept to antiquity for instance (see below), and the identifying of often very different concepts with the same term, have given the concept a, perhaps undeserved, air of historical validation. This may be especially true for the definition of repression most relevant to the question of the effects of psychological trauma and the issue of para-victims, what has been termed “robust repression” (Ofshe & Watters, 1994), the forgetting and the recovery of memories of traumatic events.

Robust repression does not seem to appear in scholarly writing until the late 19th century. Much of what we in hindsight think of as instances of repression in classical thought could best be defined as the frustration of sexual desire. This variation of the construct is intrinsically intertwined with the construct of hysteria. The ancient Egyptians treated behavioral disorders that we might put under the rubric of hysterical, such as constant lethargy or being “ill in seeing”, by prescribing treatments that seem to have been designed to correct the position of the uterus. From the sketchy evidence, left on the precious few extant medical papyri, the Egyptians
held that sexual frustration, or the "starvation" of the organ, led to the symptoms described above. They held that women that were most susceptible to such disorders were widows and 'spinsters', mature women who would presumably not have regular sexual activity. It had been thought that the Egyptians believed that thus starved, the uterus would begin moving out of its proper position, like any animal in search of 'food', and that it was this movement of the uterus that caused a variety of symptoms. Certainly the treatment regimens found on Egyptian medical documents imply a belief in this etiology as they describe what seem to be attempts to lure the straying uterus back to the pelvis. Examples of such recommended treatments included the fumigation of the vulva with dried male feces (presumably attractive to the fundamentally female uterus) on a bed of frankincense, and proscriptions against anointing the head with anything that might attract the ambulatory organ (Veith, 1965). However, contemporary examinations of ancient Egyptian medical papyri have found no direct references to the concept of the 'wandering womb' (Merskey & Potter, 1989).

Like much of Egyptian medicine, these ideas influenced the ancient Greeks. For the Greeks, however, the peregrinations of the womb implied (and perhaps even used metaphorically?) in the Egyptian papyri were quite explicit and concrete in Greek medical texts. This is evident in the name given to the disorder by the Greeks. They designated such disorders as hysteric or hysterikos, that is associated with the hysteron, the uterus. Treatment again focused on returning the womb to its proper place, by coaxing it toward the pelvis and repelling it from other areas of the body, and by encouraging the patient to (re)marry. As these ideas were enshrined in the celebrated Corpus Hippocraticum, the seventy two books traditionally attributed to Hippocrates the Great, they exerted an influence from the Classical era through the Medieval period to near

3 Nor, intriguingly enough does robust repression seem to appear in artistic or popular literate until after its
modern times (Veith, 1965). Thus when Charcot began his famous work on hysteria in the late
nineteenth century, it was still common to treat hysteria by ovariectomy or hysterectomy
(Drinka, 1984). Doubts had been cast on the uterine theory of hysteria as far back as Galen of
Pergamon (129 - 99 B.M.E.) and Aretaeus of Cappadocia (50? - 100? M.E.), doubts that were
echoed by such later thinkers as the French medical writer, Carolus Piso, (1563 - 1633), but such
doubts, whether expressed in antiquity or in the renaissance, had little effect on contemporaneous
medical thinking. More importantly however, even these writers claim that sexual frustration
was at the root of hysteria, that is, the repression of a desire could in itself be harmful (Veith,
1965). This of course was no new idea even in antiquity. For instance, in Euripides’ (481 - 406
B.M.E.) last work, the Bacchae, the god of animal ecstasies Dionysus destroys his mortal
mother’s family, the royal line of that long suffering polis Thebes, for denying his divine
paternity. As the classicist Lind (1957) notes, this is the terrible price repression exacts for the
false pose of ‘purity’.

In most cases in the classical era, the frustration of natural desires was simply due to lack of
opportunity to satisfy those urges. In later, perhaps more hypocritical times, this thwarting of
natural desires, while still thought to be potentially harmful, was often caused by internalized
societal mores. These societal mores forbid the expression of more than just sexual desire so

| introduction into scholarly literature.

4 As an interesting side bar, the wide spread acceptance of the ideas of Ernst Haeckel (b.1834 - d.1919) in the 19th
century blurred the lines between thought concerning the development, both healthy and unhealthy, of individuals,
writing on the evolution of species, and even the supposed ‘history’ of civilization. Haeckel the great popularizer
and German translator of Darwin, was the ‘discoverer’ of the biogenetic law; Ontogeny recapitulates phylogeny. That
is, the development of the individual must recapitulate the development of the species. Thus the human fetus with its
progressive development of gill slits, a three chambered heart and a tail was seen as recapitulating the evolution of
our piscine, reptilian and simian forebears. Implicit in much 19th century thinking on evolution was the idea that
evolution was progressive, that life evolved into not just better adapted forms but better forms with the modern
European male representing the epitome of the process of natural selection. Thus in 1886, John Langdon Heydon
Down could christen his, now eponymous, syndrome "Mongoloid Idiocy" because he thought those affected by
trisomy-21 were stalled at the level of development of the 'Mongoloid' (Asiatic) race, which was seen as the next rung
when the British physician Robert Brudenell Carter (1828 - 1918) developed what has been described as "the first theory of repression" (Veith, 1965), he was concerned with the repression, by social training, of not only desire but also other discreditable emotions, and the pathological effect of that repression. In his On the Pathology and Treatment of Hysteria (1853), he wrote that "an emotion, which is strongly felt by great numbers of people, but whose natural manifestations are constantly repressed in compliance with the usages of society, will be the one whose morbid effects are most frequently witnessed." (Carter, 1853, cited in Veith, 1965, p.201).

Nowhere does he touch on the issue of traumatic memories, ‘repressed’ or not, but rather concentrates on repressed emotions, such as the sexual desire of women and “unamiable” feelings, such as hatred or envy, and their pathogenic power.

Such unamiable sentiments, and equally unamiable actions, were the focus of Friedrich Nietzsche’s (1844 - 1900) construct of “inhibition” (Hemmung), a construct that has been held to be identical to the modern construct of repression (Ellenberger, 1970). Nietzsche sees inhibition as a battle between memory and pride, with pride the victor. Whatever does not measure up to

down from the Caucasian race on the evolutionary ladder (Gould, 1980). The biogenetic law was held to be a rock solid law by the scientists of the late 19th century and was only overturned by the rediscovery of Gregor Mendel’s work on genetics (Sulloway, 1992). The pervading influence of the biogenetic law blurred the perceived boundary between the individual and society. This made possible, perhaps even necessitated, that repression could be seen on the cultural level as well as the individual. Johann Jakob Bachofen (b.1815 - d.1887) was a scion of a wealthy Swiss family, a judge and a professor of Roman law. After his retirement he turned his full attentions to a subject that had always intrigued him. As a student he had made a trip to Italy where he became convinced that an intensive study of the symbolism of ancient art and mythology would reveal a heretofore unknown world from before history.

According to Bachofen’s scrying of ancient tales and artefacts, our species has gone through three stages of progressively higher development: hetarism, a period of anarchy symbolised by Aphrodite, a more chaotic version of Darwin’s primal horde; matriarchy, symbolised by Demeter, ‘a world turned on its head’ with primacy given to the female, the lunar, the nocturnal, the sinister, the irrational, the young, the dead; and patriarchy, symbolised by Apollo, the historical world. Bachofen held that the reason why history only encompassed the last of these stages was that societies found the memory of the stage of matriarchy so disturbing that it was collectively forgotten (Ellenburger, 1970). This has been regarded as the ‘discovery’ of repression (Turel, 1939, cited in Ellenburger, 1970). Nicolas Antoin Boulanger also wrote of repression on the cultural level. Boulanger held that several great world wide disasters had almost wiped out humanity and that each time civilisation was rebuilt by the survivors. The memory of the biblical flood, the latest in this series of catastrophes, had been repressed by humanity only to constantly bubble up in our myths and symbolism.
pride’s standards is expunged from memory. Nietzsche’s writings on the inhibition of shameful desires might be said to differ from Carter’s pathogenic repressed emotions on two points. Firstly, Nietzsche’s concern is not so much the harmfulness of repressing as the hypocrisy inherent in such denial. Secondly, Hemmung concerns itself not just with shameful desires but with shameful events as well, and thus the denial of memories of events. This ‘forgetting’ motivated by shame is perhaps the most innovative aspect of Nietzsche’s writing on the subject. Previous sources concentrated on only thwarted, and later merely disturbing, desires and thoughts. However, it could be said that Nietzsche would have regarded such memories as traumatic only as far as these events threatened one’s self image. ‘Robust repression’ is still several leaps of logic and faith away.

Like Nietzsche, Arthur Schopenhauer (1788 - 1860) is often cited as a philosopher whose ideas on repression, among other things, presaged those of Freud (e.g., Freud, 1959/1925; Ellenberger, 1970). However, inspection of Schopenhauer’s writings on the subject, reveals that his ideas are more of a mirror image of Freud, Nietzsche and Carter. According to Schopenhauer material is repressed not because it is an instinctual urging that threatens the person’s self-image or social training but rather material is repressed because it threatens the expression of an instinctual urge. His construct of the Will, the unconscious desires for conservation and most importantly sex, is thought to have near complete control over us. The Will can stop whatever is repellent to it from coming to the knowledge of the intellect, the conscious identity (Schopenhauer 1819/1883). Memories of trauma, for Schopenhauer, are simply irrelevant to his concept of repression. Thus past ideas concerning repression were more concerned with either frustrated desires, or disturbing thoughts regarding those unfulfilled desires, rather than memories of traumatic events. Indeed, with the exception of the pragmatic and intellectually isolated tradition of military
medicine, described in a later section, psychological trauma itself has only been a focus of inquiry for a little more than a century.
3 Charcot, Freud, and the Birth of Psychological Trauma

The prevailing ideas of the eighteenth and nineteenth centuries looked upon mental illness as largely a constitutional issue. The mentally ill were most often considered disturbed because of their 'weak natures'. By the nineteenth century, this was often perceived in evolutionary terms. Thus many writers, grounding their thought in Haekel's biogenetic law, considered mental illness a form of atavism, a 'throwback' to an earlier, and thus (as evolution was commonly perceived as inherently progressive) inferior form of development (e.g. Cesare Lombroso).

Others saw the incidence of mental illness as indicative of the evolutionary decline of the species, because of unnatural and easy urban living (e.g., Georg Cheyne) or the introduction of foreign, and again presumably inferior, stock into the population (e.g., Henry Herbert Goddard). Yet others (e.g., George Miller Beard) regarded much mental illness as a regrettable side effect of evolution. The Caucasian brain was seen as the vanguard of evolutionary progress, where creation was 'under construction' and, as such, potentially unstable.

Some nineteenth century writers, however, became interested in another potential etiologic agent; psychological trauma. These writers' use of the term psychological trauma was, both for themselves and their readers, clearly a metaphor. Trauma simply means some sort of physical injury or shock. It is indicative of how the concept of psychological trauma has permeated modern thinking that, except in medical usage, "trauma" without an adjective now invariably refers to psychological trauma while "physical trauma" requires an adjective. This has been a slow and gradual change in meaning. The inclusion of Post Traumatic Stress Disorder in DSM-III in 1980 was accomplished only after a protracted and antagonistic debate (Healy, 1993). At
present, however, both social scientists and the general public accept, almost as a truism, the harmful effects of psychological trauma.

Many of the seeds of this acceptance were sown by Jean Martin Charcot (1835 - 1893). Charcot, along with many other physicians of his day, had worked on the problem of “railway brain” or “railway spine”. The sufferers of this condition, of which there were great numbers in the last half of the nineteenth century, presented hysterical symptoms after experiencing an accident or near accident on the railroad. Many practitioners, such as the eminent German neurologist Hermann Oppenheim, thought that this was due to subtle physical damage, caused by the accident. This physical trauma soon proved to be undetectable by medical technology. Charcot turned his attentions to the possible debilitating effects of the psychological trauma of being involved or witnessing a railway accident. He hypothesized that the reaction of fear sent a damaging electrical pulse down the nervous system which caused the hysterical symptoms. This “dynamic lesion” could be caused by either a frightening occurrence or simply a terrifying idea (Drinka, 1984). Charcot viewed this as primarily a male manifestation of hysteric symptoms. To Charcot, some women, being inherently weaker, often naturally lapsed into hysteria, while most men, with their far stronger constitutions, required some form of precipitating cause (Librecht & Quacklebeen, 1995). This dynamic lesion theory of male hysteria is still a physiological theory but it is also an admission that this physical disturbance of the nervous system could be caused by a mental event, the perception of a ghastly thought or experience. This is one necessary step closer to the modern conception of psychological trauma.

Sigmund Freud, in his first version of repression, took the next important step towards one important contemporary conception of the effect of trauma, that of so called robust repression; the unconscious forgetting of traumatic events.
Freudians were once fond of saying that the ideas of psychoanalysis, including repression, leapt fully formed from the head of Freud, like Athena from the Head of Zeus. This simile has fallen out of favour in the last few decades, primarily through the efforts of scholars working outside psychoanalytical orthodoxy bent on showing the influence of other thinkers and disciplines on Freud’s thought and how Freud’s ideas themselves changed over his career. But there is some truth to be found in the simile. The birth of Athena was the direct consequence of Zeus consuming the Titans, the gods who came before him, including his own father Kronos. In the same way, Freud’s concepts owe much to those who came before him. To be sure, Freud did not simply dress up older ideas in new clothes but neither was Athena merely a regurgitated Kronos. The certainty that devout psychoanalysts would have doubtlessly not meant the simile to be interpreted in this manner, but would assuredly have been aware of the cause of Athena’s birth, could be considered delightfully ‘Freudian’.

However, this is not to say that Freud was necessarily cognizant, consciously or unconsciously, of all his intellectual predecessors. Granting precedence does not equate granting influence. We must make a distinction between anticipations and foundations. Anticipations are those ideas that may be similar to subsequent ideas but have no discovered developmental connections with those later ideas. Foundations are ideas that do have directly traceable developmental connections with succeeding ideas (Sarup, 1978). For example, no one has ever found any evidence that Freud even knew that the famous British ophthalmologist and war correspondent, Robert Brudnell Carter had ever written on repression. More equivocally, Freud claimed to have never read the works of Nietzsche and to have only perused Shopenhauer in his old age. In both these cases he freely admitted to have neglected these philosophers because he had enough knowledge of their works, and their similarities to his own ideas, to know that reading them
could open him up to the accusation that he owed them an intellectual debt (Freud 1925).

Anticipations such as these merely indicate such ideas were ‘in the air at the time’. On the other hand, an excellent case can be made that Herbart’s ideas had influence on Freud via Linder (Freud’s gymnasium psychology text author), Griesinger, Meynart, Fechner, Breuer, and Brücke (Sarup, 1978). Johann Friedrich Herbart was a German associationist psychologist who has been credited (Ellenberger, 1970) with coining the term "repression" (*Verdrängung*). In Herbart’s eyes, ideas are a form of energy and therefore must follow the Law of Preservation of Energy and cannot be destroyed but only transformed. An idea inhibited by a contradictory idea does not disappear but only “sinks below the threshold of consciousness” under the weight of the contradictory ideas (Wolman, 1968).

A strong case can also be made that the ideas of Charcot were at least an equally strong source of foundations for Freud’s thought. Freud had worked with Charcot in Paris in 1885 and Freud’s respect for the French neurologist lasted all Freud’s life. He named his first born son in Charcot’s honour (Freud, Freud & Grubrich-Simitis, 1985) and he alluded several times that important groundwork for psychoanalysis was lain in his Paris days (e.g., Freud, 1914, 1925 cited in Masson, 1984) but never specified the nature of this groundwork. It may well have been Charcot’s views on psychological trauma, that a reaction of fear, either to a frightening occurrence or simply a terrifying idea, can cause hysterical symptoms (Drinka, 1984). That is, a psychological event can cause psychological symptoms, a fairly radical idea for the times. Indeed in Freud’s obituary of Charcot, Freud declared that Charcot’s finest work was his final study of hysteria in which he wrote extensively on the “traumatic hysterias” (Librecht & Quacklebeen, 1995).

In 1892, while treating the patient known under the pseudonym of Fr. Elisabeth von R., a
statement Freud attributed to Hippolyte Bernheim gave him some encouragement. Bernheim
had remarked that events experienced during hypnosis were not truly forgotten and could be
remembered if the physician was insistent that the patient could indeed recollect them. Freud
then generalized this statement to hysterics (Jones, 1961) and seems to have combined it with
Herbart’s ideas on repression, Charcot’s views on psychological trauma, and the sexual elements
that had been interwoven with both hysteria and repression since antiquity.

In his first major public address, published later that year in the *Wiener klinische Rundschau*
under the title The Aetiology of Hysteria (S. E., 3, 191-221), Freud described what would later
come to be known as his seduction theory to a meeting of the Society for Psychiatry and
Neurology in Vienna on April 21, 1896⁵. He had already set forth much of these views in print
in France in an article for the *Revue Neurologique* published three weeks earlier, *L’Hérédité et
l’etiologie des névroses* - Heredity and the Aetiology of the Neuroses (Freud, 1896/1962a), and
would subsequently publish in German a paper, *Bemerkungen über die Abwehrneuropsychosen -
Further remarks on the Neuropsychoses of Defence* (Freud, 1896/1962b), reiterating these views
in the *Neurologisches Zentralblatt*⁶. In his speech, in typical fashion he claimed he had
discovered the neuropathologic equivalent to the source of the Nile; *aut caput Nili aut caput
nihil⁷*, the source of the Nile or the source of nothing, would not have made him an unbefitting
epitaph. He held "that at the bottom of every case of hysteria there are one or more occurrences
of premature sexual experience" and that "before they come for analysis the patients know

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⁵ The traditional date given for this address is Saturday, May 2, 1896 (e.g., Jones, 1957; Riviere, 1953) but both
Masson (1984) and Sulloway (1992) put it at Tuesday, April 21. The earlier date may be the more likely one. In his
letter to Fleiss of 28 April, Freud writes of having already given an address on the aetiology of hysteria to the
"psychiatric society" upon which Krafft-Ebbing made his famous verdict. This discrepancy is only noted in deference
to my obsession over minutiae and has no relevance to the present paper's topic.

⁶ Again, there is some controversy on the date of publication of *Further remarks on the Neuropsychoses of Defence.*
Masson (1984) puts it at May 15 but Riviere states it was not published until October of that year.
nothing about these scenes." Sexual events in puberty, from attempted rape through holding hands to a ribald riddle, set off a complex chain of interconnected memories that leads to the repressed sexual trauma. These unconscious memories are then "able to create and maintain hysterical symptoms". In support of his argument, Freud states in his address that he had analysed eighteen cases of hysteria and that in each case he discovered during treatment that the patient had experienced, but could not remember, episodes of premature sexual activity. Freud divided up these experiences into three types: sexual assault by strangers, seduction by a family member or servant and a childhood sexual relationship with a peer. All eighteen of his hysteric patients, six men and twelve women, underwent but could not recall at least one, usually two and sometimes all three of these types of premature sexual activity. He denied the possibility that either his patients were lying to him or that he had imposed false narratives upon them.

He states as proof for the first assertion that his patients, espousing disbelief of these accounts, emphasize that unlike the usual recall of previously forgotten incidents, there is no subjective sense of remembering, of familiarity. Freud also questions, if they are indeed lying, why they should cast doubt on their own mendacities.

In support of his second assertion he states that he has yet to successfully compel a patient to recall the sort of events Freud expected. This certainly implies he tried to do just that more than once with these patients. Freud in the therapy room may never have been the blank screen, waiting for his patient’s projections, of psychoanalytic legend but he was even more active and challenging with his patient in these early days (Jones, 1961). He also writes that the patients are “indignant as a rule if we warn them that such scenes are going to emerge. Only the strongest compulsion of the treatment can induce them to a reproduction of them.” (Freud, 1896, published

7 I do apologise for my poor humour and worse Latin.
Thus Freud admits to, at least occasionally, warning his patients that that may uncover forgotten sexual trauma, suggesting (although the verb seems particularly ill suited to the man) the content of those forgotten incidents and focusing the treatment on the recovery of those incidents. When these incidents are indeed recovered, as would be expected based simply on our knowledge of people’s suggestibility, even then his patients, unlike Freud, seem unconvinced of the veracity of the scenes.

He asserted that only those who underwent premature sexual activity of some kind but do not have conscious memories of it become hysterical. Freud added "But what decides whether those experiences produce conscious or unconscious memories- whether that is conditioned by the content of the experiences, or by the time at which they occur, or by later influences- that is a fresh problem, which we shall prudently avoid" (Freud, 1959/1896). At least avoided publicly, earlier in the year he had written to Fliess that "shame and morality are the repressing forces... where there is no shame (as in male persons) or no morality (as in the lower classes of society)... there too infantile sexual stimulation will not lead to repression nor, consequently, to neurosis" (Freud, 1896, published in Masson, 1985, p. 163). Freud (1896/1953a) posits that the upper age limit for the premature sexual experience as eight years old and that if the act did not inspire either “indifference or ... slight disgust or fright” but was rather a pleasurable incident, an active one for boys and a passive one for girls, then an obsessional neurosis instead of hysteria would result.

The meeting was chaired by Richard von Krafft-Ebing who famously dismissed Freud's seduction theory as sounding like a "scientific fairy tale" (Schur, 1972, cited in Masson, 1984). Freud claimed few at the meeting disagreed with Krafft-Ebing's verdict (Jones, 1961). Within months Freud’s caput Nili seems to have dried up. In the most famous of his letters to Fliess,
Freud gave four reasons for abandoning the seduction theory: (Freud, 1897, published in Masson, 1985).

First, Freud did not find his therapeutic efforts bearing fruit. Not a single analysis could be brought to a “real conclusion”. Patients were terminating their treatment with Freud. He found his hopes for complete therapeutic success dashed, and he could certainly discern alternate explanations for his partial successes.

Second, in contrast to the varied forms of premature sexual experience he described in The Aetiology of Hysteria, in Freud’s letter to Fliess he writes that in every case the patient’s father, not excluding Freud’s own, was implicated in the recovered scenes. Freud faultily reasoned that if all of his cases had been molested by their fathers then molestation by the father must be the sole cause of hysteria; aut caput Nili aut caput nihil again. Further, because he viewed the premature sexual experience, now seen exclusively as molestation by the father, as necessary but not sufficient to cause hysteria, and given the prevalence of hysterical symptoms, his theory required a far higher incidence of sexual abuse by fathers than Freud thought possible. Some writers (e.g., Masson, 1984; Sulloway, 1992) have viewed this skepticism as a refutation of Freud’s own papers of the previous year (Heredity and the Aetiology of the Neuroses; The Aetiology of Hysteria; Further remarks on the Neuropsychoises of Defence) but in none of these papers does Freud specifically discuss the seduction and/or rape of children by their fathers. When sexual trauma concerning a father is mentioned it is most often a case of the child accidentally coming across the father having sexual congress with someone else, usually the child’s mother or a servant. When Freud mentions children who have been raped, the rapist is usually a stranger and when he describes the seduction of children, the seducer is usually a servant woman. In all these examples, Freud does not deviate far from his peers. The nineteenth
century literature on the sexual abuse of children was largely concerned with the predatory inclinations of servant girls and women (e.g., Krafft-Ebing) towards the children of their employers. Freud’s seduction hypothesis, given his data of 1897 and his ‘Nile or nothing’ attitude, required him to accept an exceptionally high rate of sexual abuse by fathers. Given the prevalence of hysterical symptoms in 19th century Europe, this could require an incidence rate of father/child incest far higher perhaps than even our contemporary estimates. His rejection of his seduction hypothesis did not require him to contradict earlier published views on the general incidence of child sexual abuse, which he had stated was most likely higher than many would like to think. He also fully acknowledged that many scholars were very aware of the problem, even as far as anticipating objections to his sexual aetiology for hysteria on the grounds that such experiences were too common, essentially a ‘Barnum statement’, to be of “great aetiological importance” (Freud, 1896/1953b). Neither did this rejection of his hypothesis require him to contradict earlier published views on the specific incidence of child sexual abuse by fathers, on which he had remained silent.

Third, Freud found it impossible to “distinguish between truth and fiction cathected with affect.” The accounts, that the patients had “no feeling of remembering”, were now being doubted by Freud himself. He could find nothing in their content to distinguish them from other memories. Instead of his simplistic trichotomy of 1896, where his patients, if they were neither deliberately lying to him or bullied into the account by him, had to be telling the Freud whole truth, he now seems to suspect that true emotional substance can be expressed in a false form given an appropriate context. To Freud, the context is the sexual fantasies of the human unconscious which “invariably seizes upon the theme of the parents”. Once more, Freud insists he has uncovered an universal principle where a particular explanation might suffice. It may have
simply been that Freud, looking for forgotten childhood sexual experiences, offered his patients a 'paradigm' to express real emotional issues.

Fourth, Freud found that "in the most deep-reaching psychosis the unconscious memory does not break through, so that the secret of childhood experiences is not disclosed in even the most confused delirium." Two interpretations offer themselves to this remark. Neither is very satisfactory.

Freud could be construed as meaning that psychotic patients, unlike hysterics, are incapable of recovering repressed memories of premature sexual experiences. Such a statement would be completely irrelevant to the validity of Freud’s seduction hypothesis. The seduction hypothesis was concerned solely with the aetiology of hysteria. At the time hysteria was considered by Freud to be one of the psychoneuroses along with obsessional neurosis. It is also an explanation completely unsupported by the historical record. Freud's adamant disinterest in psychosis had in it, in Steiner's (1976) memorable phrasing, a deep "terror before the inchoate." There is simply no evidence of Freud perceived his patients of the late 1890s as being psychotic.

Conversely, this statement could be understood as meaning that Freud's severely hysterical patients are not coming up with the repressed material he expects them to. Freud (1894/1962b) had earlier subsumed hysteria along with obsessions and "certain cases of acute hallucinatory confusion" under the rubric of Defence Neuro-Psychoses. Is it possible that in his personal correspondence Freud may have informally used the term psychosis to mean extreme hysteria? This is also a very problematic interpretation and contradicts his publications of the previous year. In all three of his 1896 papers Freud states unequivocally that all of his hysterical patients (thirteen in both Heredity and the Aetiology of the Neuroses and Further Remarks on the Neuropsychoses of Defence and eighteen in The Aetiology of Hysteria) have recovered
repressed memories of a premature sexual experience.

Having repudiated his seduction hypothesis, Freud is left with the problem of why such past, and assumed pleasant, fantasies are forgotten. Like Nietzsche and Carter before him, Freud posits that self-disgust is the repressing force. But unlike his precursors, he grounds repression in an ontological framework. Freud now postulates that the levels of psychosexual development and their associated erotogenic zones are the key to repression. "Childhood memories associated with abandoned erotogenic zones should increasingly evoke disgust - not pleasure - at each successive step in development. The current memory stinks just as an actual object may stink and... the preconscious and our conscious apprehension turn away from the memory. This is repression." (Freud, 1897, cited in Sulloway, p. 202) Freud holds that this progressing from taste to distaste "is organically determined and fixed by heredity, and it can occasionally occur with out any help at all from education. In this organic repression psychic factors as yet play no role; it is the repression of pleasurable sensations (and their transformation) into unpleasurable

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8 As an aside, certain allegations in the book, The Assault on Truth, may be addressed here. This popular book was written by Jeffrey Masson, a sanskritist turned psychoanalyst who had been designated as the successor of Kurt Eissler as the head of the Sigmund Freud Archives. This designation was revoked when he put forward his views on Freud's seduction theory in a pair of articles in The New York Times (Malcolm, 1983). Masson later developed his thesis in The Assault on Truth (1984). In it he holds that Freud's abandonment of the seduction theory was predicated by pressure from the professional community and influence from his confidant at the time, Wilhelm Fliess. 'Freud bashing' has become something of a cottage industry in recent years and much of this criticism is entirely justified. Masson's thesis however, is rather unique in that his allegation seems very uncharacteristic of Freud. It is certainly true that Freud regarded the reaction to his seduction hypothesis as very negative but he also had a tendency to consistently overestimate society's hostility to his ideas (for example see Decker, 1975, for a telling contrast between Freud's beliefs and the actual German public reaction to The Interpretation of Dreams). Right or wrong, however, Freud's perception of public and professional animosity to his ideas never made him change his mind before or since. As for Fliess, as his half of his correspondence with Freud has been lost, we have no certain way of knowing what his feelings were toward the seduction hypothesis. There is nothing in Freud's letters to Fliess that point to a chilly reception to the theory. Indeed in several places in the correspondence (e.g., the letter of November, 15, 1897), Freud remarks that in both their letters and their 'conversations', neither man responds much to what the other has said but rather each takes turns holding forth his own ideas to the other. There seems to be little evidence to support Masson's contention that Freud abandoned the seduction hypothesis because of a failure of will and some evidence, however muddy, that he abandoned it due to a failure of reasoning. This seems far more in keeping with his character. Freud was a treasure house of human frailties but weakness of will was one of the rare
ones that we characterize as a portion of civilization.” Thus Freud begins to turn much of his attention away from the effects of emotionally traumatic memories to the effects of disturbing memories.

However, Freud did not completely turn his back on the effects of emotional trauma. Masson (1984) claims that there are several instances (e.g. in some of his letters to Fliess) where it seems that Freud still entertains the possibility that repressed memories of actual child sex abuse can be a cause of hysteria and that even as late in 1916, in his Introductory Lectures on Psycho-Analysis where Freud writes of there being no doubt of the imaginary nature of seductions of daughters by fathers he also adds that "we have not succeeded in pointing to any differences in the consequences, whether phantasy or reality has had the greater share in these events in childhood." It's important to note that many authorities at the time simply regarded hysterics as completely unreliable and would simply dismiss such accounts, if they came up, as lies typical of the disorder. Charcot went against this intellectual trend (Healy, 1993) and Freud, for better or worse, in this matter followed Charcot and took these accounts seriously even if he usually did not think of them as describing objectively true events. Nonetheless, Freud’s attentions, and thus the attentions of his future legions of loyal disciples, greatly turned away from the effects of traumatic events towards the more esoteric topics of psycho-sexual development and arrest. But, unbeknownst to Freud, the ‘robust repression’, he had weeded out of his carefully tended garden of psychoanalytic constructs and discarded, took root and blossomed wild.

As orthodox psychoanalysis grew as a movement it became both more static and more popular. By the end of the Second World War, analysis had become in the public’s mind the science of mind and the analytical institutes were swelling with new candidates. For years, academic failings he did not possess. He was always capable however, of failure of reasoning, especially when such a failure
psychology had been engaged in a maddening one-way debate with psychoanalysis. These critiques by researchers were either ignored or dismissed as mere unconscious resistance by the Freuds. These two groups, ostensibly studying the same topic, often found their respective paradigms to be completely incompatible. To the analysts there was no substitute for personal experience; you had to have been analyzed to criticize psychoanalysis. To the psychologists, subjectivity was anathema and objectivity was the panacea. By the forties, psychology had changed tactics in this war for intellectual territory and embarked on a campaign of testing psychoanalytic concepts, including repression, in the laboratory (Hornstein 1992). As she puts it "This reinstated psychologists as arbiters of the mental world, able to make the final judgement about what would and would not count as psychological knowledge". Within a decade, there were hundreds of such studies and countless review articles literally counting up those that supported the analytic concepts and those that did not. Unfortunately, what the researchers claimed as laboratory analogs of repression and other like concepts bore very little resemblance to the concepts as envisioned by the Freudians. For example, the effects on memory of such 'traumatic' events as failing to complete an intelligence test, being given negative feedback during a Rorschach test, and profanity presented by tachistoscope. This research has been summed up by Holmes (1990), in a much cited review article, as providing no evidence for repression. He is no doubt correct but that is akin to asserting the fictitious status of the Loch Ness Monster because it has never been found in a bathtub.

However, not only do these laboratory analogs appear, on the face of it, to fail as analogs, but they are also attempts to operationalize only a single form of repression. As we have seen, this form of repression, the repression of a memory for an event because that event caused emotional
trauma, ceased to be a major concern of Freud’s after 1896. The attempts by psychology researchers to hold up psychoanalytic concepts to the rigors of scientific examination may well have helped to establish in the public mind particular definitions of those concepts. At the very least, the researchers apparent confusion regarding the changing definitions of repression in Freud’s writings is a testament to the difficulties of following Freud’s changing ideas for even professional reader, let alone the lay public. For example, Sulloway (1992) discerns four broad, and fundamentally different, stages in Freud’s writings on repression. Freud’s ‘robust repression’ of 1896, perhaps inadvertently preserved as concept, at least in part, by the attempts of mid-twentieth century researchers to put the construct to the test of scientific scrutiny, thus managed to survive its rejection by its creator.
4 Modern Conceptions of Psychological Trauma: The Recurrence of War and Dissociation

4.1 Nostalgia

This concentration, by both the research community and the general public, on this one particular form of repression, the forgetting of traumatic events, may also be an indication of the power of the idea of psychological trauma in the present century. Western culture's perceptions of psychological trauma, have changed from a radical innovation through a stigma to a potential origin myth, that is a personal, and often powerfully evocative, explanation for current individual problems. This change in cultural perception is intertwined with modern military history.

It is of course true that there have been accounts of soldiers' reactions to the stresses of warfare since antiquity. Herodotus⁹, for instance, recounts an incident at the battle for Thermopylae in 480 BCE. A Spartan commander, Leonidas, observing his troops, thought that some had been too disturbed by earlier engagements and might break down during the coming combat and so dismissed those warriors from the battlefield (Gabriel, 1987).

Nonetheless, the classical and mediaeval accounts of such phenomena concentrate on acute reactions during battle and not on the chronic effects of experiences during armed conflicts. In the late 17th century, perhaps the first attempts were made to examine such chronic effects. Swiss military physicians in 1678 described a syndrome consisting of extreme lassitude, an incapacity to concentrate, a loss of appetite and even thirst, and feelings of utter isolation. They, unabashedly blending Latin and Greek, coined the term "nostalgia" to describe this hysteria like

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⁹ Citing the "Prince of Lies" does not necessarily imply an endorsement of the veracity of this particular anecdote. However, Herodotus' account of this incident at Thermopylae does indicate that the concept of a debilitating and acute reaction to the stress of combat existed at least as early as the writing of the Histories.
condition. Soon, military physicians from many other European countries were finding their own troops were afflicted with similar disorders. The Germans termed the condition *Heimweh* or "homesickness", the French *maladie du pays*, and the Spanish, with perhaps the most expressive appellation of all, *estar roto* or "to be broken" (Rosen, 1975). Nostalgia itself was in use by military physicians for several centuries. For example, in the American War Between the States, there were almost 10,000 servicemen diagnosed as being afflicted with nostalgia in the Union forces alone (Gabriel, 1987). Notwithstanding the lack of contemporary medical theorizing on the effects of psychological trauma, the practical martial necessities of, at least, recognizing affected soldiers and, at best, treating those soldiers, led military physicians to formulating diagnostic and remedial regimes for nostalgia. Despite the seeming continuance of nostalgia’s symptoms into near current times (for example it has been asserted by Jones (1986) that the symptom cluster of nostalgia was the modal form of psychological disturbance affecting United States troops in the Vietnam War) and 18th and early 19th centuries attempts to generalize the condition to civilian life (although in such generalizations nostalgia tended to be delimited to a form of immigrant neurosis or even mere homesickness) nostalgia became disused and almost forgotten in the mid to late 19th century10 (Rosen, 1975).

4.2 Janet and Dissociation
The beginnings of the revival of the idea of psychological trauma in the 19th century and Charcot’s contributions to that idea have already been described above. Nonetheless, an important, albeit indirect, and most certainly final, contribution to the study of trauma by Charcot remains to be discussed. Shortly before his sudden death in 1893, Charcot appointed a young physician to head the new experimental psychology laboratory at the Salpêtrière; Pierre Janet.

10 There are, of course, always exceptions to such statements. The most notable exception to this statement is Karl
Janet (1859-1947) had attended the *Ecole Normale Supérieure*, the famous preparatory school for the future professors of the lyceums, with Henri Bergson, and he and the philosopher found in each other a lifelong source of intellectual cross-pollination (Ellenberger, 1970). A fruit of this cross-pollination was Janet’s attention to the issue of self-awareness and its importance to mental health. To Janet, the ability to be aware of one’s past as well as having an accurate reckoning of current conditions were absolutely crucial in the healthy response to stress (van der Kolk, Weisaeth & van der Hart, 1996). He construed consciousness as being made up of elementary structures. These elementary structures he termed psychological automatisms. He construed psychological automatisms as consisting of both perceptions and actions. These elementary structures made up a near-seamless whole except when a single psychological automatism, or a group of interconnected psychological automatisms, would break off, i.e., dissociate, from the larger body (Kihlstrom, Glisky, & Angiulo, 1994). This would occur because of the disturbing emotional content of the dissociated psychological automatisms. According to Janet, emotions naturally interfered with narrative memory; clear recall required emotional neutrality. The dissociation of psychological automatisms containing memories of trauma from the rest of consciousness was simply this phenomenon taken to its natural extreme (van der Kolk, 1994). The now separated psychological automatisms were then hidden from the rest of consciousness. While the remaining intact system of consciousness has no control over these ‘free floating’ psychological automatisms, there is a flow of influence in the other direction. The dissociated psychological automatisms continue to function autonomously, and surreptitiously affect the individual on every level (Kihlstrom, Glisky, & Angiulo, 1994). The influence of the dissociated psychological automatisms could lead to panic attacks, obsessive

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ruminations, flashbacks, nightmares, or unintentional reenactments of the original trauma (van der Kolk, van der Hart, & Marmar, 1996), i.e., an uncontrolled repetition of the original reaction to the trauma. Janet held that while this dissociation of psychological automatisms occurred because of trauma, some people had a constitutional predisposition to dissociate. Those with such a predisposition would have a lower threshold of trauma required for dissociation to occur (Kihlstrom, Glisky & Angiulo, 1994).

Dissociation has been differentiated from the psychoanalytic construct of repression on the grounds of the passive and ‘impersonal’ nature of dissociation. That is, repression is construed as an action, albeit an unconscious one, by ego defense mechanisms to ward off disturbing material. Dissociation, on the other hand, is merely a natural splitting off of emotion laden material, and thus incompatible with other memories, from the whole of consciousness (van der Kolk, van der Hart, & Marmar, 1996). An analogy might be that repression is like the exiling of dissidents, while dissociation resembles fruit, grown overripe and too heavy for the branch, falling to the ground.

Despite this difference in how these two constructs are construed, these two lines of thought concerning trauma and memory once ran more or less parallel to each other; both Janet and Freud were originally concerned with the effects of inaccessible memories of trauma on current functioning. There is a temptation to speculate that both dissociation and robust repression are attempts at explaining the same objective phenomenon. Indeed, Freud regarded dissociation as synonymous with repression (Singer & Sinoff, 1990). Unfortunately, our current knowledge of the eighteen or so cases on which Freud based his robust repression of 1895 is so sketchy that

11 An interesting alternative reconciliation of the two constructs can be found in Hilgard’s (1977) attempt to explain both repression and dissociation in terms of depth psychology. To Hilgard, the dissociative barrier is vertical, dividing
any attempts to discern the actual phenomenon that Freud encountered (if indeed he had
encountered a unitary phenomenon) seems fruitless. As discussed above, Freud soon turned his
concentration to the repression of what might better be termed disturbing memories. Indeed,
often what was disturbing about these memories was their desirability. Thus we are on the
whole bereft of further description from Freud of cases of the repression of traumatic events. As
for contemporary cases of robust repression, many of these could just as easily be construed as
cases of dissociation. However, in many other cases, it appears that the memories thought to be
have been repressed are not so much recovered as created (see Lindsay & Read, 1995; Loftus,
1994). These are not mutually exclusive possibilities for any one particular case, however. If
memories for an event have been dissociated, they are, according to Janet, no longer accessible.
As the memories for the events in question are no longer accessible, the person is in a position of
uncertainty. In their thorough and detailed review of the literature on suggestibility, Brown,
Scheflin and Hammond (1998) hold that the primary factor in vulnerability to suggestion is
uncertainty. Therapeutic techniques that may put the patient at high risk for creating memories,
(Lindsay & Read, 1995) often contain very suggestive tactics. Thus it is certainly not impossible
for people to have dissociated their memory of an event and then produced a created memory for
that event. If Janet was correct that dissociated memories, while inaccessible to conscious
awareness, do have an influence on thought and behavior, usually through a repetition of the
reaction to the trauma, it may even be the case that the dissociated memories affect the emotional
content of the otherwise suggested and ‘false’ memory. Once more, repression seems to be a
term of too catholic a definition, labeling a myriad of different constructs.

Unlike Freud, Janet remained focused on the issue of trauma. His work was eventually obscured
both by the ever-widening scope and application of Freudian ideas, and by the mental health profession’s usual peacetime neglect of the psychological effects of trauma. However, whenever psychiatry’s attentions were forced once again toward the issue of psychological trauma by the practical requirements of war, interest increased in dissociation in general and Janet’s ideas in particular (van der Hart & Brown, 1992). The professional reaction to the First World War proved no exception to this tendency.

4.3 Shellshock
Life in the trenches of the First World War consisted of vast tracts of days filled with cold, filth, disease, and boredom punctuated with the unexpected terror of mustard gas attacks or commands to “go over the top” and become the all too easy targets of an unseen enemy. The fighters for both sides could have no sense of control over their destinies and all around them was clear evidence of what could very easily be their grim fate. In such a situation, survival becomes not a matter of skill but of blind luck (Winter, 1986). Those familiar with Seligman’s (see Seligman, 1967) classic studies on learned helplessness would certainly expect a reaction of distress on the part of these servicemen. Soon great numbers of these largely unprofessional soldiers were incapacitated by what was termed “shellshock” by Charles Samuel Myers, a British military psychiatrist, in 1915 (van der Kolk, Weisaeth, & van der Hart, 1996). On both sides of the conflict, the shellshocked soldiers’ symptomology often consisted of amnesia, loss of hearing or sight, convulsions and paralyses and other symptoms reminiscent of classical hysteria (Healy, 1993).

The term itself is of interest. It at first described what was thought to be a physical injury. The explosion of nearby shells or even the whistling of overhead bullets were considered as possible

from unconscious material.
causes of physical trauma. These traumata were, like the “railroad spine” maladies of the previous century, thought to be too subtle to be detected directly by the medical technology of the day. Rather, it was thought that the injuries could be inferred by the soldiers’ behavior and expressed feelings. This, perhaps to modern eyes bending dangerously close to circular, line of reasoning was both a holdover from the traditional 19th century viewpoints, and a way to avoid stigmatizing the stricken servicemen and the war effort itself (Stone, 1985). Some empirical data did support the hypothesis of shellshock being caused by very subtle physical injuries. A small number of soldiers who had been killed as shells exploded nearby, but whose corpses seemed unscathed, were discovered upon autopsy to have minute injuries to their spinal cords (Mott, 1919, cited in Healy, 1993). However, this indiscernible physical injury etiology hypothesis was given a serious setback with the discovery that servicemen who had never been under fire also exhibited the symptoms of shellshock (van der Kolk, Weisaeth, & van der Hart, 1996).

After they were forced to abandon this original hypothesis, there were attempts by the psychiatrists of the Triple Alliance powers (Great Britain, France and Russia) to explain the origins of shellshock in terms of degeneracy theory. This, while stigmatizing the stricken soldiers themselves, had the advantage of not stigmatizing the war itself. The combat conditions of the trench war need not be regarded as intrinsically unhealthy according to degeneracy theory. Instead, those who succumbed to shellshock did so because of their degenerate constitutions. Their levels of degeneracy were mild enough to allow them to live quite healthy and normal lives as civilians during peacetime. The rigors of wartime service simply exposed the weakness of their degenerate constitutions. The war was thus not so much an Inferno, a place of intolerable suffering, as it was a Judgment Day, where the strong and good were separated from the weak and bad. Unfortunately for this point of view, a far higher proportion of officers succumbed to
shellshock than did enlisted men (Gersons & Carlier, 1992; Healy, 1993). Given the positive correlation between social class and military rank in the European armies of the day (Woodward, 1978), this led to the unacceptable conclusion that there were higher levels of low level degeneracy in the upper classes than there were in the lower classes.

The psychiatrists of the Triple Entente (Germany, Austria-Hungary and the Ottoman Empire) framed the problem in a similar way to the degeneracy theorists. Turn of the century German psychiatry was greatly influenced by Joseph Babinski, who had been heading the Salpêtrière since 1905. Babinski, ironically enough, once Charcot’s favorite student, held that hysteria was nothing but an exaggerated tendency to simulate in response to suggestion; its symptoms are caused by suggestion and can be removed by persuasion (Ellenberger, 1970). This line of thought was taken up many German psychiatrists who concentrated on the issue of the failure of the patient’s will. The resemblance to the symptoms of hysteria was not lost on those treating the soldiers and the condition was seen as a failure or disease of the stricken soldiers’ will (van der Kolk, Weisaeth & van der Hart, 1996). Psychological trauma had ceased to be a radical innovation and was now instead a stigma.

Regardless of the suspected etiology of the condition, it quickly became apparent to the military and political authorities on both sides of the conflict that shellshock was a crucial problem that required immediate attention. Vast numbers of military personnel were becoming unfit for active duty in war time. For example, in the British Army alone, 80,000 troops were hospitalized for shellshock and a full quarter of that number were eventually admitted to psychiatric institutions (Gersons & Carlier, 1992). Efforts were made to both prevent the condition, and so limit future outbreaks; and to treat the condition, and so enable the stricken soldiers to return to active service at the front. Prevention measures that were under consideration included the court
martial and even execution of shellshocked troops as a deterrent (Healy, 1993). This is not only an indication of the unpleasantness of the context that shellshock arose in but, more importantly, testifies to the perceived seriousness of the problem. By the end of 1916, special psychiatric centers had been set up for each area of the British Army to deal with the problem (Holmes, 1985).

The hysteria like symptoms of the shellshocked servicemen eventually led to a debate amongst British military psychiatrists over the whether the underlying issue was repression or dissociation. The two concepts, while seemingly quite similar (see above), theoretically point to very different treatment approaches (van der Hart & Brown, 1992). Like a vampire dragged into daylight, a repressed traumatic memory is thought to lose its pathogenic power when brought into the light of consciousness. The treatment of dissociation is said to require not merely the flushing out of the traumatic memories, but the further reintegration of those memories into normal consciousness (van der Kolk, McFarlane & van der Hart, 1996). Naturally enough, given the change of focus in Freud’s thought from the repression of the traumatic to the repression of the disturbingly pleasant, many authorities felt that dissociation was the mechanism at the root of shellshock. These included the American neurologist James J. Putnam (van der Kolk, Weisaeth & van der Hart, 1996) and Karl Jung (van der Hart & Brown, 1992). Even Myers, the father of the originally somatic term shellshock, eventually held that the core issue of shellshock was the victim’s inability to integrate the memories of the trauma into normal memory (Myers, 1940). After the war, however, interest in trauma, and thus dissociation, waned once again (van der Hart & Brown, 1992).

Because of the mass enlistments of the First World War, and unlike the military physicians of past centuries who had dealt with servicemen afflicted with nostalgia, many of the psychiatrists
treating these shellshocked soldiers were not career military men. For example, in Great Britain more than half the peacetime civilian medical profession was enlisted into the armed forces (Winter, 1986). Yet other than limited involvement with the government compensation packages for shellshocked servicemen (Gabriel, 1987), the concept of shellshock in particular and the chronic effects of emotional trauma in general had very little influence on civilian psychiatric practice after the Armistice (Merskey, 1991). While many veterans remained in military hospitals from shellshock after the war (Gabriel, 1987), the psychiatrists returning from the battlefield to civilian practice seem to have packed away the idea of shellshock along with their khaki uniforms, and seldom generalized the phenomenon to the general public. This may sound surprising at first. Two considerations, however, may make this situation more understandable to modern eyes.

The first is the power of psychoanalytic conceptualizations of mental disturbances in the years between the wars (van der Kolk, Weisaeth & van der Hart, 1996). As discussed above, Freud and his disciples concentrated on intrapsychic issues and often regarded the patient’s accounts of experiences, whether considered as objectively true or not, as either illustrative of the patient’s psycho-sexual development or merely irrelevant.

The second consideration is that the generalization from the context of the trenches of the First World War to the context of peacetime civilian life may have seemed a far greater leap to the psychiatrists of the day than it would now. Many of the experiences which are considered psychologically traumatic today had very little attention paid to them in the first half of this century. For instance, the sexual abuse of children, often spoken of as the psychological trauma without parallel, was a topic of little concern in those years. Much of the pioneering work of 19th century writers on the topic, like Tardiue (see Masson, 1984 for a description of the work and
reputation of this French pioneer in the study of child sexual abuse), had been forgotten. When the topic of sexual abuse was broached at all, the pervasive influence of the psychoanalytic viewpoint would more often than not frame it into a question of repressed Oedipal wishes.

The sexual assaults of adults, another paradigmatic psychological trauma, was earlier in this century a far narrower category than it is today. Rape within marriage was considered by some to be an oxymoron, and by others a husband’s prerogative. What some late 20th century writers would characterize as “date rape”, would have simply been put down to ungentlemanly conduct on the part of the man and/or insufficient, and likely suspect, resistance on the part of the woman. It might well be construed as an unfortunate incident, or perhaps a foolish or immoral woman’s just desserts, but never as a crime or an experience with long-term psychological sequelae. Many other behaviors currently seen by some as sexually assaultive, such as lewd looks, sexual propositions ‘sent down’ a social hierarchy, the posting of risqué cartoons, suggestive humor, and the like, would likely be construed, depending on the social context, as either a sign of remarkably poor breeding or simply the way of the world. And even within that narrower category of sexual assault that would still be considered “rape”, the criminal justice systems in place, and their typical reactions to allegations of sexual assault, would make many a victim reluctant to come forward. The result of all this was that the issue of sexual assault and its effects was not of much concern to psychiatry, or, all too often, even the legal system.

Other experiences considered as traumatic today, kidnappings, violent robberies, terrorist attacks, the witnessing of violence against others were, on the whole, not in the common experience of the middle and upper classes in peacetime that would have been the focus of psychiatry in the first half of this century. Of course, it is likely that many people would have witnessed in their own home incidents of what we would now term domestic violence; primarily husbands
assaulting their wives and the corporal punishment of children. However, such actions would be considered either a private family shame or merely normal discipline, albeit discipline perhaps conducted somewhat over-enthusiastically.

Thus drawing a parallel from the reactions of troops to the horrors of trench warfare to peacetime civilian life would have seemed a far greater leap to psychological and psychiatric writers of the first half of this century than it would to us today. It is unfortunate that our darker view of life is probably the more accurate viewpoint.

4.4 Abram Kardiner and the Second World War
While the work on psychological trauma from the First World War was not generalized to the civilian population, it was not completely forgotten in the years between the wars. The treatment of World War I veterans still affected by their experiences during combat necessitated that some clinicians remain concerned with the effects of psychological trauma. Perhaps the single most important of these was the psychiatrist Abram Kardiner. Originally very traditionally Freudian in his outlook, his training analysis having been with Freud himself, his work with American First World War veterans beginning in the early 1920s led him in a very different direction from orthodox psychoanalysis. He construed his patients as having a "traumatic neurosis". This traumatic neurosis was characterized by a physical and psychological tendency to act as if the trauma were still happening. The veterans' mental and physical reactions to everyday life were frozen in the pattern of responses they had had to the trauma of the war. Central to this rigid, repetitive reaction to a now absent trauma was dissociation (Kardiner, 1941).

Kardiner's work, especially his concerns over the physical and psychological reactions to trauma events persisting past the duration of trauma, greatly influenced the mental health treatment of servicemen traumatized by the Second World War (van der Kolk, Weisaeth & van der Hart,
At first, many authorities thought that prophylactic methods could avoid the high psychological casualties that plagued the First World War; a natural enough belief given the intellectual trend of viewing such psychological casualties as caused more by individual weakness rather than the horrors of the situation. For example, upon their entry into the war, the Americans instituted stringent psychiatric screening procedures of inductees designed to weed out those who might not hold up to the stress of combat conditions. These screening procedures resulted in the rejecting of 18.5% of all volunteers and draftees, almost seven times higher than the American psychiatric rejection rate of the First World War. Despite these precautions, rates of World War II American servicemen being removed from duty for psychological reasons were also seven times higher than their First World War counterparts (Gabriel, 1987).

This reinvention of the wheel, the disregard of the lessons learned in the First World War and starting from scratch, that characterized the mental health profession's response to the effects of psychological trauma on Second World War has been the subject of much remark (e.g., Brett & Ostroff, 1985; Herman, 1992; Horowitz, 1976; van der Kolk, Weisaeth & van der Hart, 1996). But while the lessons of the First World War concerning the effects of trauma were being relearned, the Second World War supplied a new lesson as well. The systematic and horrific maltreatment and murder of millions of civilians in the "Final Solution" by the Nazis gave the study of the effects of trauma both vast new amounts of material to examine and a new urgency. For the next decades, right up to the present day, the study of those who survived, at least physically, the Holocaust (e.g., Eitinger, 1964; Eitinger & Strøm, 1973; Hocking, 1970) has provided a wealth of knowledge concerning human reaction to trauma. Research efforts exploring the sequelae of trauma may have slowed down with the defeat of the Axis Powers, as is so often the case in peacetime, but the survivors of the Final Solution have been a near
constant focus of scientific inquiry. Diabolic abuse perpetuated on such a scale perhaps assured that some of the lessons of the Second World War, unlike the lessons of the preceding conflict, were etched on the slate of psychiatry, not with a stick of chalk, but with a razor.

DSM-I (1952), influenced by the work that came out of the Second World War, contained the diagnosis of "Gross Stress Reaction", a response to a severe traumatic event that, if persisting, may lead to a neurotic reaction. DSM-II (1968) did not retain the Gross Stress Reaction diagnosis but rather contained the diagnosis of "Transient Situational Disturbance" which, as the name suggests, was far less concerned with long term reactions to trauma (Tomb, 1994). As well, Gross Stress Reaction was concerned with unhealthy reactions to only the most severe trauma. Transient Situational Disturbance, on the other hand, had a far wider scope of possible triggering traumatic events (Gersons & Calrier, 1992). Both Gross Stress Reaction and Transient Situational Disturbance, however, were considered manifestations of individual vulnerabilities to unhealthy reactions to trauma (Yehuda & McFarlane, 1995). Like the degeneracy theorists' attempts at explaining shellshock, this was a diathesis and stress model in which the traumatic event was merely what activated the individual's predisposition for the disorder. The Second World War may more firmly established trauma in the psychological canon but it did little to alleviate the stigma of that trauma.

4.5 Vietnam and PTSD
It is widely held that the United States' experience of the Vietnam War served to orient clinical attention away from individual vulnerability to the traumatic event itself and also to reorient that attention back to long term effects of trauma (Figley, 1978). The Vietnam War differed from prior conflicts in many ways. First, the war did not require the mass mobilization of American forces, thus a quick return to the front lines was no longer a necessary goal of the psychiatric
treatment of traumatized soldiers (Healy, 1993). In addition, the picture of combat-related stress reaction during the Vietnam War differed greatly from previous American military enterprises. During the 1960s, the rate of psychological casualties of American troops serving in Vietnam was less than a tenth of the rate of American servicemen in the Second World War (Bourne, 1970). This was at first attributed to increased knowledge, and improved prevention, of stress reactions during combat. This may instead have been a product of both the innovation of the standard 12-month rotation from active duty, and of the increased use of drugs, both prescription and illicit, by American troops (Goodwin, 1987). Whatever the cause, these rates remained low for much of the war and did not begin their tremendous rise until the Americans began their withdrawal from Vietnam (President’s Commission on Mental Health, 1978). Again, the speedy restoration of the relatively few traumatized servicemen to active duty was not a major issue for much of the war. Given this fundamental difference, as compared to previous wars, in the responsibilities of clinicians to the war effort, the idea that some experiences were inherently intolerable may well have seemed a far more acceptable thought to mental health professionals.

In 1970, the "rap group" movement was started in New York by the psychiatrists Chaim Shatan and Robert J. Lifton in tandem with the organization Vietnam Veterans Against the War. This informal format of returned servicemen discussing their war time experiences together soon spread across the United States (van der Kolk, Weisaeth & van der Hart, 1996). Shatan and Lifton’s thoughts on trauma had been primarily influenced by Kardiner’s work with First and Second World War servicemen, and the picture of the Vietnam veterans’ signs and symptoms thought to be due to trauma that came out of the rap group movement was very similar to Kardiner’s descriptions of his patients’ “traumatic neuroses” (Andreasen, 1980). The growing need for the treatment of traumatized servicemen during the final years of the war
and after the American withdrawal, without the pressure of returning those servicemen to the front, was coupled with a rather unique atmosphere of public opinion. Much of the American public’s vocal opposition to the war in South East Asia (Jacob, 1987) could not help but bolster the idea that many of the traumatic experiences of the American military personnel during the Vietnam War were innately damaging.

Many clinicians who were treating civilian victims of trauma found similarities between their patients’ condition and those of emerging from the rap groups of the Vietnam veterans, and this emerging picture of a debilitating but natural reaction to intolerable events eventually became construed as a distinct disorder (Goodwin, 1987). Perhaps the single most important advocate of this point of view was Mardi Horowitz who in a series of publications (see Horowitz, 1973; Horowitz, 1974; Horowitz, 1976) argued for the existence of a distinct “general stress response syndrome”, irrespective of individual diatheses, in reaction to unexpected and menacing events.

Horowitz claimed that this response could be elicited by many different forms of trauma, and that similar symptomology could be found in such varied samples as combat veterans, Holocaust survivors, victims of the nuclear bombings of Hiroshima and Nagasaki, and rape victims (Brown, Schefflin & Hammond, 1998). The broad modern concept of victims of psychological trauma was starting to develop. Informed by Kardiner’s work (Brett, 1996), and politically propelled by both those who were treating victims of civilian and military trauma, and the victims themselves, Post Traumatic Stress Disorder was listed in the DSM-III in 1980.

This is not to say that epidemiological research has found PTSD to be an inevitable response to trauma. For instance, it has been found that Vietnam veterans had a current PTSD prevalence rate of 15% and a lifetime PTSD prevalence rate of 30% (Kulka, Schlenger, Fairhank, Hough, Jordan, Marmar, & Weiss, 1990). Other epidemiological studies of ‘at risk’ populations, such as
veterans, disaster victims, and the like, have ranged in their findings of lifetime prevalence of PTSD from 3% to 58% (American Psychiatric Association, 1994). It does however imply that the original developers of the diagnosis viewed the development of PTSD as essentially a natural, if not invariable, reaction to trauma (Yehuda & McFarlane, 1995).

Another innovative characteristic of the new classification was the diagnostic emphasis on symptoms rather than signs. Much of the definition of the disorder is based on the sufferers’ subjective experience. For example, diagnostic criterion B is concerned with the patient’s re-experiencing of the traumatic event and four out of five of the sub-criteria are based on the subjective experience of the patient (American Psychiatric Association, 1994).

Both the framing of the disorder as a normal response to a traumatic experience (but one still in need of treatment because of its distressing or debilitating effects) and the focus on the patient’s subjective experience of the disorder were unique in modern psychiatric taxonomy (Healy, 1993). PTSD, unlike most disorders, does not carry the stigma of mental illness and the diagnosis is dependent, on a large part, on the patient’s accounts of subjective states, his or her symptoms, and does not rely overly on objective signs. As every undergraduate is rightly taught to refrain, correlation is not causation. But the lack of stigmatization and the primarily symptom-based, as opposed to sign-based, diagnosis of PTSD might well have contributed to the current situation where PTSD has been consistently broadened as a concept over the last ten years. This broadening of the concept has included even reactions to job stress and the awareness that others have been traumatized as well as milder ‘sub-clinical’ variants of the disorder (Tomb, 1994). If almost anything unpleasant can lead to a non-stigmatizing condition that is diagnosed primarily by the inferred subjective state of the patient, the diagnosis of PTSD could be one of troublesome reliability and specificity.
Interestingly enough, much current research on PTSD, while supporting the contention that it is a distinct entity, does not support its original conceptualization as the debilitating effects of a normal response. Rather findings point to an atypical response to trauma that leads to a progressive sensitization of biological systems resulting in hypersensitivity to various stimuli (Yehuda & MacFarlane, 1995). This is, of course, strikingly similar to Kardiner’s (1941) formulation of “traumatic neuroses” with their core of a physiological “lowering of the threshold of stimulation” and a psychological “state of readiness for fright reactions”. These results have been greeted with discomfort by many authors who seem to feel that many of the social gains of victims in the last few years depend, at least in part, to their ‘non-pathological’ diagnosis (Yehuda & MacFarlane, 1995). Indeed it is still very common for clinicians and researchers to stress the ‘normality’ of PTSD in their publications (e.g., Herman, 1992; Matsakis, 1992; Marmar, Foy, Kagan, & Pynoos, 1994).

Controversy also exists as to how PTSD should be classified. In the three editions of the DSM that have included PTSD, it has been included among the anxiety disorders. Those that hold that PTSD is best considered an anxiety disorder (e.g., Jones & Barlow, 1990) point to the intrusive cognitions and imagery, avoidance behaviors, and heightened arousal and vigilance found in both PTSD and anxiety disorders as well as similarities in genetic and psychological diatheses, and treatment prognoses. Some critics posit that PTSD should be placed in a new stress disorders category thus further emphasizing the normal, albeit debilitating, reaction to an unhealthy stimulus thought to be the core of the disorder by its originators (Brett, 1996) a point of view, as mentioned above, not borne out by current research.

However, another dissenting viewpoint holds that PTSD should be included among the dissociative disorders. Proponents point to the many dissociative symptoms found in those with
PTSD and even go so far as to propose that development of PTSD is dependent on the victim dissociating (Spiegel & Cardeña, 1991). This is certainly a line of thought with a long and impressive tradition. Since the beginnings of the modern conception of psychological trauma, from Charcot (van der Hart, 1993), through Janet (van der Kolk, van der Hart & Marmar, 1996), to Kardiner (Kardiner, 1941), dissociation has been regarded as the core of debilitating reactions to trauma.

This recurrence of dissociation is one of the few constants in the varied literature on psychological trauma. Regardless of the controversy over the classification of PTSD, the robustness of the correlation between dissociation and trauma may be an indication of a finding that is independent of the often radically shifting academic and clinical views on the subject of trauma.
5 From Victimization to Victim-hood: The Changing Social Meaning of Psychological Trauma

PTSD entered the official psychiatric diagnostic system at a time when societal attention had turned to focus on the issues of victims and victim-hood. Myriad organizations and movements had sprung up to address the needs of victims in what has been termed “the victim’s movement” (Dershowitz, 1994). Modern scholarly concern with victims is largely thought to have had started with the work of Beniamin Mendelsohn in the late 1930s (Karmen, 1984). Victimology, a term coined by Mendelsohn, focused its first few decades on the effects of the crime on the victim, the relationship between offenders and their victims, and various attempts at victim typologies. At first the political leit motiv of much of victimology was informed by the headily optimistic atmosphere of the late 1940s. Inspired by the defeat of the Axis powers, the founding of the United nations and the like, many people, scholars included, felt that much, if not all, of society’s problems could be solved if only enough effort and attention was paid to them (Elias, 1986). However, the United Nation’s police action in the Koreas and the escalating tensions of the Cold War soon allayed much of this faith in human nature and progress. Victimology’s focus also changed, perhaps reflecting this shift in the culture as a whole, toward an emphasis on a crime as an interaction between the criminal and the victim. This had been an idea that had been within victimology since the beginning, dating all the way to Mendelsohn’s writings but it soon became the field’s primary point of view throughout the 1950s and 1960s (Karmen, 1984).

Attention to victims from non-academic quarters only really began in the early 1970s. This attention came from several disparate movements such as advocates for the rights of such disenfranchised groups as the elderly, gays and lesbians, and children, as well as consumers’
rights groups. The two movements that seem to have paid the most attention to victims and who perhaps have had the most impact on changing public attitudes however, were the conservative ‘law and order’ movement and feminists (Elias, 1986). These two movements, while differing widely on most points, found the traditional legal and academic concern, or perhaps lack of concern would be more accurate, over victims of crime unacceptable.

The conservatives viewed the justice system as ‘soft on criminals’ in general. The Western legal tradition of crime as an offense against society and not the victim per se was often seen as contributing to an impersonal attitude to the crime which could then lead to inappropriately lenient verdicts and sentences. Personalizing the crime by paying attention to the victim could be a way of ensuring more severe, and to these conservative thinkers’ minds, more appropriate, penalties (Karmen, 1984).

The feminist point of view on victims was far more focused. Women who had been victims of sexual assault or domestic abuse found themselves particularly ill served by the criminal justice system as well as many mental health authorities. In issues of domestic assault, the legal system was often loath to interfere in matters between a husband and wife. This doubtlessly stemmed in part from a Western cultural distaste for the state to involve itself in issues within the home. Cultural issues regarding sexuality and gender power relations complicated the legal response to sexual assault as well. Women had not been viewed legally as chattel in the Western nations for decades and thus rape, despite the derivation of the word, could no longer be viewed as a property offense against a woman’s husband or family. Transferring the ‘victim-hood’ of the crime from the woman’s closet male relatives to the woman herself, however, did not mean that the perceived positive credibility of the former ‘victims’, the male relations, was passed on to the latter victim, the woman. Western legal tradition had long considered women inherently
unreliable (Wigmore, 1880). Common-law considered the corroboration of a third party (the same requirement as for case where the victim was a child or an accomplice in the crime) necessary for conviction in cases of rape (Begin, 1987). As rape was, at the time, considered a sexual act and not a necessarily a violent one, it was perceived as a crime not because of the act per se (sexual contact) but rather because of a lack of informed consent. Thus, the issues of reliability and corroboration become even more complicated and complex. The question was often not so much as “What actions happened?” as “What did those actions mean to the two people involved?” This task, difficult to do accurately at the best at times, was made even more so by a systematic framework that even the most politically incorrect might find misogynistic. For example, one of the most widely cited (Karmen, 1984) studies of the day on rape victims, an examination of the files of the Philadelphia police department for 1958 and 1960, concluded that 196 out of 646 (30%) forcible rapes to be ‘victim precipitated’. Victim precipitation was operationalized in a very wide manner indeed and included having agreed to go out with a drink with the rapist prior to the attack, not objecting in a strong enough manner to suggestive language, dressing or acting, in the opinion of either the police or the accused rapist, in a provocative manner and the like (Amir, 1971). Given the existence of such attitudes, it should be no surprise that many women rape victims found themselves unwilling to even report the crime to the police for fear of the insult of systematic trauma being added on the injury of their sexual assault (Solicitor General of Canada, 1985).

The legal response to both sexual and domestic assault can also be impeded by purely practical difficulties. They are acts that tend to be done in private and the only two ‘witnesses’ the accused and the victim are unlikely to agree on what happened.

As described above, the reaction of mental health professionals to these problems ranged at the
time from simple disbelief to calm assertions that the victims had unconsciously desired and precipitated their own physical or sexual assault.

As perhaps is typical for the feminist movement, these women, perceiving a problem, initiated their own solution. The founding by feminist groups in 1972 of the first rape crisis centers in both Berkeley, California and Washington, DC has been described as the “first grass-roots efforts to help crime victims” (Karmen, 1984). Much of their work was dedicated to changing the perceptions, of both society in general and the legal system in particular, of rape from being viewed as a sexual offense, with all the concomitant difficulties, to a violent or assaultive one. The results of their efforts are reflected in the very name of the offense in the current Canadian Criminal Code. Bill, C-127, read into law on January 4, 1983 changed the offense from one of rape to one of sexual assault. Similar reforms were made in the laws of most other common-law countries during the 1980s (Elias, 1986).

Soon afterwards, much of this grass roots movement, perhaps quite naturally, turned its attention to abuse women suffered in the home, as well as abuse women had suffered as children, and the current abuse of children (Karmen, 1984).

Feminist thought on victims has thus largely been a reaction to the criminal justice and mental health systems. Both these systems that often either disbelieved victims’ accounts or, if believed, discounted the negative effects of their victimization. As might well be expected, the central weaknesses of much of the feminist framing of the issue of victim-hood could be characterized as mirror images of the problems of the legal and mental health systems in framing the same issue. Much feminist writing on the subject of sexual assault has affirmed an almost wholly uncritical acceptance of the veracity of women’s allegations. Equally uncritical has been the accumulation of asserted, and assorted, sequelae of past abuse. It has been proposed, or
rather, given the uncritical content of much of this writing, 'identified' as an etiological agent of a lack of sexual desire, of a surfeit of sexual activity, substance dependence, over-emotionality, under-emotionality, various Personality Disorders, Eating Disorders, Mood Disorders, ad astra (Bass & Davis 1988).

This 'reactionary' point of view on psychological trauma could be described as a general trend in taking blame from the victim, and placing it on the traumatic experience. The current wide use of the term survivor as opposed to victim, points to this fundamental shift in the perception of psychological trauma. This trend is echoed in scholarly writings, for example the view of many writers that PTSD is a normative response to traumatic experience (see above).

To the military psychiatrists of the First World War, the trenches were a testing ground, where so many men were found wanting. To those who espouse the survivor movement, it was the abuse, the psychological trauma, that is found wanting. ‘Survivors’ may be perceived as being harmed by the experience, but by definition, they cannot be seen to have been destroyed by that experience. The trauma may have been horrific but it was not up to the task. This could well lead to sincere but exaggerated accounts. Anecdotes of experiences that were both grueling and formative often tend to grow in the telling.

But the issue here is far more complex than the simple and common embellishment of accounts of past hard times. Victimization as it is currently perceived by many could be described as a 'panaitia', from aitia, Greek for cause, the root of the English word etiology, and thus the opposite of panacea. Putting aside the question of the validity of these assertions, the proposition that past abuse can be used as an explanation for almost anything, while diagnostically meaningless, can be very meaningful in a personal sense. Victim-hood can account for every negative aspect of a person’s life. The existentialist dilemma may often seem rather tired and
overused, but cliché or not it still gnaws at our culture's vitals. In a seemingly cold and random world where God, the first cause, is long dead, even finding 'the root of all evil' can be a source of some comfort. This comfort could be shared by both genuine victims and para-victims. The power of a myth does not depend on its objective truth, only its psychological truth.

The power of this explanatory aspect of modern victim-hood is not merely a way to avoid some of the discomfort of the existentialist dilemma, it can also carry a great deal of narrative truth. For instance, Haaken (1994, cited in Brown, Scheflin & Hammond, 1998) sees allegations by adults of past sexual abuse as the sole socially sanctioned narrative for women to construe injury to their development. The nature of the actual injury does not have to be sexual victimization. But the expression of that victimization must be in sexual terms for it to be understood and appreciated.

Haaken may have a valid point concerning the social sanctioning of the incest narrative; Few forms of victimization of children galvanize our reactions like sexual abuse. Nonetheless, a further point may be in order. Many forms of the victimization of children, of injuries to their development (for both boys and girls), are very nebulous in nature. For instance, it can be very hard to capture a childhood full of polite emotional neglect, or random punishment and praise, or subtle psychological abuse, in a pithy phrase. To briefly resort to the use of metaphor, many of our life long wounds are not great yawning gashes. Rather they are often startlingly fine and elusive lacerations, intricately worked within us, like those of the First World War servicemen killed by the concussions of shells. Such subtle lesions do not lend themselves to simple accounts.

And we are now becoming a people, not so much of the word any longer, but of the image. The literate, verbal context of middle class 19th century Europe, within which, for instance, Freud
developed his ideas, is no longer (Steiner 1976). The West has forgotten its classical heritage, and with it much of the language needed to explore and discuss such complexities as being true to both our essences and historical truth. Yet, we so much need to speak of our injuries. Our culture has a story, available in suitably simple versions, that captures the old pain, the current incapacity, and the lost possibilities. This story contains simple accounts of actions, such as the sexual abuse of a child or other experience commonly accepted as abusive, and carries a commonly accepted meaning, that the experience has damaged the victim and that damage may last that victim’s entire life. This story reflects both the objective and subjective realities of far too many people. With many others, however, the story has nothing to do with objective reality but captures the essence of their subjective reality.

Identification as a victim can also be used as an excuse for not taking personal responsibility. This aspect of the ‘secondary-gain’ of victim-hood has received much attention from many social critics. Unfortunately much of this attention has tended to bombastic generalities that likely far overstate the point. For instance, Dershowitz (1994) has described the sex abuse survivor literature as providing “abuse excuses”. Ofshe and Watters (1994) have characterized psychotherapy patients as “victims in training”. Statements such as these have been characterized as ‘victim blaming’ (Karmen, 1984) and symptomatic of a backlash against the gains made in recent years by women, children and other victims. (Armstrong, 1994). Once again, however, we must be wary of inferring unspoken motivations. But regardless of the authors’ possible motivations, such sweeping and inflammatory remarks add much heat but little light to the debate.

Nevertheless, the temptation of an equally uncritical reaction to such statements should be resisted. It could well be that many people depend on past victimization to relieve themselves of
personal responsibility for the present and future. The likely over use of the diagnosis of PTSD and the lack of a social stigma attached to the condition would certainly exacerbate this problem. The identification of oneself as a victim can be a powerful origin myth. And once more, the potency of that myth does not depend on the objective truth of one’s victimization but only on one’s identification as a victim. Unfortunately, while myths can be used to inspire, they can also be used to oppress. The bribe of Heaven and the threat of Hell has kept many a society’s status quo intact. Within the individual too, the power of a myth can serve to inhibit positive change. This is, of course, not always the case, victim-hood as an origin myth could equally serve to motivate and empower; It is not necessarily a ‘crutch’, and can serve as a ‘ladder’. This could be even the case for some para-victims. But the facile dismissal of criticisms of “the victim movement” as mere examples of an anti-victim backlash begs the question of the effects of our culture’s ideas concerning trauma on both victims and those who may believe themselves to be victims. The staggeringly wide range of problems that victimization is thought to account for, by both much of the public and many professionals, can make the daunting and unpleasant task of sincere introspection eminently avoidable (Hughes, 1993). Why perform a slow and painful examination of your motivations when a simple explanation, that guarantees the blame being placed elsewhere, is readily available? The social meaning of victim-hood has thus gone from invisibility, through stigma, to origin myth.
6 Hysteria Reconstructed: Has the Shift in the Meaning of Trauma Influenced the Expression of Symptomology?

As stated above, victimization is a cardinal issue in criminal law and the effects of psychological trauma certainly fall under the province of Psychology. May the shift in meaning of psychological trauma over the last century, from being an innovation, through being a stigma, to, currently, being an origin myth, have some implications for the overlap of law and psychology?

Historical shifts in the expression of symptomology have been a well documented (e.g., Kirmayer, 1984; Neill, 1993; Murphy, 1978; Shorter, 1986), albeit seldom cited, phenomena. Our culture’s changing ideas concerning the meaning of being a victim may have had an influence on how certain mental disorders are expressed.

If in fact the shifting in meaning of psychological trauma has influenced the expression of symptoms, it is likely that this influence might be seen most clearly among the disorders that were formerly subsumed under the category of hysteria: Borderline Personality Disorder, the 'Histrionic Personality Disorder certainly also captures some of the interpersonal behaviors characteristic of hysteria. However, it is becoming a seldom used construct. For instance, a recent search of a popular psychological abstracts database revealed only two articles concerned with Histrionic Personality Disorder. Histrionic Personality Disorder can be very hard to distinguish from Borderline Personality Disorder (Pope, Jonas, Hudson, Cohen, & Gunderson, 1983). This may account partly for the current neglect of Histrionic Personality Disorder. The DSM IV differentiates between the two disorders on the basis of the Borderline's “self destructiveness, angry disruptions in close relationships and chronic feelings of deep emptiness” (APA, 1994, P. 653). That is, exactly what might bring a patient to the attention of mental health professionals. This confusion between the diagnoses of Histrionic and Borderline Personality Disorders is especially true with female patients. Male patients, on the other hand, often have a comorbidity, or a confusion between the diagnoses, of Borderline Personality Disorder and Antisocial Personality Disorder. This is often interpreted as Antisocial Personality Disorder and Histrionic Personality Disorder being manifestations of identical or similar pathologies. The differential gender diagnoses are regarded as reflections of the different manifestation in each of the genders due to either socialization and or biology, and perhaps to differences in perception of the diagnoser (e.g., Pope, Jonas, Hudson, Cohen, & Gunderson, 1983; Warner, 1978; Warner, 1979; Kroll, Sines, Martin, Lari, Pyle & Zander, 1981). Antisocial Personality Disorder too, has long been a problematic diagnosis and many (e.g., Hare, 1996) have argued that it simply attempts to pathologize criminal behavior and ignores the core interpersonal and affective components of the Hare/Cleckly construct of the classic psychopath. It may be that many of those given the diagnosis of Histrionic Personality Disorder may simply be Borderlines with...
Factitious Disorders, and the Somatoform Disorders (Hare, 1991).

The use of the overarching term hysteric, should not be interpreted as a dissatisfaction with the current DSM-IV nomenclature or a call for the ‘reunification’ of these various disorders. Neither is this an argument that all of these disorders lie on a continuum. The argument that these disorders represent differing levels of severity of a single condition seems obviously untenable. What is more ‘severe’, Conversion Disorder or Borderline Personality Disorder? It is merely that the commonalties, or family resemblance, between all of these disorders are all classically ‘hysteric’. For example, Nadelson (1979), examined Munchausen’s syndrome patients on their severity of symptoms and their adherence to Asher’s original (1951) criteria. He found that as severity and prototypicality increased, so did borderline pathology. The conspicuous resemblance between the core characteristics of the ‘classic’ borderline; the dramatic excesses, the mendacity, the emotional lability, and the constant search for attention, and those of the ‘archetypal’ factitious patient, is hard to deny. Indeed, it has long been noted that there is a very high co-morbidity rate between the Factitious Disorders and Borderline Personality Disorder (e.g., Bauer & Boegner, 1996; Folks & Freeman, 1985; Hudziak, Boffeli, Kriesman, Battaglia, Stanger, & Guze, 1996).

But not only are the commonalties among all these disorders all classically hysteric, these commonalties are also what makes these disorders relevant to the current topic. Hysteria has long been noted as a particularly plastic disorder, and one particularly sensitive to shifting socio-cultural currents (e.g., Critchley & Cantor, 1984; Veith, 1965). While many of the interpersonal behaviors, the signs if you will, of the hysteric, such as the theatricality and the splitting, seem to better than average ‘adjustment’ (for borderlines), while others may be merely female criminals while still others may be female psychopaths. Regardless of such speculative matters, however, given that Histrionic Personality Disorder is both a seldom used and a troublesome diagnosis, it will not be explored further in this paper.
remain constant over cultures and historical periods, many of the symptoms, such as non-organic blindness, paroxysms, glove anesthesia, *globus hystericus*, and the like, seem to almost go in and out of fashion.

However, while hysteric symptomatology is often mutable, it is seldom, if ever, meaningless. The clinical tradition, dating back to Charcot, of describing an hysteric patient's symptoms almost as if one were critiquing an artistic performance, analyzing the symbolic content of the symptoms, is likely more than a simple reflexive response to the overwrought dramatics of such patients. Rather the exaggerated displays and unfounded complaints of the hysteric are often laden with meaning. The critical, interpretative, response is often thought to lead to a understanding of the symbolism of the patient's symptoms, for instance, "glove anesthesia" denoting a feeling of helplessness.

The therapeutic utility of such interpretations is beyond the scope of the present paper. However, the long standing clinical observation, that these symptoms are not simple shamming or rebelling but rather gestures invested with a great deal of unconscious personal significance, is very relevant to the topic at hand. This is especially true given the widely held opinion, stated above, that hysteric symptomatology shifts with the passing of time and changes in society, taking "on the colors of the ambient culture and mores" (Veith, 1965). Identification of oneself as a victim (or 'survivor' of victimization), regardless of the objective truth of that account, has become one of the most meaning laden roles one can assume. If hysterics do indeed use the hues available on the current cultural pallet to paint their symptomatic picture, it would seem almost unthinkable that some would not make use of the range of colors now thought to be illustrative of past victimization.

However, at first glance, it would seem that there is a glaring difficulty with the suggestion that
false or exaggerated accounts of past victimization may be a 20\textsuperscript{th} century analog for the lassitude of Viennese bourgeois matrons and the seizures of the inmates of the Salpêtrière. The hysteric symptomology of the 1800s consisted primarily of complaints of physical sensations, or perhaps more often, the lack of physical sensations. Currently, prior psychological trauma may be at least as meaningful as physical disability was 100 years ago, but are memories of past events open to as much (incorrect) interpretation as physical sensations?

Two sets of issues that are intertwined through much of the hysteric family of disorders may help illuminate how spurious past psychological trauma may serve a similar purpose as specious physical symptoms: pseudologia fantastica, and the interrelated issues of dissociation and suggestibility.

6.1 Pseudologia Fantastica

Both Borderline Personality Disorder (Snyder, 1986) and the Factitious Disorders (APA, 1994) have been associated with pseudologia fantastica, the seemingly uncontrollable, and motiveless production of lies. There are two major issues that arise in any discussion of pseudologia fantastica: conviction and motivation.

The question of whether or not the pseudologe actually believes in these often-elaborate false stories is a question on which there has been very little agreement. For example, both Bleuler and Schneider thought of them merely as prolific liars, Jaspers held that pseudologes come to accept their falsehoods as their reality and Hoyer placed their conviction in a no-man's land between mendacity and delusion (Kerns, 1986). The APA’s current Diagnostic and Statistical Manual only mentions pseudologia fantastica in the context of the Factitious Disorders and there it seems firmly in the camp of Bleuler and Schneider regarding the conviction of the pseudologe. Yet, the DSM-IV also allows for the presence of both unintentional and intentional spurious
symptoms in the same patient, a situation leading to a dual diagnosis of both Somatization Disorder and Factitious Disorder (APA, 1994), two disorders that are differentiated on the basis of the patient’s conviction (see below). This is surely a testament to the grave difficulties often inherent in assessing conviction in others, if not ourselves.

Indeed, is faith in a clear demarcation warranted between belief and disbelief? To even address this question we must resort to rather untraditional tactics for academic psychology. We are, after all, speaking of the patient’s internal world. This is a realm where our usual tools of correlational research and group differences fail. The problem of differentiating between the Factitious Disorders and the Somatoform Disorders, is a particularly illustrative example of the difficulties inherent in assessing levels of conviction.

According to the DSM-IV, “Factitious Disorders are characterized by physical or psychological symptoms that are intentionally produced or feigned in order to assume the sick role” (p.471). The Somatoform Disorders, on the other hand, are distinguished from the Factitious Disorders in terms of conviction 13. Sufferers of Somatoform Disorders involuntarily present symptoms that are suggestive of a medical or psychological condition while not actually having any condition that might account for these symptoms.

Assessing conviction, the dimension dividing these two categories is obviously problematic. As Jonas & Pope (1985) have stated, it requires diagnoses to be made based on suppositions of patients’ objectives and levels of conscious awareness, as well as a simplistic dichotomization of unconscious and conscious processes. In their research they have found little difference on a variety of variables between those with Conversion Disorder, those with Factitious Disorders,

13 It may be argued that the Somatoform Disorders are differentiated from the Factitious Disorders based on motivation. The DSM IV clearly states that the motivation for those suffering from the Factitious Disorders is to
and even simple malingers. Given the difficulties inherent in differentiating Somatoform Disorders from Factitious Disorders, and therefore the distinct possibility of mis-classifying patients, some researchers have abandoned all attempts to tease these disorders apart. For instance, Teasell & Shapiro (1994), have simply decided to describe their subjects as having a “chronic nonorganic” paralysis.

If the current methods of clinical assessment and scientific research do not seem up to the difficulties inherent in questions of conviction, our remaining recourses seem to be that of, possibly unreliable, personal experience and the, perhaps equally unreliable, cultural experience of philosophy and literature. Given these precautions however, it is clear that there are many things that people either distinctly believe or disbelieve. But the reality of black and white does not preclude the existence of shades of gray, and there are many things that some may not so much doubt as believe intermittently. This intermittent belief may encompass not only trivial or seldom considered matters but issues, such as the possibility of romantic love or the existence of God, that can be of the utmost personal importance. Equally important is the question of whether the pseudologe’s belief or lack of belief can be ascertained by another. If the pseudologe does not admit to the deception what other recourse does one have? Even the discovery of clear

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14 However, difficulties in differentiating between two conditions does not necessarily imply that the two conditions are identical. Certainly, there is some evidence that response to treatment differs between those with Somatoform Disorder and those with Factitious Disorders. For example, hypnosis has been found to be effective in treating Conversion Disorder (Trieschman, Stolov, & Montgomery, 1970), but not Factitious Disorder (Berry, Hillis & Hitzman, 1994). Factitious Disorders, where it is thought that the simulation is conscious, tend to be diagnosed more frequently in males than females (American Psychiatric Association, 1994). Jonas and Pope (1985) suggest that this points to a gender bias on the part of the diagnosticians. This purported bias is thought to be due to an implicit belief on the part of the diagnosticians that women tend to be more at the mercy of unconscious impulses, while men are far more concerned with conscious goals. It may be possible that the fundamental difference between the Somatoform Disorders and the Factitious Disorders is not conviction. But rather, the difference may lie in how such disorders of symptoms without causes are manifested in each of the genders, or even how such disorders are perceived in each of the genders.
feigning, for example, obvious evidence that a Munchausen's syndrome patient disease has been self induced, or that a para-victim's wounds have been self inflicted, necessarily points to a complete lack of conviction only if the assumption that there is a clear dichotomy in conviction in this particular case is true.

It may be that the definition of conviction as a mere dichotomy between belief and disbelief in an account's objective truth may be far too simplistic. Indeed, the second overarching issue of pseudologia fantastica, that of the problem of the motivation of the pseudologe, may help illuminate the first overarching issue, the pseudologe's conviction. When pseudologia fantastica was first described by Delbruck in 1891 he simply meant pathological lying (Matas & Marriot, 1987). This has remained a common meaning of the term. However, an interesting elaboration of the definition of pseudologia fantastica, and one often used, was first made by Helene Deutsch (1921/1985); According to Deutsch, a pseudologe does not simply lie but rather treats psychological truth as if it were documentary truth. The falsehoods of the pseudologe, while not an accurate reflection of objective events, may mirror important subjective issues. To Deutsch, mere lying is a means to an end, pseudology, is an end in itself (Roazen, 1985 cited in Matsakis 1992). Thus the psychological meaningfulness of the pseudologe's false accounts may make them adhere strongly to them, i.e., present conviction, regardless of whether they are entirely convinced of their false account's objective truth.

The question of why someone would illegitimately, and thus needlessly, put themselves through the often unpleasant role of the victim in a criminal investigation when there is little or nothing to gain for their trouble, is a quite natural inquiry. Intrinsic motivation, by its very nature, is harder for others to appreciate than is extrinsic motivation. Avoiding an unpleasant fate, be it incarceration or a family dinner, can be easily suspected, and understood, by others. The pursuit
of an unpleasant fate in order to fulfill an idiosyncratic role is less likely to be suspected and certainly much harder to understand. The intrinsic rewards of pseudology, as compared to the extrinsic rewards of simple mendacity, can lead to behaviors that may be simply inexplicable to others. The understanding of the self mutilation in the pursuit of the presentation of false symptomology by someone with a Factitious disorder, or the impulsive choice of self destructive activities of those with Borderline Personality Disorder, requires an extensive knowledge of both clinical issues in general and the individual in particular. In the case of para-victims, understanding motivation also requires an appreciation of the current cultural meanings of victimization. As argued above, victimization can presently serve as an origin myth of great explanatory power. If pseudologia fantastica is indeed not merely uncontrollable mendacity but rather motivated by an impulsive tendency to construct a false history that nonetheless contains metaphors for many important interior truths, then inaccurate accounts of victimization would seem almost tailor made for the content of such truth permeated lies.

6.2 Dissociation and Suggestion
Along with pseudologia fantastica, exploring the interrelated issues of dissociation and suggestion may help explain how fictitious past psychological trauma may serve a comparable function in the late 20th century as non-organically based physical disabilities did in the 19th century. Dissociation is seen in both Somatization Disorder and Borderline Personality Disorder (APA, 1994). If a victim dissociates under stress, that victim's memories for the traumatic event will obviously be severely compromised. Brown, Scheflin and Hammond (1998) maintain that the core factor affecting suggestibility is uncertainty. People are far more likely to fall prey to suggestive questioning if they are uncertain of their answer because they no longer remember it.
clearly, or because they did not encode the information in the first place. In addition, those with Borderline Personality Disorder (Krohn, 1974; Rinsley, 1982), those with Histrionic Personality Disorder, and those with Factitious Disorder are often very vulnerable to suggestion (APA, 1994).

This could account for the core of truth often found wrapped in layers of falsehood in cases of para-victims. For example, a person afflicted with Borderline Personality Disorder is physically assaulted and robbed. During the mugging, he dissociates and thus has very little clear memory for the event. When giving his statement to the police, questioning that would cause no problem with someone with a clear memory for the robbery, is in fact quite suggestive for someone with a hazy memory for the event. The situation is worsened if the victim with Borderline Personality Disorder displays the common borderline characteristic of almost uncannily picking up on situational cues (Krohn, 1974; Rinsley, 1982) thereby increasing the suggestiveness of the questioning. If the victim also tends to pseudologia fantastica, like many with Borderline Personality Disorder, the situation is worsened still. Thus an actual victim can also become a para-victim.

This phenomenon is not necessarily limited to those with a psychological disorder. As we have seen, dissociation is a not uncommon reaction to trauma. If a victim’s memory for the traumatic event is compromised, there is always a danger that questioning that would be ordinarily considered non-suggestive for adults may be in fact quite suggestive.

To complicate matters further, there is much evidence to suggest that hysteria in general (Healy, 1993) and Borderline Personality Disorder in particular (Herman, Perry, & van der Kolk, 1989) may be caused by trauma. Despite widely shifting perceptions of trauma, it has been observed that psychological trauma has been a preceding (and hypothesized to be a precipitating) factor in
hysteric like symptomology in such diverse samples as 17th century Swiss mercenaries (Rosen, 1975), 19th century railway brain victims (Charcot, 1888/1988) and modern Israeli combat veterans (Solomon, Laror & McFarlane, 1996). In addition, it has been theorized that early trauma may lead to a debilitating, and often inappropriately extreme, reaction to later stressors (van der Kolk, 1989). It is theorized that this response includes a lowering of the threshold of stress necessary for dissociation to occur. If this is indeed the case then those who have undergone some form of psychological trauma early in life, whether they have developed some other form of psychopathology or not, may later find themselves dissociating during relatively mild traumatic incidences. Again, this dissociation may compromise their memory of the later traumatic incidents thus perhaps making them more vulnerable to suggestive questioning.

6.3 Victim-hood and Current Disorders
The present diagnostic system has divided the various symptoms of the classical hysteric into several different disorders. The current construction of Borderline Personality concentrates on maladaptive interpersonal behaviors such as the overly-dramatic cycle of idealization and devaluation, while the Somatoform and Factitious Disorders concentrate on the presentation of signs and symptoms without the appropriate organic causes. Thus, the objective signs of hysteria are the focus of Borderline Personality Disorder and the subjective symptoms are the province of the Somatoform and Factitious Disorders. As stated above, the signs of hysteria seem to remain constant while the symptoms seem to fluctuate with changes in cultural mores. How has our changing view of psychological trauma affected each of these separate disorders? How might the signs of hysteria, typified by the characteristics of Borderline Personality Disorder, interact with the forensic context? How might the symptoms of hysteria, currently construed using the
language of physical complaints in the Somatoform and Factitious Disorders, utilize the 
languages of the courtroom or the abuse survivor's self help book?

6.3a Factitious and Somatoform Disorders
As stated above, the dimension of conviction is an intriguing and complex question but one that 
may not be suited to the conventional tools of the psychologist. For the present it may be 
practical to put aside this question, and thus the differentiation between the Factitious and 
Somatoform Disorders, and examine the utility of both the literatures on Factitious Disorders and 
Somatoform Disorders together.

The Somatoform Disorders can be construed as the blending, and reconstructing in psychological 
terms, of hysteria, hypochondria, and some forms of melancholia, all of which had originally 
been considered physical diseases (Fabrega, 1990). The current classification concentrates on 
the expression of signs and the complaint of symptoms, in the absence of a medical condition 
that would account for those signs and symptoms, and does not focus on the interpersonal and 
affective facets once thought so indicative of the older disorders. For instance, the dramatic and 
shallow interpersonal behavior of the hysteric is now more a domain of the Axis II disorders 
while the despair and listlessness of the hypochondriac is now the province of the affective 
disorders (Hare, 1991). This focus on behavioral diagnostic criteria, which started with the 
DSM-III, has doubtlessly improved the reliability of diagnoses made with the DSM. It has also 
made the DSM classifications ostensibly free from theoretical assumptions or, perhaps more 
realistically, made those classifications more or less compatible with a wide range, although 
certainly not the complete range, of theoretical viewpoints. In this case however, it may also be 
true that the behavioral criteria chosen are too context specific.
According to the DSM-IV, there are three subtypes of Factitious Disorders, divided by the types of signs presented and symptoms claimed: Factitious Disorder with Predominately Psychological Signs and Symptoms, Factitious Disorder with Predominately Physical Signs and Symptoms (Munchausen's Syndrome), and Factitious Disorder with Combined Psychological And Physical Signs And Symptoms. The basis for this division is never explained in the DSM. It may reflect, for those with factitious disorders, the importance of the dualistic dichotomy between brain and body. The descriptive text describes those afflicted with factitious disorders as often presenting their alleged medical history and current problems with an overly dramatic flair and not infrequently exhibiting pseudologia fantastica. Both of these are of course classically hysteric symptoms.

The first contemporary description of a Factitious Disorder was Munchausen’s Syndrome put forward by Asher (1951). He used the eponym to describe patients who wandered from hospital to hospital, seeking medical treatment for a variety of spurious and or self inflicted disorders. These patients accounts of both their falsified medical histories, and their current fraudulent signs and symptoms tended to be couched with a dramatic flair. Equally dramatic would be their frequently stormy self-discharges from hospitals, only to return to another medical center with yet another false set of complaints. Both the theatrical mendacity of these patients, and their peregrination from hospital to hospital reminded Asher of the accounts of the travels and tall tales concerning the Baron Hieronymus Karl Friedrich von Münchhausen (1720-1797). Criticism has been leveled at this choice of terminology by a variety of authors (e.g., Barker, 1962; Chapman, 1957, Clark & Melnick, 1985), even to the point of taking issue with
Anglicization of the Baron’s family name (Ody, 1993). Yet one criticism over the eponym has yet been voiced. The overly dramatic dishonesty and general instability (in both emotional and geographic terms) of these patients may have reminded Asher of the good Baron Munchausen, but the striking resemblance to both the classical hysteric and Borderline Personality Disorder seems to make Asher’s term, if anything, too specific. It is as if one named alcoholism, ‘Hemmingway’s Syndrome’. Ernest Hemmingway may have been an alcoholic but he was by no means a typical one. As stated above, it has been found that the more severe and prototypical a person’s Munchausen behaviors (the symptoms of hysteria, if you will), the stronger the borderline pathology (the signs of hysteria).

As also stated above, hysteria’s symptoms can be quite mutable while the signs seem to remain constant. Thus it should not be surprising that only a little more than a quarter of a century after Asher’s original paper, a variation on the disorder, unique in modern psychopathology, was introduced by Meadow (1977). Munchausen Syndrome by Proxy is a Factitious Disorder where a parent simulates a physical or psychological disorder in her or his child. It would seem that only in the hysteric family of disorders, where the symptomology is so fluid, could one find a case of symptoms being projected onto another.

After the remarkable leap of symptomology, from the person afflicted to another, found in Munchausen Syndrome by Proxy, it should not be too surprising that the disorder seems to have also manifested in a context other then the medical context. Munchausen Syndrome by Proxy

\[15\] As an aside, this particular criticism is not only rather petty but also misrepresents the historical record. The real Baron von Münchhausen was indeed noted for his entertaining of guests with manifestly fantastic anecdotes but he was only the inspiration for the fictional Baron von Munchausen, the creation of one Rudolph Erich Raspe (1737-1794), a Hannover born scientist, mathematician, translator, and embezzler. It was Raspe’s popular book, written while he lived in England, Baron Von Munchausen’s Narrative of His Marvelous Travels and Campaigns in Russia (1785) that served to immortalize the Baron as the amusing, and utterly unreliable, travel raconteur. It was this
has also been used to describe parents who fabricate allegations of sexual abuse of their children (Meadow, 1993; Schreier, 1996). It has been proposed that the same mechanisms of a desire to maintain an intense relationship with authority figures that is at the root of the more traditional cases of Munchausen Syndrome by Proxy is also at play here (Schreier, 1996). In such cases however, the authorities in question include not only those from the medical professions, as in traditional cases of Munchausen Syndrome by Proxy, but also those from the legal system. This “expansion of the target audience”, to use Schreier’s (1996) evocative term, may be simply due to the Munchausen Syndrome by Proxy parent’s hypothesized indiscriminate need for intense relationships with those in powerful positions (Schreier, 1992). According to this model, the salient characteristic for the Munchausen Syndrome by Proxy parent’s desired ‘partner’ is power and the nature of that power, be it legal, medical, psychological or anything else, may thus be purely a matter of convenience. That Munchausen Syndrome by Proxy has been noted primarily in the medical context until only recently may be partly an artifact of where it has been looked for by medical and mental health writers. As well, until recent years the primary authority system that was concerned with parents and their children was the medical system. Since the growth of society’s awareness of child sexual abuse, however, legal authorities have become much more involved with parents and their children. Legal authorities have thus been put in a position where they are part of the potential target audience of Munchausen Syndrome by Proxy parents.

This expansion of the target audience of Munchausen Syndrome by Proxy may be paralleled by a similar expansion in the target audience of Munchausen Syndrome ‘primary’ or Factitious disorders in general. It has been noted for years that many of those afflicted with Factitious

‘Munchausen of the imagination’, sans umlaut and with but a single ‘h’, that served as Asher’s inspiration (Parker &
Disorder with Predominately Physical Signs and Symptoms have had some familiarity with the medical context and indeed have often been employed in the medical system (e.g., Carney & Brown, 1993; Reich & Gottfried, 1983; Stern, 1980). They have been, perhaps, simply 'working with the materials at hand'. As discussed above, our current societal concerns over, and conceptualization of, victim-hood have brought a new set of materials to hand. Knowledge of the potential effects of victimization is easily learned by anyone with access to daytime television or the self-help section of a bookstore. In addition, 'victim-hood' can now be construed as a role that, to a certain extent, entitles one to involvement with powerful figures in society; the presumed primary motivation of those with Factitious Disorders.

An added advantage to the possible expression of Factitious Disorder in the forensic context is the wide, some might even say limitless, range of possible sequalae of victimization. This is coupled, of course, with a complimentary lack of firm knowledge of what are the probable sequelae to victimization. Compared to our knowledge of the signs and symptoms of various physical disorders and diseases, we are still very much in the dark. Indeed drawing a parallel between our knowledge of physical disorders and our knowledge of the effects of trauma may not even be valid. Given the staggeringly broad range of possible traumatizing events, and the perhaps even broader range of interpersonal differences between victims, it may never be possible to develop a 'cause and effect' model of the effects of trauma. It is certainly the case that at present, given our current state of knowledge, the detection by legal professionals of 'factitious victimization' may be a much harder to task than the presentation of factitious medical conditions by physicians. As those with Factitious Disorders are thought to be consciously simulating their problems, albeit for unconscious reasons, the difficulty in detecting factitious
victimization, as compared to say a factitious hernia, could also serve to facilitate, if not encourage, the expression of Factitious symptoms in the forensic context as opposed to the legal context.

Much thought on the etiology of the Somatoform Disorders also does not contraindicate the 'expansion' of the symptom picture from the medical context to the forensic context. For instance, Stinnet (1987) construed three broad categories of theoretical explanations for Somatoform Disorders. The first of these Stinnet described as psychodynamic theories, where it is thought that repressed emotional trauma is converted into physical symptomology. If indeed, emotional trauma can be repressed, there seems to be no reason why, given the current meaningfulness of past victimization, why such repressed material cannot be just as easily converted into historically inaccurate, but emotionally true, accounts of prior victimization. The second broad group of etiological hypotheses Stinnet termed social theories. Such explanations focus on the implicit 'rights' a patient can assume upon adopting the sick role. These rights can be described as a set of exemptions from various responsibilities including that of getting sick in the first place. This general alleviation of responsibility is seen as the unconscious motivation for the spurious symptoms and signs in Somatoform Disorder, allowing the patient to take a blameless 'vacation' from the duties of life. Given the current 'panaitia' view of victim-hood, where psychological trauma is not only seen as an overarching cause, but can also be used as an overarching excuse, the social explanations for the Somatoform Disorders seem to work equally well in the forensic context as in the medical. The third theoretical viewpoint on the etiology of the Somatoform Disorders Stinnet labeled alexithymia, literally a lack of words for emotions. Patients with alexithymia are thought to be unable to access words to describe their feelings and are thus compelled to describe emotional states in terms of physical sensations. If anything, the
contemporary beliefs concerning the effects of psychological trauma would make false accounts of victimization more evocative and efficient ways of communicating emotional states than the claiming of spurious physical discomfort. For example, sexual abuse is widely considered to be a causal agent of a variety of emotional difficulties such as depression. Claiming to have been the victim of such abuse certainly can imply having emotional difficulties without the need of explicitly speaking of one’s emotional state.

6.3b Borderline Personality Disorder
Much of the classically hysteric interpersonal behaviors now fall under the category of Borderline Personality Disorder (Hare, 1991). How might those afflicted with these signs of hysteria interact with the criminal justice system? Those with this disorder may be at a relatively high risk for being the victims of crime, and they also may make false or exaggerated claims.

Borderline Personality Disorder is characterized by “a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity” (APA, 1994, p. 650). The often dramatic and ill thought out lifestyle, filled with intense but shallow and brief relationships, of those afflicted with Borderline Personality Disorder make them, in a way, tailor made victims of crime. They impulsively, almost obsessionally, reach out to others but with little thought of those other’s true feelings but rather incessantly attempt to impose on those others specific, predetermined roles. This may not only lead those with Borderline Personality Disorder to unwittingly associate with unstable or immoral people, but also may inspire violent reactions to the Borderline Personality Disordered person’s behaviors. This may be especially true if the person exhibits diagnostic criterion 8 of the DSM - IV and has bouts of intense, inappropriate, and ill controlled anger.
Another issue that may lead those with Borderline Personality Disorder into contact with the criminal justice system is child sex abuse. Many people with Borderline Personality Disorder have suffered sexual abuse as children (APA, 1994), so much so that child sexual abuse has been proposed as a partial etiological agent for Borderline Personality Disorder (Herman, Perry, & van der Kolk, 1989).

Once victimized, if a person with Borderline Personality Disorder comes into contact with the criminal justice system, the Personality Disorder’s symptomology may make them very poor witnesses. Diagnostic criterion 9 for this disorder is the presence of “transient, stress related paranoid ideation or severe dissociative symptoms” (APA, 1994, p. 654). Their version of events may thus be very sketchy and inaccurate. This addition to the DSM-IV diagnostic criteria is in agreement with both longstanding clinical lore (Sternbach, Judd, Sabo, McGlashan & Gunderson, 1992) and research findings (Edell, 1987) that those with Borderline Personality Disorder often exhibit distortions of perception and cognition. These distortions tend to manifest themselves more on unstructured tests, such as the Rorschach Inkblot Test, and often result in confabulations (e.g., Carr, Goldstein, Hunt, & Kernberg, 1979, Carsky & Bloomgarden, 1981; Singer & Larson, 1981). If a victim with Borderline Personality Disorder dissociated during the crime, their memory for that event will be incomplete. Attempting to construct an account of the crime might well be considered an unstructured task, which may lead the victim with Borderline Personality Disorder to confabulate part, or even all, of their account.

In addition, it is possible that a victim with Borderline Personality Disorder may project an idealized relationship between him or herself and the investigating officers or prosecuting attorneys, and greatly fear an abandonment by these investigators if the case does not proceed. Indeed, given the general pervasiveness and inflexibility of Axis II symptoms, such a prospect
seems very likely. Thus a victim with Borderline Personality Disorder may make impulsive attempts to either please the investigators or to keep the investigation, and thus the 'relationship' going. Such attempts may include false or exaggerated allegations. It has been noted in the psychodynamic literature on borderline states (a concept broader than, but very similar to, Borderline Personality Disorder\textsuperscript{16}) that those with borderline personality organization often exhibit an uncanny sensitivity to nonverbal clues and empathy for those they have projected an idealized relationship (Krohn, 1974; Rinsley, 1982). Thus what might be considered a non-suggestive question to a non-borderline adult might well contain a great deal of suggestion to a borderline attuned to the investigator’s interest in the case. In addition, although it is not as commonly found as in the Factitious Disorders, people with Borderline Personality Disorder

\textsuperscript{16} The psychoanalytic literature on borderline personality organization contains many divergent viewpoints, "reflecting the idiosyncratic views of various authors" (Aronson, 1985, p. 215) and often uses the term to encompass not only would be classified as Borderline Personality Disorder but also several other Axis II diagnoses such as Histrionic Personality Disorder. In addition to this, it should not be surprising that those same viewpoints are more concerned with broad theorizing than empirical and quantitative research. Nonetheless, some of this literature seems to reflect many of the issues involved in cases of para-victims. Aronson (1985) sees a common definition of borderline as the common thread running through the varied modern psychoanalytic writings on borderline personality organization. All these writings construe borderline as being a stable and unhealthy level of ego organization separate from, and intervening between, neurosis and psychosis. Borderline personality organization is considered by these writers as "neither a mild form of a major psychiatric disorder nor a personality disorder" (p.216) but rather as a broad category sui generis. Aronson regards the ego integration and capacity for reality testing of the borderline personality organization as the crucial points of differentiation from both psychotism and neuroticism. Unlike the psychotic, those with borderline personality organization normally maintain intact reality testing but, unlike the neurotic, the borderline can at times, often quite subtly, lose that ability. Thus the borderline, while being neither neurotic or psychotic, can behave as either at different times.

It may be that the psychoanalytic literature on borderline personality structure and the research on Borderline Personality Disorder are not incompatible. As Kernberg (1979) puts it, it is possible that "a clinical disorder might be understood in terms of psychic structure" (p.53). It is true that many implicit ideas in this literature (for instance, a common tendency to regard all forms of mental pathology as all lying on a unitary continuum, going from neuroticism through the borderline states to psychotism in terms of pathological seriousness) are not borne out by current research. Thus much writing concerning etiology and the like in the psychoanalytic literature, for example the libidinal unavailability of the mother leading to the generation of a split-object relations unit (SORU) in the future borderline patient, should be viewed with a very critical eye. Nonetheless, the descriptive efforts of these writers, while perhaps filtered through particular theoretical beliefs, can be a rich mine of clinical insights and a possible source of research hypotheses. This can be especially true of much current research on psychoanalytic concepts of borderline personality which sometimes uses DSM diagnoses of Borderline Personality Disorder as the method of classifying whether or not subjects are considered borderline, but then tests them on variables relevant to psychodynamic formulations of the borderline concept.
have been known to exhibit pseudologia fantastica (Snyder, 1986). Thus, false or exaggerated accounts may serve not only to maintain the relationship with the investigators but could also be seen as symptoms in their own right. Indeed, given the possible combination of the classic Borderline relationship pattern, of shifting suddenly from idealization of the other to near demonization, with pseudologia fantastica, it is possible that the entire allegation may be objectively false. The allegation may instead reflect the Borderline Personality Disordered person’s subjective feeling of violation and betrayal from the once idealized, now reviled, other.
Conclusion

The expression of hysteric symptomology, or, more properly perhaps, hysteric distress, as physical disability and discomfort is fitting enough in a 19th century context. In the 1800s the very idea of psychological trauma was a new, and almost counterintuitive, concept. Even if an hysteric person was familiar with the innovative notion of psychological trauma, the meaning of that psychological trauma for that hysteric would likely be either inchoate or merely stigmatizing. As discussed above, however, psychological trauma is now an implicitly accepted idea in the Western cultures. The expression of distress through unfounded signs and symptoms is no longer required to be in physical terms. Indeed, it can argued that, at present, the power of victim-hood as a personal 'origin myth' might make it far more meaningful, and thus perhaps more likely, for hysteric distress to be expressed in terms of the commonly accepted sequelae of past victimization rather than complaints of globus hystericus or glove anesthesia.

This situation is further complicated by the possibility that actual psychological trauma may affect memory, and or lead to hysteric symptomology. The trauma of being the victim of a crime may affect the victim's memory of that crime. Uncertainty in the interviewee has been proposed as the primary source of suggestibility (Brown, Schefflin & Hammond, 1998). Yet the victim's role in the criminal justice system is to give a complete and convincing account of the crime. There is both explicit pressure for the victim to assume this role from authority figures, and implicit pressure from the victim's own acculturation and desire for justice (or even perhaps vengeance). Questioning by the investigators is unlikely to take into account any memory difficulties that the victim might have. In addition, the correlation of hysteric symptomology and
suggestibility has been noted since the time of Charcot, as has the hysterical symptomology of those who have been traumatized. Reasoning cannot live on syllogisms alone, but in the absence of any empirical data these correlations should at least recommend caution in questioning anyone exhibiting hysterical symptomology. There are both social and cognitive variables present that are known to increase suggestibility and therefore the possibility of an inaccurate account.

This should not be construed as a claim that the expression of hysterical symptoms is now primarily limited to the forensic context. The social and cultural background, from which hysterical symptoms, chameleon like, seem to take their coloring, is neither unitary nor static. Even Charcot’s grande hystérie, long vanished from the bourgeois parlors of Vienna and Paris, can still be found in the backwoods of Kentucky (Critchley & Cantor, 1984). It is, however, a suggestion that the medical context is not the only context where hysterical symptoms may be expressed and an assertion that the forensic context is one that is particularly suitable, and one that is currently especially meaningful, for the expression of those symptoms.
Appendix: SYSTEMATIC AND INVESTIGATIVE ISSUES

The literature on suggestibility would suggest that inaccurate accounts are often the result of suggestibility arising from a mismatch between questioning techniques and the interviewee. Inappropriate investigative techniques such as the use of suggestive and even coercive questioning of vulnerable populations, such as the mentally challenged or severely disabled, the use of social pressure, and the use of faulty information gathering techniques such as hypnosis or facilitated communication may sometimes lead to inaccurate accounts of victimization. These inappropriate investigative techniques can potentially be the source of the distortion of the interviewee's account. If these inappropriate investigative techniques are then combined with a lack of multiple hypothesis generation and critical thinking on the part of the investigators, this fallacious account can then proceed further into the criminal justice system.

The Suggestive Questioning of Vulnerable Populations
Laboratory examinations of suggestibility, from Munsterberg (1908) to Loftus (e.g., Loftus, 1975; Loftus, 1979; Loftus, Miller & Burns, 1978), have tended to be marked by a focus on non-involving, if not trivial, matters. For almost a century, it has been found that the careful wording of a question can produce an incorrect, and predictable, response. Questions that have embedded in them incorrect information regarding the question's topic tend to lead to a minority of subjects incorporating the misinformation in their answer and even in their subsequent accounts. The vast majority of these studies, generally following Loftus' classic paradigm, have examined the effects of misinformation concerning peripheral details. Some attempts, however, have been made to examine people's suggestibility for central details. Unfortunately, many of these studies, while succeeding in replicating the misinformation effect found for peripheral details,
(1976) showed subjects a series of slides of various people in miscellaneous activities. The misinformation was in regards to which of the people did which activity. Although undoubtedly central to each slide, the question of which research confederate was reading a book or blowing up a balloon could hardly be called an involving one for the subjects. Further, in one of the few examples of a study examining undoubtedly involving events, Yuille and Cutshall (1986) found that witnesses to a real life day time gun battle between a firearms store owner and a robber were seemingly immune to the misinformation effect, even when the misinformation was concerning peripheral information. Brown, Schefflin and Hammond (1998) propose a multidimensional model of the misinformation effect but hold that the primary issue is that of uncertainty. People are more likely to fall prey to suggestive questioning if they are uncertain of their answer because they no longer remember it clearly, or because they did not encode the information in the first place, or because of the credibility of the source of the misinformation and the like.

Yuille and Cutshall (1986) proposed the term “remarkable memories” to describe the vivid and accurate recall held with confidence that they found, and which they surmised was due to the witnesses frequently ruminating and remarking upon their extraordinary experience. If Brown, 17

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17 Issues concerning flashbulb memories have often been brought into the debate over trauma and memory. The term flashbulb memories was proposed by Brown & Kulik (1977) to describe the often highly vivid, and supposedly accurate, memories of the context within which one has heard surprising and momentous news. For example, clearly remembering that you were preparing chicken soup on a rainy evening while waiting for your sister to come home when you first heard of the shooting of the American president John Kennedy. The effect was thought to be as if a flashbulb had gone off, illuminating all the sundry minor details of the event, details which otherwise would have been consigned to the indistinct gloom that is the fate of most such everyday memories. Vivid they may be, but the supposed accuracy of flashbulb memories has not been borne out by systematic research. For instance, Neisser and Harsch (1992) examined people’s accounts over time of their memories concerning the explosion of the space shuttle Challenger. They found that their subjects’ accounts of where they were when the heard of the disaster changed, often drastically, over time. Perhaps one of the most striking examples of a flashbulb memory turning out to be inaccurate is contained in Neisser’s (1982) account of his own memories of hearing a radio news bulletin announcing the Japanese attack on the American Naval base at Pearl Harbor in 1941. For years Neisser had vividly recalled that he had been listening to a baseball game on the radio when the sporting broadcast was interrupted with the bulletin that the Japanese had staged the raid on Pearl Harbor. It was not until he realized that baseball was not a game played during the month of December in the 1940s that he came to the surprising conclusion that he had been mistaken.
Scheflin and Hammond are correct that the key factor in suggestibility is uncertainty, than it should come as no surprise that Yuille and Cutshall’s highly confident witnesses were resistant to suggestion. It seems that although the content of a remarkable memory is necessarily unusual and impressive, unusualness and impressiveness are not sufficient for a remarkable memory. Memories for even the most traumatic events could be affected at the encoding stage, for example by dissociation or even by closing one’s eyes in fear. Thus many people who have been victims of actual crimes may be very uncertain about their recall of the crime and be vulnerable to suggestive questioning. Uncertainty could also arise at the retrieval stage, for example through the use of investigative techniques inappropriate for certain populations. Individual propensities to pseudologia fantastica, found for example in those with Borderline Personality Disorder, could further exacerbate this problem, leading to even completely false accounts. Thus the source of the inaccurate account likely ranges on a continuum, with some accounts originating solely from the para-victim, perhaps a form of factitious disorder manifested in the forensic context, others are a result of an interaction between the investigators and the para-victim, suggestive questioning of a person who has Borderline Personality Disorder, for instance, while still others may originate completely from the investigators such as in allegations arising from the use of Facilitated Communication. Those cases where the inaccurate account is due mostly to investigative techniques are the primary topic of this appendix.

Ground truth, how much of the allegation is true, also likely runs on a continuum, ranging from slightly exaggerated accounts of actual victimization (perhaps in the hope of a stiffer sentence for

The frequent inaccuracy of detailed, and often very convincing, flashbulb memories has been used as support for the malleability of memories of traumatic events (e.g., Loftus, 1994). However, the content of most flashbulb memories could best be described as the learning of unexpected and disturbing news events, such as assassinations, transportation disasters and the like. To assume that research concerning the accuracy of such memories has relevance to memories of personal trauma may be very incautious. Hearing the news of the killing of a public figure, however beloved, could well be a very different experience than being the victim of a rape or robbery.
the accused), through garbled and inaccurate reconstructions of dissociated memories of trauma, to utterly false allegations with nary a grain of documentary truth (although psychological truth may be another matter). Investigators must always be mindful that the inclusion of false elements in an allegation does not necessarily mean that the entire allegation is false.

The vulnerable population that has received the most attention from researchers is that of young children (see Bruck & Ceci, 1995). This population is out of the purview of the present paper. However, two inappropriate investigative techniques that may have an effect on adults are facilitated communication and hypnosis.

Facilitated Communication
Facilitated communication is an example of one extreme of the continuum for the source of the allegation, with the false allegations seeming to emanate solely from the interviewer. Facilitated communication, the use of a facilitator to aid in the communication of adults or children with severe motor or linguistic handicaps (hereafter, for simplicity's sake, the 'subject'), such as people with autism or multiple sclerosis, has received much attention in its relatively brief existence. The first widely known use of the technique was in Australia in the early 1970s (Hudson, 1995). Rosemary Crossely, a teacher at the St. Nicholas Hospital in Melbourne, a care centre for physically and mentally disabled children, used this technique with some of the resident patients at the hospital. She concluded from her facilitated communications with the children that 12 of the patients had normal or even superior levels of intellectual functioning. This was in direct contradiction of the children's diagnoses. After a lengthy legal dispute one of the twelve children was allowed to leave the hospital and was put under Crossely's care. A
Committee of Inquiry was established regarding the 11 remaining children. The Committee found that none of eleven were functioning any higher at the intellectual level than a two and a half year old child. Despite these findings the use of facilitated communication spread quickly through the Australian state of Victoria in the 1980s. Within Australia, common use of facilitated communication remained confined to Victoria but in the early 1990s, primarily through a widely read paper by Douglas Bliken in the Harvard Educational Review (Bliken, 1990), and several speaking visits by Crossely, the technique spread to North America (Hudson, 1995).

Facilitated communication has two constituent parts. The first of these has been termed the attitudinal component (Biklen, 1990); The facilitator must respect the subject and believe that the subject is capable of communicating and the facilitator must convey that respect and belief to the subject. The second component is physical support; The facilitator must, by grasping the subject’s wrist or hand or supporting them by a wrist band or sleeve, perceive and assist the subject’s subtle ‘volitional’ movements. The subject thus assisted by the facilitator points to a set of symbols or strikes a computer keyboard usually in response to questions from the facilitator. Proponents of facilitated communication hold that the technique brings to light the heretofore untapped and usually very unsuspected communicative and cognitive abilities of the subjects (e.g. Biklen, Morton, Gold and Swaminathan, 1992; Crossley and Remington-Gurney, 1992).

Systematic investigation of this technique has in general not supported the claims of facilitated communication's proponents. The methodologies of these studies are usually quite straightforward; the subject's facilitated responses to questions the answers of which are known to the facilitator are compared to the subject's facilitated responses to questions the answers of
which are not known to the facilitator. Except for a few, rather unimpressive, findings with single subjects (e.g., Crossely & McDonald, 1980; Intellectual Disability Review Panel, 1989), experimental exploration of facilitated communication has found strong evidence of, most likely unconscious, facilitator influence and nothing else (e.g., Eisen, 1980; the Interdisciplinary Working Party, 1988; Hudson, Melita & Arnold, 1993; Moore, Donovan, Hudson, Dykstra & Lawrence, 1993; Wheeler, Jacobsen, Paglieri & Schwartz, 1992). The experimental results indicate that facilitated communication is neither "facilitated" nor "communication" but rather an unintended indignity committed upon the subjects, that unintentionally treats them as if they were a tragic hybrid of a Ouija board and a ventriloquist's dummy.

Proponents of facilitated communication have countered that the testing of responses produced by this technique undermines the attitudinal component, eroding the trust and rapport between the subject and the facilitator. Subjects will thus often refuse to cooperate or even give meaningless answers which has led to the discouraging laboratory findings. Disregarding this argument’s convenience, three objections present themselves. Firstly, how do the subjects know that their responses are being tested in some cases? For example, how do they know that a facilitator doesn’t know the answer to a question? Secondly, given the startlingly sophisticated and mature content of many facilitated communications, why do subjects not realize that it is the facilitator and the technique that is being tested, and not the subject? Thirdly, why do so many subjects have the same reaction, deliberate non-cooperation, to the testing situation? For instance, why don’t at least some subjects confront the experimenters concerning their skepticism or the facilitator concerning his or her supposed lack of respect?

This is not to say that all accounts derived from facilitated communication are necessarily false. There are several case studies that indicate that accurate information unknown to the facilitator
may be produced by facilitated communication (e.g., Heckler, 1994). Given the rarity of such results, they may be more economically explained as mere type I errors but it is possible that facilitated communication may be one of those rare techniques, so distressful to experimental psychologists, that is valid but not reliable. That is, it may be a technique that can be performed accurately only by certain people who have the required aptitude and experience. But even if this is the case, we unfortunately know nothing, as of yet, of the doubtlessly complex personal variables, most likely concerning the subject as well as the facilitator, that might lead to instances of accurate facilitated communication.

Other than the well meaning and unintentional disrespect of the facilitators toward the subjects in the name of respect, the most disturbing issue of the facilitated communication controversy is the speedy importation of the technique into the forensic and social work context. In 1990 a 29 year old Melbourne woman with a severe mental handicap because of childhood encephalitis was removed from her parent's home because of sexual assault allegations against her family members produced by facilitated communication. The Guardianship and Administration Board later found that the woman could not communicate using facilitated communication and returned her to her home (Hudson, Melita, & Arnold, 1993). Hudson (1995) reports the case of a male worker of a community residential house for disabled people. Three female residents of the house, through facilitated communication, made allegations that the worker drugged and raped them. The worker was dismissed from his position and criminal charges were brought against him. The charges were subsequently dropped by a magistrate after an informal test of facilitated communication was conducted in the courtroom.

This hasty application of facilitated communication to the forensic context, while regrettable, is nonetheless also understandable. Facilitated communication is, of course, used with those with
afflictions that prohibit any form of precise and autonomous verbal, written, or signed communication. People so disabled are, by the very nature of their disability, uniquely vulnerable to abuse. A victim that cannot make an allegation must make a very attractive target for certain offenders. This is especially true in cases of sexual abuse, for many common forms of sexual abuse seldom leave any physical evidence. If the abuser is also the victim's caretaker, and is therefore often alone with the victim, the situation for the abuser is almost diabolically 'ideal'. Any investigative technique that would help in such cases would be welcomed by all involved. The front line workers, the consumers of investigative techniques, such as police, social workers, and more and more frequently clinicians, are usually not trained in the evaluative and critical methods that would allow them to accurately judge the efficacy of such techniques. Indeed, it seems that many of these consumers quite naturally assume that the techniques in question have already been validated before their introduction to the field; after all, would an eminent professional recommend the use of an untested technique? Thus, given an evident need for an investigative technique that would aid in investigating possible victimization of people with afflictions such as multiple sclerosis or severe autism, many investigators fastened on to facilitated communication and, quite unknowingly, grasped only at straws.

Allegations arising from the use of facilitated communication are a clear example of cases of para-victims being produced solely by the investigative process. It seems highly unlikely that many of those afflicted with multiple sclerosis or severe autism were even aware of the content of 'their' allegations.
Hypnosis

Hypnosis is also a frequently inappropriate investigative technique that could give rise to cases of para-victims. But in contrast to facilitated communication, hypnosis is a technique where the false allegations can originate from both the investigation and the para-victim. Little agreement exists on the precise definition of hypnosis (see Lynn & Rhue, 1991 for a review of the varied theoretical viewpoints), but whether it is defined as a social role (e.g., Spanos & Chaves, 1989), an induced change in cerebral functioning (e.g., Rossi, 1993), or an altered state of consciousness (e.g., Fromm, 1992) there is certainly some agreement on what phenomena can be called hypnosis and what can not be so designated. It is a little like trying to define art, “I don’t know how to define it, but I recognize it when I see it.”

Unfortunately, consensus does not reach much further than this. This discord certainly extends to the use of hypnosis in forensic investigations. The literature of laboratory experiments examining the utility of hypnosis in aiding recall presents a very mixed picture, with results ranging from hypnosis having a detrimental on recall, through no effect, to a positive effect. A report by the American Medical Association on the use of hypnosis to refresh recall was singularly damning regarding the accuracy of hypnotically refreshed memories (A.M.A., 1985), a view lately reaffirmed in the A.M.A.’s report on recovered memories of childhood sexual abuse (A.M.A., 1994). The American Society of Clinical Hypnosis, on the other hand, is, unsurprisingly enough, optimistic, albeit cautious, in their report in their guidelines for the use of hypnosis in the forensic context (A.S.C.H., 1994). The authors of the A.S.C.H. report hold the opinion that memories of traumatic events may be very different from memories of non-traumatic material; That traumatic material is not only more involving, but that it also may be processed differently. They point out that the to-be-remembered material in most laboratory experiments is decidedly non-traumatic. They also cite Geiselman and Machlovitz’s (1987)
review that found that the closer the experimental methodology resembled the forensic use of hypnosis in the field, the higher the likelihood that hypnosis led to increased amount without a corresponding drop in accuracy. Thus, for the authors of the A.S.C.H. report, the question is one of ecological validity; it is implied that the many laboratory experiments that found hypnosis to have a detrimental effect on accuracy are not as relevant to the forensic context as the fewer studies that supported the use of hypnosis.

However, none of the 30 studies in the Geiselman and Machlovitz (1987) review examined the effects of attempts at hypnotic facilitation of the recall of truly traumatic memories. The to-be-remembered material in the studies reviewed ranged from live staged events or films to word list or stories. Many of the studies that used more naturalistic and engaging, albeit not traumatizing, stimuli did produce findings supporting the use of hypnosis, but this trend was not significant. Rather, Geiselman and Machlovitz's analysis revealed that longer retention intervals, larger sample sizes, and increased use of interactive interviews accounted for the differences in the utility of hypnosis across studies. The stand of the A.S.C.H. report seems sophistic at best.

If traumatic memories are indeed different from memories of everyday events as many of the proponents of the forensic use of hypnosis suggest, the results of laboratory experiments examining the recall of non-traumatic stimuli, regardless of their results, may not be relevant to the question of the forensic application of hypnosis. They certainly do not support the use of hypnosis in forensic investigations. If anything, given the common law tradition of maintaining a bias in favor of a 'false positive' (a guilty accused being found not guilty) so as to avoid the possibility of a 'false negative' (an innocent accused being found guilty), the hypnosis of victims, who constitute a large proportion of all witnesses (Tollestrup, Turtle and Yuille, 1994) would certainly seem inadvisable.
If laboratory experiments have possibly little to offer on the question of the forensic use of hypnosis, there is still another scholarly line of inquiry regarding the use of hypnosis. The abreaction of dissociated memories of trauma through hypnosis has been a long standing clinical tradition (Speigel & Cardeña, 1990; Brown & Fromm, 1986). Clinical utility, however, does not guarantee a corresponding forensic utility. Attempts at hypnotic assisted recall of traumatic memories can give a patient a narrative 'pigeonhole' to explain a vague sense of distress. Even if this distress is due to a currently inaccessible to conscious memory of past trauma, whether due to dissociation or repression, the alleviation of that distress through the hypnotic (re)construction of a past trauma does not necessarily denote that the hypnotically induced recall is accurate. Any improvement on the client’s part may certainly be construed as an argument for the subjective truth of the hypnotically induced account but does not inevitably indicate objective veracity.
References


