Accuracy, timing and circumstances of disclosure in therapy of recovered and continuous memories of abuse

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Seventeen patients who had recovered memories of abuse in therapy participated in a search for evidence confirming or refuting these memories. Memories of abuse were found to be equally accurate whether recovered or continuously remembered. Predictors of number of memory units for which evidence was uncovered included several measures of memory and perceptual accuracy. Recovered memories that were later supported arose in psychotherapy more typically during periods of positive rather than negative feeling toward the therapist, and they were more likely to be held with confidence by the abuse victim.

In recent years the phenomenon of recovered memory has taken on enormous scientific, moral, and political complexity. Freud's initial faith that a therapist's false interpretation of abuse to a client would cause little harm' has given way in virtually every forum to a recognition of the importance of the social persuasion function of psychotherapy² and the attendant

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possibility of conscious and unconscious manipulation of client beliefs by lay and professional treating agents.³ It thus is quite possible that the therapist might contribute to major changes in the self-image and self-definition of the client, producing an accurate life narrative that therefore facilitates prediction and solution of future problems—or an inaccurate narrative, which may worsen client prognosis. The building blocks for these radical changes in client life narrative, offered by commentators as the great successes and failures of our field, tend often to be new or "recovered" memories, reinterpretations of continuous memories, and/or enhanced appreciation, prediction, control and understanding of current life events in the light of the new perspectives.

The historical pairing of the terms "recovered memory" and "repressed memory" is unfortunate for those attempting to study these processes. Repression as a concept is judged to be supported by a vast array of experimental and clinical literature⁴ or unsupported by this same literature,⁵ depending in part on the definition of the term. However, the evidence for recovered nontraumatic memory, a form of recovery not based on the repression theory, is unquestionable. Entire fields of study (e.g., state-dependent learning⁶) have been based on the finding that memory might be unavailable in one state and reaccessible in another. Certain memory enhancement techniques, such as reinstatement of context.7 have been shown to increase the number of accurate memories available to both children and adults, with few if any researchers questioning the honesty of those claiming recovery of memory in this setting (although the ratio of true to false recovery is at issue). Why, then, are 14% of APA research psychologists willing to state so definitively (3 or below on a 10-point scale of possibility) that trauma, unlike nontraumatic experiences, can never be forgotten and then remembered, regardless of mechanism and regardless of the length of time between forgetting and recall?⁸

If one accepts the reality of the recovery of nontraumatic memory and simultaneously rejects the possibility of recovery of memories of *abuse*, two rather dubious assumptions appear necessary to sustain the schism. The first is that child abuse is never nontraumatic at the time it occurs. Interestingly, those arguing most strongly for relatively complete rejection of abuse recovery claims⁹ are often quite open to the possibility of nontraumatic child abuse, acknowledging that such abuse may be "forgotten." But why could events forgotten through normal processes not be recalled in the highly motivated setting of therapy, where reinvocation of seldom felt emotional states and reinstatement of context of the abuse may occur?¹⁰ If such returns may occur, the reinterpretation of confusing and nontraumatic childhood sexual contact with a parent could be quite upsetting, if not traumatic, to the adult.

In addition, to sustain the dichotomy above, one must assume that traumatic memory is subject to none of the ordinary processes of loss and return described above. "Highly intrusive and traumatic events will be clearly and vividly remembered," state Wakefield and Underwager." "The exception is when the traumatic events take place when the child is in the period of infant amnesia." The traumatic event is vividly remembered or irretrievably forgotten.

This second assumption is intuitively appealing, resonating with the feeling of certainty that is attached, for many of us, to our own most intense affect-charged memories. Yet examples of decay and confabulation are quite readily available in the experimental and observational literature on trauma,¹² as are case examples of traumatic memory return.¹³ Psychophysiological and neuropsychological research have offered potential mechanisms for the loss of traumatic memory and the conditions of accurate and inaccurate recall.¹⁴ Loss of traumatic memory does appear to occur in patterns similar to loss of nontraumatic memory, both for central details¹⁵ and for peripheral ones,¹⁶ in cases in which neither injury nor infantile amnesia applies. At this point it seems plausible that both special mechanisms¹⁷ and "normal" mechanisms applicable to both traumatic and nontraumatic memory loss may be at work in the traumatic case.

The evidence for decay or absence of traumatic memory is clearly more developed than the evidence for recovery of accurate traumatic memory once it has been lost. Establishing validity of the subject's claim of abuse, claim of prior lack of memory, *and* claim of memory return is a daunting task, although a number of researchers have made important contributions (e.g., Schooler's¹⁸ case studies and Williams's¹⁹ prospective research), and public instances of reported recovery of memory with convincing corroboration have been discussed.²⁰ Surveys also have shown that substantial numbers of individuals in and outside of therapy report accurate recovered memories of abuse in their own lives.²¹ Although the evidence is arguably imperfect, it does suggest that traumatic memory, if lost, may in some circumstances be regained.

By exaggerating the necessary link between repression and recovery, and by equating repression with indelibility, the most extreme critics have created a concept that they label "robust repression."22 Freud's early idea that repressed memories were protected from decay allowed some²³ to justify acceptance without scrutiny of any memory offered in the phenomenological language of recovery, an indefensible position today. Others²⁴ were encouraged to set repression theory squarely against the voluminous literature on memory malleability, arguing as if one must accept either repression or the reality of memory decay. Even Freud, however, modified his stance on repression with clinical experience, stating in 1926 that "we begin to suspect that it is not self-evident, perhaps not even unusual, that those [repressed] impulses should remain unaltered and unalterable in this way."25 The question of whether the mechanism of repression, or any mechanism related to the temporary inaccessibility of memory, can explain loss of memory for the daily experience of severe

trauma over the course of years (the typical scenario given for "robust repression") is a question separable from that of whether recovery of traumatic material can occur at all.

We are left in a scientific position of weak theoretical support for a bias against accurate recovered memory-that is, the belief a memory that has suffered from errors of omission (amnesias) must also suffer from errors of commission (inaccuracies). Evidence for the prevalence of the phenomenon, conditions for accurate or inaccurate recovery, or likelihood of accuracy for recovered memory, however, remains inadequate. The questions are particularly crucial for memories recovered in therapy, since numerous principles operate to raise the likelihood of inaccurate recoveries as well as accurate recoveries. Among the processes undermining accuracy might be the prejudgments of the therapist,²⁶ who might communicate these expectancies to the patient. Other processes might include the motivation of the patient to produce a compassion-inducing story,²⁷ the wish of both patient and therapist for a coherent life story,²⁸ or the effect of a therapist returning repeatedly, even with open-ended questions, to a question of unspoken negative events in childhood.²⁹ The question of the general accuracy or inaccuracy of memories in therapy thus is likely to continue to be of import to the average clinician.

The present study was therefore directed toward a greater understanding of recovered memories in therapy. The 17 women who participated had recovered memories of physical or sexual abuse by their fathers during their therapy with the author, and they cooperated in gathering physical evidence confirming and refuting these memories. The research goals included addressing methodological criticisms of previous works, as well as testing theoretical predictions.

First, as is articulated more fully below, this research included a more thorough assessment of the likely accuracy of abuse memory than is typically feasible in clinical or sur-

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vey research. Herman and Schatzow's³⁰ classic study, in which women did find evidence for the accuracy of their abuse memories, has been criticized harshly on this issue by false-memory proponents.³¹ Chief among the criticisms is that Herman and Schatzow did not personally view and evaluate the evidence. However, this criticism might be seen as a necessary by-product of the ongoing clinical setting in which the study occurred, where therapist requests for the client to prove to the therapist that her statements regarding evidence were truthful might have detrimental effects. Similarly, Williams³² could not reasonably challenge her subjects' recall, or ask for further proof of the identity of the perpetrator, although medical records were available to substantiate other aspects of the memory. In contrast, in the present research the author was able to substantiate the existence of the evidence offered by the clients and to have this evidence rated for evidentiary value. Further, both the alleged victim and the alleged perpetrator participated in the evidence collection, providing a better balance for the search for confirming and refuting evidence. It was predicted that clients would in fact be able to produce evidence for some of their recovered memories.

Second, the study provided a chance for analysis of the recovery process in therapy, adding perspective to survey research on this aspect of the phenomenon. In a number of valuable projects,³³ large-scale surveys have established that roughly 20%-60% of individuals reporting a history of sexual abuse state that there was previously a period of time in which the memory had been unavailable. This question, however, could be inelegantly paraphrased as "Do you remember if there was ever a time in which you did not remember?" It is not clear that such an assessment can be reliably made. Can we know if a year ago we would have said "No, I don't remember" to a question that was not asked? Each of the survey authors above has struggled with appropriate ways to convey the targeted phenomenon to the respondents, but it is

still unclear whether this memory task is within subjects' capacities, even given their understanding of the researcher's question. Through transcript analysis it may be more easily documented that the individual did in fact fail to remember, or at least reported failing to remember, and then came to remember or report a given event.

The study of the recovery process also may give some theoretical support to repression or dissociative amnesia (defensive exclusion of information from processing, to use a more general term), state dependency, or other hypothesized mechanisms of memory return. Weiss and Sampson,³⁴ prolific researchers of the Mount Zion Psychotherapy Research Group, hypothesize from an analytic perspective that derepression, and therefore accurate recovered memory, might be more likely after the therapist passed a "transference test." At these points in therapy, the client finds disproof of a pathogenic belief about the therapist in the therapist's behavior.35 Here, accuracy of memory recovery could be tracked and compared in state-dependency sessions (defined as those sessions in which patients were experiencing strong negative affect, providing state-dependent access to previous trauma), de-repression sessions (defined by positive attitude toward therapist), or other sessions.

Third, all the women in this study completed a battery of psychological tests prior to their memory recovery experience. It was predicted that the presence of convincing evidence for both continuous and recovered memories would be predictable from measures of reality testing, particularly the X-% score in Exner's³⁶ objective scoring system for the Rorschach and Scale 8 (Schizophrenia) on the MMPI, and by available memory measures.

Finally, all studies known to the author to date compare the accuracy of one group's recovered memories with another group's continuous memories.³⁷ Although this methodology certainly contributes to the field, it is argued here that an

intra-subject approach is more relevant to the legal and clinical questions faced by professionals today. More specifically, the forensic question is less likely to be "Is Mary more reliable in stating her abuse memories than is Jane?" than to be "Is Mary's recovered memory less trustworthy than her continuous memories of her family life?" Thus, in this research, subjects were chosen who have some continuous abuse memories and other recovered memories, and evidence for accuracy of these subtypes of memory are compared.

Method

Recruitment of subjects with recovered memories of abuse The 17 women who participated in this research were introduced to the research in their normal follow-up contacts after completion of 10-month to 25-month psychotherapies with the author (M = 15.59, SD = 4.85). At the time of initial psychotherapy, six clients were married and 11 single or divorced. Average age was 29.53 (SD = 5.93). Fifteen of the subjects are Caucasian. All subjects had finished high school, and 14 of the 17 had some college background.

Women who met the criteria for the research were contacted and informed of the study.

1. Demographically, all subjects had accused their living fathers of sexual or physical abuse and had discussed these allegations in therapy.

2. All patients could reasonably be termed "recovered memory patients" in that their recoveries of abuse memories substantially changed the perceived severity of the overall level of parental abuse. Average ratings of the abuse subsequent to recovery (by independent raters) were significantly higher than ratings of the continuously remembered abuse alone (t(16) = 12.67, p < .001). The average percentage of all abuse memory elements (potentially verifiable "facts" regarding the abuse episodes) that were recovered during therapy was

33.65% (SD = 8.64). The nature of the recovered memories is described in Table 1. These subjects were not augmenting details to existing memories, but were reporting allegedly recovered full episodes of abuse, at times a type of abuse that they had not been aware that they had experienced.

TABLE 1	Type of memories recovered	
	More severe physical abuse only	Ą
	More severe sexual abuse only	5
	More severe episodes of both	
	physical and sexual abuse	4
	First memories of sexual abuse ^a	3
	First memories of physical abuse ^a	1
	These subjects had continuous memories of the o abuse.	ther type of

3. All patients had received therapy in settings that allowed tape-recording, and they had signed confidentiality agreements allowing blinded excerpts to be shared with my students and full transcripts to be reviewed within my own research. All had psychological testing available from prior to therapy.

Five potential subjects were eliminated after contact for the following reasons:

4. Three subjects were involved in the "survivor" movement, attending groups and lectures and at times serving as client experts in college courses. Although the majority of data collection took place from 1990 to 1992, prior to the explosion of the false memory/recovered memory controversy, strong support for abuse memories was a focus of the movement at the time. Since subjects were true collaborators in this research, those perceived by the author to have a commitment to this movement (beyond their own wish to find verification or nonverification) were eliminated. The father of one of these women was involved in one of the newly forming fathers' rights groups, which also might have had an agenda regarding the truth of abuse memory.

5. Since fathers also would be extremely involved in data collection, and since father-daughter sexual and physical abuse would be the subject of interviews conducted with siblings and other potential witnesses, the decision was made to exclude those families in which fathers did not give full permission for the interviews. Two fathers refused this permission, although they were interviewed themselves. One of these fathers denied all abuse allegations, while the other admitted and discussed them but did not wish to involve other family members.

Informed consent for the client subjects was very extensive, both in written and in verbal form, and deserves more attention (including critical inquiry by others) than is possible to give here. Topics included were the potential risks and benefits for the self in attempting verification, as well as the potential negative and positive effects on personal family relationships. The emergence of groups that might support the harassment of the women clients perceived as falsely claiming child abuse was not anticipated at the time of data collection; by 1993, the rare but real risk of such an outcome precluded any further subject recruitment. All subjects were told that they could withdraw at any point during or after data collection, although none chose to do so.

Recruitment of father subjects

At the time of first contact, the 17 fathers averaged age 60.35 (age 43 to 72). The modal family income was \$40,000 to \$49,999. Nine of the father-daughter pairs stated that they had never discussed the abuse issue in their adult lives. Five of the father-daughter pairs had had no contact for several years prior to the study. While 17 of the eligible 19 fathers did give full consent (see #5 above), three routed initial conversations through their attorneys.

After agreeing to the study and finding out the substance of their daughters' charges, fathers were asked what they hoped to gain from research participation. Three fathers were openly seeking expiation, believing that their participation would be perceived as a positive step by their daughters. Ten, including both denying and admitting fathers, stated more generally that they believed this cooperation would improve their father-daughter relationships, most of which were rated negatively by both participants. One father, whose daughter had disclosed to her mother, stated that he hoped the project would be perceived positively by his wife. The remaining three fathers did not speak of relationships, spoke disparagingly of their daughters, and stated that they hoped their daughters would come through the study to cease behaviors that the fathers considered disruptive of the family.

Psychological assessments and ratings available

Nature of the psychotherapy

The author's use of psychotherapy is largely informed by cognitive research³⁸ and attachment theory.³⁹ Discussion of the past is relevant both in understanding the patient's general expectations of authorities and in determining the schemata that might be guiding their choices and (mis)interpretations of reality. While much of the time in each psychotherapy session was spent on present-day issues, substantial discussion of parental relationships occurred in each case.

All subjects had taken the MMPI and Rorschach at intake.

The MMPI was taken again at the study's inception.

Given the focus on "risky" techniques thought (although not proved⁴⁰) to facilitate false memory,⁴¹ it is important to mention that the author did use a few of these methods. No subject was hypnotized, asked to imagine hypothetical abuse scenes, or told that her symptoms resembled those of a victim of some specific type of abuse. However, six of the women sporadically kept journals, two of which were at the instigation of the author. Fifteen of the women discussed at least one dream or nightmare during therapy, although the author does not engage in formal dream interpretation. No popular books on sexual abuse or incest were assigned, although in two cases scientific literature was given to the client.

Procedures Subjects were given a list of individual abuse-related "facts" that had been presented during therapy. The items were potentially verifiable, excluding thoughts of the patient, general recalled conversation between father and daughter, and perceptions of motive or intent. The procedure had been piloted in work with Dr. Judie Shields. Subjects then made a number of ratings for each memory.

1. Daughter subjects rated the perceived truth value of each abuse memory on a -5 (certain now that this is untrue) to +5 (certain now that this is true) scale.

2. The subject attempted to recall if each unit had been recovered or continuously remembered and whether it was presented to me early or late in therapy, and the trigger for the memory if it had not been mentioned in the transcript. The latter request was dropped due to multiple missing data points; subjects often reported being unable to recall the information. The definition of recovered memory used for the author's parallel rating based on transcripts was:

a. The detail had not been previously disclosed to the therapist or had been denied earlier, or the client had been amnestic earlier (e.g., said "I don't know" to a direct question).

b. Some evidence existed of the client's subjective experience of recovery—that is, a statement to this effect, or the report of a memory in the context of a flashback or dream that contained information purportedly new to the client.

The client, after evidence submission, reassessed these ratings based on the transcript (see #4 below). Memories were counted as recovered in the main analyses only if both therapist and patient (after looking at the transcript) believed that criteria a and b were met. Only one disagreement was noted for the 57 recovered episodes to be discussed, and was resolved in the client's favor. The covariation of the client's recall of whether the memory unit had been continuous or recovered and her assessment of whether it had indeed been continued or recovered (after looking at transcripts) yielded a percentage agreement score labeled Source Memory.

3. Subjects tracked down physical evidence for each memory and rated the quality (or strength) of the evidence on a 5-point scale (to be discussed later).

4. Subjects ended the evidence-gathering phase at their own discretion after a period of 4.5 to 13.5 months. After all information had been gathered, the subjects were given access to the tapes and/or transcripts. In addition to reassessing recovery, they were asked to rate or identify for each session:

a. How they believed they were feeling toward me at the time, from extremely distant (1) to extremely close (10).

b. How severe they believed their symptoms to be at the time, from nonexistent (1) to extremely severe (10). A similar rating was made by the therapist from transcript and session notes.

c. The positive or negative affect experienced in the session, from entirely negative (1) to entirely positive (10). Again, a parallel rating was made by the therapist.

d. The presence of an "alliance rupture," meaning an exchange between patient and therapist that the client experienced in one of three ways: a betrayal of the relationship or a behavior from me that led to anger; a profound misunderstanding that led to a disappointment in me; or a feeling that I was disapproving of them or shaming them.

e. For each alliance rupture, the moment of alliance repair.

6. Patient and therapist noted instances in the transcript in which the patient had referred to an earlier factual therapist behavior (that is, "You said x" rather than "You were nice to me"). Agreed-upon instances were checked against the transcript of the earlier noted session and were scored as accurate or inaccurate. The disagreements (2%) were not included in the analyses. The percentage of references to prior session events that were accurate is referred to in later sections as Session Memory.

- Procedures Fathers were interviewed with a funnel procedure, beginning with open-ended questions regarding any negative parent-child interactions, any memories of physical discipline, and any memories of sexual or sexualized contact. After fathers gave as much information as could be admitted/recalled through open-ended procedures, more specific questions were asked. The final and most specific questions followed revelations of the exact content of the daughter's memories: a request to say whether he believed the memory to be true or false and, if true, whether he had a specific memory of this event.
 - Rating of Both father and daughter participated in locating "evidence." accuracy The evidence offered was of two types, primary and contextual. For example, one client reported the following recovered memory. In this case the full memory is recovered, with the client claiming to have had amnesia for the cottage trip in general.

I remember my father toweling me down after I had been swimming. We were at a cottage at Lake X. I was 9 years old and wearing this little red swimming suit with a ruffle. He reached under the suit and put his finger in my vagina. I remember the pressure of his finger and the confusion and fear I felt.

Using the Dalenberg and Shields procedure, the memory was cut into memory units before submission to subjects for verification. Contextual evidence would be:

- 1. Did you go to a cottage on a lake when you were a child?
- 2. Was it at Lake X?
- 3. If you did go to Lake X, were you 9 at the time?
- 4. Did you own a red swimsuit when you were 9?
- 5. Did you own a swimsuit with a ruffle when you were 9?

The 5-point scale used for contextual information asked if the evidence was convincing, substantial, circumstantial, irrelevant, or disconfirming.

The primary evidence would be:

- 1. Did someone touch you under your swimsuit when you were 9?
- 2. Did this occur at the cottage at Lake X?
- 3. Was the perpetrator your father?
- 4. Did he put his finger in your vagina?

The final rating scale used for each piece of identity evidence was:

- Category 1: This evidence alone is convincing.
- Category 2: Substantial positive weight, enough for reasonable certainty.
- Category 3: Positive weight, but not enough for reasonable certainty.
- Category 4: Should have no negative or positive weight in decision.
- Category 5: Should have negative weight. [Father is not abuser]

Virtually identical ratings were given by subject, therapist, and patient for contextual information. Pairwise kappas, measures of interrater agreement, were above .90. Ratings for the primary information, however, were widely discrepant, a not infrequent pattern being that the alleged perpetrator found the evidence virtually worthless, the victim saw the same evidence as highly convincing, and the therapist rated the same information between the two extremes or agreed with one participant. The evidential value of the primary information was therefore rated by eight individuals chosen to represent a range of likely opinions.

Six raters were recruited based on their scores on a widely disseminated survey of beliefs regarding recovered memory and false memory. Two questions served as the selection criteria, both assessed on a 10-point scale (-5 to +5): (a) Do you believe in the potential accuracy of recovered memories of abuse? (b) Do you believe in the potential of false memories of abuse arising in psychotherapy?

Three judges scored -3 or below on the first question and +5 or higher on the second. Their estimates of the percentage of abuse allegations that were objectively false ranged from 15% to 50%. Three additional judges scored +3 or above on the first question and -1 to +3 on the second. All believed that fewer than 10% of abuse allegations were objectively false. Two additional judges were first-year graduate students who were unfamiliar with the controversy.

Table 2 presents the ratings of the evidence provided by the subjects. Character evidence (friends or relatives who testified generally that the father or daughter was a good person) were not rated. The range of other evidence provided, however, and the weight given by the raters, is interesting in and of itself. Kappas on the basic distinction used to divide memories into "accurate" and "unverified" (Categories 1-2 versus Categories 3-5) were above .90, as was generalized kappa. Generalized kappa for the 5-cell version, however, was .48, reflecting the differences that still appeared across raters. The author spoke personally with each alleged witness and viewed the allegedly confirming or disconfirming evidence. While evidence cannot be sorted as coming from father or daughter alone, since they most frequently collaborated in both data gathering and data submission, it should be noted anecdotally that daughters did present a substantial percentage of the disconfirming evidence. Again anecdotally, 11 fathers presented at least one piece of otherwise unavailable evidence that was rated by the eight judges as Category 2, although fathers and daughters did not always agree on the evidential value.

Results

Characteristics of the recovered and the continuous abuse memories are shown in Table 3. Subjects were not significantly younger at the time of the event relating to their first recovered memory (M = 5.53) than at the time of their first reported continuous memory (M = 5.29; t(16) = .48, ns). The average number of abuse memory units that subjects tried to verify was 212 (SD = 57.65). The number of distinct memory episodes (3.35 recovered and 5.82 continuous) was significantly lower for recovered than for continuous categories (t(16) = 7.67, p < .001). Average confidence in the truth of the memory before evidence was gathered was significantly lower for recovered than for continuous memories (t(16) = 2.79, p < .02).

Accuracy of the abuse Of those memories for which some evidence was submitted (70% of all memories), 74.6% of continuous and 74.7% of recovered memories were judged by the full set of raters as having at least one piece of Category 1 or 2 support. Support for the identity of the abuser was found for at least one recovered memory for 10 subjects and for at least one of the continuous memories for 12 subjects (see Table 4). At least one memory was supported by confession in seven recovered memory cases and 10 continuous memory cases.

> Overall, there was no consistent pattern of subjects showing superior recovered or continuous memory for abuse. However, four subjects had significantly more evidence for accuracy of their recovered memory (using the general abuse memory data), two showed significantly more evidence for accuracy

TABLE 2

Types of evidence reported

Supporting (agreement by 6 or more judges that evidence is in Category 1 or 2) Confession by alleged perpetrator Specific description and identity found in diary kept at time Sibling eyewitness Sibling continuous memory of abuse of the same type (with no alleged discussion between siblings) Relative or nonrelative eyewitness Relative or nonrelative told at the time with same account of a specific injury Neighbors witnessed abuse similar in form but in differing location Medical evidence with no reasonable alternative explanation by parent Prior written confession in setting other than divorce Father's prior conviction of child abuse unknown to client Sexual touching seen in public Circumstantial (agreement by 6 or more judges)^a Witness reports of child nightmares at time of event Grade declines Marked changes in social life or aggressiveness at alleged time of abuse Photograph of weapon allegedly used on child (hanging on wall) Father admits alcoholism or drug addiction External evidence of father's alcoholism or drug addiction Irrelevant (agreement by 6 or more judges)^a Doctor, a family friend, noted no unexplained injuries (patient alleging either type of abuse) Special accomplishments of child Reports that patient, as child, made up stories accusing others of misdeeds that she had committed Close adult family friend (parent figure) was not told by child at time No specific mention of abuse in contemporaneous diary of time of abuse Sibling who allegedly witnessed abuse does not recall it Sibling recalls positive relationship between father and client in childhood Schoolmate allegedly told at time does not recall without prompting Disconfirming (agreement by 6 or more judges)^a Confession of abuse by other with same pattern Unusual details and sequence of account found in work of fiction Unusual details or sequence found in other verified account occurring with other victim known to child

Disagreements (agreement by 5 or fewer judges)^a Schoolmate recalls being told at time of incident Sibling states recall of abuse but gives no specifics without prompting Sibling continuous memory of abuse of the same type (with alleged discussion between siblings) Witnesses viewed father slapping child in public (alleges more severe physical abuse) Neighbors state recall of abuse but do not recall specific details Child began public masturbation during year abuse is reported to have begun Medical evidence that pre-teen had been sexually active Prior written confession in divorce setting Nude pictures of child or other children found in adult's belongings Sexually provocative statements made by father to child witnessed Child's former psychologist is certain child was abused

^a Scored as nonconfirming.

(and two marginally more evidence) for continuous memory, and nine were equal in amount of confirming evidence. These individual differences might be worth further exploration.

TABLE 3	Characteristics of continuous memories and of recovered memories		
		Continuous	Recovered
	Age at youngest memory	<u>M</u> = 5.29	<u>M</u> = 5.41
		<u>SD</u> = 1.40	<u>SD</u> = 1.35
	Discrete episodes	Range: 4 - 9	Range: 2 - 6
		<u>M</u> = 5.82	<u>M</u> = 3.35
		<u>SD</u> = 1.51	<u>SD</u> = 1.17
	Memory units per episode	<u>M</u> = 16.91	<u>M</u> = 16.01
		<u>SD</u> = 3.06	<u>SD</u> = 3.51
	Average confidence		
	prior to evidence ^a	<u>M</u> = 2.95	<u>M</u> = 2.58
		<u>SD</u> = .46	<u>SD</u> = .41
	^a -5 to +5 scale of certainty analysis.	of truth treated as	absolute value for

TABLE 4 Accuracy data for continuous memories and for recovered memories

	Continuous	Recovered
Units for which		
no evidence found	<u>M</u> = 41.82 (29.4%)	<u>M</u> = 23.88 (31.5%)
	<u>SD</u> = 19.01	<u>SD</u> = 15.11
Percent of evidence		
supporting memory	<u>M</u> = 74.6%	<u>M</u> = 74.7%
	<u>SD</u> = 10.4	<u>SD</u> = 15.84
Strongest evidence for identit	y of perpetrator for eac	h subject
Confession	10	7
Medical	0	2
Eyewitness sibling	2	1
Below this point score	ed as nonconfirming	
Journal ^a	1	1
Pornographic materials	1	1
Schoolmate nonspecific		
support of recalled disclosu	re 1	0
Babysitter nonspecific		
support of recalled disclosur	e 0	1
None	2	4

^a Journal was nonspecific regarding identity of abuser.

Predictors of accuracy in abuse memory As hypothesized, the measure of reality distortion (X-%) did predict both Category 1 or 2 support for general abuse memory and the likelihood of Category 1 or 2 support for the identity and specific abusive action of the perpetrator (see Table 5). The Schizophrenia scale was not predictive. In exploratory analyses, one other MMPI scale, Pt, emerged as significant. However, pattern analysis (z for the binomial) reveals that this may be a chance finding (that is, one of the 13 MMPI scales may have appeared by chance).

The two other memory tasks in this research, Session Memory and Source Memory, also correlated significantly with amount of evidence for both recovered and continuous memory accuracy. Interpretations of X-% and Source Memory, however, are made more difficult by skewed distributions.

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5	Predictors of number of confirmed memory units		
	Percentage accurate ^a recall in		
		Continuous memory	Recovered memory
	Source memory	.52*	.63**
	Session memory	.72**	.72**
	Psychasthenia	.60*	.50*
	Schizophrenia	18	.24
	Units recalled	33	42
	X-%	53*	60*
	 <i>p</i> < .05. <i>p</i> < .01. ^a Percentage support 	orted by Category 1 or 2 e	vidence.

TABLE

Transforming the data to ordinal ranks, the correlations for Source Memory drop to .35 (with supportive evidence for recovered memory) and to .45 (with continuous memory), and X-% correlations drop to -.47 and -.40. Strongest predictions after corrections for skewness thus are made by Session Memory (r's = .72, p < .01) and Pt (r's > .50, p < .05).

Circumstances Although all subjects were in therapy at the time of the recoveries, a substantial number of the transcripts included an external trigger for the recoveries (see Table 6).

Clients reported that memories were most likely to be triggered externally, but therapist behaviors and therapy content were also mentioned.

Confidence in accuracy nonsignificantly predicted success in finding evidence in a disaggregated data set. This appears to be due in part to the subjects' underconfidence in recovered memory, as reported earlier. Within recovered and continuous memories, the correlation rose to significance (point-biserial r = .51, p < .05). Absolute certainty of the accuracy of recovery was rare (6% of ratings) but was associated with Category

TABLE 6	Self-reported triggers for recovery	
	External trigger	27 (47.36%)
	Movie/media	6
	Interpersonal event	13
	Book	2
	Traumatic event	6
	Therapy trigger	24 (42.11%)
	Strong negative affect	7
	General association	
	to material	11
	Positive affect	6
	No trigger mentioned	6 (10.53%)

1-2 support (binomial p = .88 of support-given certainty). Certainty of accuracy of continuous memory was more common (17% of ratings) and slightly less predictive (binomial p = .74 of support-given certainty).

The likelihood of finding evidence of accuracy for a recovered memory did relate to both timing and affective tone of therapy (see Table 7). Seven subjects found significantly more evidence for accuracy of memories reported during the last six months of therapy than during the first three months, a pattern that crossed recovered and continuous memories (binomial probability of seven significant results by chance < .001). Supported recoveries also were more likely in the "de-repression" sessions (identified either by the presence of an alliance repair or the presence of higher than average [top 12%] ratings of positive affect toward therapist). These sessions comprised 15% of the total. An alternative method for expressing these data is in likelihood ratios. As implied earlier, the ratio of supported to nonsupported memories in this data set was approximately 3:1. The ratio drops to 2:1 in the negative-emotion or statedependency sessions, but rises to 14:1 in the alliance-repair sessions.

Recovered and continuous memories also differed in the degree to which they were associated with specific affective descriptions (see Table 7). When affective terms were counted in the accounting of each abuse episode, explicit statements regarding fear/terror and shame were more likely to appear in recovered accounts, and sadness/loss/depression was more likely to appear in continuous accounts. Considering the episodes as independent units, the probability of fear/terror mentioned (explicitly) in a recovered memory was .72 (compared with .52 for continuous memories). Shame was men-

M=79% SD= 9.41

TABLE 7 Timing and affective tone of memory recovery sessions Average number of confirmed (Category 1 or 2) units First 3 months of therapy M=70% SD = 15.10

Last 6 months of therapy

		<u></u>
	Unsupported	Supported
	by evidence	by evidence
Percent of recoveries occurrin	g in:	
State-dependency sessions	42%	27%
Session base rate: 12%		
De-repression sessions	8%	38%
Session base rate: 15%		
	Continuous	Recovered
Percent memories mentioning	j :	
Fear/terror	54%	72%
Shame	32%	54%
Anger	43%	48%
Sadness	67%	28%

tioned explicitly in 54% of the 57 recovered memory episodes and in 32% of the 99 continuous memory descriptions. Anger appeared equally in the memory types, and sadness appeared more frequently for continuous memories (.67 compared with .28). The difference in patterns (testing the most frequently named emotion in each memory description) is significant (*Chi Square* = 37.00, p < .001).

Finally, on an exploratory note, 13 of the 17 subjects showed an increase in level of symptoms and 12 showed an increase in variance of symptoms (as measured by *t*-tests and Levine tests, all p's < .05) on their contemporaneous self-report comparing the six weeks prior to the first recovery with the 12 weeks following their first recovery. Resolution of symptoms typically occurred by four to six months following recovery. An illustrative graph is shown in Figure 1.

Case Lisa came to therapy with continuous knowledge of physical abuse by her mother, a milder form of physical abuse and sexualized behavior (nudity, provocative language) by her much-preferred father, and sexual abuse by numerous maternal boyfriends. Lisa's parents divorced when Lisa was 13, and she was reportedly abused multiple times from age 13 to age 17 (when she ran away from home) by at least three men. One of the assaults led to a pregnancy at age 14, for which the adult was not charged. The individual did not deny paternity.

> Few who read this text would be surprised to learn that as an adult Lisa had become involved many authority figures in sexual or sexualized relationships, including a former physician, a former employer, and several older married colleagues.⁴² An extra-therapy event with one of these colleagues, in which he reportedly used a pet name that had been used by Lisa's father, led to a vivid and complex recovered memory of sexual abuse by her father at a reported age of eight. Subsequent memories, which included sexual inter-



FIGURE 1
Symptom change (depression) after recovery for Patient 9

course at age 10, followed shortly, as did memories of less severe incidents at earlier ages.

Lisa's father, Leonard, on being contacted for this study, was immediately remorseful, confirming many of Lisa's memories in open-ended phases of the interview. He blamed his behavior on earlier addiction to drugs and alcohol, and on his poor marital relationship. Interestingly, although Lisa and Leonard disagreed about many of the details of the abuse scenario, Leonard's description of both physical and sexual abuse was more severe (earlier age, greater variety of acts) than was Lisa's memory in therapy. Many of these disagreements could not be resolved and therefore were coded as instances of unsupported memory units. However, one memory for which an age disagreement took place was agreed upon in terms of location and time of year. From this information it could be determined that only Leonard's age estimation could be accurate. Although the most powerful piece of evidence for Lisa's abuse was Leonard's confession, other evidence provided included a (male) sibling eyewitness for the continuously remembered physical abuse, a teacher report of memory of bruises and cuts reportedly caused (according to child report at the time) by physical abuse, a diary making vague reference to "Daddy doing you-know-what to me," and a (female) sibling who had a continuous memory of sexual abuse by her father.

Leonard's identity as an abuser was rated as confirmed by this evidence, although the many disagreements on detail (lessening the severity on the whole of Lisa's report) lowered Lisa's overall general memory score. She was able to provide Category 1 or 2 evidence for 60% of her recovered memories.

Case 2 Stephanie reported continuous memories of physical abuse (e.g., being spanked with a paddle while nude during the time before her parent's divorce), but entered therapy for unrelated reasons. After a frightening out-of-therapy experience, she recovered a memory that her father, Sam, grabbed and shook her. In the flashback, Sam was nude and shouting at Stephanie. Stephanie was convinced that this memory was a post-sexualabuse experience. She gradually added substance to the memory, including the setting, her age (16), and the type of abuse (oral sex).

> In the investigation, divorce documents were accessed that told an interesting alternative story. Stephanie could not have interacted in this way with her father at age 16, since the divorce occurred at age 12, and Stephanie subsequently saw her father only rarely and in supervised settings. At age 12, Stephanie walked in on her father while he was having oral

sex with a teenage neighbor, who the father later claimed, he did not know was underage. Sam admits chasing Stephanie while nude, shaking her and threatening her (the substance of her original flashback before details were added). The family (Stephanie, her parents, and her siblings) now believe that Stephanie placed herself in the role of the other child. Social Services did investigate at the time of the incident, and considered the possibility that Stephanie had been abused herself. No evidence emerged in support of this fear, and Stephanie did not claim it to be true at the time. The description of the event in the recovered memory is identical in form to the confirmed experience of the 16-year-old neighbor. Relevant to issues to be raised in the discussion. Stephanie reportedly (sibling evidence) had nightmares for weeks following the event. Identity here was judged as not confirmed. Stephanie was able to find support for 69% of the contextual information (e.g., her father admitted grabbing and shaking her while nude, in the location she claimed).

Discussion

For the author, this research has provided a wealth of interesting questions and clinically useful material. The subjects in this study found the quest for information to be valuable, and 16 of the 17 father-daughter pairs reported an improved relationship. Not surprisingly, the daughter's use of the "much improved" category was highly related to confession by the father. Seven (41%) of the fathers admitted to some of the recovered-memory incidents, comparable to the number (47%) of subjects in Feldman-Summers & Pope's⁴³ survey research who reported that their fathers confessed. On the negative side, eight of the fathers state that if they had been asked today, given present publicity, they believe they would not have agreed to cooperate in research with their daughter's unknown therapist. The generalizability and nongeneralizability of the sample

At times the definition of "robust repression"44 appears to center on cases in which an individual with an exceedingly happy and abuse-free childhood comes to believe in Satanic abuse and cannibalism, deteriorates, requires hospitalization, and ultimately is diagnosed as having multiple personality disorder. No subject in this study fits this description. This victim profile, however, also is not the norm within any study of recovered memory, even among those now claiming false memory.⁴⁵ Many recanters claim that they did indeed have real issues with their parents or continuously remembered abuse by other family or nonfamily members⁴⁶ that were ignored in favor of recoveries more intriguing to the therapist. The number of clinicians reporting having seen a client who recovered a traumatic memory also is quite high (e.g., roughly half of 810 British psychologists in Andrews et al.'s⁴⁷ study), while the number reporting ritual abuse survivors in their practice is much lower (15% in the same study). Finally, there is theoretical reason to argue that many patients will reject the recovered memory of abuse, or never experience it, if the new knowledge is inconsistent with existing schemata of the parents.⁴⁸ It is therefore reasonable to argue that the patient described here, who recalls some abusive events and recovers others, is the norm rather than the exception, and that the findings may or may not generalize to the rare patient who moves from no misgivings about her parents to accusations of multiple or unusual forms of abuse.

A number of other statistics—e.g., the average amount of memory recovered—are not generalizable to other settings. Subjects were chosen for their high recovery rates, since such subjects are the most frequently questioned individuals in the false memory/recovered memory literature. The average age of the subjects was undoubtedly artificially low, in comparison with a truly random sample, due to the exclusion of patients whose fathers were no longer living. The therapist's background (an experimental degree in social psychology as well as clinical training) also affected the manner of discussing memory and may therefore have affected the rate, number and accuracy of recovered memories in unknown ways. Further, the author's employment in academic settings produced an artificially high mode for education. However, parents were not affluent as a group, contradicting the profile offered by Wakefield and Underwager⁴⁹ but consistent with the survey results of Elliot and Briere.⁵⁰

The complicated issue of researcher bias deserves special attention, expanding in complexity in this study, since the father and the client arguably also are researchers here in an important sense. In any individual case, the father might have exaggerated a search for confirming information for expiation purposes, or searched disproportionately for refuting evidence for exculpatory reasons. Similarly, defensive purposes could lead patients to search for the information that blames or defends the parent, confirming or negating the memory. These processes were likely to affect both recovered and continuous memory, however. A wish to bias the process toward or away from accuracy in recovered memory would be hampered by the fact that the client remembered imperfectly and the father was not told which memories were recovered and which continuous.

Once the information reached the author, the bias issue is most relevant on the contextual information, where the author did rate incoming data. However, agreement between father, client, and author here was near 100%; evidential issues (was there or was there not proof that family A was in place B at time C?) were uncomplicated. Bias by the author would be most likely to be a problem in the primary or identity evidence, which instead was evaluated by eight independent raters akin to a jury, although members were purposely chosen to represent the most disparate range of views. The author did not participate in the decision of whether there was or was not Category 1 or 2 evidence for identity and could not influence these decisions. The intimate hours between therapist and client, before the experiment began, represented the crucial time for the author to bias results. Here the unrecorded nods, changes in sympathetic expression, etc., could well have influenced the client to express or inhibit doubt, or to expand one account and not another. The results of the study thus are not presented as representing the modal accuracy rate of continuous or recovered memory, but instead should be taken as relevant to the statement that the therapy setting in and of itself does not *preclude* accurate recovered memories, or even necessarily make such memories less likely. Other in vivo studies are no doubt necessary to extend generalizability to other samples and settings.

The prediction of evidentially supported memory

It is interesting that the impressive data for malleability in memory⁵¹ are so often applied uniquely to those memories reported by clients to be recovered rather than continuous. In fact, studies showing misinformation effects in the larger memory literature⁵² tend to be probing perceived continuous memory, not recovered memory. Here, primary abuse memory tended to be supported by evidence whether recovered or continuous, but patients could not reliably report whether they had or had not recovered a given bit of abuse information unless the memory was of extreme severity and uniqueness. This finding is in keeping with general literature on source memory⁵³ as well as with specific research on more accurate recall of salient or unusual memory features or incidents.⁵⁴ Clinically and forensically, however, this process could produce a biased recall for the client such that the most unusual or severe of the abuse recoveries would be more likely to be remembered as recoveries. The descriptions given in anecdotal reports might then gloss over a majority of normative schema-consistent recoveries in favor of a few more unique items. The therapist then may be presented as exceedingly gullible for failing to recognize obvious differences in likelihood between recovered and continuous abuse presentations that were not in fact present.

Confidence in memory had a weak predictive effect in the full study, although this was in large part due to the underconfidence placed in accurate recovered memory. Doubt in recovered memory, regardless of accuracy, appears to be the norm in the anecdotal literature,⁵⁵ and clinical encounters with underconfident clients with well corroborated abuse accounts may have been the source for Bass and Davis's⁵⁶ much-quoted advice to assume that one's initial beliefs represent factual memories despite self-doubts. Nonetheless, within recovered and continuous memory examples, the relationship between the accuracy measure and confidence was higher, such that subjects with certainty about their recovered memories were likely to locate positive evidence of it. The results raise important clinical issues regarding therapists' mistaken manipulation of doubt, suggesting either that the patient must reject the memory or that she *must* uncritically accept it. Substantial numbers of the recanters, patients who came to believe that their recovered memories were untrue, cite therapist refusal to entertain their initial expression of doubt.⁵⁷ just as other anecdotal reports from incest victims cite therapists' dogmatic rejection of their own tentative (and perhaps later confirmed) sexual abuse reports.58 As Davies and Frawley59 so eloquently point out, both of these stances may replicate abuse dynamics, inappropriately substituting the therapist's reality for the client's self-evaluation.

The finding of correlation of X-% and general memory tasks with the accuracy measures for both types of memory also may be useful in clinical settings, although the sample size precludes reliable estimations of the weight of these predictors. Form and form quality are among the most stable aspects of the Rorschach⁶⁰ and emerge on the first interpretative factor of factor analyses of normals, depressives and schizophrenics.⁶¹ The mean X-% of the sample was .19, exceeding the normative X-% of .15 for a patient depressive sample but under the reported mean (.31) of a schizophrenic sample. Dissociative symptoms were noted in the charts of all patients, perhaps serving as a mechanism for perceptual distortion on the Rorschach as the patients attempted to distance from trauma-related percepts in the blots. More recent research, however, has established that X-% may be elevated by the experience of trauma itself,⁶² and remains a predictor of trauma history when dissociation is statistically controlled.⁶³ In general, success in finding support for remembered abuse related to both reality-testing skills and to general memory abilities.

Although both fantasy proneness⁶⁴ and therapist misconduct⁶⁵ have been tied to unusual abuse and nonabuse memories, it is worth considering the alternative that actual trauma may be the source of *inaccurate* memories of trauma. That is, as humans attempt to make their imperfect distinctions between memories, dreams, fantasies, and contamination by others, characteristics such as vividness of recall, correspondence with known reality, and logical coherence of the narrative are used.66 If a child experiences serious abuse, it is possible both that fantasy and nightmare content will become more vivid and believable, and that reality will become less coherent and understandable. Children with known serious abuse are more likely to include fantasy elements in their stories than children with known abuse experiences that were less frightening or severe.⁶⁷ The story of Stephanie might be an adult example of this phenomenon, where a true frightening experience might have merged with nightmare content to produce a partially fictitious account.

Wholly manufactured memories of abuse were not found in this research, although individual memories were discussed that could be neither confirmed nor refuted. A second example of probable false memory, again probably a mixture of truth and fiction, illustrates another possible source of partially false memory. In this case, a woman who chose the pseudonym Carol represented that her alcoholic and physically abusive father had also sexually abused her. She reported both continuous and recovered memories of this experience. The recalled physical abuse (as well as numerous more extreme examples that were never recalled) were confirmed through multiple sources. However, an idealized older brother, who had consistently protected Carol and had taken multiple beatings in the process, confessed to the sexual abuse of my patient and her younger sister. The acts recalled by Carol are of the same type as the acts continuously recalled by her siblings and confessed by her brother. Her reassignment of blame for sexual abuse from her physically protective brother to her assaultive and distant father can be understood both from the schematic consistency model⁶⁸ and from a defensive memory perspective.⁶⁹ Carol's brother may have been the more available object for identification⁷⁰ and thus more in need of her psychic defense.

Timing, circumstances, and mechanisms of memory recovery It is difficult to determine the degree to which recoveries were based on therapy-generated or non-therapy-generated cues. The 17 women produced 57 recoveries, 27 of which were reported by the subject (in the transcript) to have an external trigger. There are many unknowns here, including the number of triggering events that were not perceived as such by the patient, the number perceived but not mentioned by the patient, and the degree to which the nature of the therapeutic relationship interacted with the presence of the external cue. The latter is a plausible alternative, since the cues (movies, other painful events, a related story told by a friend) had often occurred before without subsequent recovery. Most recoveries, as reported by Andrews et al.,⁷¹ appear to occur in nontherapy contexts, but even therapy-*related* recoveries may not be therapy-*induced*.

The nonsignificant difference in age of the child within recovered and continuous memory classes was an unexpected finding, contradicting both other published studies⁷² and the author's own previous survey work.⁷³ Certainly memories of the first years of life, which did not appear here (although some subjects believed that they had been abused at this time), would be likely to prove less reliable than the memories studied in this research. In fact, had the subjects been asked directly, prior to evidence gathering, when they believed abuse had begun, the frequently replicated finding could have appeared. The age differences here, based on the age of the child in the reported memories, uses a slightly different methodology than the contradictory research.

Recovered memories were more likely to contain threat, shame, or fear of death and less likely to contain references to sadness. The pattern is virtually identical to that reported by Davis⁷⁴ in her discussions of the affect-bias in the memory of repressors, leading her to conclude that it is threat or evaluation of the self, rather than unpleasure per se,⁷⁵ that motivates repression. Alternatively, the pattern could reflect several other processes, each reasonably well documented, that would produce less reliable encoding for fear- or shame-related memories.

Fear and threat are related to the physiological experiences of increased presence of glucocorticoids, which are reported to increase the activity of the amygdala and decrease activity in the hippocampus.⁷⁶ The resulting disjunction of these two memory systems theoretically produces more fragmented encoding, which may render a given memory more difficult to access. The fear/terror finding could also be an artifact of the choice of subjects who were recovering substantially different (and therefore often more severe) memories.

Poorer encoding of shame-related memories could be related to the decreased likelihood of such information being shared. "Shareability" theory⁷⁷ suggests that the process of discussing information with others reorganizes the memories into a more accessible and multiply interconnected framework. Results of recent research on memories of rape victims,⁷⁸ another set of memories that might reasonably be characterized by fear and shame, found that rape memories, compared with other unpleasant memories, were *less* clear and vivid, *less* well remembered, and *less* discussed with others, supporting both theories above. Motivated nonlearning or not-thinking⁷⁹ would also produce more limited encoding, just as experimentally demonstrated inhibitory processes may produce limited retrieval.⁸⁰ In fact, the threat of consequences for public disclosure of abuse might engage each of these mechanisms, producing a false memory of nonabuse.⁸¹

Those episodes judged more likely to be false memories, such as Carol's and Stephanie's cases, often involved a core truth, a vivid and accurate (although at times misinterpreted) memory. For the directive therapists described in recanters' anecdotes, the vivid core piece could be used as a battering ram to produce the patient's eventual acceptance of a parentalabuse memory. Alternatively, among less directive therapists, a more likely scenario for false memory creation is the powerful need for narrative clarity on the part of both patient and therapist,⁸² given impetus by an intriguing and compelling memory fragment and given plausibility by the patient's continuous negative memories of the alleged perpetrator. Brown⁸³ provides an excellent discussion of this distinction. The present research adds the possibility that the client's doubt and/or eventual certainty in her memory, absent therapist pressure, might give important information to the client regarding truth value.

De-repression and reassociation as mechanisms for recovery The covariation of abuse recoveries with state-dependency periods and "de-repression" periods described by Weiss and Sampson⁸⁴ is perhaps most open to alternative explanations. Compatible with the findings here, Gassner, Sampson, Weiss & Brumer⁸⁵ found that newly reported contents, which had been determined by raters to be previously repressed, were likely to be first expressed in low-anxiety periods in therapy. Gassner et al.'s findings are further developed theoretically by Weiss,⁸⁶ who has argued that return of memories is associated with the client's sense that they may be safely experienced in the presence of the therapist. It also is possible that the accurate memories reported in "de-repression" periods were in fact recovered as a result of the earlier negative affect and were merely *reported* during the more positive alliance repair sessions. The finding of increased memory recovery after therapeutic breakthrough is a common anecdotal report,⁸⁷ but the alternative explanation of increase in conscious disclosure remains plausible.

The defensive purpose that some of the errors appeared to serve (e.g., Carol's replacement of her brother with her father) also fits well with motivational theories rather than alternative explanations that Carol "forgot" that the perpetrator was her brother. Again, however, if the identity feature of the memory was a factor that was reconstructed rather than recalled, Carol's father was a better (more logical) candidate than was her brother. It would be interesting to subject the transcript to more thorough psychoanalytic review, investigating qualitative aspects of the memories (other than perceived severity) that may relate to initial memory loss or subsequent memory recovery.

As noted earlier, it may be useful to drop the focus on the words "repression" and "dissociation" and to concentrate on the underlying issues that lead some of us to continue to find such words useful. That is, were these memories reconstructed or recalled? (Here, given accuracy data, at least some recovered memories seem to be recalled, as predicted by repression theory.) Is memory loss motivational, and can memory return be motivationally effected? Under what circumstances, if any, is lack of traumatic memory a cost to a client? What effects, if any, reliably follow memory recovery, regardless of mechanism, and under what circumstances are these effects beneficial to the client? In vivo research such as the present study may be a needed addendum to laboratory work on these questions.

Forensic The reader has no doubt recognized a series of important implications forensic implications of this study. Three points that deserve further expansion are treated here.

First, the remarkable individual differences in subject accuracy crossed continuous- and recovered-memory capacity, and do not suggest that the therapist should selectively hammer doubt into the mind of any client producing a recovered memory of abuse. They underscore the importance of careful attention to the suggestibility, reality testing, and reality monitoring skills of the individual patient, and the possibility of modifying technique accordingly. Further, they raise the possibility that the patient who imperfectly recovered her past and now is suing her former therapist might also have imperfect allegedly continuous memory; she may imperfectly remember and describe her therapy (session memory), complicating the decision-making process for all involved.

Second, it should be noted that in the absolute sense false memories and accurate memories were almost nonexistent. Memories appeared to be a blend of the true and the false, incorporating wishes and threats, repeated stories and borrowed scenes, confabulations and correct deductions. It is certainly true, in a court of law, that the truth of the allegation of sexual abuse, the "who did what to whom" question, is the crucial issue. However, it does not follow that memories that are doubted by the therapist, even if we agree that criteria exist that would allow reasonable allocation of that doubt, should be "confronted" or less than sympathetically addressed, or that therapists who do not confront or investigate are practicing below the standard of care. Seven of these clients, in a self-evaluative and sympathetic atmosphere, became more accurate over time in therapy without confrontation or investigation, perhaps learning themselves more reliable reality monitoring skills.

Third, it is both troubling and fascinating to note how little we agree on the nature of what is reasonable evidence for accuracy of memory, quite apart from what we intend to do within therapy if our personal standard of evidence is not met. In this study an accurate memory of the identity of the abuser was determined by a "jury," who decided unanimously or in a 6:2 or 7:1 split that the evidence was confirming. Yet agreement on strength of evidence on a five-category system was .48, quite unimpressive. Surely the biases in our view of the evidence, setting extremely lenient or extremely severe definitions for "support" or "proof," would further skew our estimates on the ratio of true memory to false memory, which in turn might lead to biased treatment of further recoveries. A standard of care that requires investigation or "proof" of abuse before treatment, which is not being recommended here, nonetheless would necessitate prior (presently unavailable) professional consensus on the nature of such proof.

Clinical TI management m of recovery to

The nature of the causal relationship between the recovery of memories for these patients and their eventual drop in symptomatology is unknown. The instantaneous symptom relief associated by some with release of repression was absent in these data, as it is in most anecdotal reports and theoretical accounts of recovery. In fact, recovery appears to create a temporary increase in symptoms,⁸⁸ so that recovered-memory survivors often present a more severe symptomatic picture than do reportedly continuous-memory survivors.⁸⁹ Whatever the mechanism of recovery, the patient may well be fully experiencing and analyzing the event for the first time, and thus may be in an acute phase of symptom development.90 Patients, who often receive only cursory informed-consent information,⁹¹ should be prepared for the possibility of symptom elevation if they choose to actively engage in memory search. Most probably patients deserve this information in any trauma-related treatment, where enhanced attention to traumatic history can be predicted often to lead to temporary increases in symptoms.92

It is less clear that clients should receive the information, so often implied in the false-memory literature, that recovered memories of abuse are typically or often false.⁹³ Although Pope & Hudson and Pendergrast do recommend that patients who have recovered abuse memories "should not be told abruptly that they have created imaginary events,"⁹⁴ they fail to state that it is unreasonable that therapists should take *any* firm stand on the truth or falsity of recovered memory, absent evidence. Stating that recovered memories should be assumed false unless proved true, a stance compared to the null hypothesis by Pope and Hudson,⁹⁵ is no more supportable, no more ethical, and no less impractical than assuming *all* memories are false unless proved true. The hypothesis of equal accuracy of recovered and continuous memory also is plausibly labeled a "null hypothesis." As with continuous memories, it appears that recovered memories of abuse, barring content-related reasons for impossibility, are quite likely to be verified.

The complexity of the current state of the evidence also deserves respect, rather than declaring that there is "not a shred of evidence" in one direction and "overwhelming evidence" in the other. Researchers in the area could join clinicians in attempting to avoid "motivated skepticism,"⁹⁶ in which studies or clinical findings that do not support one's point of view are subjected to exaggerated scrutiny and then derisively rejected as "proving nothing," while equally problematic studies supporting one's own point of view are accepted with no critical attention. Examples in this field include the assumption that subjects or patients in our critics' research must be consciously distorting or withholding reports rather than falsely remembering or recovering an accurate memory (e.g., Williams's⁹⁷ subjects were withholding reports rather than exhibiting amnesia; Loftus & Pickrell's⁹⁸ subjects were consciously distorting to please the experimenter rather than reporting a false memory), while our own subjects' stories provide "existence proof." Similarly, the results of the kappa analyses on the nature of evidence, discussed in methods, show that professionals are far from agreement even on the appropriate definition of convincing support for an allegation, much less the factors that predict "accuracy" to our mutual satisfaction. At this point, "checklists" offered for use in court to determine accuracy, based

largely on assumptions and intuitions of the author (e.g., Gardner's⁹⁹ recent offering), are particularly worrisome.

In brief, the present state of the literature suggests that a healthy injection of self-doubt and increased self-evaluation are due for many of us. Physicist Richard Feynman¹⁰⁰ called it "a kind of scientific integrity, a principle of scientific thought that corresponds to a kind of utter honesty-a kind of leaning over backwards" to consider alternative points of view, in order not "to fool yourself-and you are the easiest person to fool . . ." A yearning for understanding might be a source of confabulation (if it produces premature closure), but it may also be used in a search for more complex and more fairminded approaches to the recovered-memory phenomenon. At the moment, independent of our present stance on the recovered-memory controversy, it appears that we are better served by "cherishing our doubts," as recommended by Judaic meditation texts,¹⁰¹ than by continuing to adopt the tools and rhetoric of war against opposing experts and their heliefs.

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