

The background of the slide is a photograph of an interior space. It features a textured brick wall on the left and a window with a white frame on the right. In the foreground, there is a light-colored, upholstered chair. The lighting is soft and natural, coming from the window.

Recovered Memory of Childhood Sexual Abuse: An overview of research evidence and guidelines

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Foreword

This Occasional Paper, written by Ann McDonald, is an overview of the contentious debates in the literature about recovered memory and therapy, and is intended as a resource for counsellors and psychotherapists working with traumatised clients. This paper outlines the fierce debates about recovered memory of childhood sexual abuse. The history of these debates is complex, with societal, therapeutic, legal, ethical and individual factors entwined. After twenty-five years of significant research and discussion, there are significant areas of agreement, as well as continuing divisions, about the validity of recovered memories and how memory functions under stress and trauma. The various stakeholders in this debate are researchers, clients, practitioners, associations and foundations. The review presents and compares position statements and guidelines developed by relevant professional associations on appropriate therapeutic practice with clients with recovered memory.

The PACFA Research Committee recognises the importance of counsellors and psychotherapists having access to research evidence in the field of historical child sexual abuse to inform their clinical practice. At the same time, PACFA is publishing the related *Consensus Guidelines for Working with Recovered Memories*.

The Research Committee is committed to supporting PACFA Members, Registrants and Member Associations to develop research protocols that will help the profession to build the evidence base to support the known effectiveness of counselling and psychotherapy modalities and fields of practice. We hope that you will find this paper, and the Consensus Guidelines, useful in your practice. We welcome your feedback on this paper, and the submission of further reviews for publication in this series.

Dr Ione Lewis
Chair, PACFA Research Committee
2017

Abstract

Recovered memory of childhood sexual abuse is one of the most fiercely debated topics in therapy. Its history is complex with societal, therapeutic, legal, ethical and individual factors entwined. Significant research and discussion conducted over the past twenty-five years has led to consensus in some areas; however, in other areas the divisions are as wide as ever. This paper explores the history of the debates, provides an overview of the controversies, and examines the agreements reached. In addition, it provides a summary of professional organisations' statements and guidelines. These guidelines provide direction in appropriate therapeutic practice for working with clients who experience a return of memories of childhood sexual abuse.

Introduction

During the 1980s and early 1990s reports of clients forgetting and remembering historical sexual abuse emerged into the public arena. There were serious consequences for the multiple stakeholders; those who had forgotten and subsequently remembered abuse, those who were accused of abuse, and therapists who could be sued for using questionable therapeutic practices. Rival groups, one group consisting predominantly of clinicians, and the other predominantly of experimental psychologists, promoted their differing perspectives with such fervor it was called a 'war' (McNally, 2005; Ost, 2003). Clinicians argued it was possible for individuals to forget and remember traumatic experiences, and that mechanisms such as repression and dissociation accounted for the processes involved (Dalenberg, 2006; Dalenberg & Palesh, 2010; Erdelyi, 2006). Experimental psychologists were dismissive of these processes, arguing that emotional stress enhances memory and therefore traumatic events are rarely forgotten (Mc Nally, 2005). The groups competed to have their respective positions accepted as truth, and thereby gain power to provide expert opinion in court cases, determine therapeutic practices, and shape societal opinion through disseminating information from an authoritative position. To win this contest, both groups embarked on extensive research. In the dissemination of research, a pattern emerged; of publication, followed by attack and counterattack. This pattern has continued as evidenced by two recent articles, "*Unconscious repressed memory is scientifically questionable*" (Patihis, Ho, Tingen, Lilienfeld, & Loftus, 2014) and "*Why it is scientifically respectable to believe in repression: A response to Patihis, Ho, Tingen, Lilienfeld and Loftus*" (Brewin & Andrew, 2014) published in *Psychological Science*.

Research indicates many therapists during their career will encounter clients who experience the loss and return of memories of childhood sexual abuse (Legault & Laurence, 2007; Polusny & Follette, 1996; Pope & Tabachnick, 1995). However, contradictory narratives in the published literature may cause uncertainty, particularly among new therapists. As with all fields of therapy, it is important that therapists work from an informed position. This paper contributes to meeting that need by providing an overview of the historical background, the debates, and the recommended guidelines for therapeutic practice.

Background to debates on memory

Dissociative amnesia is one of the dissociative disorders described in DSM-5 (American Psychiatric Association (APA), 2013). Its defining features are "the inability to recall important autobiographical information that 1) should be successfully stored in memory and 2) ordinarily would be remembered" (APA, 2013, p. 298). Furthermore, the DSM-5 asserts that dissociative amnesia may occur for an event, or events; a part of an event; or for a period of time. In addition, the greater numbers of adverse childhood experiences, such as childhood sexual abuse, increase the likelihood that dissociative amnesia will occur.

However, as straightforward as this may now seem, the forgetting and remembering of sexual abuse has a long and complex history dating back to the nineteenth century. Both historical and socio-political forces have shaped this history (Belli, 2012; Dalenberg & Paulson, 2010; Freyd &

Quina, 2000; Sivers, Schooler, & Freyd, 2002). It is significant that historically there has been acceptance that memory for traumatic events may be forgotten and later remembered; however, when forgetting and remembering childhood sexual abuse is discussed, there has been derision and dismissal (Berwin, 2012).

In 1896, at the Society of Psychiatry and Neurology in Vienna, Freud first theorised about the links between hysteria, childhood sexual abuse and memory. He proposed that the cause of hysteria was abuse in childhood by adults, and that subsequent repression of the event served as a defense mechanism to remove memories of the experience from consciousness (Freud, 2001/1896). Some writers have argued that Freud's theory triggered such discomfort in his colleagues that they ostracised him, and as a result Freud abandoned his theory (Masson, 1984). When links between childhood sexual abuse and amnesia re-emerged there was considerable backlash. Belli (2012) argues that it was the potential for criminal proceedings to be instigated against perpetrators that led to this backlash and the subsequent controversies and conflicts that developed.

In the early 1990s, antagonism was directed towards clinicians who were accused of holding unscientific theoretical positions and of utilising suggestive therapeutic techniques responsible for the creation of false memories (Golstein & Farmer, 1993; Loftus, 1993; Wakefield & Underwager, 1992). Although there was never any therapeutic approach specifically promoted as recovered memory therapy, there is consensus that techniques used by some therapists may possibly lead some clients to believe they had been sexually abused in childhood when they had not.

Techniques that caused alarm included the use of hypnosis for memory retrieval (Siegel & Romig, 1990), and asking clients to talk about their experience of childhood abuse without them having previously mentioned being sexually abused (Prendergast, 1993). Another directive approach recommended by Ellenson (1986) advised therapists that if they thought a client was in denial about childhood sexual abuse, they could inform the client that similar symptoms were experienced by clients who had been abused, and then ask the client who abused them. Criticism was targeted at the authors of the popular book *Courage to Heal: A Guide for Woman Survivors of Sexual Abuse* (Bass & Davis, 1988, p. 22) for their lack of training in mental health, and for statements in the book, such as, "If you think you were abused and your life shows the symptoms then you were".

An increase in both the number of individuals speaking publicly about their experiences of forgetting and subsequently remembering experiences of childhood sexual abuse and the number of individuals accused of historical crimes, led to the formation of groups whose purpose was to counteract the emerging narrative. The first and most influential group, The False Memory Syndrome Foundation (FMSF), was founded in Philadelphia in 1992 by a couple whose daughter had recovered memories of her father sexually assaulting her as a child. The FMSF established a Scientific and Professional Advisory Board that became very adept at using media and conferences to promote their message (Butler, 1995; False Memory Syndrome Foundation, 2013).

The organisation promoted the idea that clients who recovered memories of sexual abuse were suffering from false memory syndrome. False memory syndrome, a term developed by one of the FMSF board members, is described as, "a condition in which a person's identity and interpersonal

relationships are centred on a memory of traumatic experience which is objectively false but in which the person believes" (Kihlstrom, 2012/1993, para.38). Pope (1996) argues that the FMSF did not furnish evidence validating the syndrome nor could they provide methodology that could be utilised to ascertain whether memories were false. As was usual of the disputes that flourished during this period, seventeen researchers authored a statement rejecting the assertion of a syndrome, stating that it was "a non-psychological term originated by a private foundation whose stated purpose is to support accused parents" (Carstensen et al., 1993, p. 23).

During this period, it was predominantly women making public statements about the return of memories of childhood sexual abuse. This led to women, the feminist movement and sexual assault services becoming targets of attack. One of the most outspoken FMSF members was psychiatrist, Ralph Underwager, who with his wife, Hollider Wakefield, provided an interview to the Dutch, non-academic, pro-paedophilia journal, *Paidika: Journal of Paedophilia*. In this interview, Underwager suggested that radical feminists and lesbians may be jealous of the closeness and intimacy of sexuality between men and boys (Geraci, 1993). In the same interview, Underwager made statements that paedophilia could be considered an "acceptable expression of god's will" (Geraci, 1993, p. 12). This interview troubled the FMSF, and although Underwager in other writings had declared that sexual abuse was harmful to children, the impact of the published interview led to his resignation from the FMSF board.

By 1997, the debates about recovered memory were so divisive that the editors of the *Journal for Interpersonal Violence* invited prominent authors, Lindsay and Briere, to provide a commentary on the controversy. The authors identified that inappropriate generalisations about memory had been made, that the media had thrived on the polarisation of the controversy, there was ongoing tension between various clinical psychologists and experimental psychologists, that wealthy individuals with access to media and professional organisations had promulgated false information, and that legal cases were profitable to psychologists acting as expert witnesses (Lindsay & Briere, 1997).

As the field of inquiry developed, it became popularly known as the recovered memory or false memory debate. However, in fact there are multiple debates. These debates centre on whether memories can be forgotten and remembered; the mechanisms involved in forgetting abuse; the processes by which memories return; and the accuracy and reliability of returning memories. In addition to the debates on memory and trauma, debates also centre on research design, the interpretation of data, and the ethical use of results. A discussion of these significant areas for counselling and psychotherapy follows.

Researching forgetting and remembering of childhood sexual abuse

Studies of events that occur mostly in private, that may be forgotten and later remembered, is a complex task. The body of evidence is characterised by a diverse range of research approaches and research populations. There are two main types of research studies. The first type consists of approaches that study differing populations who have, or may have, experienced childhood sexual abuse. The second type is experimental research, which is conducted in laboratories on

memory, and the results are generalised to the phenomena of forgetting and remembering childhood sexual abuse.

Three main population-based research approaches used to investigate this phenomenon are: (1) survey studies on patient/client populations which aim to ascertain if there were times when clients may not have remembered childhood sexual abuse; (2) prospective studies whereby adults with a documented history of childhood sexual abuse are interviewed about their childhood experiences to determine if they have memories of the abuse; and (3) in-depth case studies which involve researchers conducting detailed analysis of individuals who have recovered memory (Sivers et al., 2002).

Sivers et al. (2002) critique the methodologies used in each of these research approaches. They argue that many of the participants in these research studies were familiar with the concept of recovered memories, thereby creating the potential for bias. Furthermore, participants taking part in self-report studies often lack corroboration for the abuse and this impacts on the validity of the results. In addition, there is a further complication with prospective studies, which is that participants who do have memories of childhood sexual abuse may choose not to disclose when interviewed.

The second type of research informing the debates is experimental research mainly conducted by cognitive psychologists in laboratory settings. These researchers aim to understand the many facets of memory, in particular, the functioning and reliability of memory in both children and adults. They argue that their findings are highly relevant to understanding the forgetting and return of memories of childhood sexual abuse (Geraerts, 2012; Kihlstrm 2004; Laney & Loftus, 2013; McNally, 2005).

However, the generalising of results of laboratory experiments to the forgetting and remembering of childhood sexual abuse is highly contentious due to contextual and ethical concerns. Those who dispute the validity of generalising such findings argue that memory experiments conducted in the laboratory cannot replicate the complex, interpersonal and deeply emotional nature of sexual abuse (Axmacher, et al., 2010; DePrince et al., 2012; Freyd, 1998; Freyd & Gleaves, 1996; Freyd & Quina, 2000).

For example, Berwin (2007) argues that differing memory processes operate under stress, and therefore laboratory experiments measuring mild levels of stress are limited in what they can reveal about memory when extreme stress is experienced. He cautions that memory research conducted on groups with different characteristics, namely, data from non-traumatised and traumatised groups of participants, may yield very different results, which makes generalising findings inappropriate.

Various authors are concerned about the lack of ethical and socially responsible reporting of laboratory findings (DePrince et al., 2004; DePrince et al., 2012; Freyd, 1998; Freyd & Quina, 2000). These authors argue that researchers' voices are privileged and have the power to define reality. Given this influence, there is an imperative to report data accurately. Many people who have been sexually abused are from marginalised groups and research in this area potentially can empower or further oppress victims and survivors.

Brown (1996) raises a concern about confirmatory bias in research. She identifies that those researchers who believe memory is highly malleable produce results confirming this position, and vice versa. Similarly, Brown argues that researchers who are more convinced about the malleability and suggestibility of childhood memory are more likely to generalise these findings to support the suggestibility of adults and the fabrication of childhood sexual abuse memories.

Another concern in the body of evidence is the lack of consistency in terminology and definitions. Experimental researchers are criticised particularly for how they have defined false memory. Pedzek and Lam (2007) claim the term originally referred to a memory for an entirely new event that had never actually been experienced by an individual. However, only 26 (13.1%) of 198 false memory research articles adhered to this definition. Pedzek and Lam argue that data from experiments on the accuracy of memory such as participants misremembering words in lists, is more accurately described as flawed memory, and this should be made clearer when applying research findings to a discussion of recovered memory. Similarly, Dalenberg and Paulson (2010) highlight instances when researchers have departed from the accepted definition of recovered memory and compared data that is not comparable.

In published research, the terminology for both forgotten and returned memories varies. Dissociative amnesia is also called “traumatic amnesia, dissociated memory or repressed memory” (Dalenberg, 2006, p. 290). Other terms used are “blocked memories” (Health Services Commission, 2005, p. 35; Kihlstorm, 2004, p. 34) and “ordinary” forgetting (McNally, 2005, p. 183). Memories that return are generally called returned or recovered memories; however, another term used by Schooler (2001) is “discovered memories” (p. 105). The language used generally depends on the position adopted by the authors. Those researchers who are supportive of unconscious processes use terms such as traumatic amnesia, and those who do not support such processes use terms such as forgetting.

Controversies about memories of childhood sexual abuse

Can memories of childhood sexual abuse be forgotten and then return?

Surveys, prospective research studies, and case studies conducted since the 1990s have provided credibility for the phenomena of forgetting and remembering childhood sexual abuse. Two pioneering research studies contributed significantly to the provision of evidence. A prospective study by Williams (1994) focussed on 129 women who presented to hospitals as children for sexual abuse. The women were interviewed about their life, including hospitalisations. Thirty-eight percent of the participants did not remember or describe the hospital visit. Although it is possible some participants chose not to disclose their history, the researchers concluded that some participants had no memory of these events. Evidence that is generally accepted as conclusive for the potential for memories to be forgotten and return is provided in case study research conducted by Schooler (2001). Seven participants in his study had independent corroboration of childhood sexual abuse. Detailed analysis of their circumstances revealed that they did not remember the abuse until adulthood.

More recently, twenty-five survey and prospective studies on recovered memory conducted between 1993 and 2007 were systematically analysed by DePrince et al. (2012). They found that

between 14-68% of participants in reviewed studies had experienced partial or complete forgetting of childhood sexual abuse.

Finally, independent research conducted by professional organisations provides further credibility to the claim that childhood sexual abuse may be forgotten and later remembered (American Psychiatric Association, 1993; American Psychological Association, 1998; Australian Psychological Society, 2000; Roth & Friedman, 1998). The following is indicative of the independent research findings: “Memories of such experiences may be incessant, intrusive, complete, selective, fragmented, distorted or absent depending on the context and nature of the abuse and the survival strategies available to the individual child or later in life” (Australian Psychological Society, 2000, p. 1).

How is childhood sexual abuse forgotten?

It is well known that individuals find ways to control disturbing memories (Anderson & Huddleston, 2012), however, the processes individuals utilise to avoid them is the subject of extensive debate. By 1998, Roth and Friedman had produced a report for The International Society for Traumatic Stress Studies titled: *Childhood Trauma Remembered: A report on the current scientific knowledge base and its applications*. They summarised the situation in this way:

It is not currently known how traumatic memories are forgotten, and different mechanisms may operate under different circumstances. These questions are of great interest to researchers, and we can expect a rapid growth in information in this area in the next decade (p. 13).

The authors were accurate in their predictions, and despite voluminous research there is currently no agreement about the processes involved. Below are the processes most frequently discussed.

Repression

Repression is commonly cited as one of the mechanisms to explain the process by which traumatic amnesia occurs. However, differences abound as to whether repression exists, and if so, the actual process involved. Dalenberg (2006, p. 89) notes that early literature on recovered memory describes repression as both a conscious and unconscious process:

Repression is a mechanism occurring after a trauma, often beginning with conscious expulsion and then progressing to unconscious action, whereby the memory is pushed out of the conscious mind and held away from consciousness by the victim’s fear and anxiety about confronting the memory.

More recently, Dalenberg and Paulson (2010, p. 29) argue that writers have used the term repressed memory to describe a more conscious process, “motivated amnesia”.

Primarily, it is experimental psychologists who conduct or analyse laboratory experiments on repression who deny its existence. Often cited is Holmes (1990), who, after examining sixty years of laboratory experiments on repression concluded that there is no evidence for the concept. However, as is typical of the debates, Axmacher et al. (2010) dispute the methodologies used by

Holmes to test repression. They argue that repression involves an overwhelming negative emotional reaction involving a lack of voluntary control beyond the person's ability to cope and that these conditions cannot be replicated in laboratory conditions.

Dissociation

Dissociation as a result of trauma may impact an individual's perceptions, sense of self, connection to body, and memory (Sivers et al., 2002). The memory disturbances accompanying dissociation are thought to occur as a result of disturbances in the encoding of the memory or the subsequent processing and storage. Sivers et al. (2002) argue that poor encoding of memories at the time of the trauma may result in memories becoming fragmented or absent. Similarly, Dalenberg, (2006) suggests that dissociative detachment occurring at the point of the trauma results in inhibition of the emotional processing of the event. When this occurs, the normal route of memories into long-term memory storage and subsequent memory recall is impacted. Berwin (2012) provides a further explanation of the impact of dissociative processes on memories. He proposes that extensive trauma in childhood may lead to the development of a fragmented self, or parallel selves, with some aspects of the self, including memories, hidden from awareness.

Furthermore, the compartmentalisation of memory that may occur with dissociation has also given rise to the theory of state dependent memories (Christianson & Engleberg, 1997; Dalenberg, 2006; DeMonte, 2000; Sivers et al., 2002; van der Kolk, 1998). This theory proposes that memories stored while an individual is in "a specific psychological state (such as fear) are less accessible when the individual is not in this state" (Dalenberg, 2006, p. 290). It is posited these memories will only be accessible again when an individual is in a similar emotional state to when the memories were initially stored.

Betrayal trauma theory

Betrayal trauma theory focusses on the motivation for forgetting abuse. Freyd (1994) argues against the predominant trauma models that describe fear as the motivator for trauma reactions. She instead focuses on levels of betrayal as a predictor of outcome. Similar to attachment trauma theory, betrayal trauma theory argues that there are differing responses to trauma, depending on the attachment relationship between the victim and the perpetrator (Bernstein & Freyd, 2014).

Freyd (1994) argues that it is the social context, namely, the closeness of the relationship between the victim and the perpetrator that determines whether abuse is likely to be forgotten. Based on this premise, she contends that children are more likely to forget incestuous abuse than abuse perpetrated on children by individuals with distant or no relationship to them. Betrayal trauma theory views the forgetting of abuse as an adaptive response as it enables children to continue to maintain an attachment to caregivers on whom they are reliant (DePrince et al., 2012). In support of betrayal trauma theory, meta-analysis on the variables associated with the forgetting of abuse has found there is a link between the victim-perpetrator relationship and the degree of forgetting of childhood sexual abuse (DePrince et al., 2012).

Brain and traumatic memories

With the advent of MRI scans, researchers embarked on studying the impact of traumatic stress on the brain. They identified that both Vietnam veterans with PTSD and women with histories of sexual abuse have significant damage in the hippocampus (Bremner, 2005). The hippocampus is responsible for transmitting information into long-term memory. Some researchers consider that changes in brain chemistry may play a role in forgetting traumatic memories. Authors hypothesise the damage to the hippocampus arises due to an increase in cortisol levels at the time of a traumatic event, and the continuation of high levels once the traumatic event has ceased (Bremner, 2005; Bremner et al., 1997). Berwin (2014) endorses this hypothesis, however, he notes that reduced hippocampal volume is also observed in individuals with depression and schizophrenia. For this reason, it is not possible to make definitive claims that damage in the hippocampus is responsible for an individual forgetting traumatic events. In addition, it raises further questions about the links between trauma and memory in depression and schizophrenia.

Night-time abuse

Schooler (2001) proposes that childhood sexual abuse that occurs at night may be immediately forgotten. He developed this hypothesis as a result of analysing information collected from in-depth interviews. Three participants described how by morning they had forgotten abuse experiences which occurred at night. Schooler contends the absence of memory for night-time abuse is comparable to the absence of memory for dreams, and that similar to dreams, unless memories are brought to mind in the morning, they are likely to be forgotten. One participant in his study recounted, “When I woke in the morning I didn’t have any knowledge of what happened the night before, which is why I could continue to go on trips with him and enjoy it” (Schooler, 2001, p. 129).

Explanations favoured by experimental psychologists

It is characteristic of experimental psychologists to discount many of the theories and processes described above by arguing that when individuals do not recall events for a period of time, it cannot be concluded that processes such as repression and dissociation are involved. Instead, alternative explanations for why events may not be remembered are proposed, including poor encoding into memory at the time of the event, insufficient cues to remind the person of the event, the decay of memory (Johnson et al., 2012; McNally 2003, McNally, 2012), and the normal deterioration of childhood memory (Geraerts, 2010; Kihlstrom, 2004; McNally, 2003).

The theory of motivated forgetting has gained prominence amongst experimental psychologists as a plausible explanation for why memories may be forgotten. This theory proposes that individuals may intentionally forget when motivated to do so in order to keep unpleasant memories out of awareness (Geraerts, 2012). According to Anderson and Huddleston (2012), motivated forgetting allows individuals to maintain their emotional state, sense of self, and well-being in order to focus on what needs to be done. It is theorised that motivated forgetting involves a process of active retrieval suppression, is continuously employed, begins as a conscious process and becomes unconscious over time (Anderson & Huddleston, 2012).

Remembering processes

Data collected directly from clients, therapists, and case studies, have provided information on the processes involved in the return of memories (Berwin, 2012). In the early history of the debates, vigorous campaigning by the FMSF promulgated the idea that suggestive therapy, sometimes referred to as recovered memory therapy, was the primary catalyst for the returning of childhood abuse memories. However, many authors (Berwin, 2007; Chu et al., 1999; Health Services Commission, 2005; McNally, 2005; Wilsnack et al., 2002) present an alternative view, and argue that the majority of people who recover memories do so outside of therapy. A large scale national United States study of women and their experiences of childhood sexual abuse, including the return of sexual abuse memories, concluded, “this study suggests that therapist-assisted recall is not a major source of CSA memories among women in the US general population” (Wilsnack et al., 2002, p. 139).

Closer to home, the practices of therapists and their suspected use of suggestive practices came under the spotlight in the Australian Health Commissioner’s inquiry into recovered memory therapy (Health Services Commission, 2005). Twenty-four individuals who had recovered memories of childhood sexual abuse participated in the inquiry. Nineteen of the twenty-four participants indicated that they had completely forgotten childhood abuse, and five indicated they had partially forgotten. The majority of participants reported that they recovered fragments of memories prior to seeking therapy, with only one participant stating that she initially recovered memories of abuse during therapy. Importantly, and contrary to the view promoted by some interest groups, participants in the inquiry indicated that practitioners were unlikely to encourage, or focus, on memories that returned.

Malmo and Laidlaw’s (2010) research provides insight into the recall processes of 29 participants who recovered memories of childhood sexual abuse outside of therapy, and 13 participants who recovered memories of abuse in therapy. Of interest to the researchers were the triggers that activated the return of memories. Both internal triggers, such as dreams, repetitive thoughts and images, and external triggers, such as context, and seeing the perpetrator, were investigated. External triggers were the main catalyst for the return of memories for participants whose memories of abuse returned prior to entering therapy. For participants whose memories returned once they were receiving therapy, the triggering factors were primarily internal. After entering therapy, 85% of participants whose memories returned prior to therapy, and 92% of those who remembered the abuse while in therapy, indicated they had new memories return outside of therapy sessions.

Malmo and Laidlaw (2010) measured participants’ symptoms and the subsequent impact on symptoms of returning memories. Each participant group showed both symptom improvement and symptom deterioration during their therapy. Those with no prior memory of abuse prior to therapy experienced more changes than those who had memories return prior to entering therapy. Participants in the no prior memory group reported a “decrease in emotional numbing, a sense of something missing and generalized amnesia for childhood” (Malmo & Laidlow, 2010, p. 38). In addition, there was a decrease in risk taking and dangerous behaviours.

However, symptoms that increased markedly in this group were “medical/physical symptoms, overwhelming fear and terror, intrusive images and flashbacks and intrusive body sensations” (Malmo & Laidlaw, 2010, p. 38). Malmo and Laidlaw (2010) hypothesise that these participants may have had greater dissociative symptoms and therefore experienced a greater increase in symptoms as they integrated the trauma.

Three quarters of the participants who had memories of abuse prior to entering therapy reported medical/physical symptoms prior to therapy and a slight decrease in these symptoms once in therapy.

In addition to internal and external factors triggering the return of memories, two other explanations are proposed in the literature. As previously discussed, state dependent theory argues that memories will only be accessible if individuals experience the same emotional state experienced at the time of dissociation and fragmentation of the memory (Dalenberg, 2006; Del Monte, 2000; Christianson & Engleberg, 1997; Sivers et al., 2002; van der Kolk, 1988). Other authors (McNally, 2005; Sivers et al., 2002) propose that a process of reinterpretation may trigger the return of memories. They posit that young children may not have understood the meaning or significance of the sexual abuse. It is only when children are older and gain understanding that the events were abusive that they experience awareness of abuse for the first time. Furthermore, it is proposed a change in interpretation may activate associated memories leading to an increase in awareness of the events.

Several studies focus on the manner by which memories return. Participants in Malmo and Laidlaw’s (2010) study describe how their memories returned as fragments, and how over time they pieced together the fragments to gain a narrative of events. Similarly, a study focussing on triggers and the process of returning memory for multiple types of childhood abuse found that traumatic memories, particularly of childhood sexual abuse, frequently returned in a piecemeal fashion (Andrews et al., 2000). The authors found this consistent with the theory proposed by Alpert et al. (1998) and Van der Kolk and Fisler (1995).. These authors argue that if dissociation impacts on the encoding of memory, causing the memory to fragment, and there is no subsequent processing of the memory, then the memory is likely to return as fragmented and piecemeal.

There are comparable and divergent findings in other studies. The gradual return of memories, sometimes over years, is a frequent finding. Individuals construct narratives over time in response to sensations and visual images (Milchman, 2008; van der Kolk et al., 2001). In contrast, participants in Schooler’s (2001) study describe memories returning as complete episodes rather than in fragments.

Having memories of sexual abuse may be disorientating. As memories arise, individuals may have to sit with uncertainty about the events and what occurred. This lack of clear memory can be distressing (Milchman, 2008). Other reactions identified are shock, disbelief and confusion (McDonald & Webb, 1998; Schooler, 2001).

This section has discussed the body of research that accounts for a range of different processes involved in the return of memories. It is only with further investigation and greater methodological rigour that greater clarity about these processes will be gained.

Authenticity of memories

Research to determine the authenticity of memories is primarily undertaken by cognitive researchers. According to Geraerts (2012), outcome data from three types of laboratory experiments are generalised to analysing the authenticity of recovered memories. The first type of experiment involves giving false information to participants after they have witnessed an event. These experiments have shown that in subsequent recall, participants may include this false information in their later accounts of the event. The second type of experiment involves giving participants lists of words. When participants are given an additional list of words similar to the first list, false recall may occur for items from the first list. The third type of experiment involves planting childhood memories in participants for events that never occurred. Geraerts (2012) concludes that experiments such as these demonstrate that returning memories may be false. There is general agreement with this statement.

Of interest to researchers is the degree of accuracy of returned memories, in particular the question as to whether returned memories are as accurate as memories that have been continuously known. There are differing responses to this question. DePrince et al. (2004) examined the relevant research to determine if returned memories were less accurate. They summarised, "Research to date has not shown that abuse memories that were previously unavailable are inherently less accurate than abuse memories that were continuously available" (p. 213).

Cognitive researchers Anderson and Huddleston (2012) contend otherwise. They reason that it is highly unlikely that returned memories are preserved in their pristine form. The results of cognitive research suggest that suppressed memories are more likely to be distorted on their return.

Suggestibility and the ease, or otherwise, of therapists implanting memories in clients is a focus of research. According to Kihlstrom (2004), research results are mixed, with some reports indicating that it is difficult to implant memories and other results suggesting that it is not. Importantly, Kihlstrom notes that a combination of therapist and client factors may render a client more prone to the development of false memories. These include: therapists who hold strong beliefs in repression and who consider symptoms such as depression and anxiety to be strong indicators of historical trauma; therapists who communicate ideas to clients who may already be familiar with the concept of recovered memories from media or word of mouth, and therapist/client dynamics of power and social influence.

DePrince et al. (2012) express concern about the validity of studies demonstrating that memory is suggestible. They argue that these findings ought not be applied to all individuals who have recovered memories of childhood sexual abuse. Furthermore, given the multiple factors involved in the processes of both forgetting and remembering, it is considered inadvisable for therapists to make generalisations about the authenticity, or otherwise, of clients' memories. Instead it is recommended that each client's unique factors and situation are carefully considered (Freyd & Quina, 2000; McNally & Geraerts, 2009; Ost, 2003).

Corroborating evidence for the occurrence of abuse provides verification for the authenticity of recovered memories (Schooler, Ambadar, & Bendiksen, 1997; Schooler, 2001) with "medical,

documentary, eyewitness, and confession” (DePrince et al., 2012, p. 216) deemed to be the most credible types of evidence. Unfortunately, due to the secrecy of most abuse and the time elapsed, many individuals will be unable to corroborate their experiences and are therefore reliant on their own perceptions and conclusions.

Clinical guidelines

Diverse opinions and lawsuits against therapists for poor clinical practice spurred organisations and professional associations to produce statements on memory and guidelines for therapeutic practice. By 2000, many of these were in place, providing clinicians with a sound foundation for practice when working with clients who have recovered memories of childhood sexual abuse or who recover memories in therapy. It is noteworthy that despite the turbulent debates in the literature, there is a high degree of consensus evident in the statements and guidelines. In subsequent publications, recommendations and guidelines for practice have remained consistent, even though there continue to be fundamental differences in authors’ views about recovered memory.

In the following section, Table one summarises position statements about trauma memory, and tables two to three analyse the guidelines produced by the following organisations: International Society for Traumatic Stress Studies (as cited in Roth & Friedman, 1998), Australian Psychological Society (2000), Australian Hypnotherapists Association (2009), American Psychiatric Association (1993), American Psychological Association (1998), and The British Psychological Society (1995).

Table one: Position statements about memory

Statements	Organisations
<p>Memories of trauma may be forgotten and then remembered</p> <p>Memories for abuse that never occurred may be constructed</p> <p>Returning memories of abuse may be partially true and partially false</p>	<p>American Psychiatric Association (APAA), 1993; American Psychological Association (APAb), 1998; Australian Psychological Society (APS), 2000; The British Psychological Society (BPS), 1995; Australian Hypnotherapists Association (AHA), 2009</p>
<p>Memories may present in different ways: fragmented, distorted, and intrusive</p>	<p>APS, 2000</p>
<p>There are gaps in knowledge about memory and how it operates with regards to recall of childhood sexual abuse</p>	<p>APAA, 1993; APAb, 1998</p>
<p>Memories are vulnerable to alteration from the event to disclosure</p>	<p>APS, 2000</p>
<p>Powerful flashbacks or vivid memories cannot be relied on as evidence of truth of recovered memories</p>	<p>AHA, 2009; BPS, 1995</p>
<p>Strong beliefs about, and intense emotion with memories, do not confirm the accuracy of memories</p>	<p>APS, 2000</p>

There are no standard methods for verifying accuracy of memories Clients need to draw their own conclusions	International Society for Traumatic Stress (ISTSS), 1998
Some individuals who have recovered memories of childhood sexual abuse have corroborated their memories	APAa, 1993
Memories may return in therapy or outside of therapy	BPS, 1995

Table two: Therapeutic practices not supported by evidence

Practice	Organisations
Exerting pressure on clients to believe in events that may not have occurred	APAa, 1993
Using symptom lists or presenting symptoms as the sole indicator of childhood sexual abuse	APS, 2000; BPS, 1995; ISTSS, 1998
Probing for forgotten or repressed memories	AHA, 2009
Using hypnosis which makes memory less dependable	BPS, 1995
Suggesting to clients that they may have been abused	ISTSS, 1998

Table three: Recommended therapeutic practices

Processes and practices	Organisations
Maintain an empathic, non-judgmental and neutral stance	APAa, 1993; APS, 2000; BPS, 1995
Accept and respect clients' reality Avoid making premature judgements about the truth of recovered memories	BPS, 1995; AHA, 2009
Be comfortable with uncertainty and ambiguity	AHA, 2009; APS, 2000; BPS 1995
Avoid searching for memories, giving suggestions, and asking leading questions Be open to working with clients on their past	AHA, 2009; APS, 2000; BPS 2000; ISTSS, 1998
If clients are not certain of their memories and they do not have corroboration, therapists are to assist clients to adjust to uncertainty	APAa, 1993
Assist clients to consider carefully any action, such as prosecution against an alleged abuser	APS, 2000; BPS 1995
Keep appropriate records	APS, 2000; BPS, 1995; ISTSS 1998

Seek supervision before engaging in activities designed to recover memory	AHA, 2009
Therapists need to be aware of their own beliefs and values, and the societal and scientific context in which recovered memory debates occur	APS, 2000
Explore the meaning and implications of recovered memory with clients Discuss with clients who recover memories that memories may be “true or false, partly true, distorted, selective, thematically true, metaphorically true, or a blend of accurate, distorted and symbolic material” (APS, 2000, p. 4)	APS, 2000
Allow clients to come to their own conclusions about their past	ISTSS, 1998
Remember that the primary goal of therapy is to increase client functioning	ISTSS, 1998
Keep abreast of both scientific knowledge, and recommended clinical practice	APS, 2000
Specialist training is needed to work with clients who report having memories of childhood sexual abuse return	APAa, 1993

This analysis of clinical guidelines shows that therapists from diverse professions are encouraged to provide environments in which clients are able to explore suspected memories of childhood abuse. Included in this process is helping clients “examine the basis for their suspicions, consider alternative explanations, learn about various abuse, and non-abuse related origins of psychological distress, and become informed about the ways that memory works and can be altered or distorted” (Roth & Friedman, 1998, p. 16).

DePrince et al. (2012) discourage the use of suggestive techniques to help clients access memories of childhood sexual abuse. Exposure therapy techniques may be utilised to assist clients to process memories that arise, and in this process new memories may emerge naturally. However, delving for new memories or further details is not recommended.

The need for appropriate training of therapists is recommended in certain guidelines (APAa, 1993; APS, 2000). Similar, and additional recommendations, emerged from the inquiry conducted by the then Australian Health Services Commissioner. The purpose of the inquiry was to “identify opportunities for improving practice and protecting the public” (Health Services Commission, 2005, p. 7), and therefore the recommendations contained in the report were broad. The report recommended that teaching organisations review their trauma training programs; that professional bodies who had not done so develop best practice guidelines for their members; that all practitioners offering therapy services become members of appropriate professional bodies;

that a community education campaign be provided by the then Department of Human Services to educate the public about selecting practitioners; and that the Office of the Health Services Commission continue to monitor developments in the field. Each state and territory has since established their own health care entities.

Three years later, parliamentary records (Parliament of Victoria, 2008, pp. 1461-1462) outline progress in the preparation of public education materials. By 2009, both the Australian Hypnotherapists Association and the Australian Psychological Society had produced guidelines for their members (Australian Hypnotherapists Association, 2009; Australian Psychological Society, 2000) and PACFA had produced draft guidelines (Schofield & Kettle, 2005).

Conclusion

The history of the recovered memory debates is fraught with conflict between foundations, researchers, practitioners and clients. Controversy still remains, particularly about how memory functions under stress. Concerted efforts by many have resulted in agreement in some areas. Of particular interest to therapists are the professional association guidelines developed to guide practice. When guidelines are adhered to, the public and clients can be assured that, despite unresolved controversies, therapy services provided follow best practice and take into account clients' unique circumstances.

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