The Trauma-Memory Argument and Recovered Memory Therapy

John F. Kihlstrom

Yale University

The trauma-memory argument proposes that memories of childhood trauma can affect adult behavior outside awareness, and that such unconscious memories can return to awareness even after long delays—a situation which recovered memory therapy is intended to foster. Unfortunately, both the argument and the therapy are based on case reports of unknown representativeness and on clinical studies which are methodologically flawed or which do not consider alternative explanations. Of particular concern is the general lack of independent verification of the ostensibly forgotten memories. The trauma-memory argument is plausible, in at least some respects, given what we know about the processes of remembering and forgetting; but considerably more empirical research is needed before it can serve as a basis for scientifically sound clinical practice.

INTRODUCTION

> Why would adult memory researchers contradict the clinical findings and some research findings that adult women who were sexually abused as children may have memory problems and often remember the abuse during therapy? Certainly personal biases, such as distrust of therapists, desire to support male perpetrators, denial that "nice" men can molest children, enjoyment of the recognition provided by groups that rally around men who are allegedly falsely accused, prior experience with one or more unfounded (not untrue but unprovably legally) cases, and need to stand by a previously expressed position, may figure into such motivation. (Lenore A. Walker, 1994, p. 85)

An increasing number of researchers, clinicians, and members of the public at large have become interested in two related propositions: (a) that memories of childhood incest, sexual abuse, and other trauma can affect adult personality outside awareness; and (b) that such unconscious memories can return to awareness, even after long delays. This *trauma-memory argument* (e.g., Bass & Davis, 1988; Frederickson, 1992; Herman, 1992; Terr, 1994) typically begins with a child who has been the victim of trauma such as incest or sexual abuse. Under certain circumstances, it is argued, the child defensively invokes a mental process such as repression or dissociation, which in turn results in an amnesia for the trauma. Nevertheless, representations of the trauma have been encoded in memory; these representations persist and affect subsequent experience, thought, and action in the form of intrusive images, bodily feelings, repetitive dreams, and other mental and behavioral symptoms. The presence of these symptoms, then, is taken as a sign that a traumatic event occurred, and a traumatic memory for that event exists. At some later time, this unconscious memory may be recovered spontaneously in response to certain cues in the environment, or it may be exhumed by means of certain therapeutic techniques such as

The Recovered Memory/False Memory Debate
Copyright © 1996 by Academic Press, Inc.
All rights of reproduction in any form reserved.

guided interviews, hypnosis, and barbiturate sedation.[1] Exhumation of the original traumatic memory is an important step in the recovery process; in cases in which the memory cannot be verified, its essential accuracy is demonstrated by its explanatory value in the context of the person's presenting symptoms and overall life history.

Acceptance of the trauma-memory argument has led to the development and promotion of a set of treatment techniques known as *recovered memory therapy*. This term covers a wide variety of therapeutic techniques which share three assumptions: (a) the patient's current symptoms are caused by past traumatic experiences, (b) memories of these events have been lost to conscious recollection, and (c) restoration of conscious recollection (or at least acknowledgment that the trauma occurred) is essential to the successful treatment of the patient's symptoms. Psychoanalysis is a prime example of recovered memory therapy: for contemporary examples of the technique in action, see the cases of Miss F. T. (reanalyzed by Prozan, 1992) and Penelope (analyzed by Prozan, 1993). The counseling and therapeutic techniques advocated by Bass and Davis (1988, 1992) and by Frederickson (1992) are other examples.

It should be understood that recovered memory therapy rarely advertises itself as such, although perusal of the telephone book in almost any large American city will reveal large numbers of therapists offering hypnosis, journaling, guided imagery, and other techniques, including past-life regression, intended to recover forgotten memories of trauma, abuse, and neglect—which, in turn, are assumed to lie at the bottom of the client's problems. Some therapists simply assume that their patients' memories, however they are recovered, are true, without any attempt to seek collaboration. Other therapists set aside the issue of factual accuracy, adopting the solipsistic stance that the memories are *true for him or her*. Still others refrain from doubt or criticism in an attempt to create a supportive and accepting therapeutic environment. In any case, recovered memory therapists risk losing the ability to distinguish among what is true (or even plausible) in their patients' memories, what is unknowable, and what is fantasy.

In the final analysis, recovered memory therapy is best considered as a class of therapies which accept the general terms of the trauma-memory argument and therefore focus on the patient's memories of the past—however they are recovered. At one end is psychoanalysis, which in its classic form makes all three of the preceding assumptions. Other therapies may make only some of them. Some psychotherapies do not make any of these assumptions, and they do not qualify as recovered memory therapies. For example, outside the continuum entirely are insight therapies and exposure therapies that do not make reference to mem-

[1]The phrase *exhumed memory* was coined by Paul Buttenweiser (1993). In my view, it perfectly captures the process by which ostensibly forgotten events are ostensibly discovered in the course of therapy or self-help; I also prefer it because it is neutral with respect to the mechanism (e.g., repression or dissociation) ostensibly responsible for the ostensible forgetting. The metaphor is particularly apt: in paleontology, sometimes you get an *Australopithecus* skull, sometimes Piltdown man.

ories of abuse, or use such memories in any formal way, and which do not make *a priori* theoretical assumptions about the historical causes of present symptoms. Recovered memory therapy is not the name of a particular therapeutic technique; it is a label for a class of therapies. Like all categories, its boundaries are somewhat fuzzy, but there are some clear exemplars, and maybe even a definite prototype, of recovered memory therapy.

THOSE WHO CANNOT REMEMBER THE PAST ARE CONDEMNED TO REPEAT IT

If all of this seems familiar, it is because it *is* familiar. It is the same argument that Freud made about hysteria, abreaction, and catharsis 100 years ago as he began to promote psychoanalysis as a technique of psychotherapy (e.g., Breuer & Freud, 1893–1895/1955). It is an interesting argument, but there is one problem with it. Although we can agree that the exploitation and mistreatment of children, including incest and other forms of sexual abuse, is a major social problem, the scientific evidence supporting the rest of the trauma-memory argument was scant 100 years ago (Schimek, 1987; see also Esterson, 1993; Macmillan, 1991), and the situation has not really changed 100 years later (Baker, 1992; Kihlstrom, 1994b, 1995b; Lindsay & Read, 1994, 1995; Loftus, 1993; Loftus & Ketcham, 1994; Pendergrast, 1995; Ofshe & Waters, 1994; Yapko, 1994).

For the most part, evidence for the trauma-memory argument comes in the form of clinical case reports, similar to Freud's, in which a person, typically an adult receiving counseling or psychotherapy, recovers long-forgotten memories of abuse, trauma, deprivation, and neglect. Such anecdotes are often vivid and sometimes compelling, but we are all too familiar with the limitations of cases as evidence. Observations are likely to be nonsystematic and even biased. Data can be condensed or elaborated during the collection process. Interpretation can be confused with reporting. Hypotheses cannot be tested, and causal inferences cannot be made. Most important, we have no idea how representative a particular case, or series of cases, is—or how much we can generalize from them to the population at large. These problems are compounded when, as in a recent paper by Harvey and Herman (1994), the report presents *composite* cases: composites may be useful literary devices, and they help disguise the identities of individual patients, but they should not be confused with scientific evidence.

There is, of course, a considerable body of clinical research implicating childhood trauma, including incest and sexual abuse, in adult psychopathology. For example, Herman, Perry, and van der Kolk (1989) found a high incidence of incest and sexual abuse in a group of women with borderline personality disorder. There are many similar studies, especially in the domain of eating disorders and dissociative disorders (for a review, see Spiegel & Cardeña, 1993). Unfortunately, all of these studies are based on retrospective self-reports, raising the possibility that the patients' memories may be biased by their current clinical state (not to mention the biases of the interviewer); moreover, the claims of incest and sexual abuse are rarely corroborated by independent evidence. What we need are prospective studies of the adult outcomes of victims of confirmed

child abuse. Even if such studies yield positive results, however, we need to separate the effects of the abuse as such from the confounding effects of the patient's social identification, including self-identification, as a victim of abuse. The context in which abuse occurs may be as important as the fact of abuse itself, or more so. More to the point, validation of the trauma-memory argument and recovered memory therapy requires separate evaluations of the effects of abuse which is remembered and of abuse for which the victim is amnesic.

With respect to the question of amnesia for childhood trauma, the evidence is even more scanty, and even more ambiguous, if only because some of the mechanisms that could be responsible for forgetting are in no way pathological. Four studies apparently exhaust the modern literature on this subject: each of them suffers from methodological problems relating to the manner in which trauma and amnesia are documented.

The Herman and Schatzow (1987) Study

Perhaps the most commonly cited contemporary study of trauma and memory, by Herman and Schatzow (1987), was based on 53 participants in a therapy group for incest survivors. Of these, 14 patients had severe amnesia for their abuse: they strongly suspected that they had been abused, but could not remember it clearly. As part of the therapeutic process, the patients were offered the opportunity to gather evidence that would corroborate their memories, or suspicions, of abuse. Herman and Schatzow reported that such efforts were successful for 39 of the cases, or 74%. In interpreting this finding, however, it is important to recall that 39 of the group members had little or no amnesia to begin with. It would not be surprising if individuals who always remembered their abuse were able to validate their memories of it. The important questions are (a) whether any of the 14 patients who were amnesic for their abuse when they entered therapy subsequently recovered memories of abuse, in or out of therapy; and (b) whether any of these patients were able to verify those memories of abuse.

On these critical questions, the Herman and Schatzow (1987) study is silent. Although Herman and Schatzow (1987) provide information about the source of collaboration, they fail to report the relationship between the extent of memory and the quality of the corroboration obtained. All we know is that 14 patients had severe amnesia for their abuse, and that 14 patients were unable to obtain direct corroboration of their beliefs or suspicions that they had been abused. Nevertheless, Herman and Harvey (1993) cited this study as "directly addressing whether these adult memories [e.g., of abuse] can be verified," and as suggesting "that delayed recall of sexual abuse is as verifiable as any other form of disclosure" (p. 5).

Even if some of the initially amnesic patients did succeed in obtaining putative evidence of abuse, it is important to indicate what the nature of that corroboration was. Of the four cases offered in evidence by Herman and Schatzow (1987), Andrea (Case Example 1) had no memory problem; she confronted her father, who essentially confirmed her memories. Bernadette (Case Example 2) had some

memories of abuse at the beginning of therapy and recovered additional memories during treatment; her memories were confirmed by her mother. Claudia (Case Example 3) recovered memories of abuse by her brother and found physical evidence of his behavior among his belongings after he died. Doris (Case Example 4) had a dense childhood amnesia at the beginning of treatment and experienced a flood of recovered memories during therapy; however, her corroborating evidence, which consisted of a question about her father posed by her sister, was indirect and highly inferential. On the other hand, it turns out that these cases, like those cited by Harvey and Herman (1994), are composites—that is to say, worthless as scientific evidence.

Setting the matter of corroboration aside, Herman and Schatzow (1987) further reported that their amnesic patients reported an average age of onset for the abuse of 4 to 5 years of age, whereas the nonamnesic patients reported onsets at about 8 to 11 years of age. They concluded that "massive repression appeared to be the main defensive resource available to patients who were abused early in childhood" (p. 9). But of course there are other possibilities. For example, the authors failed to consider the impact of infantile and childhood amnesia arising from physiological, cognitive, and environmental changes occurring normally over the course of early development.[2] Moreover, there is another alternative: lacking actual memories for abuse, but believing that they were incest survivors and knowing something of the concept of repressed memory, these patients may have *assumed* that their abuse occurred during that period early in childhood when their memories were poorest. Thus, the dating of their abuse may be based on attributional processes, and not on fact retrieval.

The Briere and Conte (1993) Study

Similar problems attend the work of Briere and Conte (1993), another commonly cited study claiming to provide evidence of repression for childhood sexual abuse. This research involved 468 patients with self-reported histories of sexual abuse. These individuals, who were mostly women, were recruited by their therapists and asked to complete a survey, on which appeared the following question: "During the period of time between when the first forced sexual experience happened and your eighteenth birthday was there ever a time when you could not remember the forced sexual experience?" Almost 60% of these patients reported that they had not remembered their abuse at some point in time after it had occurred.[3] Unfortunately, Briere and Conte (1993) provide no corroboration for the episodes remembered by the clients, nor do they offer any analysis of the nature of the forgetting reported.

By far the strongest predictor of amnesia (out of 40 variables entered into a

[2]Infantile amnesia covers the first 18 to 24 months of life and is commonly attributed to the lack of language ability; childhood amnesia covers the subsequent period up to about 5 to 7 years of age and is commonly attributed to poor encoding. For reviews of memory in infants and children, see Fivush and Hudson (1990).

[3]Because of a typographical error, this figure is mistakenly cited as 69% in Kihlstrom (1995c, p. 65).

discriminant function analysis) was the age of the patient at the time the abuse began: patients who had been amnesic for their abuse claimed they had been molested earlier than those who had not experienced amnesia. Again, it is important to note that the molestations were self-reported and not independently corroborated. Furthermore, no distinction was made between repression and ordinary forgetting due to infantile and childhood amnesia and other benign factors. For Briere and Conte (1993), as for Herman and Schatzow (1987), many of the ostensibly amnesic patients may have inferred that they were molested as children, perhaps on the basis of their current problems, and then attributed their molestation to a period in their lives covered by normal infantile and childhood amnesia.

Interestingly, Briere and Conte (1993) found that patients reporting a period of amnesia for the abuse obtained higher scores on the SCL-90, an instrument commonly used to assess the severity of psychiatric symptoms. This is the only evidence that connects memory failure to the severity of the individual's symptoms. However, because the reports of abuse were uncorroborated and the nature of the forgetting unknown, the meaning of this evidence is unclear.

The Loftus, Polonsky, and Fullilove (1994) Study

A survey reported by Loftus, Polonsky, and Fullilove (1994) presents similar problems. In this study, 105 women in a substance abuse treatment program completed a face-to-face interview about life stressors. A total of 57 (54%) of the clients reported that they had experienced some form of sexual abuse during childhood. When they were asked about their memory for the abuse, 36 (63%) of these clients reported that they had always remembered the abuse, 6 (10.5%) said that they remembered parts of the abuse but forgot other parts, and 10 (17.5%) said that they had forgotten the abuse entirely for a time and the memory returned later; the remaining 5 clients did not respond to this question. Interestingly, clients who reported onetime partial or total forgetting rated their current memories as less clear and detailed than those who reported that they always remembered; and clients who reported total forgetting rated their affect at the time of the abuse as less intense than those in the other two groups. In terms of the characteristics of the abuse itself, however, those who forgot their abuse apparently did not differ significantly from those remembered it.

Loftus et al. (1994) correctly point out that not every instance of forgetting, not even every instance of forgetting trauma such as abuse, counts as evidence of repression. There are many reasons why a person might forget unpleasant experiences and then remember them later. In any event, as with the previous two studies, no corroboration was available for the abuse reported by the clients surveyed; and no information is available that would permit independent evaluation of the reports that memories of abuse were lost and subsequently recovered. Loftus et al. (1994) attempted to compare the incidence of amnesia in their study with that found by Herman and Schatzow (1987) and Briere and Conte (1993), but differences in sampling methods across the two studies, not to mention the failure of each of the three studies to corroborate the abuse, makes any such comparison difficult.

The Williams (1994) Study

With respect to the issue of corroboration, something of an advance was attempted by Williams (1994a), who followed up a group of 129 women who had been treated for sexual abuse as children some 17 years earlier.[4] Under the cover of a routine interview ostensibly concerning the medical care they had received as children, these subjects were asked questions about childhood sexual victimization. A total of 38% of the informants failed to report the incident of abuse which had brought them to the hospital as children, although most (68%) of these did acknowledge other experiences of abuse. A small minority of the sample, 12%, failed to report that they had ever been abused in childhood.

Although Williams (1994a) framed her findings in terms of repression, there is no reason to conclude that her informants' reporting failures were due to repression or dissociation, as opposed to benign processes. For example, the highest rates of reporting failure occurred in women who had been abused before 7 years of age: perhaps these events were covered by normal infantile or childhood amnesia. Alternatively, the index admission to the hospital—the only evidence against which the clients' reports were evaluated—may simply have been lost through normal forgetting. Nor, frankly, is there any compelling reason to conclude that the subjects' behavior reflected memory failure at all. There are any number of reasons why individuals who remembered their childhood abuse perfectly well might decline to disclose it to an unfamiliar interviewer (Della Femina, Yeager, & Lewis, 1990).

The Williams (1994a) study is an important advance because it allows for the independent confirmation of self-reports of childhood trauma; but like its predecessors, it does not provide enough evidence to permit the conclusion that amnesia for victimization experiences is common, nor does it provide any evidence that these experiences, or amnesia for them, are associated with pathological adult outcomes. Better methodology is required to distinguish between patients who do not recall actual abuse and those who do not report it; and among the former, between memory failures that reflect repression, dissociation, and other pathological processes and those mechanisms of forgetting that are benign.

AMNESIA AND FORGETTING, MEMORY AND BELIEF

Issues pertaining to corroboration and the distinction between remembering abuse and believing that one was abused should not be dismissed lightly. Whenever a claim is made about what a person remembers and what he or she has forgotten, this claim can only be evaluated against some objective record of what happened in the past. There are huge epistemological differences among the possibilities: explicitly remembering that one was abused, believing that one was abused even though one does not remember it, reconstructing memories around such a belief, and reinterpreting as abuse an event that was not perceived as

[4]For other critiques of this study, see Lindsay and Read (1994), Pope and Hudson (1995), and Loftus, Garry, and Feldman (1994); for responses to the critique, see Berliner and Williams (1994) and Williams (1994b).

abuse when it occurred. These distinctions are not commonly made by advocates of the trauma-memory argument and recovered memory therapy, and they are only some of the possibilities.

Equally important, and equally uncommon, are other distinctions that apply to cases in which an individual fails to remember a documented episode of abuse. As in many of the cases discussed by Della Femina et al. (1990), the failure may be one of disclosure rather than of memory. But setting this possibility aside, even genuine failures of memory are not all of the same kind. Some experiences may have been lost to the normal forgetting that occurs with the passage of time. Others may have been covered by infantile and childhood amnesia. In neither case is there any reason to think that the forgotten episode has any untoward effect on adult behavior and adjustment; and in neither case is there any reason to think that therapeutic exhumation of such memories is possible, or, even if it were possible, to think that dredging them up would have any positive effect on therapeutic outcome.

Another possibility that is commonly ignored is that individual episodes of abuse have been assimilated to a generic (or semantic) memory of abuse, with the details of individual episodes forgotten. In this respect, Terr (1991) has distinguished between two types of trauma. Type I trauma consists of "unanticipated single events" (p. 14), and Type II trauma consists of "long-standing or repeated exposure to extreme external events" (p. 15). Terr (1991) notes that Type I traumas are typically remembered well, whereas Type II traumas are typically remembered poorly. Terr further attributes the memory failures in Type II trauma to such coping mechanisms as denial (in the psychodynamic sense), psychic numbing, repression, and dissociation (1991, p. 15). However, the memory failure observed in Type II trauma may be no different from the ordinary forgetting observed in normal adults, who may know that they attended third grade, for example, but have difficulty remembering particular events that occurred during the school year. There is no reason to think that such forgetting is reversible, or that reversal, even if it were possible, is therapeutically advantageous. Nor, in the case of generic memories of documented abuse, is there any reason to think that the person's inability to recall individual episodes has anything to do with any adjustment difficulties he or she may be experiencing.

Of course, some cases of forgetting may represent genuine functional amnesias produced by repression, dissociation, or some other pathological process (for reviews, see Schacter & Kihlstrom, 1989; Kihlstrom & Schacter, 1995). These should also not be dismissed out of hand. Although more than a half-century of research has failed to produce compelling laboratory evidence of repression (for reviews, see Pope & Hudson, 1995; Singer, 1990), experimentally produced dissociative amnesias, in the form of posthypnotic amnesia (Kihlstrom, 1985) and state-dependent memory (Overton, 1984)—including mood-dependent memory (Eich, 1995)—strongly indicate that it is indeed possible to disrupt, and then restore, conscious access to available memories. However, it should be understood that the laboratory research is as convincing as it is because there is independent evidence of the events which are to be remembered. Without such independent corroboration, clinical evidence for dissociative amnesia must remain ambiguous.

COMMENTS ON THE REPORT OF THE BRITISH PSYCHOLOGICAL SOCIETY WORKING PARTY ON RECOVERED MEMORIES

Over the past few years, a number of professional associations have taken critical positions on the trauma-memory argument and recovered memory therapy (American Medical Association, 1994; American Psychiatric Association, 1993; Australian Psychological Society, 1994).[5] In their statements, each of these organizations noted that recovered memory therapy rests on a weak scientific base, warned of the problem of uncorroborated and false memories, and urged caution in dealing with patients' memories and beliefs about childhood sexual abuse. By contrast, the British Psychological Society (BPS; 1995) issued a report that seemed to take a more lenient attitude toward these problems. Among other conclusions, the report agreed that memories of psychological trauma could be lost and then recovered, even after a long period of forgetting; that instances of memory recovery were reported by therapists who were aware of the problems of suggestion; that clear, detailed recovered memories were likely to be broadly accurate; and that there was no evidence of widespread creation of false memories of childhood sexual abuse in the United Kingdom (nevertheless, the report ended with a number of guidelines for therapists intended to reduce if not eliminate the false memory problem).

Although the BPS Working Party attempted to grapple with the issues of trauma and memory in an evenhanded way, and reached many conclusions with which one can agree, their report has also drawn some criticism (Lindsay, 1995; Weiskrantz, 1995a, 1995b).[6] For example, the Working Party erred when it wrote (1995, p. 3) that the ground of the debate over recovered memories has shifted from the possibility of therapy-induced false beliefs to the question of the prevalence of such beliefs. For most scientific critics of the trauma-memory argument and recovered memory therapy, the issue has never been either the existence or the prevalence of false memories. Because the memories in question are typically not subject to objective verification, we will never know how many such memories are accurate and how many are inaccurate or false outright. The primary question of interest concerns the scientific validity of the trauma-memory argument and the scientific status of recovered memory therapy. Both the argument and the therapy, although intuitively appealing and well-intentioned (especially by those who have read their Freud and taken him to heart), rest on very shaky scientific ground. There is virtually no evidence supporting the claims on which recovered memory therapy is based and considerable evidence going against these claims.

[5]At the time this chapter was written, a report by the American Psychological Association Working Group on Investigation of Memories of Childhood Abuse had not yet been released. However, an interim report (American Psychological Association, 1994) concluded that although most victims of childhood sexual abuse remember all or part of what happened to them, it is possible for memories of such events to be forgotten and then later recovered; furthermore, the working group concluded that pseudomemories of abuse were possible, but that the processes underlying accurate and inaccurate recollections of childhood abuse were largely unknown.

[6]The remainder of this section is an elaboration, with permission of the editor, of material that first appeared in *The Therapist,* the journal of the European Therapy Studies Institute (Kihlstrom, 1995a).

Relatedly, the Working Party created something of a straw person with its depiction of extreme critics (unnamed) who maintain that recovered memories are impossible in principle and that all therapists lead patients into recovering memories of abuse (1995, p. 6). In fact, most critics of recovered memory therapy, including myself, are quite willing to concede the possibility of recovered memories; we just do not find the available evidence for the phenomenon remotely convincing. And although there clearly exists a subset of therapists who are predisposed to elicit recovered memories from their patients, nobody has claimed that all, or even most, therapists fall in this category.

Similarly, the Working Party erred in criticizing (1995, p. 6) those who, in turn, criticize the illogical and inflammatory statements contained in such popular self-help books as *The Courage to Heal* (Bass & Davis, 1988). This book, and others like it, has been enormously influential on both popular culture and therapeutic practice, and its empirical, logical, and rhetorical defects deserve wide advertisement so that therapists and practitioners will not continue to be misled by its errors and exaggerations (Kihlstrom, 1994b).

The conclusion of the Working Party that, with certain exceptions, the source of our memories is accurately attributed (1995, p. 10) was misleading for the simple reason that the exceptions noted by the Working Party include the typical therapeutic situation in which recovered memory occurs. Whether by self-help books such as *The Courage to Heal* or by therapists who base their practices on theories of "memory work," patients are encouraged to think about, and focus on, possible instances of past abuse, and to imagine situations in which such abuse might have occurred. These exercises effectively constitute rehearsal opportunities of just the sort that the Working Party (correctly) concludes lead to errors in source attribution. To be concrete, the available research (reviewed by Johnson, Hashtroudi, & Lindsay, 1993) suggests that the possibility of source misattributions is increased whenever the following typical characteristics of recovered memory therapy are present:

- the patient is seeking an explanation for his or her current troubles and the therapist is inclined to find it in the patient's childhood;
- the patient's past is unknown or uncertain;
- the therapist believes, and implies, that the patient's presenting complaints are the symptoms of abuse;
- the concept of repression or dissociation is offered as a convenient explanation for why the patient has no memory of abuse;
- trauma and abuse are broadly defined, so that ambiguous memories may be interpreted as evidence of trauma and abuse;
- imagination and other techniques of memory work (Frederickson, 1992) are used as routes to remembering;
- inference, supposition, and belief substitute for actual recollection;
- narrative truth is preferred to historical truth, or at least is considered satisfactory for therapeutic purposes (Spence, 1982, 1994);
- the therapist believes that his or her obligation is to support the beliefs of the patient, regardless of whether they are accurate.

The Working Party repeated the claim that repeated or extended abuse is more likely to be subject to amnesia (1995, p. 13) without critically analyzing the empirical basis for this claim. In fact, as discussed earlier, this claim rests on unsystematic clinical observations, anecdotally reported (e.g., Terr, 1994). The Working Party did properly suggest that individual episodes of such abuse might be assimilated into a generic memory in which the details of particular episodes are forgotten (1995, p. 9), but it should have emphasized that this form of forgetting has nothing to do with trauma per se, is not indicative of repression, dissociation, or any other pathological process, has no causal relation to the later development of clinical symptoms, and is unlikely to be reversed by any form of memory-enhancement technique, whether biological or psychological. Therefore, the fact that individual episodes of repeated or extended abuse are forgotten—if indeed this is the case—may have absolutely no therapeutic significance.

The Working Party noted that forgetting of trauma is often reported, but it failed to emphasize that this forgetting is rarely verified (1995, p. 13). That is to say, it is rarely clear whether the patient has forgotten the episode, merely failed to disclose it, or even that the episode in question occurred at all. And, as noted earlier, even in the case of verified amnesia it is not clear whether the forgetting is a product of normal or pathological processes. More important, it is often unclear whether the event in question actually occurred.

The Working Party believes that there is little danger that a few suggestive questions from therapists will lead patients to construct false memories of the past (1995, p. 15). It is somewhat ironic that the Working Party quotes Lindsay and Read (1994) in support of this conclusion, because Lindsay himself emerged as a critic of the Working Party's report (Lindsay, 1995).

Actually, the Working Party quoted Lindsay and Read (1994) out of context, and consequently distorted their meaning. Here is the passage as quoted by the BPS (1995, p. 15):

> There is little reason to fear that a few suggestive questions will lead psychotherapy clients to conjure up vivid and compelling illusory memories of childhood sexual abuse.

And here is the full passage from Lindsay & Read (1994, p. 294):

> There is little reason to fear that a few suggestive questions will lead psychotherapy clients to conjure up vivid and compelling illusory memories of childhood sexual abuse. However, as described above, the techniques some authorities advocate for recovering repressed memories of childhood sexual abuse are vastly more powerful than the laboratory procedures, and there is good reason to be concerned about the possibility that they sometimes lead to the creation of illusory memories.

It is apparent that Lindsay and Read (1994) were quite concerned about the very possibility that the Working Party dismissed.

If all we had to worry about were "a few suggestive questions," there might, indeed, be little cause for concern. But this is not the actual situation presented. Many therapists, including doctoral-level clinical psychologists, apparently believe, in the absence of convincing scientific evidence, that a history of abuse, especially abuse covered by amnesia, is causally associated with a wide variety of clinical symptoms. In many cases, these beliefs are explicitly communicated

to patients early in therapy and are readily incorporated into the patient's system of beliefs and expectations as he or she works through his or her problems.

Moreover, of course, therapeutic encounters do not occur in a vacuum. Rather, therapy transpires in a cultural context that is increasingly permeated by unwarranted beliefs about the prevalence of abuse, traumatic amnesia, the clinical consequences of both abuse and amnesia, and the efficacy of recovered memory therapy. Within this sociocultural milieu, even a few probing questions and suggestive remarks by an authoritative figure such as a therapist may be sufficient to inculcate a belief on the part of a patient that he or she was abused, and start the patient on the road toward the "recovery" of false memories. Even a totally neutral therapist cannot prevent these cultural influences. For this reason, it is no comfort to discover, as the Working Party did, that a large portion of recovered memories first appear outside a formal therapeutic context.

The danger of false recollection is underscored by the Working Party's discovery that 9 out of 10 therapists surveyed believe that recovered memories are sometimes or usually essentially accurate (Andrews et al., 1995; for a critique, see Weiskrantz, 1995b).[7] Precisely because most recovered memories are not subject to independent corroboration, such beliefs on the part of therapists are completely unwarranted. Thus, we are returned to the essential issue in recovered memory therapy: the trauma-memory argument and recovered memory therapy are not supported by the available scientific evidence.

INTUITIVE APPEAL AND SCIENTIFIC EVIDENCE

The trauma-memory argument derives its power from the social problem of child abuse and from the vivid case histories presented by its proponents. In some respects, it also gains some plausibility from scientific research on memory (Kihlstrom, 1995b). For example, studies of cued recall, recognition, and hypermnesia show that it is possible for people to remember at one point events that had been forgotten earlier (Kihlstrom & Barnhardt, 1993). Similarly, research on hypnosis shows that people can block conscious access to particular memories and regain access sometime later; and that in the meantime, the unconscious memories can have implicit effects on the person's experience, thought, and action (Kihlstrom, 1985).

In the final analysis, however, the available base of scientific evidence, especially direct evidence from clinical studies of the victims of trauma, is simply too weak to support global assertions about trauma and memory, amnesia and recovery, and related issues. As much as we sympathize with those who exhume memories of trauma, and the therapists and counselors who seek to help them, there is nothing in the available evidence that would permit us to have any confidence in any exhumed memory in the absence of independent confirmation, or

[7] Out of a sample of 202 certified psychotherapists from the United States and the United Kingdom responding to a recent survey, 25% engaged in psychotherapy focusing on memories of child sexual abuse, and 71% reported using hypnosis, dream work, body work, and other techniques to help their patients remember such episodes (Poole, Lindsay, Memon, & Bull, 1995).

to have any confidence that there are causal links between trauma, amnesia and psychopathology.[8] To demur in this way is not to "cast a chill on serious scientific dialogue" (Harvey & Herman, 1994, p. 296), or participate in a backlash against adult survivors of child sexual abuse (Bass & Davis, 1994, p. 475; Harvey & Herman, 1993) or against the gains rightly achieved by the women's movement, or to choose denial over accuracy (Walker, 1994, p. 85). On the contrary, it is to hold clinical theory and practice up to established standards of scientific knowledge.

ACKNOWLEDGMENTS

This chapter is an expanded version of an invited commentary that initially appeared in a special issue of *Consciousness and Cognition* devoted to "The Recovery of Lost Childhood Memories for Traumatic Events" (Kihlstrom, 1995c). The point of view represented in this chapter is based on research supported by Grant MH-35856 from the National Institute of Mental Health. For more extensive coverage of these issues, see Kihlstrom (1994a, 1994b, 1995b). I thank Lawrence Couture, Jennifer Dorfman, Elizabeth Glisky, Martha Glisky, Victor Shames, Michael Valdiserri, and Susan Valdiserri for their comments during the preparation of this chapter.

REFERENCES

American Medical Association. (1994). *Memories of childhood abuse* (Council of Scientific Affairs Report No. 5-A-94). Washington, DC: Author.

American Psychiatric Association. (1993). *Statement on memories of sexual abuse.* Washington, DC: Author.

American Psychological Association. (1994). *Interim report of the Working Group on Investigation of Memories of Childhood Abuse.* Washington, DC: Author.

Andrews, B., Morton, J., Bekerian, D. A., Brewin, C. R., Davies, G. M., & Mollon, P. (1995). The recovery of memories in clinical practice: Experiences and beliefs of British Psychological Society practitioners. *The Psychologist,* **8**, 209–214.

Australian Psychological Society. (1994). *Guidelines relating to the reporting of recovered memories.* Sydney: Author.

Baker, R. A. (1992). *Hidden memories: Voices and visions from within.* Buffalo, NY: Prometheus Press.

Bass, E., & Davis, L. (1994). *The courage to heal: A guide for women survivors of child sexual abuse* (3rd ed.). New York: Harper & Row. (Originally published 1988; rev. ed., 1992)

Berliner, L., & Williams, L. M. (1994). Memories of child sexual abuse: A response to Lindsay and Read. *Applied Cognitive Psychology,* **8**, 379–388.

Breuer, J., & Freud, S. (1955). *Studies on hysteria.* In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 2). London: Hogarth Press. (Originally published 1893–1895).

Briere, J., & Conte, J. (1993). Self-reported amnesia for abuse in adults molested as children. *Journal of Traumatic Stress,* **6**, 21–31.

British Psychological Society. (1995). *Recovered memories: The report of the Working Party of the British Psychological Society.* Leicester, UK: Author.

Buttenweiser, P. (1993, August 1.) The exhumed memory [Book review of *Once upon a time: A*

[8]The exception to this conclusion is post-traumatic stress disorder, which is related to previous trauma by definition. I thank David Gleaves for pointing this out. Nevertheless, and somewhat paradoxically, it is important to recognize that the difficulties in operationalizing *trauma*—that is, whether it can, or even should, be objectively defined—call even this truism into question.

true story of memory, murder, and the law by H. N. MacLean] (pp. 9–10). *New York Times Book Review*.

Della Femina, D., Yeager, C. A., & Lewis, D. O. (1990). Child abuse: Adolescent records vs. adult recall. *Child Abuse and Neglect*, **14**, 227–231.

Eich, E. (1995). Searching for mood-dependent memory. *Psychological Science*, **6**, 67–75.

Esterson, A. (1993). *Seductive mirage: An exploration of the work of Sigmund Freud*. New York: Open Court.

Fivush, R., & Hudson, J. A. (Eds.). (1990). *Knowing and remembering in young children*. New York: Cambridge University Press.

Frederickson, R. (1992). *Repressed memories: A journey to recovery from sexual abuse*. New York: Simon & Schuster.

Harvey, M. R., & Herman, J. L. (1994). Amnesia, partial amnesia, and delayed recall among adult survivors of childhood trauma. *Consciousness and Cognition*, **3**, 295–306.

Herman, J. L. (1992). *Trauma and recovery*. New York: Basic Books.

Herman, J. L., & Harvey, M. R. (1993, April). The false memory debate: Social science or social backlash? *Harvard Mental Health Letter*, pp. 4–6.

Herman, J. L., Perry, J. C., & van der Kolk, B. A. (1989). Childhood trauma in borderline personality disorder. *American Journal of Psychiatry*, **146**, 140–145.

Herman, J. L., & Schatzow, E. (1987). Recovery and verification of memories of childhood sexual trauma. *Psychoanalytic Psychology* **4**, 1–14.

Johnson, M. K., Hashtroudi, S., & Lindsay, D. S. (1993). Source monitoring. *Psychological Bulletin*, **114**, 3–28.

Kihlstrom, J. F. (1985). Posthypnotic amnesia and the dissociation of memory. In G. H. Bower (Ed.), *The psychology of learning and motivation* (Vol. 19, pp. 131–178). New York: Academic Press.

Kihlstrom, J. F. (1994a). Delayed recall and the principles of memory. *International Journal of Clinical and Experimental Hypnosis*, **4**, 357–345.

Kihlstrom, J. F. (1994b). Exhumed memory. In S. J. Lynn & N. P. Spanos (Eds.), *Truth in memory* (in press). New York: Guilford.

Kihlstrom, J. F. (1995a). Recovered memories: British Psychological Society "misleading" [Letter to the editor]. *The Therapist*, 2(4), 45–46.

Kihlstrom, J. F. (1995b). Suffering from reminiscences: Exhumed memory, implicit memory, and the return of the repressed. In M. A. Conway (Ed.), *Recovered memories and false memories* (in press). Oxford: Oxford University Press.

Kihlstrom, J. F. (1995c). The trauma-memory argument. *Consciousness and Cognition*, **4**, 63–67.

Kihlstrom, J. F., & Barnhardt, T. M. (1993). The self-regulation of memory, for better and for worse, with and without hypnosis. In D. M. Wegner & J. W. Pennebaker (Eds.), *Handbook of mental control* (pp. 88–125). Englewood Cliffs, NJ: Prentice Hall.

Kihlstrom, J. F., & Schacter, D. L. (1995). Functional disorders of autobiographical memory. In A. Baddeley, B. A. Wilson, & F. Watts (Eds.), *Handbook of memory disorders* (pp. 337–364). London: Wiley.

Lindsay, D. S. (1995). "Unsubstantiated claims" from the British Psychological Society [Letter to the editor]. *The Therapist*, 2(4), 45.

Lindsay, D. S., & Read, J. D. (1994). Psychotherapy and memories of childhood sexual abuse: A cognitive perspective. *Applied Cognitive Psychology*, **8**, 281–338.

Lindsay, D. S., & Read, J. D. (1995). "Memory work" and recovered memories of childhood sexual abuse: Scientific evidence and public, professional, and personal issues. *Psychology, Public Policy, and the Law*, **1**, 846–908.

Loftus, E. (1993). The reality of repressed memories. *American Psychologist*, **48**, 518–537.

Loftus, E. F., Garry, M., & Feldman, J. (1994). Forgetting sexual trauma: What does it mean when 38% forget? *Journal of Consulting and Clinical Psychology*, **62**, 1177–1181.

Loftus, E., & Ketcham, K. (1994). *The myth of repressed memory: False memories and allegations of sexual abuse*. New York: St. Martin's Press.

Loftus, E. F., Polonsky, S., & Fullilove, M. T. (1994). Memories of childhood sexual abuse: Remembering and repressing. *Psychology of Women Quarterly*, **18**, 67–84.

Macmillan, M. (1991). *Freud evaluated: The completed arc* (Advances in Psychology, No. 75). Amsterdam: North-Holland.

Ofshe, R., & Watters, E. (1994). *Making monsters: False memories, psychotherapy, and sexual hysteria.* New York: Scribner's.

Overton, D. A. (1984). State-dependent learning and drug discriminations. In L. L. Iverson, S. D. Iverson, & S. H. Snyder (Eds.), *Handbook of psychopharmacology* (Vol. 18, pp. 59–127). New York: Plenum.

Pendergrast, M. (1995). *Victims of memory: Incest accusations and shattered lives.* Hinesberg, VT: Upper Access Press.

Poole, D. A., Lindsay, D. S., Memon, A., & Bull, R. (1995). Psychotherapy and the recovery of memoires of childhood sexual abuse: U.S. and British practitioners' beliefs, practices, and experiences. *Journal of Consulting and Clinical Psychology,* **63,** 426–437.

Pope, H. G., & Hudson, J. I. (1995). Can individuals "repress" memories of childhood sexual abuse? An examination of the evidence. *Psychiatric Annals,* **25,** 715–719.

Prozan, C. K. (1992). *Feminist psychoanalytic psychotherapy.* Northvale, NJ: Jason Aronson.

Prozan, C. K. (1993). *The technique of feminist psychoanalytic psychotherapy.* Northvale, NJ: Jason Aronson.

Schacter, D. L., & Kihlstrom, J. F. (1989). Functional amnesia. In F. Boller & J. Graffman (Eds.), *Handbook of neuropsychology* (Vol. 3, pp. 209–231). Amsterdam: Elsevier.

Schimek, J. G. (1987). Fact and fantasy in the seduction theory: A historical review. *Journal of the American Psychoanalytic Association,* **35,** 937–965.

Singer, J. L. (Ed.). (1990). *Repression and dissociation: Implications for personality theory, psychopathology, and health.* Chicago: University of Chicago Press.

Spence, D. P. (1982). *Narrative truth and historical truth.* New York: Norton.

Spence, D. P. (1994). Narrative truth and putative child abuse. *International Journal of Clinical and Experimental Hypnosis,* **42,** 289–303.

Spiegel, D., & Cardeña, E. (1993). Disintegrated experience: The dissociative disorders revisited. *Journal of Abnormal Psychology,* **100,** 366–378.

Terr, L. (1991). Childhood traumas: An outline and overview. *American Journal of Psychiatry,* **148,** 10–20.

Terr, L. (1994). *Unchained memories: True stories of traumatic memories, lost and found.* New York: Basic Books.

Walker, L. E. A. (1994). *Abused women and survivor therapy: A practical guide for the psychotherapist.* Washington, DC: American Psychological Association.

Weiskrantz, L. (1995a). Comments on the report of the working party of the British Psychological Society on "recovered memories." *The Therapist,* **2**(4), 5–8.

Weiskrantz, L. (1995b). Commentary. *The Psychologist,* **8,** 507–508.

Williams, L. M. (1994a). Recall of childhood trauma: A prospective study of women's memories of child sexual abuse. *Journal of Consulting and Clinical Psychology,* **62,** 1167–1176.

Williams, L. M. (1994b). What does it mean to forget child abuse? A reply to Loftus, Garry, and Feldman (1994). *Journal of Consulting and Clinical Psychology,* **62,** 1182–1186.

Yapko, M. D. (1994). *Suggestions of abuse: True and false memories of childhood sexual trauma.* New York: Simon & Schuster.