DISSOCIATIVE DISORDERS

Remembering the past, anticipating a future

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Objective: *To provide an overview of the phenomena of recovered memories and false memories of past traumas and to provide illustrations with clinical vignettes as well as historical observations.*

Conclusions: *The questions concerning the recovery of memories of trauma do not readily reduce to simple dichotomies. Whatever the terminology applied, be it repression, dissociation or forgetting, humans have a capacity to not consciously know about aspects of their traumas for extended periods of time. The nature of memory is reconstructive. Memory is not a digital recording that provides for a totally accurate replay. Multiple factors including the age at which traumas occurred, the relationships to the person responsible or the nature and extent of the traumas influence what will be accessible to memory. In regard to those patients who describe recovered memories, it is important that clinicians take an individualistic approach and remain open-minded. They should not feel pressure to validate or reject the claim; rather, they should respect and empower patients.*

Key words: *abuse, dissociation, false memory, recovered memory, trauma.*

The brain function that is conveniently conceptualised as memory is central to almost every facet of clinical psychiatry. The modification of Descarte's dictum, 'I think, therefore I am,' to 'I remember, therefore I am', is not an extreme departure.[1]

This paper examines memory and, just as relevant, forgetting, in relation to traumatic experiences. Clinicians have known for over a century that traumatic experiences can be forgotten and sometimes later remembered. This phenomenon has been evidenced for war trauma, or 'shell shock' (Wiltshire, as cited in Brewin), and interpersonal traumas such as child sexual abuse, rape and torture, to name a few.[2–4] Forgetting and later remembering trauma has raised many questions and has spurred a debate about 'recovered' memories. The questions and controversies have been, and will continue to be, a catalyst for research about memory systems. By way of introduction to the debate, we will provide some historical background to the clinical understanding of amnesia for traumatic events, and the incipient growth of the recovered memory literature in the 1990s. We examine 'false memories' and the conflation of recovered memory and false memory. By examining theories for understanding traumatic memories, we provide a basis for examining empirical research in the field. Finally, we discuss from a clinical perspective how one can integrate the current information about recovered memories into care of one's own patients.

HISTORICAL OBSERVATIONS OF TRAUMATIC EFFECTS ON MEMORY

Over a century ago, Janet observed that instead of being routinely integrated into narrative memory, trauma persists at a subconscious level. He stated that: 'Forgetting the event which precipitated the emotion . . . has frequently been found to accompany intense emotional experiences in the form of continuous and retrograde amnesia' (as cited in van der Kolk *et al.*, p. 285).[5] Forgetting of war trauma is well known. Reports of combat trauma and associated

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amnesia can be traced through war history. In the American Civil War, combat trauma syndromes were called ‘nostalgia’; in World War I, ‘shell shock’, and in World War II, ‘traumatic war neurosis’. It was only in 1980 that the present term, post-traumatic stress disorder (PTSD), was coined by the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).[6] Regardless of the name used to describe war trauma, amnesia has consistently characterized many of the most severe cases.

Typifying the literature concerning combat amnesia are reports from World War II. For example, Sargant and Slater documented that 144 out of 1000 consecutive admissions to a field hospital following the evacuation from Dunkirk, France, were soldiers who had significant amnesia for their trauma.[7] Those with the most severe war stress were more likely to have amnesia for combat than those with moderate stress. Similarly, Henderson and Moore reported a 5% amnesia rate for combat-related events in the first 200 of their war-related cases admitted to a military hospital for psychiatric reasons.[8] Grinker and Speigel also observed that some combat veterans had total amnesia both for battlefield events and events from their personal lives.[9] Interestingly, Grinker and Speigel noted that the majority of their patients made persistent attempts to recover these lost experiences. Despite modern psychological interventions and debriefing, amnesia continues to be evident in war trauma. Solomon documented the case of Yossi, a 21 year old platoon sergeant in an elite parachute unit at the time the Yom Kippur War broke out.[10]

> He fought with the commandos and then in the ‘Chinese form’ battle, notorious among Israeli soldiers for its slaughter. He remembered little of the course of the battle, but feelingly recounted a gruesome incident in which the head of a soldier, still bearing its helmet, came flying from an adjacent trench into his own.... In the course of battle, 8 out of his 30 men were killed. Except for himself and another platoon commander, all the commanders in his company were killed; not a single squad commander survived. Yossi’s position of responsibility made the bloodshed even worse for him. As he explained it, it was he who had to urge reluctant soldiers to fight; then, when he tried to save the situation, his request for permission to retreat was turned down.
>
> Yossi was finally evacuated to a hospital in Israel, riddled with shrapnel in his hands and legs. In addition, he suffered from amnesia – remembering almost nothing, not even how to read.... (pp. 197–198)

Solomon describes Yossi as experiencing ongoing severe PTSD symptomatology, affective instability and depression. His memory loss persisted and he had to learn to read again. She describes how in the subsequent Lebanon war,

> Yossi did not function from the very beginning.... When they came under heavy Katushya bombardment, he felt ‘on the verge of exploding’. Eventually, he was saved by routine home leave, from which he refused to return to duty.
>
> For a month, he stayed at home just lying around, smoking cigarettes, and drinking coffee. He did not bathe or shave, talk to his wife, or look at the son who had been born the year before.... Constantly enraged, he would scratch the walls with his nails. He had terrible dreams in which his Yom Kippur War experiences ‘all came back in a huge onslaught.’ He was finally referred to an IDF mental health clinic after he cursed and threatened to shoot the army representative who had been sent to bring him his military recall order. (pp. 198–199)

War trauma and resulting amnesia affects not only soldiers, but also civilians. For example, Nazi concentration camp survivors provide many examples of individuals who have amnesia for their experiences. Henry Krystal is noted for writing about this ‘massive psychic trauma.’[11] He illustrates how large areas of one’s traumatic past can be blocked out in extraordinary ways with the following vignette:

> Recently, I had an opportunity to work with a ‘juvenile’ concentration camp survivor who... brought himself to confess to me that he had still, untouched by his analysis or with me, a total amnesia for the events of 1942–45, although by talking to fellow survivors, reading, and other sources he has reconstructed the story which he still cannot recall directly. (p. 852)

As Janet so intuitively observed so long ago, these amnesia experiences are accompanied by psychological and/or physiological problems, which manifest despite the lack of explicit memory for a traumatic event. Sometimes, this amnesia persists despite somatization and even re-enactment of traumatic events.

One phenomenon that exists in cases of those with amnesia is known as the repetition–compulsion dynamic. This occurs when trauma survivors do not explicitly recall their trauma, yet somehow re-enact the events. van der Kolk described treating a Vietnam veteran:[12]

> who had lit a cigarette at night and caused the death of a friend by a Viet Cong sniper’s bullet in 1968. From 1969 to 1988, on the exact anniversary of the death, to the hour and minute, he yearly committed ‘armed robbery’ by putting a finger in his pocket and staging a ‘hold-up’, in order to provoke gunfire from the police. The compulsive re-enactment ceased when he came to understand its meaning. (p. 391)

CONTEMPORARY EXAMPLE OF TRAUMATIC EFFECTS ON MEMORY

A patient of the first author illustrates an elaborate example of repetition–compulsion:

> A 27-year-old health worker with no history of psychiatric treatment admitted herself to a hospital when she began to feel suicidal. She acted disturbed, at times walking around clutching a doll, behaviour that was thought to exhibit severe borderline features. After a series of pseudoseizure-type ‘fits,’ she was transferred to a neurology ward of another hospital. She caused concern

when she suddenly slammed her right arm into a wall with such force that she fractured it. Afterwards, she provided no explanation. That evening, she was transferred to another psychiatric unit, but she left the following morning and jumped two storeys from a car park. She sustained further fractures, yet had complete amnesia for the jump.

It is important to emphasise that this woman previously had been able to give a history of extensive physical, sexual, and emotional abuse in an extremely disturbed family in which an idealised brother had suicided. Whilst there were gaps in her memory, she was fully aware of having been made a ward of the State and of having had multiple foster placements, the majority of which were abusive.

Over the days following her jump, there was a progressive recovery of memory for the events leading up to and surrounding the jump. As she began to spontaneously recover memories for her jump, she also experienced intense flashbacks to elements of her childhood abuse, of which she had not previously been conscious. She became aware that her idealised dead brother had also severely abused her. She recalled an occasion when she was walking on a bush track and he approached her sexually. She resisted and he responded by throwing her over a high embankment, resulting in her fracturing an arm – her right. Equally traumatic for her was the associated return of memories of this same brother sexually abusing her in her bedroom, their mother opening the door, looking in, and then closing it. She would experience as an auditory hallucination the sound of her mother's receding footsteps symbolising for her the totality of her abandonment. Whereas previously she had rationalised that her mother cared for her and had not intervened because she did not know about the ongoing abuse, this was no longer sustainable.

The event precipitating the unravelling of this patient's psychic defences was a chance meeting with one of her past foster mothers, who had been party to her abuse and who had recently moved into her neighbourhood.

For decades, clinicians have seen cases of memories being recovered after a period of forgetting. There is over a century in which amnesias for all sorts of traumas, particularly those occurring on the battlefield, have been documented. More recently, the diagnostic significance of amnesia for trauma was well embedded in the 1980 DSM-III diagnostic criteria for PTSD.[6] Although countless cases of amnesia have been reported by early trauma theorists and therapists such as Janet and even Freud, in what was perhaps an interesting twist, the clinical phenomenon became a polarized sociopolitical debate in the modern era. The historical emergence of this debate is described here.

WIDER CONTEXT: CONTROVERSY OF THE MEMORY WARS

In what might be considered an incipient fireball, society was attempting something that had never been achieved before: progressively exposing to public gaze traumas that had previously remained in quiet darkness. By the 1960s, there was emerging awareness of the human response to disaster. In 1962, Kempe *et al.* described the 'battered child' syndrome.[13] By the 1970s, society was beginning to grapple with the syndromes of Vietnam veterans, while at the same time feminist writers and researchers were challenging decades-old rationalizations about child sexual abuse as Oedipal phantasies and hysterical mendacity. Adding to the fire, in the 1980s was Herman's book *Father–Daughter Incest* (1981) and Russell's *The Secret Trauma: Incest in the Lives of Girls and Women* (1986), a large-scale epidemiological study on incest and other childhood sexual abuse.[14,15] Society's confrontation with the extent of child incest (Russell's study suggested 16% of American females had been incestuously abused, one-quarter by their fathers) was to be joined by others. There were confrontations about the extent of abuses perpetuated in state and church institutions, and about abuses more generally by clergy and health care professionals. In the new technological era, the Internet added a high-tech modus operandi for paedophile networks.

To a large extent, the exposed abuses were perpetuated against powerless, easily discredited, and probably the least protected individuals in our society: children. Perhaps it was inevitable that forces previously operating below society's subterfuge would erupt in denial and combative self-protection. The False Memory Syndrome Foundation (FMSF) is one such outcropping that fuelled the social controversy with rhetoric independent of a substratum of empirical research. The researchers quickly joined the dialectic, however. The hitherto uncontroversial area of cognitive laboratory research concerning remembering and forgetting was suddenly on the frontline in a war zone.[16] The memory wars, which gathered momentum in the early 1990s in North America, saw acrimonious divisions on the social front with law suits, TV documentaries, and the picketing of therapists'offices. On the academic front, there was the production of numerous discourses, some polemical (e.g. Ofshe and Watters; Wakefield and Underwager),[17,18] some generated by memory researchers (e.g. Erdelyi; Schacter *et al.*)[16,19] and others by therapists (e.g. Alpert; Courtois).[20,21]

STANCE OF PROFESSIONAL ORGANIZATIONS

The polarizations, the proliferation of law suits involving questions of recovered memory and a climate of anxiety in the 1990s saw professional mental health organizations attempt to formulate position statements regarding recovered memories. In trying to formulate short statements based upon the extent literature, some groups were deeply divided. For instance, in 1993, the American Psychological Association formed a six-member working group to analyse the evidence about recovered memory. The group consisted of three eminent

psychotherapists with a principal focus on child sexual abuse (Laura S. Brown, Christine Courtois and Judith Alpert) and three eminent experimental psychologists involved with memory research (Elizabeth Loftus, Stephen Ceci and Peter Ornstein). In 1996, unable to reach consensus on many of the issues before them, the three clinicians on one hand and the three memory researchers on the other, had issued their conclusions in a point–counterpoint exchange.[22]

The British Psychological Society exemplified a cautious handling of issues. Their statement in 1995 read, 'Forgetting of certain kinds of trauma is often reported, although the nature of the mechanism or mechanisms involved remains unclear,' and, 'While there is a great deal of evidence for incorrect memories, there is currently much less evidence on the creation of false memories' (p. 173).[23]

A more comprehensive statement by the American Psychiatric Association had been published in 1993. They suggested that 'children and adolescents who have been abused cope with the trauma by using a variety of psychological mechanisms, in some instances their coping mechanisms result in a lack of conscious awareness of the abuse for varying periods of time' (p. 154).[23]

Echoing the stance of the American Psychiatric Association, the position paper of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) on the question of recovered memories of trauma was a document less inherently conflicted than that of the British and American psychological societies and associations.[24] Adopted in 1996 and amended in 1998, the RANZCP Clinical Memorandum emphasized the extent of physical and sexual abuse of children, the harmful nature of such abuses, and that 'memory of such abusive experiences may be absent for considerable and varied periods of life and may be recalled under any of a variety of circumstance, including as a vicissitude of undergoing psychiatric treatment for (at least initially) apparently unrelated reasons.' The document emphasized 'that psychiatrists, while supporting the clinical interests of the patient, maintain a position of neutrality in the consulting room – no matter what personal views they may have formed. This is no different from the stance which psychiatrists must take on many other matters raised by patients.'

LEGAL ASPECTS

The legal aspects of memories for child abuse and recovered versus false memory continue to be complex. Despite efforts to provide answers to the recovered memory debate, the legal landscape reflects the scars of controversy. McNally reported that as of 1998, 803 claims that had arisen from recovered memories resulted in litigation in the USA.[25] Not all of these were against alleged perpetrators, however. The courts saw 139 malpractice claims filed against therapists by their former patients relating to allegations of 'implanting' false memories and 152 third-party malpractice suits were filed against therapists on the grounds of claimed damage arising from 'false allegations'. Clearly, the debate wages in the courtroom, but is recovered memory representative of most child sexual abuse cases?

Simply put, no. By way of forming a perspective on the relative magnitude of the number of legal child sexual abuse cases based on recovered memory, van der Kolk examined the Massachusetts Department of Social Services records for a single year, 1993.[26] These records confirmed sexual abuse in 2149 children. More than 200 men were jailed for sexual offences against children, and another 278 were put on probation. In the law library, van der Kolk could locate only five Massachusetts' cases over the previous 3 years where adults had taken an alleged abuser to court after recovering traumatic memories. This provides compelling evidence that only a small minority of child sexual abuse cases that reach the courts involve recovered memories. How valid are recovered memories? The answer to this question is at the crux of the recovered memory debate. However, in van der Kolk's research, of the five recovered memory cases he identified, all produced convictions, with one of them being James Porter, a notorious former Catholic priest who was thought to have molested at least 155 children and who currently remains incarcerated. Some of his accusers had suffered from years of amnesia of the abuse. Why the controversy?

The heated memory controversy in the courts is seen by some as being driven by a 'sophisticated' defence that conjures up denial and disinformation.[27] The 'False Memory Defence' uses such tactics as shifting the blame to the plaintiff, shifting the blame to a third party (the therapist) and selling the accused as the 'real' victim (see Whitfield for a review).[27] This tactic, sometimes called the 'looking good defence', is a highly motivated source for fuelling the controversy in the courts. Pope cautions against the pseudoscience of the courtrooms and elaborates the 'booming, buzzing confusion' that is fraught with unclear terms, inferential errors and *ad hominem* fallacies (p. 1160).[28]

CRITICAL SCIENTIFIC QUESTIONS

One positive outcome of the heated memory wars has been a plethora of research about traumatic memory. Many critical questions have been pursued. For example, is it possible for someone to truly 'forget', repress, dissociate or otherwise not have access to the memory of a significant past trauma? How can one be sure that an individual has truly 'forgotten' an event rather than simply not had occasion to think about it? Can someone accurately remember that they previously forgot something? If previously forgotten memories are recovered, are they as accurate as memories for trauma that have never been forgotten? The next section examines evidence that will shed light on some of these questions.

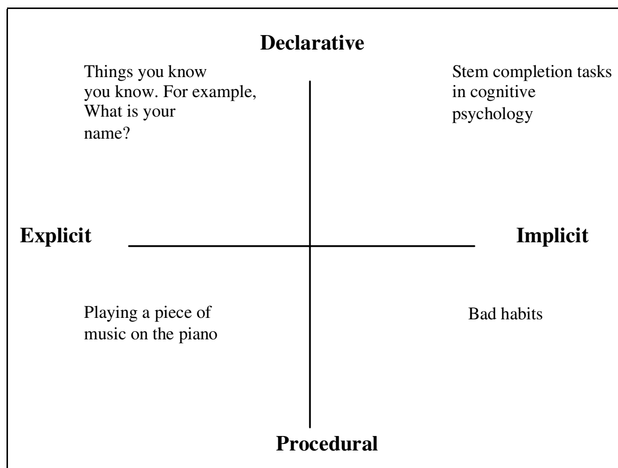

Figure 1: The types of memory.

NATURE OF MEMORY AND THE EFFECTS OF TRAUMA ON IT

Memory is active, selective and reconstructive.[29] Since the early work of Bartlett, psychologists have considered memory to be largely constructive (or reconstructive), and influenced by knowledge structures and schemas (Bartlett, as cited in Hirt *et al*.).[30] Memory is heavily influenced by information processing, in particular, executive functioning, attention and experience. In Freyd's representational momentum work, she found that the anticipation of future action and motion influence memory.[31] For example, in recalling a static picture where motion is implied (e.g. a basketball player in mid-air), people recall the actor (basketball player) as farther along the path of motion than what they actually saw. It is also well-established in cognitive psychology that memory is influenced by attention.

Memory can be thought of as a dichotomy between declarative (knowledge) and procedural (skill) memory (Figure 1). Complementary to this is the dichotomy of implicit and explicit recall.

The vertical axis in Figure 1 represents the content of memory. Declarative memory refers to the ability to consciously recall facts (semantic memory) and the ability to formulate a narrative of events (episodic memory). Procedural memory refers to having behavioural or performance knowledge (both skills and cognitive). The horizontal axis represents how memory is accessed. Explicit memory is knowledge that you consciously recall and implicit memory is knowledge that is not consciously recalled. Figure 1 provides examples of the intersection of these types of memory. These distinctions are relevant for forgetting of trauma because such forgetting may pertain to only declarative knowledge, while procedural knowledge is retained. Similarly, the forgetting may be evidenced by a failure of explicit recall while implicit recall is present.

AMNESIA AND FORGETTING

Freyd reviews several explanations for how forgetting can occur in her review of motivated forgetting, interference and inhibition.[32] It is well established that passive decay or erosion of memory can occur for short-term memories, which require active effort to maintain information, so that there can be rapid 'forgetting' of new information. Thus, information may be rapidly lost from short-term memory before being committed to long-term memory. If the information being rapidly lost is seemingly important, such as information about a traumatic event, the result will be considered amnesia. If only some declarative information is rapidly lost, while at the same time some sensory or procedural information is retained, the result may be amnesia for the event accompanied with inexplicable and intrusive sensory fragments along with the display of puzzling learned behaviours.

MOTIVATED, INTERFERENCE AND INTENTIONAL FORGETTING

> *If we remembered everything, we should on most occasions be as ill off as if we remembered nothing.* (William James (1890), as cited in Freyd, 1998)[32]
>
> *Life would be unbearable if we were forced to always carry unpleasant memories with us in our conscious awareness.*[4]

William James eloquently intuits what cognitive psychologists in the last century have empirically observed: memory is necessarily selective.[32] In 1923, Freud described how 'the ego defends itself against the instructural impulse by the mechanism of repression' (p. 150).[33] In 1948, Waldfogel reported that adults selectively forget unpleasant childhood events but not pleasant ones and, more recently, Kihlstrom and Harackiewicz found that negative memories tend to be recalled in a more neutral or trivialized way.[34,35]

Forgetting can occur through interference. Proactive interference occurs when existing knowledge interferes with the creation of new memories, such as when one has difficulty remembering a new phone number and mistakenly dials the old phone number. Retroactive interference occurs when one has difficulty recalling old information because of new information, for example, having difficulty remembering your old license plate number once you have memorized your new license plate number. We all experience interference when trying to recall a friend's new email address or phone number – the old number interferes with the new number. Where one parked the car is also a common example – we inhibit where we parked yesterday in order to remember where we parked today. This mechanism is likely involved in some child abuse cases. The competing events of happy times can interfere (adaptively) with the unhappy experience of abuse.

Intentional forgetting occurs when people try to forget something. Cognitive psychologists have found that in laboratory studies, when subjects are directed to forget previously encoded material, they can successfully inhibit this recall with selective retrieval.[36] Anderson *et al.* have identified neural systems that may be involved in the suppression of such unwanted memories.[37]

FORGETTING OF TRAUMA STIMULI

In two studies using a directed forgetting paradigm (a laboratory task in which participants are presented with items and told after each item or a list of items whether to remember or forget the material), DePrince and Freyd found that highly dissociative participants recalled fewer charged words (e.g. 'incest') and more neutral words than did participants with low Dissociative Experience Scale scores for items they were instructed to remember when divided attention was required (item method: DePrince and Freyd, 2001; list method: DePrince and Freyd, 2004).[38–40] The high dissociators report significantly more trauma history and significantly more betrayal trauma.[39] Similar findings have been found with children using pictures instead of words as stimuli. Children who had trauma histories and who were highly dissociative recognized fewer charged pictures relative to non-traumatized children under divided attention conditions; no group differences were found under selective attention conditions.[41]

DISCOVERED MEMORIES

Schooler distinguishes discovered memories from regular memories by drawing attention to the concept of a meta-awareness component to memory.[42] In discovered memories, it is the meta-awareness that is either gained or regained and which changes the meaning of a memory. This can occur either when individuals have an experience without being explicitly aware of their interpretation of that experience, or confuse the discovery of (new) meta-awareness with the discovery of a memory itself. An example of this would be learning as an adult that intentionally hurting a child as punishment is abusive. In coming to embrace this knowledge, one may recall being beaten as a child and suddenly 'discover' the memory of being abused, whereas before the memory was merely part of the fabric of just another childhood experience. The 'discovery' increases the salience, meaning and relevance of the particular memory or memories. Sivers *et al.* relate this mechanism to the activation of schema, and the reinterpretation of events as new information is learned.[43]

STATE DEPENDENCY

Psychologists have shown experimentally that memory improves when one is in the same state in which the memory was encoded. This has been found in some recovered memory cases, where there has been notable correspondence between the original abuse situations and when memories were eventually recalled.[43]

RECOVERING MEMORIES

Memory recovery depends on the nature of the forgetting.[32,43] If forgetting is due to a complete absence of encoding, then memory recovery is not possible because the memory was never formed. However, if some parts were encoded and others not, recovery may involve weaving together fragments with a new narrative. In contrast, if a memory was initially fully formed but then later inhibited, eventual recovery may result in a fairly complete memory suddenly being available.

ACCURACY OF RECOVERED MEMORIES

Perhaps the greatest confusion created in the wake of the memory wars is the conflation of memory accuracy with memory persistence. A memory, apparently, is no more or less accurate if it is continuously recalled or if it is forgotten and later recalled.[32,44,45] Williams, in investigating women who had been admitted to a hospital emergency room for sexual assault, found their memories 17 years later were no more or less accurate if they were recovered or had been continuous.[45] Although there is some research to suggest that highly emotional events may be more memorable than other events, there is no clear evidence that traumatic memories, whether recovered or continuous, are any more accurate than other sorts of event memories.[46]

WHAT IS A FALSE MEMORY?

Before defining 'false memory', it is useful to understand the historical origins of the term. False memory did not originate in cognitive psychology, but rather gained notoriety vis-a-vis a social movement in 1992: the formation of False Memory Syndrome Foundation (FMSF). This group formed in order to question the veracity of child sexual abuse claims. Interestingly, FMSF has primarily focused on contested recovered memories of childhood abuse. The issue of amnesias occurring in combat veterans, for example, never generated similar discord.

In the period that followed, a successful press campaign saw the phrase 'false memory syndrome' gain prominence in the media despite an absence of empirical evidence or validity for the concept. As false memory was adapted into everyday language, it was rapidly adopted by cognitive psychologists as well. The term replaced formerly used cognitive terms such as memory errors and intrusions.[47] Today, false memory in cognitive psychology often refers to errors in details for learning and recall tasks (e.g. recalling the word *sandal* instead of *foot* or *needle* instead of *thread and eye*). Thirteen years after the formation of FMSF, there is still no empirical evidence of an actual syndrome.

False memory remains an active social movement. In common usage, the reference to false memory encapsulates a broad range of meanings, from simple lexical errors and mis-recalled information, to fabricated memories. Media publicity of false memory focuses on sensationalized and unusual cases, while the empirical evidence for false memories is often based on simple lexical manipulations in the laboratory.[47]

HETEROGENEITY OF TRAUMAS AND AMNESIA

van der Kolk noted in 1996 that amnesias for traumatic experiences, with delayed recall for all or parts of the trauma, have been documented in the literature after natural disasters and accidents, war-related traumas, kidnapping, torture and concentration camp experiences, physical and sexual abuse and committing murder.[48] A general population study showed that virtually all categories of severe traumas produced victims with amnesia.[49,50] Elliott and Briere found that a history of 'complete' memory loss was most common among victims of child sexual abuse (20%), and a substantially higher proportion of victims had significant amnesia for particular details of their traumas.[49] Of the 505 who completed the survey, 72% reported some form of trauma and, of these, 32% reported delayed recall of the event. This phenomenon was most common among those who observed the murder or suicide of a family member, sexual abuse survivors and combat veterans. The severity of the trauma was predictive of memory status while the most commonly reported trigger for recall of the trauma was some form of media presentation such as a TV show or movie (54%), whereas psychotherapy was the least commonly reported trigger (14%).

ROLE OF BETRAYAL

Writing in 1996, van der Kolk stated, 'For reasons that are not at all clear [compared with other traumas], childhood sexual abuse seems to result in the highest degree of total amnesia prior to memory retrieval' (p. 285).[48] Freyd embarked on a line of research that became formalized as betrayal trauma theory.[32,51] This theory examines the way the relationship between the abuser (who is also an attachment figure) and the victim will impact on how childhood sexual abuse is remembered.[52] Ongoing childhood sexual abuse is frequently incestuous or the perpetrator is a trusted adult well known to the family. Betrayal trauma theory suggests psychogenic amnesia as an adaptive response that functions not so much to reduce immediate suffering, but to promote long-term survival by not rupturing attachment to a figure vital to development. If the betrayer is a primary caregiver, it is particularly important that the child complies in order to maintain attachment. For a child to withdraw from a caregiver upon whom he/she is dependent would further threaten his/her life, both physically and mentally. Thus, the trauma of child abuse necessitates that knowledge about the abuse be blocked from those mental mechanisms that control attachment and related behaviours. The information that gets blocked may be partial (for instance, blocking emotional responses only), but for many partial blocking will lead to a more profound amnesia.

In a prospective community study, Williams found that among a sample of 129 adult women whose childhood histories of sexual abuse were documented by medical and social service records, 38% failed to recall these events at a follow-up interview 17 years later.[53] In fact, Williams' study is one of numerous studies of varying methodology that have found that a significant proportion of adults who report a trauma history also describe a period of time when they did not recall the experience, with the rates of reported forgetting in the case of child sexual abuse ranging from approximately 12 to 77% depending on the study. Included within this range, Loftus *et al.* reported 19% of subjects experiencing total amnesia before memory retrieval.[45,54,55] Freyd reported finding, from re-analyses of a number of relevant datasets, that incestuous abuse was more likely to be forgotten than non-incestuous abuse.[32] These datasets included the prospective sample assessed by Williams and retrospective samples assessed by Cameron and Feldman-Summer and Pope.[45,52,56,57]

When viewed from an interpersonal and attachment perspective, the ambivalence toward one's caregiver/abuser and the traumatic memories that underpin this, lead not unnaturally to the phenomena of accuser/recanter as in child sexual abuse accommodation syndrome (pp. 51–54).[32] Kluft points out in his naturalistic study of the memories of 19 patients with dissociative identity disorder (DID), that some patients recanted and rescinded multiple times.[3] Recantation is not unexpected in child sexual abuse cases, and may result from denial. In fact, recantations themselves are often rescinded.[32] There is no fundamental reason to disbelieve a recovered memory and then to believe a subsequent recantation. Recantation is not evidence that a recovered memory is false, nor does it serve as corroboration for the veracity of a recovered memory.

CASE EXAMPLE: LAURA

In response to the recovered memory controversy, a growing number of cases have published in meticulous detail individuals' experiences in which early trauma is well documented but is followed by a period of documented amnesia for the traumas, followed by the recovery of memories of the traumas. One such example is provided by Duggal and Stroufe.[58] They report the case of a young woman who happened to be a subject in a prospective longitudinal study from early childhood. Background information concerning the family had been obtained before any report of sexual abuse. Four and a half years into the study, child protection officers and police were called in following the child

('Laura') reporting sexual abuse. (Her parents were divorced and she was in joint custody.) It was noted by her mother at the time that Laura would cry, tantrum, and have nightmares when she went to stay with her father. Around the time Laura reached third grade, it was documented that she had told a friend that she had been sexually abused, a case-note that was to constitute the last childhood record of memory for trauma.

At age 16, in response to direct questions regarding past sexual abuse, Laura indicated that she had never been sexually abused. A similar response at the 17 year assessment was obtained. At 18 years, 10 months Laura discussed her memory of abuse openly in a structured interview administered by a research assistant who was blind to Laura's previous history. Laura indicated that in the previous few months she had memories about being sexually abused as a child by her father. The memories had returned progressively over a 1–2 week period, culminating in explicit memories of her father sexually abusing her. At one point, Laura went to a friend's house where she thought she heard her father's voice. She noted, 'I totally went into shock all over again, just like screaming "get him away from me" ' (p. 315).

Laura's father never denied that she'd been sexually abused. A child therapist who saw Laura initially after the involvement of Child Protection had met her father at various times. Her father stated that if Laura had experienced sexual abuse, it had been perpetuated by somebody else, adding the qualification that if he had done it, it would have occurred while he was on drugs and he had no memory of it.

ISSUE OF CORROBORATION

The clinical account of Laura is representative of corroborated cases of recovered memory. Despite these cases, some writers continue to deny the validity of recovered memories. To counter such arguments, Professor Ross Cheit launched the Recovered Memory Project in August 1997. This project takes the form of a website (www.RecoveredMemory.org) that contains a growing archive of corroborated cases of recovered memory of child sexual abuse. At the time of this writing, it includes 96 cases. One of the more famous cases on Cheit's archive is that of Marilyn Van Derber, Miss America 1958. Her recovered memories were corroborated by her sister, Gwen Mitchel, who had continuous memory of similar abuse and who long thought she was the only one in the family sexually abused by her father. Van Derber experienced amnesia for the abuse until she recovered the memories at age 24.

Traumatized dissociative individuals are perhaps the most likely to experience amnesia for traumatic events. When examining the literature for corroborative evidence of abuse in patients with DID or dissociative disorder not otherwise specified (DDNOS), it often can be found. Kluft reviewed six studies involving collectively 125 patients with DID/DDNOS. Confirmation of abuse was obtained for 115 of the patients (92%).[3] In the only published Australian series with DID patients (n = 62, plus 10 with incomplete data), corroborating evidence was available for 29%.[59] Although this was not a forensic investigation (and many patients were not seen in circumstances that afforded ongoing follow up), there was little to distinguish patients whose abuse was corroborated, for example, by an admission from an abuser, police records etc. from those where such material was not available at the time. Although evidence of corroboration in the literature helps to establish the validity of reports, in the case of individual patients in therapy, corroboration does not always occur. Some patients may choose to seek medical records, school records, search through childhood diaries or talk to acquaintances who knew them as children. These resources are not always accessible, however, and not every patient may possess the wherewithal to seek this information. Clinically, it is the duty of therapists to support patients, even if it means supporting the acceptance that they may never know what happened with absolute certainty.[60] This raises the question: what is the responsibility of the therapist?

RESPONSIBILITY OF THE THERAPIST

One important responsibility is competency and training. Briere stated in 1992, in addressing the eruption of the memory wars, the opinion that 'although part of the outcry regarding incompetent therapists who "implant" false memories of abuse is undoubtedly specious, it is also true that some very bad "therapy" in this area is being done by individuals with insufficient training, experience, and/or psychological stability' (p. 292).[61] Knapp and Van de Creek make the point that lack of training among therapists leads to impoverished treatment quality, for example, the psychotherapist who 'helped' Stephen Cook recover untrue memories of abuse by the respected Cardinal Bernadin.[23] Lindsay and Read suggested from equally anecdotal reports that negligence in respect of dealing with recovered memories came from untrained and unlicensed professionals.[62]

Undoubtedly, it is vital that therapists carefully assess patients' needs and ascertain whether treatment is within their area of expertise and competency. Therapists should know the constantly evolving theory and research about memory, suggestibility and child sexual abuse.[60] Further, it is critical that an individualistic approach is taken, because symptoms, assessments and circumstances vary widely from patient to patient. Pope and Brown elaborate that the therapist would do well to keep an open mind, and support ambiguity, particularly where recovered memories are concerned.[60] Additionally, therapists need to be sensitive to the changing needs of patients. For example, an individual seeking treatment for an eating disorder may realize that sexual abuse was the catalyst for the behaviour. A therapist untrained in sexual abuse (regardless of whether the memory was continuous or recently recovered) would need to

consider whether transferring care to another clinician is appropriate without deserting a patient, or whether consultation would enable the therapist to meet the patient's needs.

Equally important to competency, is the awareness of power balance between patient and therapist.[60] Therapists who collaborate with patients will be far more likely to empower and support them. Coercion and suggestion in treatment with a sexually abused patient should be avoided. Rather, these individuals benefit from receiving support for their adult autonomy and as experts on themselves. It is the therapist as expert, authority or all-knowing who runs the risk of overpowering a patient and influencing him/her with his or her own biases and preconceived notions. Berliner and Briere proposed that therapists' beliefs and practices can 'create the conditions under which vulnerable patients may come to believe, falsely, that they had been abused in childhood' (p. 11).[63]

CONNECTIONS

Issues concerning patients' memories and how they are dealt with by health professionals probably have more relevance to the paradigm of respect and patient autonomy than any other. A therapist could perhaps be defined in part as a trained professional with whom one shares memories and the thoughts and feelings that go with them. The therapist should not have a 'power over' dynamic in which one 'acts on' the patient.[64] Some might consider the therapist a custodian of pieces of another's life, providing a space in which a hurt or deprived person can learn to trust in order to share and sort out his/her past experiences.

A therapist who fails to exercise ambiguity with respect to a patient's memories, recently recovered or not, can do harm. Goals, whether they be theoretically based in connection as in feminist theory, reconceptualization, as in acceptance and commitment therapy or otherwise, should provide support, safety, ongoing assessment and consistency.[65]

It is imperative that the therapist not actively pursue memory recovery. In one respect, it would disempower the patient by overemphasizing the need for remembering rather than focusing on one's internal states and experiences. By emphasizing a need for details or corroboration, it can create the dynamic of therapist as judge, needing evidence, with concern for the patient's well-being at the wayside. It is far better, as Pope and Brown suggest, to model the acceptance of doubt, ambiguity and uncertainty, and de-emphasize the content (or need for content) for a particular memory.[60] After all, it is likely the patient's confusion or distress brought him/her to therapy, not a specific memory alone, or a desire to recover an elusive memory. Therefore, the memories in themselves should not be pursued in therapy.

There is substantial research to show that women who have been sexually abused often do not disclose the abuse, even to a therapist.[66,67] Therefore, the therapist should ask about the experiences in a non-suggestive, unbiased way (see Pope and Brown, for discussion, pp. 156–159).[60] A therapist may never be totally sure of the historical accuracy of some particular account; the emphasis should be on authenticity rather than on forensic discovery.[64]

Although the crux of the memory wars was about allegations for child abuse and memories for that abuse, independent of any therapy, the flames were at least in part fanned by incompetent therapists.[23,62] A few therapists practising something along the lines of what Pendergrast and others referred to as 'recovered memory therapy', provided substance to the 'false memory' defence.[68] Because of this, it is worth noting that the competent therapist will not ethically use suggestion and imagination to influence patients, and will not urge patients to take pre-emptive legal action against presumed abusers. The competent therapist will not induce patients into other actions that have more to do with the therapists' identifications, projections or self-promotion needs than their patient's welfare. The therapist is principally not a social advocate, abuse crusader, biographer, researcher or forensic investigator.

Therapy is not particularly about the therapist. When therapists fail to provide a therapeutic frame that is safe and does not involve coercion or feeling of obligation in fulfilling a therapist's agenda regarding one's memories, it is highly likely that multiple other boundary problems will be emerging that will further undermine the therapy. This is not to imply that the therapist should ever forget their humanity, rigidly enforce some narrow notion of therapeutic neutrality, or fail to consult common sense and the hard-won lessons of clinical experience. Every patient and situation is in some ways unique. A wide appreciation of the spectrum of boundary issues and the differences between boundary violations that damage/exploit the patient, and carefully justified boundary crossings made to support and empower the patient, is a fundamental requirement.

The competent trauma therapist is a collaborator who forms a therapeutic alliance. He/she might provide balanced and factual information on the nature of trauma and remembering, and demonstrate appropriate tolerance for ambiguity and uncertainty. Therapy is not manualized but rather focused on, and developed at, the individual level. It does not proceed 'from rule to rule, but rather from concern to concern, from question to question, and from hypothesis to hypothesis... [and] must emerge from the therapists' efforts to explore the concerns, and to aid the patient in becoming an active participant in making sense of what is being recalled, and in deciding how, when, and at what speed to take the next steps in therapy and in life' (p. 148).[60]

CONCLUSIONS

During a controversial period that reached its zenith in the mid-1990s, in which there were numerous allegations regarding the excesses of so-called 'recovered

memory therapists', it was actually difficult to find any therapists who defined themselves principally as practising 'recovered memory therapy'. McNally observed in 2003, 'As far as I can tell, no one practicing psychotherapy today endorses this term as descriptive of what they do' (p. 3).[25] It was also hard to find many writers in the field of trauma and memory who placed particular emphasis on the entity of 'repression'. Perhaps it was because the term repression uncomfortably straddles many meanings such as denial, suppression, spacing out, traumatic amnesia, resistance and unawareness. Dissociation, on the other hand, has been intensely observed, operationalized and measured. It is embedded in the diagnostic criteria of a range of DSM-IV disorders, including the dissociative disorders, PTSD, acute stress disorder and borderline personality disorder.[69]

It has been a long time since psychiatry and psychology have witnessed a more acrimonious dispute than that which focused on the phenomena of recovered memories of childhood sexual abuse. This dialectic is typified in the DSM-IV definition of PTSD.[69] Two of the principal symptom clusters relate to persistent re-experiencing phenomena such as intrusive recollections and distressing dreams and to persistent avoidance of trauma-related stimuli (e.g. detachment, avoidance of thoughts or reminders). The parallel paradox is that traumatic memories are both the least forgettable and the most forgettable of all memories.[32]

A decade beyond the memory controversies, our world has vastly changed. In 1980, the most authoritative and comprehensive textbook of psychiatry in the world cited a 1955 reference that incidence rates of incest were approximately one case per million.[70] This cultural denial was radically transformed in the last two tumultuous decades as the phenomenon of child sexual abuse gained exposure and notoriety. We now are left to ponder a world that has widespread paedophiliac abuses of children by clergy capturing the public's attention. We've seen senior and ceremonial figures such as the Cardinal of Boston and the Governor-General of Australia forced to resign their positions because of how they handled past allegations of child abuse in their precincts and we have witnessed how police operations worldwide have netted many thousands of individuals (including in 2004 over 2000 in Australia) using the Internet to buy or distribute pictures of children being sexually abused. As these atrocities come to light, we can be more prepared as clinicians to be competent in their treatment. We can target awareness and prevention programmes. As we learn to accept and heal the past, we can hopefully look to a quiescent future in our field.

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