

## Scientific Status of Recovered Memories

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Clinicians working with survivors of traumatic experiences have frequently noted the existence of psychogenic amnesia and the recovery of additional memories during clinical sessions, although amnesia for significant parts of a traumatic event is probably only found in a minority of cases. Amnesia is described in DSM-IV as a feature of post-traumatic stress disorder and acute stress disorder, although its presence is not necessary for these diagnoses. Recently, however, doubt has been cast on the process whereby forgotten memories of child sexual abuse appear to be recovered within therapy, and it has been suggested that many if not all of these memories are the product of inappropriate therapeutic suggestion. This suggestion has been promulgated in particular by the False Memory Syndrome Foundation in the US and by its counterpart, the British False Memory Society. New studies provide evidence that may be useful to practitioners in evaluating these claims and in guiding their own practice.

### The "false memory" position

Loftus (1993) suggested that at least some of the memories of child sexual abuse recovered in therapy may not be veridical, but may be false memories "implanted" by therapists who have prematurely decided that the patient is an abuse victim and who use inappropriate therapeutic techniques to persuade the client to recover corresponding "memories". The false memory societies have claimed that there are many cases known to them in which previously happy families have been disrupted by accusations of abuse that were only triggered by adult offspring entering therapy with a poorly-trained or "fringe" practitioner. Loftus (1993) and Lindsay & Read (1994) have marshalled evidence to suggest that this is a possibility that must be taken seriously. For example, they review studies concerning the fallibility and malleability of memory, note the potential for inaccurate recall involved in techniques like hypnosis, and report evidence that some therapists adopt beliefs and methods that run counter to generally accepted notions of good practice.

Various members of the scientific advisory boards of the false memory societies have warned about the likely unreliability of memories recovered in this way (Wakefield & Underwager, 1992; Loftus, 1993; Pope & Hudson, 1995; Kihlstrom, 1995; Merskey, 1995). Pope & Hudson (1995) excluded from consideration clinical observations of recovered memories on the grounds that they were "unsystematic anecdotal reports" (p. 121) and argued:

"Laboratory studies over the past 60 years have failed to demonstrate that individuals can "repress" memories. Clinical studies, which extrapolate from the laboratory to the study of real-life traumas, most consequently start with the null hypothesis: namely, that repression does not occur". (p. 125)

Wakefield & Underwager (1992, p. 487) commented along similar lines.

"Claims of repressed memories of childhood abuse recovered in the course of therapy are not supported by credible scientific data. The scientific and popular literature in this area seems dominated by believing therapists who simply repeat clinical anecdotes, state subjective speculation, and make unsupported assertions about repressed abuse."

### The prevalence of forgetting

Claims to scientific authority made in the above quotations notwithstanding, opinion on these issues appears to be shifting rather rapidly in response to studies published in the last few years. Although experimental psychologists laboured in vain to convincingly demonstrate repression for material consisting largely of sexual, aggressive, or other generally threatening words, it is now widely accepted that the ecological validity of these studies was low and that it is very difficult to model the effects of trauma in the laboratory. In contrast, retrospective clinical studies have now found that a substantial proportion of patients in therapy for the effects of child sexual abuse (somewhere between 20–60%) report having periods in their lives (often lasting for several years) when they could not remember that the abuse had taken place. Although the rates vary between studies, broadly similar findings have been obtained by clinical psychologists

(Briere & Conte, 1993; Elliott & Briere, 1995), psychiatrists (Herman & Schatzow, 1987; van der Kolk & Fisler, 1995), and cognitive psychologists (Loftus *et al*, 1994b), in both clinical and community samples. A national survey of the experiences of American psychologists (Feldman-Summers & Pope, 1994) also found that, of those reporting abuse, 40% said they had had periods of forgetting some or all of the abuse. Both sexual and nonsexual abuse were subject to forgetting, and in only one quarter of cases was memory recovery solely triggered by being in therapy.

Nevertheless, evidence from prospective community surveys of individuals with documented histories of child sexual abuse is of great interest. Bagley (1995), for example, reported a study of women aged 18–24 years who had been removed from home 10 years previously by social services and had been separated from their natural mothers for at least one year. Prior to leaving home there had been intrafamilial sexual abuse according to the girl's own report and the report of an adult familiar with the household. Of 19 women for whom there was evidence for serious sexual abuse, 14 remembered events corresponding to the original records. Two remembered that abuse had taken place but could recall no details. Three did not report abuse when specifically asked whether they had been sexually abused as children. Of these three, two described long blank periods for their memory of childhood corresponding to the age when abuse had taken place.

Williams (1994a) reported a 17 year follow-up of women referred to hospital as children and diagnosed as having been sexually abused. Of 129 women interviewed, 38% failed to report anything resembling the abuse experience documented in the hospital records, and 12% reported no abuse experience of any kind. In her paper Williams explored several alternative explanations of her data, for example that respondents were too young to remember the abuse or deliberately withheld information about the abuse, but concluded that the abuse had probably been forgotten (but see Loftus *et al*, 1994a, for an alternative view).

#### Corroboration of memories

Interpretation of these data is hampered by a number of issues of which one of the most important concerns the corroboration of facts apparently recalled after a period of amnesia. Some authors (Pope & Hudson, 1995) demand stringent evidence of the authenticity of a memory before they are willing to concede that it has been

recovered after a period of amnesia. Feldman-Summers & Pope (1994) asked their respondents for any corroborative evidence for recovered memories of abuse. Forty-seven per cent reported some corroboration, for example the abuser acknowledged some or all of the remembered abuse, someone who knew about the abuse told the respondent, or someone else reported abuse by the same perpetrator.

Despite the problems arising from the relatively recent appreciation of the extent and importance of child sexual abuse, and the fact that such events often occur in secret, Pope & Hudson argue that independent, documented evidence is required if the concept of repression is to be accepted at all. In fact there are reports of individual cases where documentary corroboration of forgotten trauma has been reported (Schooler, 1994). Such evidence is also available from Williams' study reported above. In her sample, approximately one in six of the women who recalled the abuse at interview said that there had been a period when they had completely forgotten the abuse. When current accounts of the abuse and the original records were compared, Williams (1995) reported that the accounts of women with recovered memories were just as accurate as those of women who had always remembered the abuse.

#### The context of memory recovery

Surveys of practitioners have been informative about other claims made by the false memory societies. Andrews *et al* (1995) sent questionnaires to chartered psychologists and obtained a response rate of 27%. Almost half of the 810 with relevant caseloads who replied had had a patient retrieve a memory from total amnesia while in therapy with them. In the previous year 23% had had a patient recover a memory of child sexual abuse while in therapy with them, 19% reported they had had a patient who had recovered a memory of child sexual abuse (CSA) while in therapy with another therapist, and 31% had had a patient who reported recovering a memory before entering any kind of therapy. Twenty-eight per cent had had a patient recover a traumatic memory not concerning CSA in therapy with them during the past year.

#### Forgetting or repression?

The current scientific debate is concerned, not so much with whether forgetting of trauma occurs, but with how it can best be explained. Loftus *et al* (1994a) argue that the mechanism involved is

ordinary forgetting, and that there is no need to posit a special mechanism such as "repression". None of the studies discussed above offers any direct evidence about the mechanism involved, but trauma researchers argue that Loftus *et al's* argument is implausible. In rebuttal they point to several characteristics often associated with recovered memories, namely the extreme emotions that accompany them, the patients' reluctance to discuss them, and patients' accounts of deliberate attempts to avoid the memories intruding after the trauma. Williams (1994b) offers several examples of dramatic and personally meaningful events that she argues would be extremely hard simply to forget.

What is needed to support the concept of repression is evidence that there is an active inhibitory process that is keeping memories out of consciousness, not simply a passive failure to remember. Although there is as yet little direct evidence from the trauma field, there are numerous indications from laboratory research that such a process is possible, and that it may be particularly marked in certain individuals (Bjork, 1989; Dagenbach & Carr, 1994; Myers & Brewin, 1994, 1995). These kinds of data suggest that there may well be inhibitory processes in both attention and memory that could account for clinical hypotheses concerning repression, although much more research is clearly needed.

### Conclusions

There is agreement that traumas are sometimes forgotten. Commenting on the Williams (1994a) study, Loftus and her colleagues commented:

"The findings do support the claim that many children can forget about a sexually abusive experience from their past. Extreme claims such as "if you were raped, you'd remember" are disproven by these findings" (Loftus *et al*, 1994a, p. 1177).

There is also convincing experimental evidence from studies of cued recall, recognition, and hypermnesia that people are able to remember events that they had previously forgotten (Kihlstrom & Barnhardt, 1993). Research into hypnosis shows that people can temporarily block conscious access to certain memories and that, while access is blocked, the unconscious memories can influence the person's experience, thoughts and actions (Kihlstrom & Barnhardt, 1993).

What remains disputed is whether traumatic events, and particularly repeated traumas, can be forgotten and then remembered with essential accuracy. It has not been doubted that individuals

with fugue states subsequently recall reasonably accurately the details of their identity and autobiography, as many of these facts are easily checked. It is far more difficult to collect indisputable evidence relevant to childhood experiences that may have taken place with nobody else present. However, it seems clear from the surveys of practitioners that, since memories are often recovered prior to therapy and do not necessarily concern child sexual abuse, the hypothesised implantation of false memories by misguided practitioners cannot account for more than a subset of recovered memories (and at present it is unclear how large or small this subset is). False memories may conceivably arise for other reasons, but as yet there is little evidence for this hypothesis.

Although False Memory Society advisory board members mostly remain sceptical, on the basis of the kind of evidence reviewed above many commentators now appear to accept that traumatic events can be forgotten and then remembered. For example, cognitive psychologists Lindsay & Read (1995) concluded:

"In our reading, scientific evidence has clear implications . . . : memories recovered via suggestive memory work by people who initially denied any such history should be viewed with scepticism, but there are few grounds to doubt spontaneously recovered memories of common forms of CSA or recovered memories of details of never-forgotten abuse. Between these extremes lies a grey area within which the implications of existing scientific evidence are less clear and experts are likely to disagree".

The consensus view among independent commentators, repeated in the 1995 report of the British Psychological Society's Working Party on Recovered Memories and the 1995 interim statement of the American Psychological Association's Working Group on Investigation of Memories of Childhood Abuse, appears therefore to be that memories may be recovered from total amnesia and they may sometimes be essentially accurate. Equally, such "memories" may sometimes be inaccurate in whole or in part. Thus there are no grounds for complacency. The warnings of the false memory societies and their scientific advisors, although largely based on indirect evidence, deserve to be taken seriously. They are a reminder to practitioners to approach the issue of memory recovery with an open mind, and to be scrupulous about the methods they use and about the inferences they draw from therapeutic material.

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