Trauma and Taboo

Traumatic Memories Are Alive and Well and Eating Your Innards Out

The name may have changed, but recovered memories haven't gone away. They're claimed to be destroying our minds and bodies. The reason has more to do with taboo than trauma.

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Corticeps is a nasty but fascinating genus of fungus that burrows into the bodies and brains of insects. As fungal enzymes dissolve and disrupt neurotransmission, the infected insect's behavior is changed, and it makes itself available to be eaten and eventually excreted by predators, thereby increasing the fungus's own chances of propagation. Lots of zombie films base their plots on Corticeps-like pathogens infecting humans, munching away on their brains, and changing their behaviors to spread more pathogens, making more zombies. The films are mostly silly and occasionally entertaining.

There's a subset of psychotherapy called "Trauma Therapy." It argues that childhood abuse is the human equivalent of Corticeps. Worse, in fact. Trauma therapy argues that childhood abuse not only eats out the brains of its victims, changing their behaviors, but their bodies as well. Like zombie films, the research is mostly silly. Unlike the films, the therapy is potentially dangerous.

Trauma Therapy is the phoenix reborn from the ashes of Freud's Child Seduction Theory, which presumed that childhood sexual abuse, buried away in the unconscious, was responsible for subsequent mental illnesses. The mechanism for the seduction theory's amnesia was repression—the belief that those unacceptable memories of childhood sexual molestation could be buried in young minds, eating away at mind and body, and emerging as mental illnesses in adulthood. Even Freud didn't believe it and abandoned the theory (Freud 1897).

But belief in a connection between childhood sexual abuse and repression wouldn't die. In America, therapists trained in Freudian, semi-Freudian, or quasi-Freudian techniques kept the discarded theory alive. During the 1980s and 1990s, repressed memories of childhood abuse became the etiological foundation of Multiple Personality Disorder, a disorder said to be obvious in its "hiddenness." Therapists, whether professional, lay, or religious, all set out to find their clients' different personalities and uncover the repressed memories of childhood abuse—usually in numbers inversely proportional to the therapist's level of education.

After numerous lawsuits and professional licenses were lost during the Memory Wars of the 1980s and 1990s, the terms *repression* and *Multiple Personality Disorder* (MPD) were finally put to rest by the American Psychiatric Association. But, unfortunately, the underlying beliefs remain.

Below is the pre-war definition of MPD in the *Diagnostic and Statistical Manual Third Edition-Revised* (*DSM-IIIR*), the "bible of psychiatry" (1987):

> The essential feature of this disorder [MPD] is the existence within the person of two or more distinct personalities or personality states. Personality is here defined as a relatively enduring pattern of perceiving, relating to, and thinking about the environment and one's self that is exhibited in a wide range of important social and personal contexts. ... At least two of the personalities, at some time and recurrently, take full control of the person's behavior.

You'd be forgiven for failing to understand the difference between MPD and Dissociative Identity Disorder (DID), whose definition in the next edition, the *DSM-IV* (1990) was:

> The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self). ... At least two of these identities or personality states recurrently take control of the person's behavior.

The etiology of both was trauma, almost always childhood sexual abuse. While Freudians would have claimed the memories were repressed, today's therapists claim that the memories have been *dissociated*. The difference? Repression is an *isolation* of traumatic memory from consciousness, but dissociation is a *separation* of traumatic memory from

consciousness. It's a subtle distinction. Oddly, no one's ever been able to adequately explain why Multiple Personality Disorder was never classified as a personality disorder.

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Repressed Memories, Still Munchin' Away

MPD/DID's status has waned in psychiatric literature, and when (if rarely) the topic is discussed at conferences, it tends to be met by attendees looking around the room, checking the dirt under their fingernails, or dusting the dandruff off their jackets.

Post-Traumatic Stress Disorder (PTSD), however, still maintains diagnostic respectability. And it has trauma in its name. Previously classified as an anxiety disorder—assessing the patient's heightened responses to a perceived and past stressor—PTSD is now in a new category, Trauma- and Stressor-Related Disorders, which emphasizes the stressor over the patient. Adding to the confusion, PTSD now comes both with and without dissociative symptoms. This hybrid PTSD merges PTSD with the Dissociative Disorders.

But joining dissociation and PTSD through trauma presents a problem in logic and consistency. PTSD is said to be caused by exposure to traumatic events: war, violence, assault, etc. Its symptoms include intrusive memories, re-experiencing the event(s), avoidance of similar situations, and increased startle response.

Dissociative disorders such as MPD/DID also claim to be the result of traumatic events—mostly child sexual and physical abuse, which has somehow been hidden from consciousness. The problem? PTSD is a disease whose etiology is a trauma so severe it cannot be forgotten, but dissociation is a disease whose etiology is a trauma so severe it cannot be remembered!

Mind-Munching Memories

Hundreds of papers have been published on the effects of childhood abuse on adults. Early research began with the hippocampus, a part of the brain that consolidates senses, thoughts, and emotions into memories. Trauma researchers measured hippocampal volumes of victims and controls. Finding differences, they proclaimed that those differences were the result of trauma—not bothering to examine anything else. Sometimes the right hippocampus was affected, sometimes the left, and sometimes both. In fact, hippocampal size is now known to change over time and is dependent on genetics, blood flow, medication, age, mood, and alcohol and drug use (Jelicic and Merckelbach 2004). Even exercise can affect hippocampal size, and thus it's hardly specific to trauma.

With their main hope of causally relating trauma to the hippocampus found wanting, traumatologists set out to discover brain damage from child trauma in other areas of the brain. Scampering all around and through gray and white matter, they found volumetric differences between victims and controls. Purported results of trauma have included decreased sizes of the amygdala, the lateral prefrontal cortex, the medial prefrontal cortex, the motor cortex, the visual cortex, the cingulate gyrus, the hypothalamus, gray matter thickness, the cingulate gyrus, the corpus callosum, the pituitary, etc. Differences in neurotransmitter measurements of serotonin, dopamine, monoamine oxidase, vasopressin, and others have also been tallied and published.

The sum of all of these papers might lead the reader to accept that a causal connection had been found between childhood trauma and adult brain pathology. However, the problem with most of these papers mirrors those of the hippocampal studies; i.e., brains are dynamic—they change over time, depending on circumstances. There are a host of other problems, beginning with whether the purported traumas were verified or merely accepted at face value.

Mostly the latter. Or whether the subjects were male or female. Mostly the latter.

Body Munching Memories

A second group of articles, published in psychology or therapy journals rather than medical journals, implies that childhood trauma is a factor in adult medical disorders. The diseases include osteoarthritis, rheumatoid arthritis, chronic fatigue, fibromyalgia, psoriasis, alopecia, COPD, cancer, asthma, congestive heart failure, hypertension, heart attacks, arterial thickening, hypothyroidism, diabetes, obesity, dyslipidemia, breast cancer, irritable bowel disease, and at least a dozen others. The causal mechanism(s) through which childhood trauma causes, or at least exacerbates, the severity of any of these disparate adult diseases remains unexplained, although epigenetics and DNA methylation are the current popular targets (Guggisberg 2017). Physicians who specialize in treating those disorders would probably be surprised to learn their work has mostly been in vain and that what their patients really need is a hefty dose of trauma therapy.

Societal Munching Memories

A third group of articles links childhood abuse and trauma to current social malfunctioning: decreased social status, antisocial behavior, increased incarceration, parental fatigue, smoking, drug and alcohol use, even subsequent rape (both victim and perpetrator) are some of the reports. Some papers even note a correlation between childhood abuse and alien abduction (Powers 1994).

Psychiatric Munching Memories

The fourth and largest group of publications correlates childhood trauma with current or past psychiatric disorders. The list includes just about every one of the 600 plus diagnoses in the *DSM* from anxiety to schizophrenia, although DID is still the most popular.

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Like the other categories, these correlation papers set out to prove the connection between child abuse and mental illness—allowing for nothing else. However, despite all the published correlations, the world consists of more than abuse and trauma. People have genes and environments and histories and behaviors and misbehaviors and friends who misbehave and accidents and love affairs gone sour, as well as environmental pathogens and bacteria and viruses and fungi. Try hard enough and you can find a correlation between two of just about anything, even Cordiceps and zombies[1] (Doan et al. 2017). But unless all variables can be studied and causal mechanisms can be shown, the myriad correlations amount to little more than speculation. Or wishful thinking. Mostly the latter.

Taboo

Why do so many therapists insist on pointing to childhood (sexual) abuse as the root cause of so many diseases and dysfunctions? And why is lax research methodology so typical of abuse literature? The answer lies not in studies of research or medicine or psychology or even therapy but rather in those of morality.

It's always helpful to get an overview of childhood abuse in America, which has been provided by the Childhood Protective Services (CPS) statistics for many years. Below in Table 1 are the statistics from 1997 and 2015 from CPS (Childhood Protective Services 2016). These are strictly founded cases (absolute numbers in parentheses). This is without doubt an under-representation since the numbers only reflect founded cases; however, it provides an overview of how abuse cases are broken down in the United States.

But compare the CPS stats to the abuse research literature (Google, PubMed, and Google Scholar) (Table

	Child Protective Services[2]	
1997 (716,000)		2015 (683,000)
	Childhood Neglect	
60 percent		75.3 percent
	Childhood Physical Abuse	
4 percent		17.2 percent
	Childhood Sexual Abuse	
12 percent		8.4 percent

Table 1. Incidence of different types of child abuse reported to Child Protective Services, 1997 and 2015.

2) and you get an entirely different picture.

Why do traumatologists obsess over childhood sexual abuse? It's not just because pain was inflicted on someone, but because the person inflicting the pain achieved pleasure through that someone's pain. As British historian Thomas Babington Macaulay wisely recognized, "The Puritan hated bear-baiting not because it gave harm to the bear, but because it gave pleasure to the spectator." If you think Macaulay was just being witty and sarcastic, compare his 1849 epigram to the Veterans Administration's current unwitty and unsarcastic definition of child sexual abuse, or CSA (Whelan and Bartlett 2016):

> Child sexual abuse includes a wide range of sexual behaviors that take place between a child and an older child or adult. These sexual behaviors are intended to erotically arouse the older person, generally without consideration for the reactions or choices of the child and without consideration for the effects of the behavior upon the child.

The association of CSA with long-term medical, psychiatric, and social pathologies is based on retrospective, *post hoc* rationalizations and low p-values. Important variables are excluded. In nearly every paper, the conclusion was that CSA was the major, if not the only, factor examined in long-term physical, mental, or emotional harm to the subjects—even when no evidence of harm could be shown.

For example, the majority of studies on smoking state that most people take up smoking because their close family or friends smoke. This result holds across the world in epidemiologic studies (Islam and Johnson 2005; Garcia-Rodriguez et al. 2010; Wiecha et al. 1998). But if you browse the abuse literature, the only variable studied is—you guessed it—abuse.

This predetermined belief reveals a taboo—a powerful social or religious custom placing a prohibition on certain behaviors. Break a taboo and society reacts with moral outrage. Researchers Gutierrez, Giner-Sorolla, and Russell ran a series of elegant studies on taboo-breaking behaviors at the University of Kent (Russell and Giner-Sorolla 2011; Gutierrez and Giner-Sorolla 2007). Their studies demonstrated that the initial emotions elicited from broken taboos are anger and disgust. A taboo that has been violated provokes society to presume that harm has been caused, even if no harm can be objectively demonstrated. The damage is moral—not just to the abused but to the society itself.

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The hundreds of CSA studies reviewed in PubMed exemplify the results of a broken taboo—anger and moral outrage. Whether or not CSA can be associated with long-term physical or psychological damage to the victim still remains unanswered; the research is overwhelmingly poor. But what is undoubtedly clear is that anger and moral outrage fuel the published research. If there is still any doubt that this is the result of a powerful taboo, recall the fate of Bruce Rind, Phillip Bauserman, and Robert Tromovitch.

In July 1998, Rind, Tromovich, and Bauserman published the results of their research in *Psychological Bulletin* (Rind et al. 1998), a meta-analysis of over 35,000 college students—women and men—who reported CSA. They could find no evidence of long-term psychological harm, with the exception of some mild depressive symptoms. And when family dysfunctions were factored out, the students appeared to be psychologically normal and healthy. This should have been considered good news—great news, in fact. If the findings were correct, victims of CSA would recover and get on with their lives as normal women and men. It would be like learning that your child didn't contract polio; you ought to be overjoyed.

Instead, the response from the therapeutic community was outrage. The

Google	PubMed	Google Scholar
	Childhood Neglect	
458,000 (5.3 percent)	532 (16.2 percent)	7,670 (6.4 percent)
	Childhood Physical Abuse	
237,000 (2.8 percent)	349 (10.6 percent)	11,000 (10.2 percent)
	Childhood Sexual Abuse	
7,900,000 (91.9 percent)	2,401 (73.2 percent)	102,000 (83 percent)

Table 2. Incidence of child abuse by source.

meta-analysis was furiously denounced—not only by therapists, psychologists, and psychiatrists, but also by both APAs (American Psychological and Psychiatric Associations), who published position papers opposing the findings. Reports of the conclusions made national headlines, and on July 12, 1999, by a vote of 355 to 0, with thirteen abstentions, the research was condemned by the House of Representatives. The Senate unanimously condemned it on July 30 (Lilienfeld 2002).

Rind, Bauserman, and Tromovitch's meta-analysis is the only scientific research in U.S. history to have ever earned the dubious honor of congressional condemnation. It was subsequently learned that almost none of the congressmen had even bothered to read the article. But, despite the uproar from therapists and the public, and the condemnation from the Congress, their findings have held. The paper was reviewed by the American Association for the Advancement of Science, and the entire meta-analysis was even rerun at the University of Montana (Ulrich et al. 2005) with similar results. (For more on the Rind et al. study, see "Damaged Goods," by Margaret A. Hagen in the January/February 2001 issue of SI and "When Scientific Evidence is the Enemy" by Elizabeth Loftus in the November/December 2001 issue of SI.)

What was clear was that most people in the therapy professions wanted, perhaps even *needed*, the abused women and men to become damaged and to remain damaged. Therapists reacted with moral outrage when no long-term harm could be shown. Why? Because long-term damage would justify the moral outrage and anger, and thus maintain the taboo. Without damage, the justification for the taboo is weakened along with the need for treatment.

Traumatologists have endeavored to keep the taboo strong by publishing papers that seek out associations between child abuse and any number of disorders. Some have even manipulated data to justify the predetermined moral conclusion: childhood abuse results in long-term damage to the victim. That's strong evidence of a powerful social taboo.

Not All Abuse Is Created Equal

It's a truism that childhood sexual abuse—or any abuse for that matter—ought to be prevented. But there's abuse, and then there's abuse. Abuse is a catch-all word that differs in type and severity and, like paint, it covers a multitude of sins. Being insulted is not the same as being knifed or shot. Hearing a distasteful joke about race or sex is not the same as being lynched or raped. Yet all of them are labeled abuse. The responses of the afflicted, ranging from disappointment to death, are all labeled trauma. Just as the word that means everything means nothing, so abuse and trauma have lost any definition and now mean essentially nothing.

Therapy, if necessary (and that's a big *if*), ought to be tailored accordingly. Certainly different types of abuse can be harmful and persist for years. Some can even be lethal. But in most cases people can and will recover *if allowed to do so*. That should be the goal of trauma therapy: to help people recover from their problems and get on with their lives. They don't need to be continuously reminded of their traumas. They don't need therapists to ascribe their adult illnesses—physical, mental, or emotional—to their abuse in childhood. And they certainly don't need long-term therapy to reinforce that myth. It would be tantamount to turning them into zombies—eaten away from the inside out.

Notes

1. Recently, sixty cases of Cordiceps ingestion and poisoning, including one death, were discovered in Vietnam. "Zombie" symptoms, which included agitated delirium, hallucinations, somnolence, and coma, occurred within one hour of ingestion. Patients were examined, labs drawn, and analyses performed. Ibotenic acid was identified as the toxic culprit.

2. Cases in which there is more than one type of abuse are counted only once.

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