Psychotherapy & Counselling
Federation of Australia

Consensus Guidelines for Working with Recovered Memory

Preamble

The Consensus Guidelines provide information and guidance to PACFA members, and members of Member Associations, when working with clients who recover or have recovered memories of historical traumatic events. The intention of the Guidelines is to inform clinical practice, thereby providing safeguards for clients and therapists[1].

Whilst much of the literature into recovered memory has specifically examined childhood sexual abuse, the Consensus Guidelines are relevant for all situations where recovered memory is a focus of clinical practice.

The first section in the Consensus Guidelines provides position statements on recovered memory; the second section provides consensus guidelines for working with recovered memory, the third section outlines ethical and legal aspects of working with recovered memory; and the fourth section provides recommendations for further research. These position statements and guidelines are compiled from the outcomes of review studies, guidelines of other professional associations, and draft guidelines produced for PACFA in 2005. The sources consulted in the development of these guidelines are provided in the reference list.

The first draft of the Consensus Guidelines was developed for PACFA by Professor Margot Schofield and Dr Jon Kettle in 2005. The current version of the Consensus Guidelines has been written by Ms Ann McDonald. The related publication to the Consensus Guidelines is *Recovered Memory of Childhood Sexual Abuse: An Overview of Research Evidence and Guidelines* (McDonald, 2017), published by PACFA as an occasional paper. The Consensus Guidelines are annotated with links to relevant sections in the review.

Section 1: Position Statements on Recovered Memory

1. There is evidence that memories of historical traumatic events may be forgotten and later remembered[2].

2. Memories may return during therapy or independently of therapeutic processes.

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[1] Therapist is an inclusive term used to describe counselling and psychotherapy practitioners in these Guidelines

[2] American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

3. Memories for events that never occurred may be constructed, and returning memories may be true, or partially true and partially false[3].

4. Memories of historical trauma return in a variety of ways. They are known to return piece by piece, or an entire event may be recalled at one time[4].

5. Unusual, powerful or vivid memories and strong bodily sensations are not an indicator that recovered memories are historical truth, nor that the memories are false[5].

6. Strong beliefs about, and intense emotion associated with recovered memories do not confirm the accuracy of these memories[6].

7. There are no standard methods for verifying the accuracy of recovered memories, however evidence by way of confession by the perpetrator, documentation such as child protection and medical reports, and witness accounts, may provide independent corroboration. Due to the secrecy around sexual abuse, many people with recovered memories are unlikely to find independent corroboration[7].

8. Strong beliefs held by therapists about memory, and the use of suggestive techniques aimed at accessing memories, have the potential to influence the creation of memories for clients recovering memory[8].

9. It is hypothesised that differing routes and processes result in the forgetting of traumatic events. Disruption in memory processes may occur at the stage of encoding, during storage, and with retrieval. Explanations for the processes and mechanisms that pertain to the forgetting of traumatic events include:

    dissociation, repression, suppression, motivated forgetting, betrayal trauma, a failure of consolidation, and interference in memories[9].

10. While it is not possible to research the mechanisms utilised by individuals during actual traumatic events, studies on individuals who have recovered traumatic memories, those with PTSD, those with amnesia for known events, and non-traumatised populations, provide information which contributes to the understanding of biological and neurological processes involved in the forgetting of traumatic events. The following research findings contribute to the discussion[10]:

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[3] Refer to discussion on authenticity of memory in *Recovered Memory of Childhood Sexual Abuse: A review of research evidence and guidelines,* pp. 13-14 .

[4] Refer to discussion on remembering processes in *Recovered Memory of Childhood Sexual Abuse: A review of research evidence and guidelines,* pp. 11-12.

[5] Refer to review of guidelines on recovered memory in *Recovered Memory of Childhood Sexual Abuse*: *A review of research evidence and guidelines,* pp. 14-17.

[6] Ibid.

[7] Refer to DePrince, Allard, Oh, & Freyd (2004).

[8] Refer to background on memory debates in *Recovered Memory of Childhood Sexual Abuse: A review of research evidence and guidelines,* p. 3.

[9] Refer to discussion on how childhood sexual abuse is forgotten in *Recovered Memory of Childhood Sexual Abuse*: *A review of research evidence and guidelines,* pp. 8-10.

[10] Refer to discussion of remembering processes in *Recovered Memory of Childhood Sexual Abuse*: *A review of research evidence and guidelines,* pp. 11-12.

a. There is some agreement that extreme traumatic stress impacts the neurobiological processes of the brain during encoding. Studies indicate that with high emotional arousal stress, hormones impact primarily on three interacting structures in the brain, leading to dissociative amnesia in some individuals. These structures are the hippocampus, amygdala, and the medial prefrontal cortex. It is proposed that other areas of the brain are also involved in the development of amnesia for traumatic events. Research in this field is incomplete.

b. Functional MRI studies on individuals with dissociative amnesia highlight differences in neural processing. Results from memory tasks with adult participants with known severe dissociative amnesia reveal differences in neural activity for the duration of the amnesia, and for the period once memories have returned. It is observed that during the amnesic period, neural activity intensifies in the prefrontal cortex and decreases in the hippocampus. Researchers conclude that with dissociative amnesia, the repression of memory is related to changes in neural functioning.

c. The theory of 'motivated forgetting' proposes that individuals use active methods to keep memories of emotionally stressful events from consciousness. Neuroimaging studies have identified processes that individuals may utilise to achieve this. These include processes of (i) intentionally disrupting the encoding process, (ii) direct suppression of the retrieval of the memory, and (iii) the substitution of the unwanted memory with an alternative memory. Although these last two processes block the recall of unwanted memories, studies have identified that different neural networks operate for each of these processes.

Section 2: Consensus Guidelines for Working with Recovered Memory

1. The welfare and interests of clients are the primary concern of therapists. This includes maintaining respect for clients' autonomy[11].

2. When assessing clients, questions about historical events may be asked, however sensitivity is required. Therapists must be alert to the possibility that therapeutic interactions, such as subtle suggestions and leading questions, may cue clients towards particular conclusions[12].

3. Symptom checklists and the presence of specific symptoms are not reliable methods for determining the presence of forgotten memories[13].

4. Therapists should take any emergence of clients' memories of trauma seriously. The client's experience should be accepted, and therapists should provide an environment whereby recovered memories can be safely explored. An empathic and non-judgmental stance is recommended.

5. Therapists should be open to a range of possibilities when working with recovered memories, including that the memories may be historically true, thematically or metaphorically true, or

[11] PACFA Code of Ethics (2017)
[12] Refer to: Kihlstrom (2004); DePrince, Brown, Cheit, Freyd, Gold, Pezdek, & Quina (2012).
[13] Refer to therapeutic practices not supported by evidence in *Recovered Memory of Childhood Sexual Abuse*: *A review of research evidence and guidelines,* pp. 15.

derive from fantasy or dream material. It is recommended that therapists avoid making premature judgements about the accuracy, partial accuracy, or falsity of the memories.

6. Therapists should avoid imposing their own interpretations about recovered memories, and instead work with clients to assist them to come to their own meanings and conclusions about their memories and their past.

7. In situations where historical truth is not clear, or cannot be known, therapists need to manage the uncertainty and ambiguity, and work with clients on their experience of this lack of certainty.

8. Therapists should not utilise methods and techniques that search for memories of events for which the client has no current knowledge.

Section Three: Ethical and Legal Aspects of Working with Recovered Memories

Ethical Aspects of Work with Recovered Memories

1. Therapist interventions with recovered memory should be guided by the PACFA Code of Ethics (2017), and relevant codes and guidelines of regulatory bodies.

2. At the beginning of therapy, therapists should provide opportunities for discussion of therapeutic processes, and obtain informed consent from their clients.

3. Therapists should be aware of their own beliefs and values about recovered memories, and understand the implications of these for the therapeutic relationship and therapeutic practice.

4. Consultation and supervision, working within the therapist's level of competency, and appropriate record keeping, are essential to ensure safe and ethical practice.

5. Therapists should keep up to date with scientific research and recommendations for therapeutic practice with recovered memory.

Legal Aspects of Work with Recovered Memories

1. Therapists must recognise that their primary responsibility is to their clients' needs. It is not the role of therapists to advise clients to take any particular course of action with external parties. When clients decide to make a report to police, or confront family members, it is advised that therapists explore the desired outcomes of such actions with their clients.

2. In the case of a criminal prosecution or civil action, therapists may be in the position of providing evidence or having their records subpoenaed, and therefore their knowledge, skills, practices and clinical records may come under external scrutiny. It is important that therapists are aware of relevant confidentiality and privacy laws in their state or territory, and keep accurate records of sessions[14].

3. Recovered memories and abuse experiences described by clients may alert therapists to the risk of harm to other individuals. It is essential that therapists are aware of their legal

[14] Refer to PACFA Guidelines for Record Keeping

responsibilities, including child protection reporting, and ensure an appropriate assessment of risk factors is undertaken.

Section Four: Recommendations for Future Research

1. Further research is needed to understand more fully the mechanisms involved in the processing, storage and retrieval of traumatic memories.
2. Further research is needed to ascertain the extent to which outcomes from laboratory experiments on memory can be generalised to the actual experience and memory of traumatic events.
3. Therapists are encouraged to contribute to research in this field.

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