Crime and Memory

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The conflict between knowing and not knowing, speech and silence, remembering and forgetting, is the central dialectic of psychological trauma. This conflict is manifest in the individual disturbances of memory, the amnesias and hypermnesias, of traumatized people. It is manifest also on a social level, in persisting debates over the historical reality of atrocities that have been documented beyond any reasonable doubt. Social controversy becomes particularly acute at moments in history when perpetrators face the prospect of being publicly exposed or held legally accountable for crimes long hidden or condoned. This situation obtains in many countries emerging from dictatorship, with respect to political crimes such as murder and torture. It obtains in this country with regard to the private crimes of sexual and domestic violence. This article examines a current public controversy, regarding the credibility of adult recall of childhood abuse, as a classic example of the dialectic of trauma.

What happens to the memory of a crime? What happens to the memory in the mind of the victim, in the mind of the perpetrator, and in the mind of the bystander? When people have committed or suffered or witnessed atrocities, how do they manage to go on living with others, in a family, in a community, and how do others manage to go on living closely with them?

This is the question I propose to explore. As my starting point, I would like to recount a case reported by Dan Bar-On, an Israeli psychologist who has investigated the generational impact of the Nazi Holocaust. Bar-On has done extensive interviews not only with children of Holocaust survivors, but also with children of the Nazi SS. In fact, for some years now, he has been conducting workshops, in both Israel and Germany, in which he brings members of these two groups together. In these workshops, the children of victims and the children of perpetrators disclose to one another the stories of the crimes that their families kept secret. Such encounters represent the highest form of therapeutic endeavor, for they carry the potential for both personal and social healing.

During the mid-1980s, Bar-On interviewed 48 men and women whose fathers (and, in one case, a mother) had participated either directly or indirectly in extermination activities during World War II. He asked them to recall whether their parents had ever discussed wartime experiences at home and whether they had shown any signs of guilt, regret, or moral

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conflict. Recognizing that to address such questions would be emotionally stressful for both his subjects and himself, he took care to build rapport and trust with his subjects, and to maintain his own institutional, collegial, and personal support. No one can do this kind of work alone.

The adult children of Nazi war criminals could not initially remember any discussion whatsoever in their families, either of the extermination program in general or of their parents' participation. They also reported that they saw little evidence of distress or moral conflict in their parents. They dealt with the problem of their lack of knowledge by repeatedly using one sentence that may sound all too familiar: "We had a very normal family life."

Some of the adult children constructed their own version of historical events from small bits of information they had gleaned from various sources, minimizing the role their fathers had played. One man explained that his father had been a train driver during the war, but only drove ammunition transports, and had never personally transported Jews to the death camps. When Bar-On expressed skepticism, on the basis of well-established historical evidence, this man agreed to ask his father for more information. For the first time in his life, he asked his father direct questions about the past; a few days later he recounted their conversation to Bar-On. At first he reiterated the original story: his father denied any involvement in the transport of Jews and had not known anything about it. On further inquiry, he said that his father had admitted hearing about it from others at the time. Just as the interview was about to end, he suddenly added: "And this time, my father told me of another matter. He was on duty when they took a big group of prisoners of war and shot them on the platform in front of his eyes."

"How terrible!" Bar-On exclaimed. "It must have been very difficult to keep that hidden all these years."

"This was the first time he spoke to me about it," the son replied, matter-of-factly. "He never told anyone about it."

A year later, Bar-On reinterviewed the same informant. The memory that had been recovered in the previous interview was gone. The man did not remember his father's disclosure, nor that he had in turn repeated the story to Bar-On. Reflecting on this case, Bar-On invoked the image of a double wall erected to prevent acknowledgment of the memory of crime. The fathers did not want to tell; the children did not want to know.[1]

The ordinary human response to atrocities is to banish them from consciousness. Certain violations of the social compact are too terrible to utter aloud; this is the meaning of the word *unspeakable*. Atrocities, however, refuse to be buried. As powerful as the desire to deny atrocities is the conviction that denial does not work. Our folk wisdom and classic literature are filled with ghosts who refuse to rest in their graves until their stories are told, ghosts who appear in dreams or visions, bidding their children, "Remember me." Remembering and telling the truth about terrible events are essential tasks for both the healing of individual victims, perpetrators, and families and the restoration of the social order.

The conflict between the will to deny horrible events and the will to proclaim them aloud is the central dialectic of psychological trauma. I would like to explore the impact of this dialectic on the phenomenon of remembering. I will speak first about what perpetrators remember, then about what victims remember, and finally—and this is perhaps the most complicated of all—what bystanders and witnesses remember.

What do perpetrators remember? Here our professional ignorance is almost perfect. We know so very little about the inner lives of people who commit atrocities, that relatively sophisticated investigations, such as studies of memory, are utterly beyond our current capability. We know so little about perpetrators, first of all, because they have no desire for the truth to be known; on the contrary, all observers agree on their deep commitment to secrecy and deception. Perpetrators are not generally friendly to the process of scientific inquiry. Usually they are willing to be studied only when they are caught, and under those circumstances they tell us whatever it is they think we want to know. In general, we have wanted to know very little. The dynamics of human sadism have almost entirely escaped our professional attention. Our diagnostic categories do not comprehend the perpetrators; they present an appearance of normality, not only to their children, but also to us.

By contrast, we now know a fair amount about what victims remember. It seems clear that close-up exposure, especially early and prolonged exposure, to human cruelty has a profound effect on memory. Disturbances of memory are a cardinal symptom of posttraumatic disorders. They are found equally in the casualties of war and political oppression—combat veterans, political prisoners, and concentration camp survivors; and in the casualties of sexual and domestic oppression—rape victims, battered women, and abused children. These disturbances have been difficult to comprehend because they are apparently contradictory. On the one hand, traumatized people remember too much; on the other hand, they remember too little. They seem to have lost "authority over their memories" (I borrow the phrase from my colleague Mary Harvey).[2] The memories intrude when they are not wanted, in the form of nightmares, flashbacks, and behavioral reenactments. Yet the memories may not be accessible when they are wanted. Major parts of the story may be missing, and sometimes an entire event or series of events may be lost. We have by now a very large body of data indicating that trauma simultaneously enhances and impairs memory. How can we account for this? If traumatic events are (in the words of Robert J. Lifton) "indelibly imprinted",[3] then how can they also be inaccessible to ordinary memory?

When scientific observations present a paradox, one way of resolving the contradiction is to ignore selectively some of the data. Hence we find some authorities even today asserting that traumatic amnesia cannot possibly exist because, after all, traumatic events are strongly remembered. Fortunately for the enterprise of science, empirical observations do not go away simply because simplistic theories

fail to explain them. On the contrary, I believe that some of our most important discoveries arise from attempts to understand apparent paradoxes of this kind. I would like to offer two theoretical constructs that may help us clarify and organize our thinking in this area. The first is the concept of state-dependent learning; the second is the distinction between storage and retrieval of memory.

The common denominator—the A criterion—of psychological trauma is the experience of terror. Traumatic events are those that produce "intense fear, helplessness, loss of control, and threat of annihilation."[4] This is the definition in the fourth edition of the *Comprehensive Textbook of Psychiatry*, and extensive studies in the DSM-IV field trials have essentially confirmed this observation. People in a state of terror are not in a normal state of consciousness. They experience extreme alterations in arousal, attention, and perception. All of these alterations potentially affect the storage and retrieval of memory.

The impact of hyperarousal on memory storage can be studied in the laboratory with animal models. James McGaugh and his colleagues[5] have demonstrated in an elegant series of experiments that high levels of circulating catecholamines result in enhanced learning that stubbornly resists subsequent extinction. This is an animal analogue, if you will, of the "indelible imprint" of traumatic events on memory. Building on McGaugh's concept of overconsolidated memory, Roger Pitman and his colleagues[6] have demonstrated that activation of trauma-specific memories in combat veterans with post-traumatic stress disorder (PTSD) produces highly elevated physiologic responses that fail to extinguish even over periods of half a lifetime. They interpret their findings as evidence for overconsolidation of memories laid down in a biologic state of hyperarousal.

When people are in a state of terror, attention is narrowed and perceptions are altered. Peripheral detail, context, and time sense fall away, while attention is strongly focused on central detail in the immediate present. When the focus of attention is extremely narrow, people may experience profound perceptual distortions including insensitivity to pain, depersonalization, derealization, time slowing and amnesia. This is the state we call dissociation. Similar states can be induced voluntarily through hypnotic induction techniques, or pharmacologically, with ketamine, a glutamate receptor antagonist.[7] Normal people vary in their capacity to enter these altered states of consciousness.

Traumatic events have great power to elicit dissociative reactions. Some people dissociate spontaneously in response to terror. Others may learn to induce this state voluntarily, especially if they are exposed to traumatic events over and over. Political prisoners instruct one another in simple self-hypnosis techniques in order to withstand torture. In my clinical work with incest survivors, again and again I have heard how as children they taught themselves to enter a trance state.

These profound alterations of consciousness at the time of the trauma may explain some of the abnormal features of the memories that are laid down. It may

well be that because of the narrow focusing of attention, highly specific somatic and sensory information may be deeply engraved in memory, whereas contextual information, time-sequencing, and verbal narrative may be poorly registered. In other words, people may fail to establish the associative linkages that are part of ordinary memory.

If this were so, we would expect to find abnormalities not only in storage of traumatic memories, but also in retrieval. On the one hand, we would expect that the normal process of strategic search, that is, scanning autobiographical memory to create a coherent sequential narrative, might be relatively ineffective as a means of gaining access to traumatic memory. On the other hand, we would expect that certain trauma-specific sensory cues, or biologic alterations that reproduce a state of hyperarousal, might be highly effective. We would also expect that traumatic memories might be unusually accessible in a trance state.

This is, of course, just what clinicians have observed for the past century. The role of altered states of consciousness in the pathogenesis of traumatic memory was discovered independently by Janet and by Breuer and Freud 100 years ago. The concepts of state-dependent memory and abnormal retrieval were already familiar to these great investigators. Indeed, it was Janet[8] who first coined the term "dissociation." More recently, civilian disaster studies, notably those by David Spiegel and his colleagues[9] have demonstrated that people who spontaneously dissociate at the time of the traumatic event are the most vulnerable to developing symptoms of PTSD, including the characteristic disturbances of memory retrieval: intrusive recall and amnesia.

Abnormal memory retrieval in posttraumatic disorders has also now been demonstrated in the laboratory. This is a very fertile and exciting area of current investigation. For example, a research team at Yale University have been able to induce flashbacks in combat veterans with PTSD using a yohimbine challenge; the same effect could not be produced in veterans who did not have PTSD.[10] Studies of traumatized people now demonstrate that some have abnormalities not only in trauma-specific memory but also in general memory. Richard McNally and his colleagues[11] have noted that combat veterans with PTSD have difficulty retrieving specific autobiographical memories, especially after being exposed to a combat videotape. As they interviewed their subjects in the laboratory, McNally and his colleagues were struck by the fact that the men who showed the greatest disturbances in autobiographical memory were those who still dressed in combat regalia 20 years after the war.[11] These men remembered nothing in words and everything in action. The contemporary researchers had rediscovered what was already well known to the great 19th century clinical investigators, namely that traumatic memories could manifest in disguised form as somatic and behavioral symptoms. Janet[12] attributed the symptoms of hysteria to "unconscious fixed ideas." Breuer and Freud[13] wrote that "hysterics suffer mainly from reminiscences."

This puzzling and fascinating phenomenon has been extensively documented in contemporary clinical studies as well. For

example, among 20 children with documented histories of early trauma, Lenore Terr found that none could give a verbal description of the events that had occurred before they were two and one-half years old. Nonetheless, these experiences were indelibly encoded in memory and expressed nonverbally, as symptoms. Eighteen of the 20 children showed evidence of traumatic memory in their behavior and their play. They had specific fears and somatic symptoms related to the traumatic events, and they reenacted these events in their play with extraordinary accuracy. A child who had been sexually molested by a babysitter in the first two years of life could not, at age five, remember or name the babysitter. Furthermore, he denied any knowledge or memory of being abused. But in his play he repeatedly enacted scenes that exactly replicated a pornographic movie made by the babysitter. This highly visual and enactive form of memory, appropriate to young children, seems to be mobilized in adults as well in circumstances of overwhelming terror.[14]

In Bessel van de Kolk's[15] phrase, "the body keeps the score." Traumatic memories persist in disguised form as psychiatric symptoms. The severity of symptoms is highly correlated with the degree of memory disturbance. Data from numerous clinical studies including DSM-IV field trials for PTSD now demonstrate a very strong correlation between somatization, dissociation, self-mutilation, and other self-destructive behaviors, and childhood histories of prolonged, repeated trauma.[16]

Although it is clear by now that abnormalities of memory are characteristic of posttraumatic disorders, they are not seen in all traumatized people, even after the most catastrophic exposure. For example, in a community study of refugee survivors of the Cambodian genocide, Eve Carlson[17] found that 90 percent reported some degree of amnesia for their experiences but 10 percent did not. In childhood abuse survivors, we now have several clinical studies and two community studies. Memory disturbances seem to fall on a continuum, with some subjects reporting that they always remembered the traumatic events, some reporting partial amnesia with gradual retrieval and assimilation of new memories, and some reporting a period of global amnesia, often followed by a period of intrusive and highly distressing delayed recall. The percentage of subjects falling into this last category ranges from 26 percent in a study I conducted with my colleague Emily Schatzow,[18] to 19 percent in a more recent study by Loftus *et al.*[19] Degree of amnesia may be correlated with the age of onset, duration, and degree of violence of the abuse. Further research is needed to clarify both the determinants of the memory disturbance and the mechanism of delayed recall.

The 19th century investigators not only documented the role of traumatic memory in the pathogenesis of hysterical symptoms, but also found that these symptoms resolved when the memories, with their accompanying intense affect, were reintegrated into the ongoing narrative of the patient's life. These discoveries are the foundation of modern psychotherapy. "Memory," Janet wrote, "like all psycho-

logical phenomena, is an action; essentially it is the action of telling a story . . . A situation has not been satisfactorily liquidated . . . until we have achieved, not merely an outward reaction through our movements, but also an inward reaction though the words we address to ourselves, through the organization of the recital of the event to others and to ourselves, and through the putting of this recital in its place as one of the chapters in our personal history."[20]

Throughout the next century, with each major war, psychiatrists who treated men in combat rediscovered this same therapeutic principle. They found that traumatic memories could be transformed from sensations and images into words, and that when this happened, the memories seemed to lose their toxicity. The military psychiatrists also rediscovered the power of altered states of consciousness as a therapeutic tool for gaining access to traumatic memories. Herbert Spiegel[21] pioneered the use of hypnosis with acutely traumatized soldiers in World War II. Roy Grinker and John Spiegel[22] used sodium amytal. These psychiatrists understood, however, that simple retrieval of memory was not sufficient in itself for successful treatment. The purpose of therapy was not simply catharsis, but rather integration of memory.

Those of us who treat civilian casualties of sexual and domestic violence have had to rediscover these same principles of treatment. Retrieval of traumatic memory, in the safety of a caring relationship, can be an important component of recovery, but it is only one small part of the "action of telling a story." In this slow and laborious process, a fragmented set of wordless, static images is gradually transformed into a narrative with motion, feeling, and meaning. The therapist's role is not to act as a detective, jury, or judge, not to extract confessions or impose interpretations on the patient's experience, but rather to bear witness as the patient discovers her own truth. This is both our duty and our privilege.

In my review of the current state of the field, it may be noticed that I have not said anything about the accuracy or verifiability of traumatic memories. It has been widely presumed that traumatic memories, especially those retrieved after a period of amnesia, might be particularly prone to distortion, error, or suggestion. In fact, a careful review of the relevant literature yields the conclusion that traumatic memories may be either more or less accurate than ordinary memories, depending on which variables are studied. For example, such memories may be generally accurate, or better than accurate, for gist and for central detail. They may be quite inaccurate when it comes to peripheral detail, contextual information, or time sequencing.[23, 24]

On the matter of verifiability, we have some fascinating single case reports of traumatic memories from childhood retrieved after a period of dense amnesia and later confirmed beyond a reasonable doubt.[25] These anecdotal reports prove only that such memories can turn out to be true and accurate; they do not permit us to draw any conclusions about how reliable such memories might be in general. I know of only two systematic studies in which subjects were asked whether they

knew of evidence to confirm their memories of childhood trauma. The first is the clinical study Emily Schatzow and I conducted with 53 incest survivors in group therapy. The majority of these patients undertook an active search for information about their childhood while they were in treatment. As a result, 74 percent were able to obtain some form of verification. More recently, Feldman-Summers and Pope[26] conducted a nationwide study of 330 psychologists. Of these, 23.9 percent gave a history of childhood physical or sexual abuse, a figure consistent with general community surveys. Exactly half of these subjects reported that they had some independent source of information corroborating their memories. In these two studies, the subjects who reported amnesia and delayed recall did not differ from those with continuous memory in their ability to obtain confirming evidence. The limitations of these studies should be noted, however; because these were not forensic investigations, the researchers did not independently confirm the subjects' reports.

Finally, I know of no empirical studies indicating that people who report histories of trauma are any more suggestible, or more prone to lie, fantasize, or confabulate, than the general population. Nevertheless, whenever survivors come forward, these questions are inevitably raised. In the absence of any systematic data, those who challenge the credibility of survivors' testimony repeatedly resort to argument from anecdote, overgeneralization, selective omission of relevant evidence, and frank appeals to prejudice. The cry of "witch hunt" is raised, invoking an image of packs of irrational women bent on destroying innocent people. When this happens, we must recognize that we have left the realm of scientific inquiry and entered the realm of political controversy.[27]

This brings us to the final subject: When a crime has been committed, what do the bystanders remember? For we are the bystanders, and we are called upon to bear witness to the many crimes that occur, not far away in another time and place, but in our own society, in normal families very much like our own, perhaps in our own families. Like the son of the man who drove the trains in wartime, we have been reluctant to know about the crimes we live with every day. We have sought information only when prodded to do so, and once we have acquired the information we have been eager to forget it again as soon as possible. We can see the phenomenon of active forgetting in operation as it pertains to crimes against humanity carried out on the most massive scale of organized genocide. It operates with the same force in the case of those unwitnessed crimes carried out in the privacy of families.

When we bear witness to what victims remember, we are inevitably drawn into the conflict between victim and perpetrator. Although we strive for therapeutic neutrality, it is impossible to maintain moral neutrality. To clarify the difference—therapeutic neutrality means remaining impartial with regard to the patient's inner conflicts, respecting his or her capacity for insight, autonomy, and choice. This is a cardinal principle of all psychotherapy and is of particular importance in the treatment of traumatized peo-

ple, who are already suffering as the result of another's abuse of power. Moral neutrality, by contrast, means remaining impartial in a social conflict. When a crime has been committed, moral neutrality is neither desirable nor even possible. We are obliged to take sides. The victim asks a great deal of us; if we take the victim's side we will inevitably share the burden of pain and responsibility. The victim demands risk, action, engagement, and remembering. The perpetrator asks only that we do nothing, thereby appealing to the universal desire to see, hear, and speak no evil, the desire to forget.

In order to escape accountability for their crimes, perpetrators will do everything in their power to promote forgetting. Secrecy and silence are the perpetrator's first lines of defense, but if secrecy fails, the perpetrator will aggressively attack the credibility of the victim and anyone who supports the victim. If the victim cannot be silenced absolutely, the perpetrator will try to make sure that no one listens or offers aid. To this end, an impressive array of arguments will be marshalled, from the most blatant denial to the most sophisticated rationalizations. After every atrocity one can expect to hear the same apologies: it never happened; the victim is deluded; the victim lies; the victim fantasizes; the victim is manipulative; the victim is manipulated; the victim brought it upon him- or herself (masochistic); the victim exaggerates (histrionic), and, in any case, it is time to forget the past and move on. The more powerful the perpetrator, the greater will be his prerogative to name and define reality, and the more completely his arguments will prevail.

This is what has happened in our profession. In the past we have been only too ready to lend our professional authority to the perpetrator's version of reality. For decades we taught that sexual and domestic crimes are rare, when in fact they are common; for decades we taught that false complaints are common, when in fact they are rare. At times, we have been willing to see what happens to men assaulted on the battlefield and women and children assaulted in the home. But we have been unable to sustain our attention for very long. The study of psychological trauma has had a discontinuous history of our profession. Periods of active investigation have alternated with periods of oblivion, so that the same discoveries have had to be made over and over again.

Why this curious amnesia? The subject of psychological trauma does not languish for lack of scientific interest. Rather, it provokes such intense controversy that it periodically becomes anathema. Throughout the history of the field, dispute has raged over whether patients with posttraumatic conditions are entitled to care and respect or deserve contempt, whether they are genuinely suffering or malingering, whether their histories are true or false, and, if false, whether imagined or maliciously fabricated. Despite a vast body of literature empirically documenting the phenomena of psychological trauma, debate still centers on the most basic question: whether these phenomena are credible and real.

It is not only the patients but also the investigators of posttraumatic conditions whose credibility has been repeatedly challenged. Clinicians and researchers

who have listened too long and too carefully to traumatized patients have often become suspect among their colleagues, as though contaminated by contact. Investigators in this field have often been subjected to professional isolation. Most of us are not very brave. Most of us would rather live in peace. When the price of attending to victims gets to be too high (and recently, we learned that the price can be as high as half a million dollars),[28] most of us find good reasons to stop looking, stop listening, and start forgetting.

We find ourselves now at an historic moment of intense social conflict over how to address the problem of sexual and domestic violence. In the past 20 years, the women's movement has transformed public awareness of this issue. We are now beginning to understand that the subordination of women is maintained not only by law and custom, but also by force. We are beginning to understand that rape, battery, and incest are human rights violations; they are political crimes in the same sense that lynching is a political crime, that is, they serve to perpetuate an unjust social order through terror.[29] The testimony of women, first in the privacy of small groups, then in public speakouts, and finally in formal epidemiologic research, has documented the fact that these crimes are common, endemic, and socially condoned. Grass-roots activists pioneered new forms of care for victims (the rape crisis center and the battered women's shelter), and advocated for legal reforms that would permit victims to seek justice in court. As a result we now find ourselves in a situation where for the first time perpetrators face the prospect of being held publicly accountable.

I should emphasize the fact that the odds still look very good for perpetrators. Most victims still either keep the crime entirely secret or disclose only to their closest confidantes. Very few take the risk of making their complaints public. The most recent data we have indicate that although the reporting rate for rape may have doubled in the last decade, it is still only 16 percent.[30] For sexual assaults on children, the rate is even lower, ranging from two to six percent.[31] These numbers are further reduced at each step along the way to trial. Victims of sexual and domestic crimes still face an uphill battle in court. Besides the strong constitutional protections which all defendants enjoy (and which no one is proposing to abrogate), perpetrators are also aided by the widespread bias against women that still pervades our system of justice. Nevertheless, even the prospect of accountability is extremely threatening to those who have been accustomed to complete impunity.

When people who have abused power face accountability, they tend to become very aggressive. We can see this in the political experience of countries emerging from dictatorships in Latin America or in the former Soviet bloc. In many cases the military groups or political parties that were responsible for human rights violations retain a great deal of power, and they will not tolerate any settling of accounts. They threaten to retaliate fiercely against any form of public testimony. They demand amnesty, a political form of amnesia.[32] Faced with exposure, the dictator, the torturer, the batterer, the

rapist, the incestuous father all issue the same threat: if you accuse me I will destroy you and anyone who harbors or assists you.

This social conflict over accountability has reached a peak of intensity just at the same moment that we in the mental health professions are struggling to relearn and integrate the fundamental principles of diagnosis and treatment of traumatic disorders. We professionals are just now feeling the backlash that grass-roots workers in women's and children's services have already endured for quite some time. Just as mental health professionals are starting to figure out how to treat survivors (often by trial and error), we suddenly find ourselves and the work we do under very serious attack. Some of these attacks are funny; some are quite ugly. Most of us are not accustomed to threatening phone calls, pickets in front of our homes or offices, entrapment attempts, or legal harrassment; but we're going to have to learn fast how to cope with these and other intimidation tactics.

We have three choices. We can ally with, and become apologists for, accused perpetrators, as some distinguished authorities have done. We can back away from the whole field of traumatic disorders, as has happened many times in the past.[33] Or we can determine not to give in to fear, but rather to continue our work—in the laboratory, in the privacy of the consulting room, and ultimately in public testimony.

We need to be clear about the nature of the work that we do. The pursuit of truth in memory takes different forms in psychotherapy, where the purpose is to foster individual healing; in scientific research, where the purpose is to subject hypotheses to empirical test; and in court, where the purpose is to mete out justice. Each setting has a different set of rules and standards of evidence, and it is important not to confuse them. It is no more appropriate to apply courtroom procedures and standards of evidence in the consulting room or the laboratory than to apply therapeutic or laboratory procedures and standards of evidence in the courtroom. But if we pursue the truth of memory in scientific and therapeutic setting, then we will inevitably have to defend our work in the courtroom as well. For our work places us in the role of the bystander, bearing witness to the memory of crimes long hidden. Some of our patients will eventually choose to seek justice. Our stance regarding this decision should be one of technical neutrality. Nowhere is the principle of informed choice more important. When I am consulted I always suggest that patients think long and hard about the consequences of taking this step; it is not a decision to be made impulsively. But when, after careful reflection, some of our patients choose to speak publicly and to seek justice, we will be called on to stand with them. I hope we can show as much courage as our patients do. I hope that we will accept the honor of bearing witness and stand with them when they declare: we remember the crimes committed against us. We remember, we are not alone, and we are not afraid to tell the truth.

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