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The Recovery of Memory: Does it Help?

Kevin M. McConkey and Amanda J. Barnier

The recent debate about recovered memories of childhood events, particularly memories of childhood sexual abuse, has polarised the psychiatric and psychological communities, influenced forensic and legal procedures and decisions, and changed the lives of patients and their family members.[1–3] At the heart of this debate are different definitions, assumptions, and data about memory, repression, and abuse.

> *'At the heart of this debate are different definitions, assumptions, and data'*

The paper by Goodyear-Smith *et al.* is but one example of the intense focus that has been placed on the accuracy or inaccuracy of the recovered memories, and the validity and utility of core concepts such as 'repression', 'dissociation', 'and traumatic amnesia'.[3–5] One important question in this debate has been ignored or pushed aside, both in the paper (and in the proliferation of other literature). This is: does the recovery of memories (either accurate or inaccurate) of particular events of childhood provide therapeutic benefit?

Although the authors conclude that 'there is evidence that the use of recovered memory techniques may at times be dangerous to health and well-being',[6] they do not adequately consider the scientific and clinical evidence for and against the efficacy of this approach for treatment. Instead they concentrate on the issue of accuracy, and argue that if memories are not reliably accurate, then treatment is of no value and should not be used at all, or only under specific circumstances.

Certainly, in forensic and legal contexts, the focus on accuracy is warranted. Generally speaking, decisions in these settings should not be based on uncorroborated memories of long-ago events. But what of the clinical context? In this setting, the focus on accuracy may be missing the possible value of therapeutic techniques, irrespective of the veracity of the memories recovered.

> *'. . . a focus on accuracy may overlook the possible value of therapeutic techniques irrespective of the veracity of the memories'*

It is a reasonable expectation that only those health care procedures that have been proven to be effective, either on the basis of laboratory investigations or controlled clinical evaluations, should be endorsed and resourced. As the authors note, some therapeutic approaches assume that in order for people to function well, we have to uncover the truth about our past. More specifically, some therapists seem to believe that a range of adult problems are associated with repressed memories of traumatic childhood events, and that the recovery of memories of sexual abuse is an essential part of the therapeutic experience and is central to the successful outcome of therapy. Moreover, they believe that the recovery of intact, accurate memories is possible. However, memory recovery procedures are not supported strongly by current scientific findings.[7–10]

This is not to suggest that potentially innovative and useful techniques that are not yet fully investigated in appropriate laboratory or clinical settings should never be used. Rather, any claims made about such techniques should be tempered accordingly. The authors attempt to walk this line, but at times fail to recognise that

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the majority of practitioners are knowledgeable, professional, and cautious, albeit engaged in therapeutic activities that have not been fully explored. It should be acknowledged that research in this area is comparatively new, and that finding appropriate ways to investigate these issues is a complex task. Therapeutic techniques can and should be used as long as they make some theoretical sense, and do not fly in the face of decades of carefully collected and reliable empirical and clinical evidence.[11]

Uncovering Stories

The paper effectively demonstrates that the theoretical basis for claims that recovered memories are accurate is tenuous. Claims for the efficacy of memory recovery therapy are equally weak. The paper also usefully underscores the social and personal forces that shape reports made in both a therapeutic setting and our day-to-day lives. Consistent with this, research has demonstrated that individuals will often attempt to organise and structure their memories of traumatic events in an effort to make sense or bring a sense of cohesion to their recall of the event.[12] That sense of cohesion may provide a strong feeling of narrative truth and may feel right, but it may not provide an unblemished indication of the historical truth of the event, especially given the changes that occur to memory over time.[13–15] Thus, clinicians and clients must recognise that some therapy is no more than telling a story that makes sense to the individual and that helps them to make sense of events in their life.

Recovering Memory Can Be Bad Therapy

The authors highlight the potential for iatrogenically created false memories, but do not discuss fully the therapeutic implications of this. Scientific and clinical evidence suggests that the utility of psychotherapeutic techniques may have little, or even nothing, to do with uncovering the truth about a patient's past.[16] Indeed, therapy that focuses on recovered memory has been shown, in some cases, to have negative effects on well-being.[17–19] For instance, McElroy and Keck[18] provided case analyses of three women with eating or obsessive–compulsive disorders who were told that their symptoms were based on child sexual abuse and that the recovery of memories of this abuse would be important for treatment. Two of the women were unable to recover any such memories and their conditions deteriorated, yet their conditions improved in response to traditional treatment. Placing clients under pressure to recover memories of abuse, when they do not believe that they have been abused, may have significant negative consequences. Following a review of the literature, Read and Lindsay[5,20] concluded that:

1. 'research evidence does not support the idea that a large percentage of clients who have no conscious recollections of childhood sexual abuse were in fact abused'
2. 'there is no compelling evidence in support of the idea that therapeutic approaches designed to help clients recover suspected repressed memories are helpful.'

and

3. 'there is substantial evidence consistent with the idea that overzealous use of such techniques and ancillary practices may lead some clients who were not abused as children to come to believe that they were abused'.

To date there has not been a single controlled study demonstrating any beneficial effect of therapeutic intervention based on the recovery of repressed memories in clients who report no history of abusive experiences. Thus a conclusion must be drawn that the risks to the patient's well-being are likely to be greater than the potential benefits.[5,17–21]

What Is Good Practice?

What are the implications for ethical professional practice in the face of uncertainty about both the accuracy of recovered memories and the efficacy of treatments based on recovered memories? The authors make a number of suggestions in this regard. They suggest that until this form of treatment is shown to be effective and safe, then it should be considered

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experimental, and not be used without specific informed consent; they suggest that the attitude of the courts toward recovered memories should change such that it is excluded as testimony; and they suggest that compensation (in the form of lump-sum payments or paid counselling) should not be awarded in the absence of corroboration that sexual abuse has occurred. These proposals may be appropriate, but they do not move us very far forward in determining what should be done to deal both professionally and scientifically, as well as ethically and humanely, with these professional issues.

It is neither reasonable nor productive to blame any single set of individuals or factors (such as the women's liberation movement, psychotherapists, or social workers) for the development of recovered memory therapy and the subsequent controversy surrounding it. As practitioners, we should employ techniques that help patients progress in a direct way with the problems of their present and their hopes for the future, and we should limit the degree to which we may inadvertently create an imbalance in the lives of patients by inappropriately focusing on uncertain events of the past. Also, we should be more sensitive to the assumptions underlying our therapeutic approaches, and recognise that the assumption that memories of childhood sexual abuse need to be recovered can encourage an attitude of victimisation counterproductive to successful therapy.[3,11,16] Finally, we should pay particular attention to the possible individual, family, legal, and societal implications of our therapeutic approaches. Our responsibilities are best met through an approach of caution and care about the assumptions that we make and the techniques we use.[22,23]

As scientists, we need to better understand the issues involved in memory, trauma, and repression by conducting both clinical and basic research in laboratory and naturalistic settings in a way that moves beyond ideology and belief. Such research must investigate more carefully the differences among memory reports of patients who do not report, normally forget, and repress memories of particular events of childhood; it must involve systematic case studies of patients who recover memories of childhood sexual abuse that are determined independently to be either accurate or inaccurate, and it must investigate more carefully the different effects of therapeutic practices used to recover memories of particular events of childhood. Most importantly, it must address the question of whether a focus on the past is of any real value in addressing the problems of the present.

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Dichotomies Which Ignore Complexity

Warwick Middleton and Jeremy Butler

While we are sympathetic to some positions offered in the above paper and able to offer qualified support for others, the piece by no means represents a balanced scientific appraisal of the 'repression' or 'dissociation' of traumatic memories and the ways in which such memories may surface. The authors repeatedly invoke the scientific method yet offer so little data about their own research that conclusions are difficult. To say that 'sexual abuse memories had surfaced whilst the complainants were undergoing psychotherapy' is quite vague and furthermore is a perception on the part of one about the intrapsychic life of another whose version of events has not been examined.

Bias: A Common Feature of Human Life

Just as there are dangers in suspending critical judgement with respect to what patients may present in therapy, this suspension of balance seems to be a common human feature and by no means absent from both poles of the so called 'Repressed Memory Debate', for example, in the case of a 38 year old Canadian woman who laid a complaint against her doctor of sexual abuse extending over 10 years, Dr Harold Merskey testified that the woman 'very likely' suffered from 'false memory syndrome' despite the fact that he had not examined the woman, and despite the fact that the doctor in question had previously pleaded guilty at a College Discipline Board hearing of sexually abusing this woman and four other women who had likewise lodged complaints of sexual misconduct.[1] In another case, in which Lynn Crook won a civil suit against her parents based on her delayed memories of childhood sexual abuse, the presiding judge criticised the testimony of Richard Ofshe, thus:

> 'Dr Ofshe characterises plaintiff's memories as a progress toward ritual, satanic cult images, which he states fits a pattern he has observed of false memories.[2] It appears to the Court, however, that in this regard, he is engaging in the same exercise for which he criticises therapists dealing with repressed memory. Just as he accuses them of resolving at the outset to find repressed memories of abuse and then constructing them, he has resolved at the outset to find a macabre scheme of

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