

**Inquiry into the Practice of Recovered Memory Therapy:
Draft Report**

2005

Report by the Health Services Commissioner to the Minister for Health, the Hon.
Bronwyn Pike MP under Section 9(1)(m) of the *Health Services (Conciliation and
Review) Act 1987*

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1 DEFINITIONS

Some terms used throughout this Report, such as ‘accuser’, ‘accused’, and ‘survivor of childhood abuse’, can be considered value laden and emotive. The Health Services Commissioner has endeavoured to be impartial and the use of such terminology should not be perceived as supporting a particular group in the debate on false and recovered memory. Rather, the terms were chosen for convenience of expression and to reflect the wording participants chose to describe themselves and their experiences.

Accused: An individual accused of committing childhood sexual abuse.

Accuser: An individual who has accused another person of childhood sexual abuse.

False Memory: A memory of an event that did not take place.

False Memory Advocates: Individuals or associations who do not believe traumatic events can be forgotten for a period of time and subsequently remembered. Rather they believe recovered memories are false memories. Throughout this report ‘false memory advocates’ also refers to persons who believe Repressed Memory Therapy is a type of psychological therapy currently taught and practised in Australia, which has the potential to implant false memories of childhood sexual abuse in patients. This group of people also includes adults who report they have been falsely accused of childhood sexual abuse, and believe the allegations are based on memories recovered during therapy.

Mental Health Professional: This term refers to a variety of professionals who work with patients with mental health problems. For example, practising and academic psychologists, psychiatrists, hypnotherapists, general practitioners, counsellors, psychotherapists, and neurolinguistic programming therapists.

Prospective Research: A study that looks forwards in time.

Recovered Memory: The recollection of a memory perceived to have been unavailable for some period of time.

Repressed Memory/Repression: A cognitive process used to explain how a memory of an event can be forgotten or unavailable for a period of time. That is, a defence mechanism whereby the unconscious exclusion of painful impulses, desires, or fears from the conscious mind. ‘Repressed memory’ and ‘recovered memory’ are also often used interchangeably, and ‘repression’ and ‘forgetting’ are also used interchangeably. Using these terms interchangeably are incorrect as they refer to distinct concepts.

Recovered Memory Therapy: Also referred to as Repressed Memory Therapy and False Memory Therapy. There is disagreement regarding the definition of Recovered Memory Therapy. False memory advocates report Recovered Memory Therapy is the name used to describe therapies based on the belief that memories can be repressed and certain therapeutic techniques employed by therapists can be used to elucidate or ‘recover’ such memories. Practitioners, who believe traumatic events can be blocked and subsequently recovered, report that Recovered Memory Therapy refers to unprofessional practice whereby therapists suggest memories of childhood sexual abuse to patients who have no memory of the event.

Retractor: An individual who has reported memories of childhood sexual abuse, and subsequently believes them to be false.

Retrospective Research: A study that looks backwards in time.

Survivor of Childhood Abuse: An individual who reports they have experienced childhood abuse, including physical, emotional and/or sexual abuse. These individuals also believe traumatic events, such as childhood sexual abuse, can be forgotten and subsequently remembered in adulthood. ‘Survivors of childhood abuse’ are also referred to as ‘survivors’ throughout this document, as this is how they describe themselves.

2 EXECUTIVE SUMMARY

Under section 9(1)(m) of the *Health Services (Conciliation and Review) Act 1987 (Vic)* (the *Act*), the Health Services Commissioner (the Commissioner) has powers to inquire into matters referred by the Minister. The Commissioner was requested to investigate and report to Victoria's Minister for Health, The Hon Bronwyn Pike, by July 2005 about the practice of 'Recovered Memory Therapy' (RMT). RMT, as defined in the Terms of Reference, "is any ... form of therapy, or other clinical or therapeutic strategies that have a component based on or incorporating a belief that memories can be repressed and focusing on or adopting methods designed to assist the patient/client to elucidate those memories." This type of therapy has been associated with the recovery of memories of childhood sexual abuse (CSA). The aim of the Inquiry was to identify opportunities for improving practice and protecting the public. This Report presents the findings and recommendations.

Methodology

In accordance with the Terms of Reference, the Inquiry examined and analysed the national and international literature on the practice of RMT. The Inquiry also consulted with health practitioner registration boards, and examined the *Act* to assess any problems associated with the practice of RMT, such as difficulties in dealing with third party complainants. A questionnaire, developed to determine the extent to which RMT is practised in Victoria, was distributed to over 640 psychiatrists, counsellors and psychotherapists. The comments received on these questionnaires were analysed for themes and issues relating to the Terms of Reference. The methodology also included a call for submissions from any interested persons with information about RMT and advice was sought from experts in this area. Submissions were also analysed for issues and themes related to the Terms of Reference.

Respondents

Twenty-four submissions were received from individuals who reported they had recovered memories of CSA, and one from a child abuse support group. Thirty-nine submissions were received from individuals, who reported they were falsely accused of CSA, and believed the accuser to have undergone RMT, and four from

false memory support groups. Twenty-six mental health professionals and 16 professional bodies made submissions to the Inquiry.

Findings

The key findings are listed under each of the Terms of Reference.

1. A review of the national and international literature on the practice of RMT, addressing, amongst other things:

a. The evidence base for its practice including the scientific understanding of memory.

- The nature of memory is the subject of ongoing academic research and debate.
- There is profound disagreement amongst experts regarding whether recovered memories are true or false.
- The critics of the recovered memory phenomenon report that RMT involves therapists employing clinical techniques to help patients to recover memories of CSA. The most controversial clinical techniques implicated in RMT include hypnotism, guided imagery / visualisation, dream interpretation and interpretation of body memories.
- The literature review found no research on clinical techniques used to recover memories of trauma, or the practice of RMT in the mental health literature.
- Some researchers have suggested that the issue may not be whether a particular therapeutic technique is used, rather whether it is used in an ethical and professional manner.
- The literature review indicated memory is prone to inaccuracies.
- Empirical evidence for false memory comes from retractors, court cases alleging recovered memories of CSA, and anecdotal reports of false memory of CSA.
- Empirical evidence for recovered memory comes from retrospective and prospective studies. These studies indicate memory loss with subsequent recovery of the complete or partial memory in relation to many traumatic events including, but not limited to sexual assault.
- The research indicates that the recovery of memory is often not associated with therapy, as patients typically recover memories before entering therapy, with the most common triggers for memory recovery occurring outside therapy.

- Review of the literature indicates there are various theoretical explanations for traumatic memories that are blocked and recovered, for example, dissociation, repression and suppression. Research suggests that the explanation for recovered memory is likely to be due to more than one process that occurs simultaneously.
- Experimental evidence of the two phenomena comes from laboratory research generally testing research participants' memories of lists of words or suggesting mundane memories to non-clinical participants.
- The evidence has been criticised for being indirect and having limited generalisability, however, the available evidence suggests a reasonable foundation for the existence of both phenomena.

b. Media coverage and the popular press

- The media reports do not show reliably that RMT exists in Australia.
- Some media reports inaccurately report on legal cases by stating that the allegations of CSA arose from RMT, when in fact the complainants deny such allegations and the judge's summations do not mention RMT.
- The reports also highlight issues such as the differences between the objectives of therapy versus legal proceedings in relation to the issue of recovered memories. The objective of therapy is to help patients live with their experiences of abuse, and uncertainties about their experiences. In contrast, the objective of a legal proceeding is to determine whether the memory is true or false.
- All persons, including police and therapists, working with allegations of CSA need to be mindful of the impact of suggestion, their position of authority and their own beliefs on patients or complainants.

c. Litigation and court reports

- Little case law exists in Australia and New Zealand in relation to the admissibility of expert evidence about memory of traumatic events, sexual or otherwise.
- Expert evidence has been admitted in Canada.
- If the expert evidence is thought to be common knowledge it is inadmissible.
- At present, in national and international courts, profound controversy still exists about the dangers posed by evidence that is therapeutically recovered.

- Given the profound disagreement within the expert communities regarding whether a particular recovered memory is true or false and the lack of controlled studies on traumatic recovered memory, in most cases, expert evidence is likely to be inadmissible as it is unlikely to assist the tribunal to better understand the issues or dispel falsehoods.

d. Government reports and any practice or other relevant guidelines issued by governments and professional bodies.

- The literature search found limited government reports on the practice of RMT.
- Professional guidelines exist for therapists working with patients recovering memories of trauma and these are reasonably consistent between international and national professional bodies.
- Similar to the research, there is much disagreement on the issue, but the reports and guidelines show many similarities:
 - Memory in general is not always accurate and the degree of accuracy can be susceptible to a range of factors.
 - Traumatic events, including CSA, could be partially or completely forgotten, and subsequently recalled.
 - The accuracy of recovered memories is unknown.
 - It is possible to create false memories for events that have not occurred.
 - Professionals who work with people who report recovered memories of CSA, such as practitioners and police officers, are advised to use caution by avoiding assumptions, premature conclusions, unfounded diagnoses and suggestive or leading questioning.
 - Professionals should remain non-judgemental towards recovered memories, acknowledge their personal beliefs and avoid imposing them onto the patient, and avoid initiating a search for memories.
 - There is a need for more research in the area of traumatic memory.

2. The extent to which RMT is practised in Victoria, including the types of therapists and their qualifications and training.

- The majority of respondents to the questionnaire did not complete the questionnaire, and therefore the data could not be statistically analysed.

- The respondents' comments on the questionnaire stated that the term, RMT, is not used by health professionals but has been created by false memory associations for political purposes.
- Respondents did not agree with the definition of RMT in the Terms of Reference as they reported it was too broad and did not distinguish between good and poor professional practice.
- They also stated they do not initiate the recovery of memories, nor do they suggest the occurrence of past events, but understand and accept that recovered memories are sometimes relevant.
- Respondents reported they do not recognise RMT as a type of therapy.
- The Inquiry was unable to ascertain the extent to which RMT is practised in Victoria.

3. The perspectives of those whose interests are or have been affected by the practice of this form of therapy, including patients, their family members, therapists, and professional and regulatory bodies.

Patients who report recovering memories of abuse

- Submissions from respondents who describe themselves as survivors of CSA addressed concerns regarding what they believed to be the focus of the Inquiry that is, on false memory. They reported that the focus on false memory conveys a disbelief in the concept of recovered memory, especially in relation to CSA. They reported this could be damaging to survivors as it invalidates their experiences.
- The majority of respondents also reported they had recovered fragments of memories prior to seeking therapy, with only one respondent stating she had recovered initial memories of CSA during therapy.
- The majority of submissions outlined memory triggers that occurred in a variety of situations outside of therapy, with therapy representing the least commonly reported cue.
- Respondents stated they did not encounter practitioners who suggested memories of CSA. By contrast, they described practitioners as unlikely to encourage their recovered memories. This treatment was described as damaging, as it continues

what has often been a lifetime experience of invalidation and denial of the abuse, and therefore was reported to hinder the healing process.

- The submissions addressed issues of professional practice, with respondents describing productive treatment as practitioners who acknowledge and accept their experiences and help to deal with them.
- When this type of practice occurs, respondents reported an improvement in their wellbeing.

Accused families

- This group reported false allegations of CSA, which they believe are based on memories recovered with the use of RMT.
- Respondents criticised the cognitive process of repression, and generalised the evidence to all mechanisms by which memory blocking and recovery can occur.
- They reported that society, the media and courts of law generally believe allegations of CSA without corroborating evidence.
- They reported that the book, *The Courage to Heal* (Bass & Davis, 1994), promotes the ideas and practice of RMT and some respondents called for it to be banned.

Therapists

- There was no consensus within this group of respondents regarding:
 - Whether traumatic events can be blocked and recovered.
 - Whether recovered memories are a literal or symbolic interpretation of past events.
 - The accuracy of recovered memories.
 - The importance of accuracy in therapy.
 - The cognitive process with which memories may be forgotten.
 - Whether events before the age of two can be remembered.
- Practitioners have differing opinions on the above issues, and views occurred along continuums.
- Submissions from this group reported they do not recognise RMT as a type of psychological therapy.

- Some respondents were critical of the term, RMT, as they believe false memory supporters created it for political purposes, and health professionals do not use it.
- Respondents were concerned about the definition of RMT that appeared in the Terms of Reference because they believed it was too broad.
- Practitioners reported they do not practice RMT, that is, they do not suggest, or intentionally search for memories of CSA.
- They assumed some inexperienced or under qualified practitioners inadvertently or intentionally may contribute to the creation of false memories of CSA.
- Practitioners noted that remembering or revisiting different periods of a patient's life is a basic part of most psychological therapies. Therefore, they reported that an Inquiry into recovered memory questions the essence of most psychological therapies.
- Practitioners were concerned the focus of the Inquiry was on false memory, therefore potentially invalidating all recovered memories.
- Submissions noted patients present to practitioners in a variety of ways, such as with complete, partial, or no memory of the trauma.
- The most common way clients present to therapy are with fragments of memories, and they rarely ask for assistance to recover memories.
- Some practitioners believe trauma is a significant aetiological factor in many psychiatric illnesses. However, practitioners reported they do not assume the occurrence of CSA solely on the basis of presenting symptoms, as that would be considered unprofessional practice.

Perspectives of professional bodies

- Guidelines issued by professional bodies advise:
 - The practitioner to remain non-judgemental towards recovered memories
 - The practitioner to inform the patient about the potential inaccuracies of memory
 - It is the patient's prerogative to draw their own conclusions regarding the accuracy of their memories
 - The responsibility of the practitioner should be the therapeutic needs of their patients, and not issues of legal or punitive action

4. The nature and extent of any problems associated with the practice of RMT including issues of privacy and confidentiality of the therapeutic relationship and difficulties in dealing with third party complainants.

- The Commissioner and registration boards may consider third party complaints, but it is difficult to investigate such complaints without the consent of the patient because practitioners cannot and should not discuss the patient without their consent.
- Submissions from false memory advocates addressed concerns that third parties have no redress if they suspect the use of RMT.
- False memory advocates reported that RMT causes the accuser to cease all communication with the accused, and the practitioner also refuses to discuss the case. Therefore, it was reported the accused party often feels alienated, and are unable to defend themselves against the allegations of CSA.
- False memory advocates reported that RMT causes both the patient's and the accused party's wellbeing to deteriorate.

Conclusion and Recommendations

It was concluded that reports of the practice of RMT are often based on speculation. Therefore, at present, there is no reliable evidence base for the practice of RMT in Victoria. Respondents assumed some inexperienced or underqualified practitioners inadvertently or intentionally might contribute to the creation of false memories of CSA. The extent to which this occurs is unknown. The Commissioner recommended:

1. The government undertake a review of the risks and examine any need for further regulation of unregistered providers of counselling and psychotherapy services.

Respondents reported it was important to ensure practitioners are appropriately trained in the area of trauma in order to avoid the creation of false memories. As practitioners assumed that inexperienced or underqualified therapists might be causing harm by using inappropriate techniques, the Commissioner recommended:

2. Collaboration between universities and professional bodies to review the adequacy of training regarding trauma, with a view to ensuring practitioners are being adequately trained.

Respondents agreed what constitutes professional practice. However, there was some concern that some professional bodies have not established guidelines to assist practitioners working with patients recovering memories of CSA. In addition, some practitioners reported that many guidelines outline what not to do, such as how to avoid contributing to the creation of false memories, but fail to document what to do, such as how to effectively and safely facilitate the recovery of memories in ways that prioritise patients' interests, including the patient's right to decide the extent and timing of recovery. The Commissioner recommended:

3. Professional bodies (including those for registered and unregistered practitioners) and registration boards which have not established best practice guidelines related to recovered memories do so.

Best practice guidelines, in general, and specifically related to recovered memories of CSA, include a number of systems, such as:

- The establishment of a code of ethics
- The establishment of ongoing peer supervision and ongoing professional training
- Mandatory member participation in ongoing peer supervision and ongoing professional training
- Training in maintaining adequate patient records
- Training and support of members whose patients are involved in legal processes in order to prevent patient re-traumatisation

Some therapeutic practises raised concern such as some unregistered practitioners completely and unreservedly encouraging early or preverbal memories (before the age of two) of CSA without educating patients about memory. There appears to be increased scepticism about preverbal recovered memories, and there is a danger in encouraging such memories, as they may be false. Professional guidelines advise therapists to keep an open mind and allow patients to come to their own conclusions. However, there is also a danger in completely discouraging any recovered memories of CSA, as there is the risk of pushing a needy individual away, and of overlooking a real memory of abuse. In order to ensure that unregistered practitioners maintain ongoing professional training in the area of trauma, and

continue to practice in an ethical and professional manner, the Commissioner recommended:

4. Any unregistered providers of trauma counselling and psychotherapy services become a member of the Psychotherapy and Counselling Federation of Australia.

Individuals who report they have been sexually abused and patients with mental health issues are vulnerable and easy prey to charlatans. To assist vulnerable groups in finding appropriate treatment and making informed decisions the Commissioner recommended:

5. The Department of Human Services take a leadership role with professional bodies, registration boards and advocacy groups to conduct a community education campaign aimed at ensuring members of the public have the information needed to choose appropriately qualified practitioners.

As confidentiality is the cornerstone of the therapeutic relationship, the Commissioner cannot demand patient and practitioner cooperation in order to deal with third party complaints concerning RMT, while maintaining the confidentiality of the patient. To further investigate the extent of third party complaints related to the current practice of RMT the Commissioner recommended:

6. The Office of the Health Services Commissioner considers ways to receive and record new third party complaints relating to RMT for the purpose of further review of this issue.

3 RECOMMENDATIONS

It is desirable that any practitioner who provides trauma counselling has suitable qualifications and is bound by a code of ethics. However, there are difficulties with such a proposal, for instance: What constitutes the area of trauma? What are suitable qualifications? Considering these difficulties, the Health Services Commissioner recommended:

1. The government undertake a review of the risks and examine any need for further regulation of unregistered providers of counselling and psychotherapy services.
2. Collaboration between universities and professional bodies to review the adequacy of training regarding trauma, with a view to ensuring practitioners are being adequately trained.
3. Professional bodies (including those for registered and unregistered practitioners) and registration boards which have not established best practice guidelines related to recovered memories do so.
4. Any unregistered providers of trauma counselling and psychotherapy services become a member of the Psychotherapy and Counselling Federation of Australia.
5. The Department of Human Services take a leadership role with professional bodies, registration boards and advocacy groups to conduct a community education campaign aimed at ensuring members of the public have the information needed to choose appropriately qualified practitioners.
6. The Office of the Health Services Commissioner considers ways to receive and record new third party complaints relating to Recovered Memory Therapy for the purpose of further review of this issue.

4 BACKGROUND TO THE INQUIRY

4.1 Introduction

In October 2002, the Department of Human Services (DHS) commenced a review of the system of regulation of Victoria's registered health professions. The review aimed: to ensure the framework for regulating Victoria's health professionals is up-to-date, responsive and equips health practitioner registration boards to protect the public and address emerging challenges; to promote consumer and community confidence in the operation of Victoria's regulatory scheme; and to ensure good links between mechanisms that oversee practitioner quality and those that ensure health system quality. Of the 116 submissions received in response to the Discussion Paper, 15 addressed the issue of Recovered Memory Therapy (RMT). During 2004 there was some media interest in response to the issues raised.

In response to the concerns raised, in November 2004 the Minister formally requested the Health Services Commissioner (Commissioner) to conduct an Inquiry into the practice of RMT under section 9(1)(m) of the *Health Services (Conciliation and Review) Act 1987 (Vic)* (the Act). The Terms of Reference required the investigation to be completed and a final report provided to the Minister by July 2005. A penultimate Report was provided to the stakeholders for comments. The final Report was presented to the Minister on ...

4.2 Terms of Reference

The Commissioner is requested to:

1. Investigate and report to the Victorian Minister for Health by July 2005 on the following matters in relation to the practice of 'RMT', also known as 'repressed memory therapy' and 'false memory therapy'¹:
 - a. A review of the national and international literature on the practice of RMT, addressing, amongst other things:
 - The evidence base for its practice including the scientific understanding of memory
 - Media coverage and the popular press
 - Litigation and court reports

¹ Included is any other form of therapy, or other clinical or therapeutic strategies that have a component based on or incorporating a belief that memories can be repressed and focusing on or adopting methods designed to assist the patient/patient to elucidate those memories.

- Government reports and any practice or other relevant guidelines issued by governments and professional bodies.
- b. The extent to which RMT is practised in Victoria, including the types of therapists and their qualifications and training.
 - c. The perspectives of those whose interests are or have been affected by the practice of this form of therapy, including patients, their family members, therapists, and professional and regulatory bodies.
 - d. The nature and extent of any problems associated with the practice of RMT including issues of privacy and confidentiality of the therapeutic relationship and difficulties in dealing with third party complainants.
2. Make recommendations concerning:
 - a. The need, if any, for consumer and community education about the practice of RMT.
 - b. The need, if any, to develop best practice guidelines or other quality assurance measures to guide therapists.
 - c. The need for improvements if any in the management of complaints about the practice of RMT, including any statutory reforms in the context of the Victorian Review of Regulation of the Health Professions currently being conducted by the Victorian Department of Human Services.
 - d. Any other opportunities for improving practice and protecting the public that are identified during the course of the investigation.

4.3 The Inquiry Team

The Health Services Commissioner, Beth Wilson, conducted the Inquiry, and was assisted by Anne-Maree Polimeni, Project Officer, and Lynn Griffin, Manager Assessment & Investigation.

4.4 Methodology

4.4.1 Literature review

In accordance with the Terms of Reference (1a), a literature review of national and international sources on the practice of RMT was undertaken. In reviewing the literature, the Inquiry adopted the position of researchers such as Gleaves, Smith, Butler and Spiegel (2004), Schooler (1994) and Sivers, Schooler and Freyd (2002), refraining from making absolute judgements on the topic, and briefly reviewing the

empirical and experimental evidence for both recovered and false memories. The literature review was not intended to be a comprehensive research review, but a summary of the scientific understanding of recovered and false memory and of the national and international government responses and guidelines issued by professional bodies concerning recovered memories of childhood sexual abuse (CSA). Specifically, the literature review included a discussion of the conceptualisation of memory, and a brief outline of the factors that may interfere with the accurate recall of past events. It also included reviews of the evidence for false memories and blocked and recovered memories, and possible cognitive mechanisms for blocked and recovered memories. Some of the more controversial psychotherapeutic techniques associated with recovering memories of traumatic events were summarised, plus responses from governments and professional bodies to concerns about recovered memories of CSA.

4.4.2 Legislative review

In accordance with the Terms of Reference (1d), complaint processes and procedures for the Office of the Health Services Commissioner (OHSC) and health practitioner registration boards were reviewed to examine any problems associated with the practice of RMT, such as difficulties in dealing with third party complainants. Health practitioner registration boards were consulted, and the *Act* was examined to assess the difficulties in dealing with third party complainants.

4.4.3 Questionnaire

In accordance with the Terms of Reference (1b), a questionnaire was developed to examine the extent to which RMT is practised in Victoria, including the types of therapists and their qualifications and training. The questionnaire was based on the definition of RMT provided in the Terms of Reference. The questionnaire was sent to 640 Victorian members of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and to several member associations of the Psychotherapy and Counselling Federation of Australia (PACFA).

4.4.4 Written and verbal submissions

In accordance with the Terms of Reference (1c, 1d), advertisements were placed in the *Herald Sun* and *The Age* on 27 November 2004. The advertisements

called for submissions from persons with information about RMT, including patients, their family members, practitioners and professional and regulatory bodies. With the consent of the respondents, all relevant submissions to the DHS Review were forwarded to the Commissioner for consideration.

Given the sensitive nature of the topic, respondents were afforded the opportunity to make written and/or verbal submissions. Verbal submissions consisted of either individual face-to-face meetings or telephone conversations where an individual was given an opportunity to tell their story while notes were taken. The Commissioner also sought advice from recognised experts in the field.

4.4.5 Forums

In accordance with the Terms of Reference (1c), representative members from professional bodies, such as the RANZCP, PACFA, and the Australian Psychological Society (APS), and support/advocacy groups, such as the Australian False Memory Association, were invited to separate forums. Forums provided eight to 10 representative members of a professional or support group an opportunity to express their views on RMT in a group situation.

5 FINDINGS

5.1 Literature Review

The literature review is attached as Appendix A of this Report. A summary of the literature review follows.

5.1.1 Introduction

Memory loss with subsequent recovery or recall of the complete or partial memory has been documented in relation to many traumatic events such as natural disasters or accidents (Madakasira & O'Brian, 1987), combat during war (Fisher, 1945), kidnapping, torture and concentration camps (Kinzie, 1993) and physical and sexual abuse (Cheit, 1998). Recovered memories of traumatic events were first acknowledged in the 1800s by Sigmund Freud and colleagues (Alpert, Brown & Courtois, 1998; Gleaves et al., 2004). Some researchers have suggested the topic has only become controversial since its association with memories of CSA (Cossins, 1997). Some writers (for example, Gawenda & Gurvich, 1995) have also suggested

that at the centre of the debate is the disagreement on what constitutes CSA and its prevalence.

5.1.2 Conceptualising memory

There are four stages of memory which involve selection, encoding, storage and retrieval. Human beings can consciously or unconsciously select and turn their attention to information in the environment. The information is then encoded for storage. Encoding refers to interpreting incoming information into a meaningful mental representation that can be stored in memory (Matlin, 1998). Information can be encoded in several different ways, such as according to its sound (acoustic encoding), what it looks like (visual encoding), and its meaning (semantic encoding). Storage is the process of keeping information in memory (Matlin, 1998). A distinction is made between short-term and long-term memory. Short-term memory or working memory is brief and transient and only contains the small amount of information which is actively being used. Long-term memory has a large capacity and contains old and new memories, which are reasonably permanent. According to some researchers (Atkinson & Shiffrin, 1968), material, which has been rehearsed or repeated, passes from short to long-term memory for example, repeating someone's name several times. Later, when needed, information can be retrieved by using a search strategy that parallels the way the information was encoded and stored (Matlin, 1998). For example, if a list of terms is encoded acoustically and visually, they may be recalled relatively easily however, there may be some difficulty in explaining the meanings of each term (Matlin, 1998).

Memory can be explicit (also referred to as declarative or semantic) or implicit (also referred to as non-declarative or somatic), and this can affect recall. Explicit memory is intentional or conscious recollection of information. Everyday memories that most people are familiar with are known as explicit memories, as they usually have the quality of being organised in a sequential manner to become the basic structure of story telling. Implicit memories tend to occur without conscious awareness, but they have an affect on performance and behaviour. The theory is that traumatic memories, which can be blocked, tend to be described as implicit memories, which may impact on behaviour despite the inability to consciously recollect them (Cozolino, 2002). Explicit and implicit memories are encoded differently, and when retrieval matches the type of encoding, memory performance is better (Matlin, 1998).

5.1.3 Determinants of accuracy

Within this conceptual framework of memory, memory failure can be attributed to a breakdown at any one of the four stages (Thomson, 1995). For example, in the selecting stage, the extent of the opportunity to perceive events is essential to what can be recalled. In the attention stage, if the observer is tired, the degree of accuracy of the memory will be limited. In the storage stage, recall is likely to be less detailed and accurate if there is a greater period of time elapsing since the event was observed (Thomson, 1995). In the retrieval stage, recall is better if the retrieval context is similar to the encoding context, and may be hindered when the two contexts do not match (Matlin, 1998).

5.1.4 Experimental evidence for false memories

The experimental evidence for false memories includes studies from patients with frontal lobe damage, who have shown memory distortions such as false recognition and confabulation (Schacter, Kagan & Leichtman, 1995). The evidence also includes studies which indicate individuals can confuse the origin of information, for example, misattributing an experience to perception when it was only imagined (Johnson, Hashtroudi & Lindsay, 1993). In addition, studies, which demonstrate the 'associative memory illusion', suggest when research participants study a list of related words (such as fish, fishing rod and bait), and are asked to recall the list, they falsely remember having studied a related word (such as lure) (Roediger & McDermott, 1995). The 'misinformation effect' indicates individuals can integrate misleading post event information into memory. For example, in Loftus' (1997) famous 'Lost in the Shopping Mall' study, she enlisted the help of family members, and successfully convinced participants they had been lost in a shopping centre as a child.

The generalisability of the experimental evidence showing the phenomenon of false memory has been questioned (Gleaves et al., 2004). Some researchers (Gleaves et al., 2004) suggest the majority of laboratory research on false memories has limited generalisability as it involves recognition of words in word tests, or suggesting relatively common, believable and non-traumatic memories to non-clinical participants, and eliciting false reports with no long-term personal consequences, such as family disruption or a jail sentence for a family member. In addition, laboratory

research may have limited generalisability as it may underestimate the degree of influence and suggestion that may occur in therapy. Contact between the experimenter and participant is normally brief in comparison to therapist and client contact. Studies suggest participants are more likely to report false childhood memories with increasing contact with the experimenter (for example, Hyman, Husband & Billings, 1995; Zaragoza & Mitchell, 1996). Gleaves et al. (2004) state the possible effects of repeated exposure to suggestion have not been experimentally studied.

5.1.5 Empirical evidence for false memories

Primary clinical evidence for the existence of false memories comes from anecdotal evidence from people known as ‘retractors’ (See De Rivera, 2000), letters from people reporting to be falsely accused of sexual abuse (See Loftus, 1993), legal cases, investigations conducted by the Commissioner and media reports.

5.1.5.1 Legal cases

“Little case law as yet exists in Australia and New Zealand in relation to the admissibility of expert evidence about the processes of recall by adults or children of assaults, sexual or otherwise, perpetrated upon them. Expert evidence has been admitted in Canada ... This enables the evidence potentially to pass through the doors of the common knowledge² rule for those jurisdictions where it still exists” (Freckelton & Selby, 1993, 13.290). In other words, if the expert evidence is thought to be common knowledge it is inadmissible. Cases, which have set a legal precedent, in relation to the admissibility of expert evidence about recovered traumatic memories are summarised below (See Freckelton & Selby, 1993 for a thorough review of case law in relation to recovered memories).

5.1.5.1.1 Canadian authority: R v Norman

In the Canadian case of *R v Norman* (1993) 87 CCC (3d) 153, the Ontario Court of Appeal expressed concerns about the risks posed by evidence from complainants in sexual abuse cases where memories are retrieved by therapeutic

² Expert witnesses may not give evidence on matters considered to be common knowledge to the jury, because it is believed the jury will not benefit from expert assistance (Freckelton, 1993).

techniques. Namely, the techniques might draw out false memories, but the patient believes they are real memories of the sexual abuse. The court said that a mistake might be made in such situations by placing too much weight on the appearance of honesty and confidence on the part of the patient who has engaged in therapy to recover memories.

In *R v Norman* the Court of Appeal did not rule authoritatively on the admissibility of expert evidence about memory. However, it placed considerable weight on the evidence of an expert on recovered memories of sexual abuse, who emphasised that a memory may arise from a therapist's suggestions. The court found that in historical sexual assault cases, expert evidence was important and helpful, as courts may not be familiar with the processes of recall by individuals of sexual assault. However, it said that the possibility that a psychiatric condition could be responsible for lack of memory does not lessen the responsibility of the court to ensure that the Crown has presented its case beyond reasonable doubt.

5.1.5.1.2 New Zealand authority: R v R

In the case of *R v R* (1994) 11 CRNZ 402, a single judge of the New Zealand High Court was called to rule on the admissibility of expert evidence relating to recovered memories of sexual abuse. The accused was charged with the sexual abuse of his two daughters (aged 21 and 18 years at the time of the trial), which was reported to have occurred between 1983 and 1990. The elder daughter had her first memory of the alleged abuse in 1990. It was reported that the memory was recovered during counselling. The younger daughter had her first memory of the alleged abuse in 1991.

The Crown sought to call an expert to give evidence about the way in which memories are created, reconstructed and retrieved. The expert was also going to describe the different types of memories, such as explicit and implicit memory, and the psychological defences against trauma, such as dissociation, denial and repression. The Counsel for the accused objected that the evidence was not relevant and could be detrimental to the credibility of the complainant. However, the judge found the evidence was relevant and believed the expert evidence in this particular case was both necessary and admissible as he considered the issues were beyond the knowledge of a Judge or jury.

5.1.5.1.3 Australian authority: R v Bartlett

The main Australian authority on recovered memories and the admissibility of false memory evidence is the Victorian Court of Appeal decision in *R v Bartlett* [1996] 2 VR 687. The decision of *R v Bartlett* established the legitimacy, in certain circumstances, for the defence in criminal trials to adduce suitably qualified expert evidence, such as from a psychologist, about the unreliability of recovered memories (See Freckelton, 1997). In that case, the accused was convicted of indecent assault and false imprisonment of a nine-year-old girl, which was reported to have occurred 13 years before the trial. The complainant gave evidence that her memories of abuse were recovered during therapy.

The accused sought to call expert evidence from a psychologist regarding recovered and false memories, but the trial judge rejected it on the basis that there was no scientifically accepted body of knowledge concerning memory, and persons without knowledge in the area of memory and trauma would be able to form a sound judgement without expert evidence. The court found this ruling to be incorrect and found that the phenomena in question were beyond the general knowledge of the layperson. As the expert evidence was able to convince the jury that the events described by the complainant were false memories, the Court of Appeal decided that the convictions of the accused should be quashed.

At present, in national and international courts, profound controversy still exists about the dangers posed by evidence that is therapeutically recovered. Given the profound disagreement within the expert communities regarding whether a particular recovered memory is true or false, and the lack of controlled studies into traumatic recovered memories, in most cases expert evidence is likely to be inadmissible as it is unlikely to assist the tribunal to better understand the issues or dispel falsehoods (Freckelton & Selby, 1993).

5.1.5.2 An investigation into Recovered Memory Therapy by the Health Services Commissioner

In March 1999 a complainant contacted the Commissioner because of concerns about the wellbeing of her sister. Her sister was living in a Victorian country town and was attending the medical clinic where she was being treated for, amongst other things, depression. She was also receiving psychotherapy from a psychologist. The complainant was concerned about the possible financial and sexual

exploitation of her sister. She was also concerned about her sister's medication, and the duration of her counselling sessions, which exceeded the standard 50-minute session. She mentioned a "blackmailing" letter demanding money that had been sent to her father by the psychologist. The complainant was told that as the Commissioner had no complaint from the patient (her sister), the OHSC could not intervene. In November 1999, the Minister for Health requested the Commissioner to undertake a formal investigation of the medical clinic to assess the accuracy of the complainant's allegations under section 9(m) of the *Act*. The patient gave her consent for the medical clinic to discuss her care with the Commissioner.

After extensive inquiries the Commissioner found no evidence of financial exploitation by the medical clinic, but she noted that the clinical management of the patient by the general practitioner and the psychologist raised a number of concerns. The psychologist was conducting late night counselling sessions with the patient, her prescribed medication was a concern, and she was in a state of exhaustion. The general practitioner was aware of these issues, but did nothing to stop the occurrences, and appeared instead to have encouraged it. Eventually it was the nursing staff that put a stop to the psychologist's late night removal of the patient. The Commissioner recommended that the general practitioner's management of the patient be referred to the Medical Practitioners Board of Victoria for action.

The Commissioner had serious concerns about the psychologist's conduct and considered he put the health and safety of his patient at risk. As a registered psychologist he had a duty to uphold the standards of his profession and behave in an ethical manner. The Commissioner decided there was *prima facie* evidence that the psychologist either created the illness in his patient, or contributed to its longevity and seriousness. There is evidence in the form of the letter to the patient's father that he did this for financial gain. The letter "requesting" payment of \$30,000 in fees also contained a threat that legal action would be taken if the money were not paid. The Commissioner considered it was inappropriate for the psychologist to seek fees from the patient's father in this way. The Commissioner noted, "The area of repressed memory therapy is fraught with controversy and the psychologist's treatment regime with the late night visits, the exhausted state of his patient, the claims of thousands of memories recovered from the age of two years following therapy sessions lasting for hours could not be described as professional. The psychologist himself told the Commissioner that the recovery of so many memories was, amazing, incredible and

difficult to believe.” The Commissioner recommended that the psychologist’s management of the patient be referred to the Psychologists Registration Board for action.

5.1.5.3 Media reports

Recent media reports about recovered memories of CSA was reviewed and compared to the legal proceedings relating to the cases. In December 2000, an article appeared in Brisbane’s *Sunday Mail* (Taylor, 3 December 2000) reporting on the case, *R v Kenward* [2000] QCA 482, of a Queensland man, Robert Kenward, who was jailed on child sex charges. In the mid-1980s, the complainant, her sister and their mother lived in Kenward’s home. In April 1995, the complainant started attending the Royal Brisbane Hospital for a work related shoulder injury. At the time an occupational therapist and a psychologist assessed her to ascertain whether her chronic pain might have a psychological basis. On 18 June 1997, to obtain relief from her shoulder pain the complainant gave the Royal Brisbane Hospital her personal history. In the course of the assessment at the pain clinic, she made the allegations of CSA against Kenward to her psychologist. She reported this was the first statement she made to any person implicating Kenward in any form of sexual misconduct with her. The complainant said she had always remembered the abuse, but for approximately 20 years was too afraid to speak about it. However, the newspaper article reported that Kenward believes it was a false memory created in counselling.

In April 2000, Kenward was arraigned on sex charges and found guilty at trial of one count of rape and one of indecent dealing, but was acquitted on four others. He was sentenced to six years in prison and spent several months behind bars before being allowed bail pending his appeal. In *R v Kenward*, Kenward’s convictions were quashed on appeal. The Appeal Court judges said the contradictory evidence plus the complainant’s behaviour, such as her emotional outbursts in court, warranted the quashed convictions.

On 26 April 2001, reporter Simon Royal from the ABC’s *7.30 Report* gave an account of Robert Kenward’s story. The report involved Kenward, Anton Maher (Kenward’s barrister), Brian Hazell (a psychologist), Liz Mullinar (founder of Advocates for Survivors of Child Abuse), a survivor of CSA, and Professor Gina Geffen (board member of the Queensland Psychology Board). Maher stated that in trials dealing with a complaint, which occurred many years ago, the central feature is

the reliability of the memory. Maher stated that in cases where the defence believes the memory has been altered by therapy, the defence has to find evidence that the complainant has undergone therapy that has changed his/her memory; otherwise, there is no basis upon which to make an application to the court to exclude the evidence. In Kenward's case, the report described that the defence could not examine the complainant's counselling records, as they could not be located. Brain Hazell and another psychologist examined the complainant's psychological and counselling history for the defence and believed that therapy may have altered her memory. Royal, from the *7.30 Report*, reported the complainant denied this. It was also reported the judge ruled that Hazell could not be heard because the defence lacked the documentary evidence for its argument.

Recently, articles appeared in the *Sydney Morning Herald* (Lamont, 6 July 2005; Maley, 9 July 2005) reporting on the case of *AW & Ors v State of New South Wales* [2005] NSWSC 543. These proceedings arose out of events in 1994 in which charges were laid against a mother, father and grandmother alleging they had committed sexual offences against their four children. In 1993, in the course of counselling from a Family Planning Association, the eldest child (known as SW) said that a number of physically violent boyfriends had previously raped her and that her father had sexually molested her. In subsequent counselling sessions, SW said her father had raped her. The *Sydney Morning Herald* newspaper articles reported that some of the claims allegedly came from repressed memory counselling sessions however, the case, *AW & Ors v State of New South Wales*, did not discuss claims of RMT.

SW reported the alleged abuse to the police where she provided a statement detailing a history of abuse by her father commencing at five years of age. At subsequent police interviews, SW also made allegations against her mother and grandmother. Police questioned the SW's three siblings who initially denied the abuse but over time came to make allegations of ritual sexual abuse against one or both parents and the grandmother. In 1994, police arrested the mother, father and grandmother.

In November 1995, the three youngest children retracted their statements and a Children's Court Magistrate ruled their allegations were untrue due to the many inconsistencies between the children, and within each child's statements. However, he found there was inadequate supervision of the children, there had been

inappropriate sexual touching between the children, and ordered they be taken into care. In 1996, after a committal hearing, a magistrate dismissed charges against the parents and grandmother involving the four children.

On 5 July 2005, the Supreme Court ruled the mother, father and grandmother had been wrongfully arrested and suffered malicious prosecution, awarding them \$165,000 in damages. *AW & Ors v State of New South Wales* at 611 commented: “I have concluded that MOD (the investigating officer) lacked a degree of objectivity in the conduct of the ... investigation. He appears to have accepted the accounts offered by SW (eldest daughter) and EW (13 year old daughter) notwithstanding features of them that were improbable and to have concluded that AW (father) and LW (mother) were likely to be members of a paedophile ring. However, I do not find that MOD’s motive in instituting the prosecution of charges against AW and LW on 23 June on the strength of the unsupported and in some instances implausible allegations made by their children was the product of any motive other than a desire to see them brought to justice.”

Julia Limb (6 July, 2005) from ABC Radio also reported on the above case and she spoke to the Director of the New South Wales Institute of Psychiatry, Louise Newman. Newman made an important distinction between the use of recovered memories, which are used as evidence in court, and those in therapy. She stated that recovered memories do make unreliable evidence but are important in therapy. She said, “Sometimes in clinical practice we don't ever know the truth, which means if someone is looking at a legal proceeding it's actually very difficult because the court is in the position of trying to determine whether something was true or false.” As patients who recover memories may only recover partial memories of the event, “In many clinical situations that (the veracity of memories) becomes less of an issue and we're really trying to help people live with their beliefs and some memories of what's happened to them without necessarily wanting them to reconstruct in an active way a whole story of abuse.”

Newman also discussed the uncertainty that comes from working with patients who may not know how accurate their memories are and patients who cannot recall the entire event: “So it's always extremely difficult to know with any degree of certainty about the veracity of someone's memories. And I think that really becomes quite a complex clinical issue when we see people who have questions that they would like the answers to about what actually happened to them and we need to work

with those individuals to help them reconstruct or put together a story of what might have been particularly negative experiences.” Newman also said that recovered memories have not always been used appropriately and should be dealt with by experienced and appropriately trained professionals: “Children have falsely in some cases, it appears, as adults, accused parents. So the consequences of this sort of therapeutic approach in unskilled hands or in overenthusiastic hands are very serious. Certainly working with repressed memories or working with people who've survived abuse is not the sort of therapy that should be undertaken by people without a lot of experience working in this area.”

The above media reports do not show reliably that RMT exists in Australia. The reporters appear to have reported inaccurately on the legal cases by stating that the allegations of CSA arose from RMT, when in fact the complainants have denied such allegations and the judge's summations did not mention RMT. The reports also highlight issues such as the differences between the objectives of therapy versus legal proceedings in relation to the issue of recovered memories. The objective of therapy is to help patients live with their experiences of abuse, and uncertainties about their experiences. In contrast, the objective of a legal proceeding is to determine whether the memory is true or false. All persons, including police and therapists, working with allegations of CSA need to be mindful of the impact of suggestion, their position of authority and their own beliefs on patients or complainants.

5.1.5.4 Limitations

Some researchers have criticised anecdotal evidence for false memories for a number of reasons, such as they do not believe that false allegations of CSA are a common occurrence, and there may be alternative explanations of why those accused of CSA or retractors may be denying the abuse occurred. These criticisms are outlined in more detail.

Much of the literature supports the notion that false allegations occur in a small proportion of total allegations of sexual abuse. For example, a recent review of false allegations of sexual abuse in the Family Court in South Australia concluded that approximately nine per cent of allegations were false (Brown 2003, cited in Crime and Misconduct Commission, 2003). False allegations of CSA do not appear to be a common occurrence.

Rubin (1996) suggests it is important to consider the source of the report of false memory, especially of CSA. For example, Rubin (1996) stated that when the source of the report is the person accused of abuse, there might be several interpretations of what actually occurred. Rubin noted that guilty persons might deny they are guilty of sexual abuse for a number of reasons, such as denial, secrecy, alcohol-induced blackouts, and dishonesty. In addition, some researchers believe that just as victims of CSA report forgetting or blocking of the abuse, so can perpetrators (Resneck-Sannes, 1995).

When the source is an individual who has retracted accusations of CSA, it is important to consider that people with verifiable histories of abuse are known to alternate between accepting and denying their memories. A victim may also be more susceptible to suggestions their memories are false (Gleaves, 1994).

5.1.6 Experimental evidence for recovered memories

Experimental evidence for recovered memory includes studies which show the phenomenon of 'retroactive interference', which is where an event is stored in memory, and subsequent similar events can cause it to become inaccessible for a period of time. Some researchers have found the greater the length of time that the event is stored in memory, the greater the likelihood the memory will become accessible (Brown, 1976). The experimental evidence also includes studies that demonstrate the tip of the tongue phenomenon, which is where after a period of time, the previously inaccessible word is likely to be remembered (Brown & McNeill, 1966). In addition, research has also shown when participants have been hypnotised and given suggestions to forget an event, memories of the event become inaccessible (Kihlstrom, 1979). However, the memories can be recovered if participants are given a prearranged signal to cancel the amnesia.

In common with the experimental evidence for false memories, the experimental research on recovered memories is subject to the limitation of generalisability. The laboratory research examines blocking and recovering for routine memories, which may be different from memories of trauma. For ethical reasons, memories for traumatic events cannot be directly assessed as researchers cannot traumatise participants and then assess the degree to which memories are blocked and subsequently recovered. Although the available evidence remains

primarily indirect, there is nevertheless a reasonable foundation for the existence of both recovered and false memories.

5.1.7 Empirical evidence for recovered memories

There have been many empirical studies using clinical and non-clinical populations, to assess the potential for forgetting and subsequently recovering memories of a range of traumatic events such as witnessing a murder or suicide, car accidents, physical and sexual abuse, and combat (e.g., Elliot, 1997; Feldman-Summers & Pope, 1994). Studies indicate between 30 to 70% of participants reported memory loss for the traumatic event, which ranged from partial to complete memory loss (e.g., Elliott & Briere, 1995; Herman & Schatzow, 1987; Williams, 1992). Where studies addressed how memories were triggered, they found memory triggers included media reports, being informed by a witness to the event or being in a situation similar to the original trauma. Participants reported therapy was the least likely trigger. The research suggests memory loss is related to feelings of fear and shame, interpersonal victimisation, and also appear to be age and degree related. For example, the younger the individual at the time of the trauma or the more prolonged the event, the more likely the individual will experience memory loss.

Studies which use clinical samples have been criticised on the basis that findings may not be generalisable to the general population, as the degree of amnesia may be overestimated due to the composition of the sample (Gleaves et al., 2004). The manner in which the degree of memory loss is assessed and the lack of corroboration of abuse reports have also been criticised. Some researchers are also reluctant to rely on retrospective reports of trauma, as they may be unreliable.

Andrews and colleagues (Andrews, Brewin, Ochera, Morton, Bekerian, Davies & Mollon, 1999; 2000) questioned a sample of practising psychologists who were members of the British Psychological Society by using qualitative and quantitative research methods to investigate the prevalence of patients who recovered memories of trauma, and the characteristics of the memories. Andrews et al.'s (1999) findings were consistent with other studies suggesting people recover memories of non-sexual traumatic events, as one third of the recovered memories reported in therapy involved traumas other than sexual abuse. The sample of psychologists reported the recovered memories were also generally independently corroborated.

The researchers concluded therapy is not always the basis for memory recovery, as the findings indicated approximately one third of the patients had recovered memories before entering therapy. The psychologists reported the most common triggers for memory recovery for all patients were events and circumstances involving their own children and other events involving physical threat and danger to themselves. Memories were less commonly triggered by books and media reports on CSA or by therapy. Andrews et al. (2000) found the degree of amnesia prior to seeking therapy varied widely. For example, the psychologists reported some patients had prior amnesia, others had a prior vague sense of the existence of a traumatic memory and others had prior partial memories. It was also found the features of the traumatic memories were similar, for example psychologists reported they were fragmented but detailed, accompanied by high levels of emotion, such as fear, and experienced as reliving the original event.

Research examining recovered memories from different viewpoints, such as by speaking to patients and to therapists is useful. By seeking various forms of information from different sources, researchers seek to draw conclusions that are corroborated in a number of ways. The conclusions that can be drawn from the above research include, memory loss is not only associated with sexual abuse, some patients recover memories, or are at least aware that a trauma occurred prior to seeking therapy, and memories are triggered by a range of circumstances.

5.1.8 Theoretical explanations for blocked and recovered memories

There are a number of mechanisms which have been used to explain the phenomenon of recovered memory. These include dissociation, repression and suppression. The recovery of traumatic memories may involve multiple cognitive processes occurring simultaneously.

5.1.8.1 Infantile amnesia: Storage difficulties or retrieval failures?

The concept of infantile amnesia is used to explain the phenomenon that most adults, adolescents and older children are unable to recall events from infancy or early childhood. Theories about infantile amnesia have been divided into two broad categories: memory loss is due to storage difficulties (early experiences are not adequately transformed into long-term memories) versus memory loss is due to retrieval failures (early memories exist but they are difficult to recollect)

(Schaffhausen, 2000). The idea that infantile amnesia may be caused by inadequate memory storage originates from studies that indicate that neural circuitry of the brain is not fully functional in infants and myelination (which is the process of insulating nerve fibres in the nervous system) in much of the brain surface is not complete before two years of age.

Some researchers believe part of the brain called the hippocampus, which involves explicit memory (See Bremner, Krystal, Southwick & Charney, 1995), does not develop in children until the age of approximately three. Therefore, memory for children under the age of three is regulated by the implicit memory system, which involves the more primitive parts of the brain, which do not store conceptual, factual and verbal material. Neurologically, children may not be able to store an explicit memory in a verbal form (Cozolino, 2002). In adulthood, memories of early childhood may be difficult to retrieve because adults tend to store and retrieve memories as conceptual, factual and verbal material. This type of memory failure provides an explanation of a breakdown in the retrieval stage, because the encoding and recall contexts do not match.

5.1.8.2 Dissociation

The concept of dissociation is used to describe the lack of connection between things usually associated with each other. Dissociated experiences are not integrated into the usual sense of self, resulting in discontinuities in conscious awareness. In the *Diagnostic and statistical manual of mental disorders* (4th ed.) dissociative amnesia is defined as “a reversible memory impairment in which memories of personal experiences cannot be retrieved in verbal form” (American Psychiatric Association, 1994, pp. 478). The experiences that cannot be retrieved are “usually of a traumatic or stressful nature (American Psychiatric Association, 1994, pp. 478). Sivers et al. (2002) explain that present understandings of dissociation describe three components of an acute dissociative response to a traumatic event: derealisation (alteration in one’s perceptions), depersonalisation (alterations in one’s sense of self and connection to one’s own body), and memory disturbances.

It is reported that acute dissociative states lead to poor encoding of the traumatic event because the various sensations and perceptions fail to be integrated as a conscious memory (van der Kolk, 1996). However, later the event can become integrated as a memory and consequently retrieved. Another possibility is a

dissociative state may be functionally different from a 'normal' state. Dissociation occurs in situations of terror, this state causes the event to be encoded in terms of snapshot pictures, smells and sounds (Cozolino, 2002). Memory failure occurs because the dissociated information is only available when one enters the dissociative state (Sivers et al., 2002). When individuals encounter similar sounds, smells and sensations to the original trauma (in other words, when the encoding and retrieval contexts match), it is likely to produce feelings of terror and trigger the memories.

5.1.8.3 Repression

Repression is a term used to describe an unconscious defence mechanism where the contents of the unconscious are kept hidden from conscious awareness, thereby protecting the individual from psychological threat (Thomson, 1995). It has been reported that memories that have been repressed can become accessible under limited circumstances, such as when the person is in an altered state of consciousness (for example, under hypnosis or when the person is asleep) (Thomson, 1995). However, many researchers have observed it has been difficult to obtain evidence for the existence of repressed memories (Loftus, 1993; Thomson, 1995).

5.1.8.4 Suppression

Suppression is a term used to describe a conscious and deliberate process of blocking painful memories (Thomson, 1995). It has been suggested that by deliberately not thinking about a certain event, one is not rehearsing the event, which may result in the formation of weak memory traces and poor retention (Anderson & Green, 2001). In addition, repeatedly denying the reality of the event can become a well-learned and automatic response, and the event may be forgotten.

5.1.9 Clinical techniques associated with recovered memories of sexual abuse

The critics of the recovered memory phenomenon describe clinical techniques which are used by therapists in therapy sessions, which they believe have been used to recover memories of traumatic events, especially those of CSA (See Lindsay & Read, 1994). The most controversial of these techniques include hypnotism, guided imagery / visualisation (patients are asked to play out scenarios suggested to them by their therapist), dream interpretation and interpretation of body memories (therapists interpret certain physical symptoms as unconscious memories of CSA). Critics of

recovered memory also report that some therapists tell patients who report no history of CSA, that their symptoms indicate repressed memories of CSA, that many patients cannot recollect their abuse, but healing depends upon recovering memories of abuse.

Critics also believe the book titled *The Courage to Heal: A Guide to Women Survivors of Childhood Sexual Abuse* by Ellen Bass and Laura Davis (1994), has been used by therapists to assist them in recovering memories of CSA. This book is a self-help book for women who have been sexually abused as children. The book explores the effects of CSA (including blocked memory of the abuse), the stages common to the healing process, strategies for partners and family members, and stories from women who have been abused. The book also has an accompanying workbook titled, *The Courage to Heal Workbook* by Laura Davis (1990). This workbook describes exercises which women can work through to help them deal with the sexual abuse. The book was written in the 1980s and some practitioners have reported the book is dated and over-represents the extent of recovered memories of CSA amongst patients. However, other practitioners have reported that some patients continue to find it helpful. Some practitioners believe that if patients want to read it or if practitioners suggest the book to patients, therapists should provide the patient with some preliminary education about current research on memory and trauma or a discussion placing the book in context.

The literature review found no research on the incidence of use of such techniques to recover memories or empirical or experimental research examining techniques used to recover memories of trauma. However, Yapko (1994) stated that it is necessary to distinguish between professional and unprofessional practice. He stated it is necessary to distinguish (1) those cases in which someone knows and has always known that he or she was abused, from (2) those cases in which someone independently remembers forgotten memories, from (3) those cases in which a therapist facilitates recall of forgotten memories, from (4) those cases in which a therapist suggests memories of abuse. He reported that unprofessional practice would be classed in the latter phenomenon.

Clinical techniques, such as hypnosis and guided imagery, are considered controversial because it has been reported patients may be at an increased risk of suggestibility, and of recovering false memories (Lindsay & Read, 1994). A therapist's interpretations of body memories or dreams are considered controversial because interpretations may reflect the therapist's own biases and beliefs, and it is

difficult to determine in any particular case whether dreams or physical symptoms should be attributed to unconscious or conscious memories. Some researchers have suggested the issue may not be whether a particular therapeutic technique is used, rather whether it is used in an ethical and professional manner.

5.1.10 Government responses and guidelines from professional bodies

A search of the literature found that a number of professional bodies have responded to concerns surrounding recovered memories of CSA. These include the American Psychological Association (1998), American Psychiatric Association (2000), Canadian Psychological Association (2001), British Psychological Society (1984, cited in Royal College of Psychiatrists, 1996), and the Australian Psychological Society (2000). There have been few responses from international and national governments. An examination of the international literature revealed the Netherlands' Government issued a series of reports from 1997 to 2004 (Netherlands Health Council, 2004; Mak, 2004) regarding recovered memories and allegations of CSA. An examination of the national literature found in 2003, the Crime and Misconduct Commission³ also examined the way in which sexual offences were handled in Queensland.

5.1.10.1 International professional bodies

5.1.10.1.1 American Psychological Association

The American Psychological Association's Working Group on the Investigation of Memories of Childhood Abuse issued a report in 1998. The six-member group was divided in their views but did agree on the following conclusions.

- “Controversies regarding adult recollections should not be allowed to obscure the fact that child sexual abuse is a complex and pervasive problem in America that has historically gone unacknowledged.
- Most people who were sexually abused as children remember all or part of what happened to them.
- It is possible for memories of abuse that have been forgotten for a long time to be remembered.

³ The Crime and Misconduct Commission is an independent law enforcement commission set up to combat major crime in Queensland, including organised crime and paedophilia, and official misconduct in the Queensland public sector.

- It is also possible to construct convincing pseudomemories for events that never occurred.
- There are gaps in our knowledge about the processes that lead to accurate and inaccurate recollections of childhood abuse” (American Psychological Association, 1998, pp. 933).

The American Psychological Association’s Working Group (1998) advised therapists:

- To exercise caution when working with patients who believe they are recovering memories of trauma.
- To exercise special care in dealing with patients and other groups who are affected by recovered memories, such as family members and the wider community.
- Give patients information about possible treatment strategies, including the risks and benefits of each strategy.
- Do not ask leading questions.
- Avoid imposing beliefs and values on the patient
- It would not be wise to initiate a search for memories.
- To be aware of the ways in which they can influence their patients’ memories, such as the questions they ask or the statements they make during the session.
- To allow the patient to direct the therapy session, to be open to discussion of abuse, but nevertheless, cautious in interpreting the patient’s response.
- Provide ample opportunities for clarification and discussion.
- Obtain informed consent in relation to the details of the therapeutic process and possible consequences.

The major difference of opinion within the Working Group related to the extent to which recovered memories are accurate or false. The Guidelines neither support nor deny the accuracy or inaccuracy of recovered memories, but do highlight that memory in general is unreliable, and the accuracy of memories can be affected by many variables. The Guidelines also acknowledge there is inconclusive experimental evidence regarding recovered memory, and whether traumatic memory is processed, stored and recalled differently to non-traumatic memory. The Working Group concluded that more research is needed to determine:

- The mechanisms by which accurate and inaccurate memories of events may be created.

- The techniques which lead to the recovery of accurate and false memories.
- The impact of trauma on memory.
- If there are client groups who are more susceptible to memory suggestions, and if so, what characterises them from other client groups.

Additionally, on the website of the American Psychological Association (<http://www.apa.org/pubinfo/mem.html>), questions and answers about memories of childhood abuse have been released, which is partly based on the work of the Working Group. This web page includes guidelines for patients in choosing a psychotherapist to help deal with a childhood memory and what can be expected from a competent psychotherapist.

5.1.10.1.2 American Psychiatric Association

In March and May of 2000, the American Psychiatric Association approved a Position Statement on ‘Therapies Focused on Memories of Childhood Physical and Sexual Abuse.’ The Position Statement stressed:

- Psychiatrists must not allow the confusion and controversy surrounding recovered memories, particularly in regard to CSA, to discredit the reports of patients who have memories of abuse.
- Memory in general is not always accurate and certain variables, such as severe or prolonged stress and suggestion, may interfere with accurate recall.

The report concluded with recommendations to psychiatrists.

- “ ... maintain an empathic, non-judgemental, neutral stance towards sexual abuse.
- As in the treatment of all patients, care must be taken to avoid prejudging the cause of the patient’s difficulties, or the veracity of the patient’s reports.
- A strong prior belief (on the part of the therapist) that physical or sexual abuse, or other factors, are or are not the cause of the patient’s problems is likely to interfere with appropriate assessment and treatment” (American Psychiatric Association, 2000, pp. 1).

It was also recommended when there is no supporting evidence for patient’s reports of new memories of childhood abuse, “treatment may focus on assisting patients in coming to their own conclusions about the accuracy of their memories or in adapting to uncertainty regarding what actually occurred. The therapeutic goal is to help patients to understand the impact of the memories/abuse experience on their lives

and to reduce the impact of these experiences and the detrimental consequences in the present and future” (American Psychiatric Association, 2000, pp. 1). It concluded more research is needed in this area. The Position Statement did not address the possibility of imaginary or false memories.

5.1.10.1.3 Canadian Psychological Association

The Canadian Psychological Association also updated its ‘Guidelines for Psychologists Addressing Recovered Memories’ (2001). The Guidelines acknowledged:

- There are “... many theoretical approaches to counselling and therapy, many of which support the existence of repressed memories which, in entrenched emotional disturbances, may need to be brought to consciousness to address the past painful experiences more realistically” (Canadian Psychological Association, 2001, pp. 1).
- Psychologists need to remain up-to-date with the latest literature in the area.
- Psychologists are required to continue professional training throughout their career.
- Psychologists must be familiar with and acknowledge the benefits and limitations of therapeutic techniques.
- Psychologists should be aware of their own personal values and beliefs which they bring to the therapy session.

5.1.10.1.4 British Psychological Society

The Working Party of the British Psychological Society released a review of the scientific basis for recovered memories (British Psychological Society, 1984, cited in Royal College of Psychiatrists, 1996). The review reported:

- Complete or partial memory loss is a frequently reported consequence of experiencing certain kinds of traumas, including CSA.
- Memories may be recovered within or independent of therapy and recovered memories may contain errors, which may be dependent on the age at which the event occurred.
- Pressure or persuasion by an authority figure could lead to the retrieval of false memories.

- At the time of publication, there was no reliable evidence to suggest this was a concern in Britain.

5.1.10.2 National professional bodies

5.1.10.2.1 Australian Psychological Society

The Australian Psychological Society (2000) revised special Guidelines for its members relating to recovered memories. “Amid the controversy ... there is general agreement about the following points:

- Childhood trauma involving physical, sexual and/or emotional abuse is not uncommon;
- Children who are subjected to such experiences are likely to be adversely affected, and evidence exists that varying degrees of psychological damage can be attributed to a child’s experience of such abuse;
- Child sexual abuse should not be retrospectively assumed solely on the basis of presenting symptoms;
- Memories of such experiences may be incessant, intrusive, complete, selective, fragmented, distorted or absent depending on the context and nature of the abuse and the survival strategies available to the individual as a child or later in life;
- All memories are susceptible to revision and influence from the time of encoding up to and including the time and context of retrieval, as well as in the disclosure and reporting process; and
- The percentage of child sexual abuse experiences that (a) are recalled for the first time during therapy and (b) are the subject of litigation, is very small in comparison to those that are remembered but unreported, and whose effects may or may not require treatment (Australian Psychological Society, 2000, pp. 1)”.

5.1.10.3 International government reports

5.1.10.3.1 Netherlands Health Council

The Netherlands’ Government commissioned a series of reports from 1997 to the 2004 (See Netherlands Health Council, 2004; Mak, 2004) examining the issue of false sexual abuse allegations made to police. The conclusions included:

- Memory is reconstructive, and remembering is affected by the social context in which it occurs. Forgetting and recovering memories are normal occurrences involving a range of different mechanisms.
- It is also plausible that memories for traumatic events can become inaccessible, either partially or temporarily, albeit sometimes in fragmentary form.
- The cognitive mechanism involved in forgetting and recovering traumatic memories is unknown.
- Individuals can experience imaginary or false memories.
- Influencing memories by suggestion must be avoided.
- The theory that certain symptoms, such as bulimia, were indicators of forgotten childhood trauma was heavily criticised.
- The risk of creating false memories is increased when an individual, who has certain personality traits, psychological disorders, vague memories or symptoms that are difficult to explain, is exposed to an influential authority figure (such as a police officer or therapist) who believes in the theory that certain symptoms are indicators of CSA, who employ suggestive techniques and who impose firmly their personal convictions on the individual. The reports did not specify the personality traits or psychological disorders that place individuals at increased risk.
- Professionals should produce a pamphlet outlining the benefits, limitations and potential risks of various therapeutic techniques.
- The importance of continued education in the field of memory.
- Further research into the underlying mechanisms of memory phenomena associated with traumatic experiences (Netherlands Health Council, 2004; Mak, 2004).

5.1.10.4 National government reports

5.1.10.4.1 Crime and Misconduct Commission

In 2003, the Crime and Misconduct Commission released a report, *Seeking Justice: An Inquiry into how Sexual Offences are Handled by the Queensland Criminal Justice System*. Public concern about the issues arose during the investigation, prosecution and discontinuance of charges against swimming coach Scott Volkens in September 2002 prompted the Crime and Misconduct Commission to conduct a general Inquiry into how the Queensland criminal justice system deals with

sexual offences. With regard to recovered memories, the Inquiry examined disclosures of sexual abuse and concluded:

- Disclosures of sexual abuse can be brought about by, but are not limited to, recovered memories.
- There is much evidence that experiences of sexual abuse can be forgotten.
- The validity of recovered memories has been the focus of much controversy within the criminal justice system.
- Leading and suggestive questioning could be generating false allegations.
- The findings of the Inquiry did not support concerns about disclosures of sexual abuse based on recovered memory. To enhance understanding of the full implications of the disclosure of sexual abuse, the Commission recommended specialist sexual offence training for all officers and police prosecutors who are working with sexual offences.

The responses of national and international bodies to recovered memories of CSA show many similarities. For example, each professional body reported:

- Memory in general is not always accurate and the degree of accuracy can be susceptible to a range of variables, such as stress.
- Traumatic experiences, including CSA, could be partially or completely forgotten, and subsequently triggered and remembered later in life.
- The difficulty with recovered memories is the ambiguity about the accuracy of the recollection.
- It is possible to create false memories for events that never occurred.
- Considering the possibility of creating pseudomemories, the professional bodies have advised therapists to use caution when working with patients who believe they are recovering memories of trauma. Their advice is:
 - To avoid assumptions and drawing premature or unfounded diagnoses based on symptoms, to remain non-judgemental, acknowledge personal beliefs and avoid imposing them.
 - Avoid leading questions and avoid initiating a search for memories.
 - There is a need for more research in the area of traumatic memory.

5.1.10.5 Summary of the literature review

Memory in general is a reconstructive process, that is, memory is reconstructed by using one's current knowledge, understanding and life situation. All memory, including continuous and forgotten memories, has the potential for inaccuracy. A search of the literature found experimental evidence for both recovered and false memories. The literature shows empirical evidence that memory for a range of traumatic events can be unavailable or forgotten for a period of time and subsequently retrieved. There are also anecdotal reports and legal cases indicating evidence for false memories of CSA. The available evidence for both phenomena has been criticised for being primarily indirect and having limited generalisability to real life situations. There is a range of mechanisms for explaining memory blocking and recovery processes, but generally, researchers agree the likely process involves many cognitive mechanisms occurring simultaneously.

Recovered memory critics believe there are a variety of memory recovery techniques, for example, hypnosis and dream interpretation. The use of such techniques has been criticised for placing patients at an increased risk of suggestibility, and of contributing to the recovery of false memories. The literature review found no research on the incidence of use of such techniques to recover memories. The issue may not be whether a particular therapeutic technique is used but whether it is used in an ethical and professional manner.

Professional bodies acknowledge traumatic experiences, including CSA, can be partially or completely blocked for a period of time, and subsequently recovered. They also acknowledge it is possible for therapists to create pseudomemories. In addition, professional bodies also agree on ideas of good professional practice, such as supporting the patient, keeping assumptions to oneself, and remaining non-judgemental.

5.2 Legislative review: Difficulties in Dealing with Third Party Complainants

The OHSC primarily accepts complaints from the patient / recipient of the health service. The patient may also nominate a person to complain on their behalf. Patient confidentiality is very important, because without it the therapeutic relationship could not exist. There are some circumstances where the Commissioner is able to accept third party complaints, however it is very difficult when the patient does not provide their consent, because the practitioner cannot and should not release

confidential patient information. Under section 15(3) of the *Act*, in the event where a third party wishes to complain about the services of a health provider without the consent of the patient, they may do so if, in the Commissioner's opinion, they have "a sufficient interest in the subject-matter of the complaint." That is, if it were clear that if the patient was able to complain, and was aware of all the issues involved in receiving the services of the health provider, they too would complain. In the case of third party complaints without the consent of the patient, the health service provider may refuse to discuss the patient's case or provide any information about the patient, and there arises the difficulties in working with third party complaints.

The Commissioner's key functions are to conciliate complaints against health service providers made by users of those services, and where this is unsuccessful or the complaint is not suitable for conciliation, under section 9(1)(l) and 21 of the *Act*, the Commissioner can investigate complaints. This may occur where the complaint is very serious, or where the appropriate information could not otherwise be obtained. In the event where a health provider refuses to provide the Commissioner with the appropriate information, under section 25 of the *Act*, the Commissioner has investigative powers to compel attendance and call for evidence and documents. The Commissioner has not had to call on her powers of formal investigation or call for documents, as all parties involved in complaints have always been willing and open to consultations. A person may refuse to answer a question or produce a document in some circumstances. That is, under section 26(2)(c) of the *Act*, "Nothing in section 25 or the provisions of the Evidence Act 1958 applied by that section prevents a person from refusing to answer a question which relates to medical records or to produce medical records unless (1) those medical records relate to the subject-matter of the complaint; and (2) the person to whom the records relate has consented to the disclosure of information in the records." In addition, if a health care provider did provide the medical records of a patient without their consent, this would be in breach of the *Health Records Act 2001 (Vic)*.

In September 2000, Minister Thwaites endorsed publication of a discussion paper on the review of the *Act*. The paper was released for consultation via public advertisement and mail out, and 22 responses to the paper were received. The purpose of the review was to (1) improve its clarity and operational effectiveness and (2) strengthen the capacity of the Commissioner to deal effectively with complaints concerning providers of health services, including unregistered providers of health

services. A working party was established to consider responses to the discussion paper. It was concluded that it was not appropriate to give the Commissioner power to impose sanctions in respect of unregistered providers where complaints against them had been found to be justified. Essentially the reasons for this were that the fundamental conciliation/cooperation framework of the legislation does not support the introduction of enforceable sanctions, and the necessity for such enforceable sanctions was not well established at the time. In this review, the issue of accepting third party complaints without the consent of the patient was not well established therefore, it was also inappropriate to change the legislation in this regard.

Registration boards consider all complaints, including third party complaints. However, when the patient does not consent to the complaint, registration boards have the same difficulties in working with third party complaints as the Commissioner. That is, due to patient confidentiality restrictions sets out in the *Health Records Act 2001 (Vic)*, the practitioner cannot and should not discuss the patient or allow the registration board to examine their medical records or case notes. Therefore, the registration board cannot investigate the complaint.

5.3 Questionnaire: The Extent to which Recovered Memory Therapy is Practised.

Of the 640 questionnaires sent to RANZCP members, 335 were returned. Sixteen questionnaires were returned by PACFA members. A large number of questionnaires (329) which were returned were not completed. Thirty-four RANZCP members and four PACFA members responded in writing raising their concerns about the questionnaire. These respondents reported dissatisfaction with the definition of RMT provided in the Terms of Reference. They queried the validity of the questionnaire because it was based on a definition of RMT, with which they did not agree. They believed analysing the results would be misleading. This response led the Inquiry to place more importance in discussing RMT with academics and practitioners who have expertise in the area of trauma. The data from the questionnaire were not analysed statistically. Therefore, the extent to which RMT is practised in Victoria could not be answered. Instead, the content of the written comments was analysed according to common themes. The questionnaire was not distributed to other professional organisations as originally intended.

Subsequently, in February 2005, the Commissioner advised the Minister some complications had arisen during the initial stages of the investigation and requested a three-month extension. The complications focused on concerns raised by respondents regarding the definition of 'RMT' provided in the Terms of Reference, and the need to revise the Inquiry's timeframes to allow for additional discussions with academics and practitioners with expertise in this area. The Minister endorsed the extension by three months, requesting the final report by the end of July 2005.

The common themes found in the written comments are outlined below.

Respondents reported:

- They did not recognise RMT as a type of treatment.
- They were strongly opposed to the terms 'recovered memory therapy', 'repressed memory therapy' and 'false memory therapy', as some respondents expressed the view the false memory associations have created these terms for political purposes.
- There is no professionally agreed upon definition of RMT.
- The conceptualisation of RMT in the Terms of Reference was considered misleading as it is far too broad and encompasses all therapies, because reflecting and remembering is a basic component of all psychological processes. Therefore, some therapists stated although they would not consider themselves to be 'recovered memory therapists', they felt compelled to include their practice within the definition because of its comprehensiveness.
- They do not initiate the recovery of memories, nor do they suggest the occurrence of past events, but understand and accept that recalled memories are sometimes relevant.
- There was criticism that the definition did not differentiate between good and poor professional and ethical conduct because the definition included any practice that has "a component based on or incorporated a belief that memories can be repressed". Specifically, good professional conduct was seen to accept traumatic memories can be forgotten and subsequently remembered, and patients may have fragments of a memory, which they wish to explore in a nondirective environment. In contrast, poor professional practice was perceived to be an approach that intentionally embarks on recovering memories to the detriment of the patient, or suggesting events to patients who have no memory of the event.

5.4 Submissions: The Perspectives of those who have been affected by the Practice of Recovered Memory Therapy.

The written and verbal submissions were divided into three distinct groups: individuals who described themselves as survivors of childhood abuse, false memory advocates, and mental health professionals who work in the area of trauma counselling. Table 1 shows the number and types of submissions which were received. The three groups of submissions were read with the objective of combining common ideas and developing themes.

Table 1. The number and type of submissions

	No. of verbal submissions	No. of written submissions	No. of written and verbal submissions*	Forums	Total no. of submissions
Survivors of childhood abuse	16	4	4		24
Organisations for survivors of childhood abuse		1			1
False memory advocates		34	5		39
False memory advocacy organisations		4		1a	4
Mental health professionals	10	12	4		26
Professional bodies		13	2	4b	16
					110

*Number of individuals and/or associations who made both a written and verbal submission

^aOne false memory advocacy group were invited to a forum and also made a written submission

^bThree professional bodies were invited to separate forum and also made written submissions.

5.4.1 Survivors of Childhood Abuse

Table 1 shows 24 submissions were received from individuals who identified themselves as survivors of childhood abuse. All submissions from this group were from women. One woman reported she was diagnosed as having Dissociative Identity Disorder by a psychiatrist, and three women described symptoms consistent

with dissociation, such as “blinking out”, feeling physically present but mentally absent, and feeling detached. This group preferred to make verbal submissions as they reporting finding difficulty writing about their experiences. The verbal submissions included face-to-face meetings, which required 60 to 90 minutes, and telephone conversations, which required 20 to 45 minutes. During the verbal submissions, individuals in this group were asked how memories were recovered and experiences of therapy in relation to the recovery of memories.

All individuals in this group reported they had been sexually abused as a child and seven also reported they had been physically and emotionally abused. All but one respondent reported they had remembered the abuse before they sought therapy. This one respondent reported she had recovered initial memories of abuse while in a therapy session, and recovered subsequent memories both inside and outside of therapy. Nineteen of the 24 respondents reported they had completely forgotten their experiences of sexual abuse. Three respondents reported they had partially forgotten their experiences of sexual abuse, that is, they always remembered they had been abused but had forgotten specific episodes or the details of certain episodes. Two respondents had always remembered the sexual abuse. Of the seven respondents who were also physically or emotionally abused, four had completely forgotten the abuse, and three had always remembered. Following memory recovery, eighteen respondents reported they had sought therapy and one reported she had sought the support of an advocacy group.

In reading submissions, the following themes were identified:

5.4.1.1 Concern regarding the focus of the Inquiry

Twenty-one respondents expressed concern that the Inquiry, by focusing on RMT, and concepts like false memories, generated scepticism of the concept of recovered memory, thus potentially invalidating the experiences of respondents, and prolonging their recovery process. The respondents considered the origin of the term ‘false memory’ was primarily political rather than scientific, and was first created by the False Memory Syndrome Foundation in America. Parents who had been accused of childhood abuse by their daughter founded the organisation. The respondents reported recovered memories are most controversial when the memories are of CSA, rather than other types of traumatic memory, such as experiences of the Holocaust or

combat survivors. This group suggests it is the emotion associated with CSA, rather than the nature of recovered traumatic memory, that is difficult for society to accept.

The submissions addressed the fear that the current political climate, of secrecy, disbelief and marginalisation surrounding this issue, might prevent some practitioners from providing validation and belief in their patients' experiences, and that such validation is needed to heal and recover from the trauma of childhood abuse. They believe the issue needing to be addressed is not RMT, but rather the widespread extent of childhood abuse, which much of society continues to deny.

One woman wrote, "It concerns me that the Call for Submissions and the Terms of Reference both refer to the need to protect the public (from the practice of RMT), but make no mention of protecting the needs of consumers to have access to effective therapies. For many of us, protecting the public (whether in the form of a Church, a Government Agency, a family, the good name of a school or town) has often meant denying the truth and, in effect, protecting the perpetrators."⁴

5.4.1.2 Memory triggers

Ten submissions identified that across respondents in this group, a wide variety of cues triggered memories of abuse. The recovery of memories was not reported to be a function of specific therapeutic techniques, and most respondents reported memory triggers that occurred outside of therapy. Triggers included, but were not limited to, seeing an alleged perpetrator for the first time since the abuse, death of the alleged perpetrator, a sexual assault, relationship break-up, a movie or relationship dynamic which provoked feelings similar to the original abuse situation.

5.4.1.3 Types of memory

Fifteen submissions identified experiences of different types of memory, such as seeing images or flashes of the original trauma, experiencing physical sensations such as pain, reliving the memory and behavioural compulsions.

5.4.1.4 Experiences of therapy

Thirteen respondents stated no practitioner they had attended had tried to implant memories of abuse. In contrast, they reported there had been little focus or

⁴ This woman provided verbal consent to use a quote from her submission.

confidence given to the recovered memories of abuse. This group reported that disbelief, on the part of the therapist, hinders the healing process, whereas the greatest benefit comes from the therapist acknowledging and accepting the patient's experiences within a safe and validating environment.

5.4.1.5 Professional practice

Nine respondents commented on matters of professional practice. The submissions stated practitioners should:

- Be aware of their values and beliefs, not projecting them onto patients;
- Not phrase responses or statements to the patient in a leading or suggestive manner;
- Act in the best interests of the patient;
- Not allow the patient to avoid the real issues, which have brought them to therapy, but also not allow their patient to be re-traumatised by, for example, delving into the past when the patient is not ready;
- Be aware of the goals and intentions of the therapeutic techniques they practise
- Be aware patients with abuse histories have issues of space and trust, and;
- Create a safe and supportive environment to enable patients to begin to trust again.

5.4.1.6 Improvement in wellbeing

Seventeen submissions commented on the need for practitioners to address the trauma during therapy in order to increase a patient's wellbeing and enable them to function at a higher mental state. Respondents reported that recovering memories in itself is not a cure, but it is one essential step to recovery. These submissions noted that following memory recovery, certain behaviours began to make sense. For example, some respondents reported after memory recovery, they understood why certain smells associated with the original abuse event have always been upsetting or why they have always felt uneasy when seeing a father alone with a child. They reported this knowledge is experienced as liberating, as they no longer feel compelled to act in a certain manner. The respondents perceived such improvements and the ability to piece parts of their life together, as evidence of the reality of recovered memories. In addition, they did not believe a false memory would produce such an outcome.

The respondents reported false memories are possible, but did not support the belief that such a memory could be maintained for any length of time or one could understand the emotion and distress associated with a genuine memory of abuse. Many respondents described the impact of childhood abuse as devastating and questioned why anyone would endure such pain if the memories were false.

5.4.1.7 Respondents' recommendations

Submissions from this group recommended:

- Public education regarding the short and long-term effects of trauma, including childhood abuse, and the recovery of traumatic memories. For example, the potential for victims of trauma to use dissociation to survive the abuse, the physical and emotional impact of abuse and the developmental delays associated with abuse (19 submissions).
- Training health professionals, including general practitioners and community health centres, as they are often the first point of call for individuals who have experienced sexual abuse. These health professionals also need to develop better links with practitioners and support groups, to ensure this group obtains the care they need (19 submissions).
- Experienced and appropriately qualified practitioners are available to work with patients who are recovering memories. To implement this recommendation, it was suggested government funding or subsidises be available for appropriate trauma training, educating health professionals through seminars, workshops and specialised courses to effectively and safely facilitate the recovery of memories in ways which place patients' interests at the forefront of therapy (10 submissions). Most of the respondents reported it is very hard to find experienced and accessible practitioners. Respondents reported that due to the political climate, practitioners are being pushed "underground" or do not want to work in the area, thus there is a shortage of practitioners.
- Individuals who have experienced child abuse have access to resources such as appropriate educational material and a register of service providers willing and able to provide therapy. The respondents reported they require access to safe, private, accessible and affordable places dedicated to helping patients heal from childhood trauma, such as safe houses and help lines (8 submissions).

- Funding for advocacy groups such as the Advocates for Survivors of Child Abuse (6 submissions).
- Research regarding the short and long-term impacts of childhood trauma and the recovery of traumatic memories. Some respondents noted the importance of collecting information regarding therapies that have been helpful for those patients recovering memories of abuse (5 submissions).
- Increasing awareness of CSA in schools, by educating children and teachers, and learning how to recognise it. Some suggestions included advertising Help Lines such as Kid's Helpline, Domestic Violence and Incest Resource Centre, Centre Against Sexual Assault or Gatehouse Centre for Assessment and Treatment of Child Abuse and launching a television campaign increasing awareness of childhood abuse (4 submissions).

5.4.2 Organisations for Survivors of Child Abuse

One submission was received from an organisation for survivors of child abuse. The themes mirrored the major themes from the verbal and written submissions from individuals identifying themselves as survivors of abuse. For example, the organisation expressed concern that the focus of the Inquiry was on RMT. The organisation believes RMT typically refers to memories of CSA and creates scepticism about whether traumatic experiences of CSA can be forgotten and later recovered. In the organisation's experience, the extent to which traumatic events can be forgotten occurs to varying degrees, ranging from partial to complete amnesia for a period of time. In addition, the submission reported traumatic memories can be triggered by a variety of events, and therapy represents the least commonly reported trigger. The submission stated the recovery of memories is not a function of any specific therapeutic technique, and recovering memory is only one part of a long process of recovery, which also involves acknowledging the feelings associated with the abuse, accepting the trauma as part of one's life story, and reviewing maladaptive behavioural and relationship patterns which may have developed in response to the trauma.

The organisation also acknowledged the possibility on rare occasions people can genuinely believe they have recovered memories that may be false. They also believed an incompetent or inexperienced practitioner might contribute to the creation

of such false memories. The association stated that individuals who have experienced child abuse are vulnerable and easy prey to charlatans. Therefore, they strongly suggested clinicians practising trauma counselling should be well qualified and experienced. They also stated trauma practitioners should adhere to a code of ethics and follow best-practice guidelines established by a well-regarded professional body such as the Australian Psychological Society, in which members are required to participate in continuing education and supervision.

The organisation reported the recovery of memories helps to bring about improvements in the general health and wellbeing of patients. They reported that such improvement is a strong argument in support of the reality of recovered memories. In addition, they do not believe a false memory would produce such an outcome.

The association believes there is much secrecy surrounding child abuse in society despite the implementation of child protection strategies. They reported adults who have experienced abuse need to be validated and supported in order to heal. They also stated secrecy and scepticism further damage an already disadvantaged population.

5.4.3 False Memory Advocates

Table 1 shows 39 false memory advocates made submissions to the Inquiry. For those false memory advocates who wished to make a verbal submission, there were no set questions in the face-to-face meeting; rather individuals were given an opportunity to tell their story.

Of the 39 submissions, 23 were from parents, and in each of these submissions, the husband reported being falsely accused of sexually abusing one of his children. Eight were written by siblings of an accuser, four from a family friend of the accused, one submission jointly from an accused parent and a mental health professional, one retractor, one who identified as both a retractor of memories of CSA and as an accused parent, and one who identified only as a false memory advocate.

Of the 39 submissions, three referred to male accusers and the remaining submissions to female accusers. The accused were all males, with 25 submissions referring to alleged abuse by fathers, two by uncles, and one each referring to a stepfather, a grandfather, a brother, a cousin, a neighbour and a pastor.

The themes were as follows:

5.4.3.1 No scientific evidence for repression

Ten submissions stated there is no scientific or empirical evidence that individuals, especially children, who have experienced trauma (such as CSA), can forget for long periods of time and subsequently remember in adulthood. The submissions stated there is no evidence to support the concepts of repression and dissociation, and false memories are easily implanted into the minds of patients. In addition, false memory advocates reported when memories are recovered after long periods of amnesia, there is a high probability the memories are false. To support their beliefs, respondents referred to researchers such as Elizabeth Loftus and her well-known “Lost in the Shopping Mall” study (Loftus, 1997). Loftus’ research involved successfully making adult participants believe they were lost in a shopping mall as a child. False memory advocates generalise these findings to recovered memories of multiple traumatic episodes.

5.4.3.2 “Guilty before proven innocent”

Several of the submissions asserted the public unquestionably perceives those accused of CSA as guilty. Eleven submissions from false memory advocates referred to media coverage of CSA and recovered memories to support their view that the media sensationalises the issue and is perceived as supporting accusers and seldom doubting the validity of the accusations.

Five submissions reported that the accuser’s accusations are considered truthful before being trialled in court cases of CSA and therefore individuals accused of CSA do not receive just hearings. They believe this has caused an increase in false allegations of CSA in America, United Kingdom, and Australia. The submissions called for independent corroboration of accusations of CSA, and to have practitioners’ notes viewed by the defendants and their counsel. Similarly, two submissions addressed the concern that practitioners uncritically believe patients’ narratives are historically and factually correct, and thus the accused is considered guilty.

5.4.3.3 The Courage to Heal

Twelve submissions from false memory advocates addressed the book titled *The Courage to Heal: A Guide to Women Survivors of Childhood Sexual Abuse* by Ellen Bass and Laura Davis (1994). False memory advocates criticise the book and

believe it is highly suggestive literature promoting the ideas and practice of RMT. Some of the submissions reported the accuser was encouraged to read the book by a therapist, to assist with the recovery of memories. For example, a retractor⁵ reported she had attended counselling for issues of sexual abuse as a teenager. She stated the counsellor implied the abuse may not have been an isolated incident, and recommended the book, *The Courage to Heal*. The retractor believed she was susceptible to the suggestions proposed by the book and began to have flashbacks about further abuse. She reported that her counsellor supported her new memories, and her emotional and mental state deteriorated. By chance she came across a book describing false memory recovery and made the decision that her new memories of abuse were iatrogenic. Some of these submissions called for the book to be banned.

5.4.3.4 Effects of accusations

Thirty respondents described accusations of CSA as destroying their lives, because the accusers reportedly cut all family communication. The usual scenario is where a daughter alleges her father is the perpetrator of abuse, she ceases contact with her family and denies her family access to their grandchildren. After the accusations, there may also be a division within the family, with some members siding with the accuser and some siding with the accused. The accusations can also “defame the character” of the accused, sometimes inhibiting work opportunities, church activities or being free to interact with children for fear of what family members may think. Some submissions also reported because of associated stress, the health of the accused deteriorates.

5.4.3.5 Problems associated with Recovered Memory Therapy

5.4.3.5.1 Third party complaints

Ten submissions addressed the concern that when third parties suspect the practice of RMT there is no redress or avenue whereby third party complainants can be heard.

⁵ This woman provided written consent to describe her experience.

5.4.3.5.2 Prevention of communication

Ten respondents reported the practice of RMT prevents communication between the accused party and the practitioner. False memory advocates expressed concern that practitioners refuse to see them or speak to them because of patient confidentiality. As a result, they often know very little about the accusations, or about practitioners and their qualifications, and feel they do not have the opportunity to defend themselves. As most practitioners see their patient as their first priority, false memory advocates reported practitioners refuse to speak to third parties including parents, and thus, they believe practitioners are hiding behind confidentiality laws.

Most accusers do not disclose how they come to recover their memories. Therefore, those who are accused assume RMT has taken place, but often do not know if the memories had been forgotten, when they were recovered (for example in or outside of therapy), and if any techniques had been used to assist with the recovery process.

5.4.3.5.3 Deterioration in patient's wellbeing

Seven submissions addressed the concern that as a consequence of RMT, the patient's mental and emotional wellbeing deteriorates.

5.4.3.6 Respondents' recommendations

Submissions from false memory advocates recommended:

- RMT should be banned or at least be subject to legislation regarding its use, as it destroys people's lives (15 submissions).
- Consumer and community education regarding the dangers associated with RMT (17 submissions).
- A set of standards must be put into place for practitioners who work in the area of trauma. For example, practitioners should obtain the patient's informed consent prior to the beginning of treatment (15 submissions).
- Training institutions should not be permitted to teach RMT, and fines should be imposed if the new rules are transgressed (15 submissions).
- The Department of Education should issue warnings regarding the dangers of RMT to all students through schools and tertiary institutions, as with drink driving (15 submissions).

- While registration may be difficult, unregistered counsellors should be required to become a member of a professional association that has professional standards in the area of trauma and memory, a code of conduct, and continuing education in trauma and memory as membership requirements (15 submissions).
- All mental health practitioners and counsellors must be suitably qualified, registered, licensed and held accountable (23 submissions).
- Only accredited universities and institutions should train counsellors. At least a Masters degree should be the requirement for practitioners working in the trauma area, with studies in current memory research (23 submissions).
- A regulatory body should be established by statute to consider and determine complaints from third parties (for example, parents and close associates of the patient), even when the counsellor is not registered. Some submissions recognised problems associated with this potential implementation such as a possible influx of third party complaints. It was suggested limits would have to be developed, such as limits on the types of complaints accepted (17 submissions).

5.4.4 False Memory Advocacy Associations

Four false memory advocacy associations made submissions to the Inquiry. The associations offer support to families reporting they have been falsely accused of CSA by adults who have recovered memories. The content of their submissions reflected the major themes found in submissions from false memory advocates. For example, the associations expressed the view that there is no scientific evidence for repression of traumatic experiences, and one association also stated that both repressed memories and dissociative identity disorder are invariably iatrogenic. The submissions described the harm RMT causes families and patients, such as destroying and dividing families, and they believe there is no evidence to suggest recovering memories benefits the patient. Again, the issue of third party complaints was raised, as was the call to stop RMT.

These submissions stated that RMT is not recognised as a therapeutic treatment, but there continue to be practitioners in the mental health area who seek to explain to their patients that their problems may be understood by recovering repressed memories of CSA. In addition, the submissions also reported that a number of innocent men are in jail because of RMT.

The associations' recommendations mirrored the recommendations from individual submissions from false memory advocates, however, they asked for stronger controls. For example, recommending the use of the title 'psychotherapist' should be regulated, practitioners found to be practising RMT should be given penalties of \$100,000 and ordered to refund patient fees, and therapies which are not evidence-based should be banned.

5.4.5 Mental Health Professionals and Professional Bodies

As indicated in Table 1, 26 mental health professionals and 16 professional bodies made submissions to the Inquiry. The submissions were received from practising and academic psychologists, psychiatrists, hypnotherapists, general practitioners, counsellors, psychotherapists, neurolinguistic programming (NLP) therapists, and their corresponding professional bodies.

The following themes were found:

5.4.5.1 Traumatic memory and cognitive processes

Thirty-one submissions referred to the debate about whether traumatic events can be blocked and recovered after a period of time. Of the 31 submissions, some of the respondents believe it does occur and the memories are reliable. Others agreed, but there was disagreement about whether the memories are literal or symbolic. Some argued it does occur, but infrequently. By contrast, some argued recovered memories are false, and the more traumatic an event, the more likely it will be remembered. Some practitioners believe that some patients with a 'victim' mentality search for an answer or cause to their problems, and readily accept the possibility of childhood abuse as a means of explaining their problems.

Of the 31 submissions, 14 reported on the disagreement regarding the cognitive process with which memories may be forgotten. Some submissions proposed that to be able to live with the trauma, children dissociate at the time of the event, which leads to poor encoding of the event. Respondents also argued the controversy associated with forgetting trauma is only related to CSA, and is not questioned when survivors of traumatic events, such as the Holocaust and warfare, forget complete experiences.

5.4.5.2 Preverbal trauma

Six submissions addressed the issue of whether events, especially traumatic events, before the age of two can be remembered. There was a consensus among professionals and in the scientific literature that explicit verbal memory begins around two to three years of age. However, the submissions reported patients who describe nonverbal memory for significant events that occurred before the age of two. Some therapists referred to those memories as body memories. A continuum of views was expressed regarding nonverbal memories prior to the age of two. Some practitioners argued that infant memories are encoded as images and are recalled in a sensory modality, and are reliable. Others agreed preverbal events are encoded as images and sensations but are unreliable because they are representative of childhood, and may be perceived differently by an adult. For example, if a patient recalls a strong feeling of anger toward a parent at the age of two, it may be due to a number of events such as in response to punishment or not having one's needs met. The degree of emotion may not be in direct proportion to the experience. Other practitioners do not believe children of two years or younger have the neurological capability to encode and recall events. Some practitioners reported that even though adults cannot recall events before the age of two, they might nevertheless be affected by the occurrence of such events. Some therapists also argued that although biology may not allow non-traumatic memories to be encoded and stored in long term memory before the age of two, traumatic events and memory are processed differently and therefore can be remembered later in life.

The way a practitioner works with a patient who reports nonverbal or body memories that occurred before the age of two varies according to the practitioner's theoretical orientation and beliefs regarding the possibility and reliability of such memories. For example, one practitioner who does not believe that such memories are possible and therefore are unreliable does not directly challenge patients, but focuses on methods and information that would assist the patient. Another practitioner treats such memories as serious indicators of trauma but believes that "assigning a context to the memories is fraught with error and the possibility of inaccurate attributions". One practitioner reported many non-registered practitioners were working with patients who had recovered memories from the age of two or younger but did not come forward for fear of recrimination.

5.4.5.3 The terms: Recovered, repressed and false memories

Fifteen submissions referred to the terms used in the Terms of Reference. There was agreement that the terms ‘recovered memories’, ‘repressed memories’ and ‘false memories’ are three different terms signifying different concepts, and it is incorrect to use them interchangeably. Some professionals stated that to use ‘false memories’ interchangeably with recovered and repressed memories implies falsity of such memories. Likewise, it was reported that the term ‘repressed’ suggests repression is the cognitive process by which memories are forgotten, and that is unknown. Practitioners expressed the view that the terms were invented by the False Memory Syndrome Foundation for political purposes. It was also noted the terms are used by false memory advocates, not health professionals.

Ten submissions reported there is no recognised psychological therapy known as RMT. However, it was reported the very nature of counselling requires some degree of history taking and many well-established approaches subscribe to the belief that childhood experiences lay the foundation for personality development and adult adjustment. Therefore, it was stated some approaches would involve revisiting childhood experiences. In addition, respondents reported that unconscious thoughts and feelings influencing behaviour are central to psychoanalysis, and therapies influenced and derived from psychoanalysis. Such therapies help patients elucidate those influences. It was reported approaches such as cognitive behavioural therapy also help patients elucidate the way belief systems, which operate outside of usual awareness, influence automatic and maladaptive behaviours. Therefore, some practitioners expressed the view that this Inquiry questions the very essence of psychological practice.

Some submissions reported that just because practitioners would not describe themselves as undertaking ‘RMT’, does not mean some do not cause harm, but it was more likely inexperienced or under qualified practitioners may do so by using inappropriate techniques. However, the extent to which practitioners intentionally or inadvertently recover memories of CSA and the degree of harm caused was unknown. This theme has implications for the appropriate training of practitioners who work in the trauma field.

5.4.5.4 The definition in the Terms of Reference

Fourteen submissions raised concerns regarding the definition of RMT in the Terms of Reference. The definition is "... any other form of therapy, or other clinical or therapeutic strategies that have a component based on or incorporating a belief that memories can be repressed and focusing on or adopting methods designed to assist the patient/client to elucidate those memories." The submissions reported there is no agreed upon definition of RMT within the professional community, and the definition provided was too broad, and did not distinguish between good and poor practises.

5.4.5.5 Concern over impact of Inquiry

Eight submissions raised concerns about the potential impact of the Inquiry on those who have survived trauma and recovered memories. They expressed the view that the Inquiry perpetuates disbelief in the concept of recovered memories, and taking part in this debate provides a degree of credibility to the claims women either make up experiences of CSA or are so weak minded that such ideas are easily planted and accepted. They reported this is damaging to genuine survivors of trauma who have recovered memories, as they become further silenced. They stated the Inquiry needs to take into account the struggle which has taken place to have sexual and other forms of abuse acknowledged in the therapeutic and public domains.

There was also concern over the impetus of such an Inquiry, and what it was designed to elucidate. Some submissions posed questions like, why have the memories of trauma survivors been seen as flawed, yet the memories of abusers have always been believed, and who has most to gain by lying? They believe denial on the part of perpetrators of abuse is a more plausible explanation of narrative discrepancies than are false accusations or distorted memory. Perpetrators, they say, engage in active conscious suppression of memories of their crimes, unless they are psychopaths or sociopaths who feel no guilt or shame.

5.4.5.6 Presentation of patient

The manner in which the patient presents to the practitioner is a source of much argument. Six submissions noted patients present to practitioners in a variety of ways, such as with complete, partial, or no memory of the trauma. Some practitioners stated most patients present to therapy with fragments of memories such as flashes or sensations.

There were also five submissions reporting on the controversy surrounding the relationship between psychiatric disorders and a history of childhood abuse. This is a serious point of contention between advocates of recovered memory and false memory supporters. The former group report trauma is a significant aetiological factor in many psychiatric illnesses. The latter believe there is confusion between a syndrome and a condition, and report that some practitioners have a preconceived idea that just because a patient has a certain psychiatric disorder, they were sexually abused as child. They fear practitioners will then convince the patient of this belief. However, it appears this fear may be unfounded as the former group also discussed good professional practice such as, not assuming the occurrence of CSA solely on the basis of presenting symptoms, and being aware of the possibility of distortions and inaccurate attributions.

5.4.5.7 Professional practice issues

Twenty-three submissions addressed the issue of professional practice. It was reported by individual practitioners and in ethical guidelines from professional bodies that good professional practice incorporated the following features:

- The practitioner developing and maintaining professional knowledge and peer supervision.
- The practitioner using non-suggestive and well-founded therapeutic techniques.
- The practitioner explaining the inaccuracies of memory to the patient.
- Informed consent from the patient.
- The practitioner placing the therapeutic needs of the patient as their first responsibility.
- Contact with third parties should occur only with the knowledge and consent of the patient.
- Practitioners should be aware of their beliefs and values, so they do not inadvertently impose them on their patients.
- Practitioners should not impose their own conclusions on the patient, nor should they tell the patient what they should experience, or pre-empt outcomes.
- Practitioners should not initiate a search for memories, however this should not preclude them from asking their patients questions about the possibility of abuse or from dealing with patients' past events.

Eight submissions addressed the issue of whether practitioners should question, accept or remain neutral toward recovered memories of childhood abuse. Some practitioners reported the memory may not match historical fact but it is the patient's truth, and must be respected. Others reported practitioners need to learn how to convey support for their patient while not necessarily showing support for their memories. The question underlying this argument seems to be: who claims final authority on a patient's memory? Ethical guidelines from professional bodies suggest the practitioner should keep an open mind and the patient draw their own conclusions regarding the accuracy of their memories.

The Australian Psychological Society's Guidelines relating to recovering memories state, "Members should be prepared to discuss with any client who recovers a memory of abuse the nature of that memory: that it may be true or false, partly true, distorted, selective, thematically true, metaphorically true, or a blend of accurate, distorted and symbolic material. Members should explore with the client the meaning and implications of the memory for the client, rather than focus solely on the content of the reported memory. Members should explore with the client ways of determining the accuracy of the memory, if appropriate. Discovering that some aspects of a memory are displaced, metaphorical or inaccurate should not lead members to immediately discount all of that memory. Given the acknowledged difficulties in distinguishing 'false' from 'true' memories, an open mind is essential" (Australian Psychological Society, 2000, pp. 3).

Similarly, the guidelines for Australian Hypnotherapists Association members working with clients in contexts in which issues related to false memories of CSA may arise state, "Members need to be alert to a range of possibilities; for example that a memory maybe literally/historically true or false, or may be partly true, thematically true or metaphorically true, or may derive from fantasy or dream material. Discovering that some aspects of a 'memory' are displaced, metaphorical, or part of a construction or narrative derived from the therapeutic relationship, should not lead members to immediately discount the rest of that memory. Likewise, the discovery that some aspects of a memory are factually accurate does not imply that the whole content of the memory is factual. It is not really possible to establish whether a memory represents factual events without external corroboration." The guidelines also state, "It is true that an event described by a patient under hypnosis, may or may

not accurately match historical fact. In either instance, it is still the patient's 'truth' and it must be respected and handled as such."

A minority of practitioners believe that when patients recover memories in sessions, they should be taped for legal reasons. The question underlying this argument is whether the accuracy of memories is important for therapeutic reasons. Guidelines from professional bodies state the responsibility of the practitioner should be the therapeutic needs of their patients, and not issues of legal action. For example, The Australian Psychological Society's Guidelines relating to recovering memories states, "Members should be aware that some approaches and writings concerning abuse and recovered memories urge clients to engage in legal action against the alleged abuser and any others who may question the accuracy of any recovered memories. Given that the accuracy of memories, which is the focus of the courts, cannot be determined without corroboration, members should exercise caution when responding to questions from clients about legal action. Members may explore the implications of taking legal action in terms of the potential impact on the client's wellbeing, including the possibility of their being further traumatised by the legal process. Members working in a therapeutic context should recognise that their responsibilities are to the needs of their clients, and not to issues of legal or punitive action. Nevertheless, the therapeutic need of clients might include support through a litigation process" (Australian Psychological Society, 2000, pp. 4). In addition, The guidelines for Australian Hypnotherapists Association members working with clients in contexts in which issues related to false memories of CSA may arise state, "... helping the client to make reasonable sense of their lives is not the same as discovering objective facts."

Eight submissions reported that therapy is not focused on retrieving memories that are not apparent at the initiation of therapy; rather the focus rests with the patient. Respondents also reported if memories are recovered, the patient does it, and it is assumed the patient feels safe enough to venture into painful territory. Practitioners who work with patients of CSA reported that once recovered traumatic memories are processed, they no longer control and consume the patient, and their emotional, mental and physical wellbeing improves.

5.4.5.8 Respondents' recommendations

Submissions from mental health professional recommended:

- Only appropriately trained professionals should provide therapy or counselling. While unregistered professionals will take the role of practitioner or therapist, such people should have appropriate qualifications and be bound by a code of ethics (5 submissions).
- The establishment of best practice guidelines in the area of trauma therapy. Respondents reported that such guidelines should include abiding by a code of ethics, undergoing ongoing peer supervision and ongoing professional training, maintaining adequate records of patient contact and being aware these records, if subpoenaed, must be made available to a court of law. It was also noted that it would be beneficial for professional bodies to develop clinical guidelines and confidential peer review. For example, the Australian Psychological Society has a list of experienced psychologists who can be contacted for advice by less experienced members. They have also developed cluster groups/peer supervision. It was reported professionals require guidelines, resources, seminars and workshops to effectively and safely facilitate the recovery of memories in ways that prioritise patients' interests, including the patient's right to decide the extent and timing of recovery. It was stated that guidelines and resources are needed to effectively support patients involved in legal processes to prevent retraumatisation from legal proceedings. One psychologist reported that in developing guidelines, it would be useful for associations to undertake a comparative analysis of guidelines, which have been issued by professional bodies, and formulate them based on the commonalities (See McConkey, 1997, 2001). It was suggested within professional bodies, such processes needed to be marketed or formally put into place (8 submissions).
- Unregistered counsellors should be required to join a counselling association, which is bound by a code of ethics and has minimum standards of entry (4 submissions).
- Professional organisations and registration boards should embark on a campaign to educate the public about different types of mental health professionals, their qualifications, where to find them, the different types of counselling therapies and the importance of seeking therapy only from those appropriately qualified. Such a campaign would require good media management, easily accessible information about what patients should ask practitioners (such as a brochure produced and

developed with consumer involvement) and a Helpline available for advice on therapeutic relationships (5 submissions).

6 LIMITATIONS

- Many people recognised that this Inquiry came about as a result of reports from parents and families of people who have made allegations of CSA against family members, and believe the allegations are based on memories recovered by RMT. In addition, some practitioners who work in the area of sexual abuse and individuals who identified as survivors believed the results of the Inquiry were going to be used by lobby groups for political purposes. Therefore, some practitioners initially responded to the Inquiry with negativity and scepticism. This response caused them to dismiss the questionnaire and invitations to consult with the Commissioner. Due to this response, valuable information from such practitioners may have been lost.
- The nature of the area of false and recovered memory is one of controversy and conflict. It was not the Commissioner's role to make judgements about individual cases. It was difficult to make conclusions based on the stories of different groups of people who have passionate and extreme views in this area.
- Practitioners were dissatisfied with the terms and definition of RMT in the Terms of Reference, and with the questionnaire. Time did not permit consultation with practitioners to create agreed upon terms and definitions, although reaching an agreement seems unlikely given the extent of the debate. However with an agreed definition, it would have been possible to construct a more valid, reliable questionnaire.

7 KEY FINDINGS

The key findings are listed under each of the Terms of Reference.

1. A review of the national and international literature on the practice of RMT, addressing, amongst other things:

a. The evidence base for its practice including the scientific understanding of memory.

- The nature of memory is the subject of ongoing academic research and debate.

- There is profound disagreement amongst experts regarding whether recovered memories are true or false.
- The critics of the recovered memory phenomenon report that RMT involves therapists employing clinical techniques to help patients to recover memories of CSA. The most controversial clinical techniques implicated in RMT include hypnotism, guided imagery / visualisation, dream interpretation and interpretation of body memories.
- The literature review found no research on clinical techniques used to recover memories of trauma, or the practice of RMT in the mental health literature.
- Some researchers have suggested that the issue may not be whether a particular therapeutic technique is used, rather whether it is used in an ethical and professional manner.
- The literature review indicated memory is prone to inaccuracies.
- Empirical evidence for false memory comes from retractors, court cases alleging recovered memories of CSA, and anecdotal reports of false memory of CSA.
- Empirical evidence for recovered memory comes from retrospective and prospective studies. These studies indicate memory loss with subsequent recovery of the complete or partial memory in relation to many traumatic events including, but not limited to sexual assault.
- The research indicates that the recovery of memory is often not associated with therapy, as patients typically recover memories before entering therapy, with the most common triggers for memory recovery occurring outside therapy.
- Review of the literature indicates there are various theoretical explanations for traumatic memories that are blocked and recovered, for example, dissociation, repression and suppression. Research suggests that the explanation for recovered memory is likely to be due to more than one process that occurs simultaneously.
- Experimental evidence of the two phenomena comes from laboratory research generally testing research participants' memories of lists of words or suggesting mundane memories to non-clinical participants.
- The evidence has been criticised for being indirect and having limited generalisability, however, the available evidence shows a reasonable foundation for the existence of both phenomena.

b. Media coverage and the popular press

- The media reports do not show reliably that RMT exists in Australia.
- Some media reports inaccurately report on legal cases by stating that the allegations of CSA arose from RMT, when in fact the complainants deny such allegations and the judge's summations do not mention RMT.
- The reports also highlight issues such as the differences between the objectives of therapy versus legal proceedings in relation to the issue of recovered memories. The objective of therapy is to help patients live with their experiences of abuse, and uncertainties about their experiences. In contrast, the objective of a legal proceeding is to determine whether the memory is true or false.
- All persons, including police and therapists, working with allegations of CSA need to be mindful of the impact of suggestion, their position of authority and their own beliefs on patients or complainants.

c. Litigation and court reports

- Little case law exists in Australia and New Zealand in relation to the admissibility of expert evidence about memory of traumatic events, sexual or otherwise.
- Expert evidence has been admitted in Canada.
- If the expert evidence is thought to be common knowledge it is inadmissible.
- At present, in national and international courts, profound controversy still exists about the dangers posed by evidence that is therapeutically recovered.
- Given the profound disagreement within the expert communities regarding whether a particular recovered memory is true or false and the lack of controlled studies on traumatic recovered memory, in most cases, expert evidence is likely to be inadmissible as it is unlikely to assist the tribunal of fact to better understand the issues or dispel falsehoods.

d. Government reports and any practice or other relevant guidelines issued by governments and professional bodies.

- The literature search found limited government reports on the practice of RMT.
- Professional guidelines exist for therapists working with patients recovering memories of trauma and these are reasonably consistent between international and national professional bodies.

- Similar to the research, there is much disagreement on the issue, but the reports and guidelines show many similarities:
 - Memory in general is not always accurate and the degree of accuracy can be susceptible to a range of factors.
 - Traumatic events, including CSA, could be partially or completely forgotten, and subsequently recalled.
 - The accuracy of recovered memories is unknown.
 - It is possible to create false memories for events that have not occurred.
 - Professionals who work with people who report recovered memories of CSA, such as practitioners and police officers, are advised to use caution by avoiding assumptions, premature conclusions, unfounded diagnoses and suggestive or leading questioning.
 - Professionals should remain non-judgemental towards recovered memories, acknowledge their personal beliefs and avoid imposing them onto the patient, and avoid initiating a search for memories.
 - There is a need for more research in the area of traumatic memory.

2. The extent to which RMT is practised in Victoria, including the types of therapists and their qualifications and training.

- The majority of respondents to the questionnaire did not complete the questionnaire, and therefore the data could not be statistically analysed.
- The respondents' comments on the questionnaire stated that the term, RMT, is not used by health professionals but has been created by false memory associations for political purposes.
- Respondents did not agree with the definition of RMT in the Terms of Reference as they reported it was too broad and did not distinguish between good and poor professional practice.
- They also stated they do not initiate the recovery of memories, nor do they suggest the occurrence of past events, but understand and accept that recovered memories are sometimes relevant.
- Respondents reported they do not recognise RMT as a type of therapy.
- The Inquiry was unable to ascertain the extent to which RMT is practised in Victoria.

3. The perspectives of those whose interests are or have been affected by the practice of this form of therapy, including patients, their family members, therapists, and professional and regulatory bodies.

Patients who report recovering memories of abuse

- Submissions from respondents who described themselves as survivors of CSA addressed concerns regarding what they believed to be the focus of the Inquiry that is, on false memory. They reported that the focus on false memory conveys a disbelief in the concept of recovered memory, especially in relation to CSA. They reported this could be damaging to survivors as it invalidates their experiences.
- The majority of respondents also reported they had recovered fragments of memories prior to seeking therapy, with only one respondent stating she had recovered initial memories of CSA during therapy.
- The majority of submissions outlined memory triggers that occurred in a variety of situations outside of therapy, with therapy representing the least commonly reported cue.
- Respondents stated they did not encounter practitioners who suggested memories of CSA. By contrast, they described practitioners as unlikely to encourage their recovered memories. This treatment was described as damaging, as it continues what has often been a lifetime experience of invalidation and denial of the abuse, and therefore was reported to hinder the healing process.
- The submissions addressed issues of professional practice, with respondents describing productive treatment as practitioners who acknowledge and accept their experiences and help to deal with them.
- When this type of practice occurs, respondents reported an improvement in their wellbeing.

Accused families

- This group reported false allegations of CSA, which they believe are based on memories recovered with the use of RMT.
- Respondents criticised the cognitive process of repression, and generalised the evidence to all mechanisms by which memory blocking and recovery can occur.

- They reported that society, the media and courts of law generally believe allegations of CSA without corroborating evidence.
- They reported that the book, *The Courage to Heal* (Bass & Davis, 1994), promotes the ideas and practice of RMT and some respondents called for it to be banned.

Therapists

- There was no consensus within this group of respondents regarding:
 - Whether traumatic events can be blocked and recovered.
 - Whether recovered memories are a literal or symbolic interpretation of past events.
 - The accuracy of recovered memories.
 - The importance of accuracy in therapy.
 - The cognitive process with which memories may be forgotten.
 - Whether events before the age of two can be remembered.
- Practitioners have differing opinions on the above issues, and views occurred along continuums.
- Submissions from this group reported they do not recognise RMT as a type of psychological therapy.
- Some respondents were critical of the term, RMT, as they believe false memory supporters created it for political purposes, and health professionals do not use it.
- Respondents were concerned about the definition of RMT that appeared in the Terms of Reference because they believed it was too broad.
- Practitioners reported they do not practice RMT, that is, they do not suggest, or intentionally search for memories of CSA.
- They assumed some inexperienced or under qualified practitioners inadvertently or intentionally may contribute to the creation of false memories of CSA.
- Practitioners noted that remembering or revisiting different periods of a patient's life is a basic part of most psychological therapies. Therefore, they reported that an Inquiry into recovered memory questions the essence of most psychological therapies.
- Practitioners were concerned the focus of the Inquiry was on false memory, therefore potentially invalidating all recovered memories.

- Submissions noted patients present to practitioners in a variety of ways, such as with complete, partial, or no memory of the trauma.
- The most common way clients present to therapy are with fragments of memories, and they rarely ask for assistance to recover memories.
- Some practitioners believe trauma is a significant aetiological factor in many psychiatric illnesses. However, practitioners reported they do not assume the occurrence of CSA solely on the basis of presenting symptoms as that would be considered unprofessional practice.

Perspectives of professional bodies

- Guidelines issued by professional bodies advise:
 - the practitioner to remain non-judgemental towards recovered memories
 - the practitioner to inform the patient about the potential inaccuracies of memory
 - it is the patient's prerogative to draw their own conclusions regarding the accuracy of their memories
 - the responsibility of the practitioner should be the therapeutic needs of their patients, and not issues of legal or punitive action

4. The nature and extent of any problems associated with the practice of RMT including issues of privacy and confidentiality of the therapeutic relationship and difficulties in dealing with third party complainants.

- The Commissioner and registration boards may consider third party complaints, but it is difficult to investigate such complaints without the consent of the patient because practitioners cannot and should not discuss the patient without their consent.
- Submissions from false memory advocates addressed concerns that third parties have no redress if they suspect the use of RMT.
- False memory advocates reported that RMT causes the accuser to cease all communication with the accused, and the practitioner also refuses to discuss the case. Therefore, it was reported the accused party often feels alienated, and are unable to defend themselves against the allegations of CSA.
- False memory advocates reported that RMT causes both the patient's and the accused party's wellbeing to deteriorate.

8 DISCUSSION

The debate over recovered and false memory stirs intense emotion and causes conflict amongst professional and lay groups. The theory of traumatic recovered memories has not been verified by controlled studies, and the expert and lay communities are profoundly divided in relation to its validity. Individuals describing themselves as survivors of abuse and practitioners who work in the area of sexual abuse believe the concepts of recovered and false memory have only become contentious because of their association with memories of CSA. At the core of the debate stand the questions – what constitutes CSA and what is its prevalence? The intensity of the emotion is indicative of the difficulty society has in facing fundamental assumptions that safety and human kindness may sometimes be illusions; for example, children are not always safe in their own home, and human cruelty often prevails over human kindness. Nevertheless, these issues should not overshadow the reality of CSA, and the serious damage it causes. The Inquiry has caused some anxiety, as individuals who refer to themselves as survivors, and some practitioners felt it had the potential to create scepticism about recovered memory, and thus silence survivors of CSA. In addition, some practitioners expressed the view that the Inquiry questions the very essence of psychological practice. This was not the intention; rather the intention was to hear the stories of all groups affected by this debate.

Among submissions there were differences of opinion regarding the existence of RMT and if therapists recover patients' memories of CSA during therapy. Consistent with the findings from the literature review, practitioners do not recognise RMT as a type of psychological therapy. Survivors and some practitioners expressed the view that false memory associations invented the term, RMT, for political purposes and they do not use it. In addition, these respondents stated they did not encounter practitioners who made suggestions of, or intentionally searched for memories of CSA. They reported patients usually recover memories of CSA prior to seeking therapy, and thus present to therapy with fragments of memories in order to deal with them. Specifically, survivors described memories of CSA as images, flashes or somatic symptoms. Such descriptions are consistent with the literature that traumatic memory may be encoded and stored differently to everyday memory. Just as the empirical evidence on recovered memories indicated, practitioners and survivors reported that memories of CSA were rarely recovered during therapy; rather

they tended to spontaneously return in a number of unrelated contexts. In contrast to these submissions, false memory advocates reported that therapists currently practise RMT. They believe such therapists suggest or use suggestive techniques to create false memories of abuse in their patients. They report that false allegations of CSA are an outcome of RMT.

There are differences among those who made submissions addressing the impact of memory recovery on patient wellbeing. Respondents, who described themselves as survivors, reported that once memories are recovered and processed, patient wellbeing improves, whereas false memory advocates believe the patient's wellbeing deteriorates. Obviously poor practice in this area can cause the patient harm. Specifically, retractors of CSA described practitioners, who suggested memories of abuse, which they believed caused them harm. Survivors of CSA described practitioners who disbelieved or discounted experiences of recovered memories, which also caused harm as it resulted in unsuccessful treatment outcomes. Therefore, suggestions of the occurrence of abuse where a patient has no memory of such an experience, and expressed disbelief in reported abuse are two responses that reportedly cause patients harm.

Respondents expressed differing opinions regarding if recovered memories of CSA are true or false. The literature shows indirect evidence for the existence of recovered and false memories. Submissions from survivors of abuse reported the recovery of memories that produce improvements in health, as a strong argument in support of the existence of recovered memory. In addition, they do not believe that a false memory would produce such an outcome. However, some practitioners have sought to provide an alternative explanation for the health benefits of false recovered memories of CSA. They have reported some patients with a 'victim' mentality, search for an answer or cause to their problems, and readily accept the possibility of childhood abuse as a means of explaining their problems. False memory advocates also report that mental illness causes some individuals to become susceptible to suggestions of false recovered memories of CSA.

Submissions addressed the issue of which party (that is, the accused party or the accuser) is generally believed. Some submissions from practitioners and survivors also reported the memories of trauma survivors are often questioned by society, yet the memories of abusers have often been believed. These submissions also addressed the issue of the political climate of secrecy and disbelief surrounding CSA, which

prevented some practitioners from providing validation and belief in their patients' experiences for fear of harassment by some false memory advocates. By contrast, false memory advocates state that society, including practitioners, media and courts of law, readily believe accusations of abuse without corroborating evidence.

Essentially, practitioners do not need corroborating evidence to work with a patient who reports memories of CSA. Professional guidelines suggest the practitioner's first responsibility is the wellbeing of the patient, and advise therapists to remain non-judgmental towards patients' reports of recovered memories. Obviously it would be unhelpful for the patient recovering memories of CSA to see a therapist who expresses disbelief in the memories or one who vehemently encourages such memories. Patients who report recovering memories need to take the time to come to their own conclusions about their memories. In addition, history shows the struggle it has taken to have sexual and other forms of abuse acknowledged in the therapeutic and public domains. As stated above, even at present, the public's response to this Inquiry shows the difficulty society has in accepting the reality and prevalence of CSA. Society will always come to a decision about cases of CSA reported in the media, with or without corroborating evidence. However, courts of law require corroborating evidence to charge an accused person with CSA.

The existence of the practice of RMT is largely based on speculation. Specifically, most practitioners assumed some inexperienced or under qualified practitioners inadvertently or intentionally may contribute to the creation of false memories of CSA. Practitioners could not agree on the extent to which this occurs, as it would be based on speculation. However, there was a strong suggestion from experts that the types of therapy of concern to the professions, such as the use of suggestion or leading questioning, while a problem 10 years ago, were no longer in common practice. False memory advocates who have been accused of CSA report beliefs about the practice of RMT, which again are based on speculation because often, the accuser ceases all communication with the accused and the practitioner also refuses to discuss the case. Therefore, they do not know many details about the accusations, if and when the accuser recovered memories of abuse, if they went to therapy, and the details of what occurred inside therapy sessions.

The Terms of Reference asked the Commissioner to consider the need for improvements, if any, in the management of complaints about the practice of RMT. Considering the importance of patient confidentiality, managing third party

complaints of any nature, without the consent of the patient, is a difficult area. At present, the Commissioner and registration boards may consider third party complaints, but it is difficult to investigate such complaints without the consent of the patient. Under current legislation and in accordance with professional ethics, practitioners cannot and should not discuss the patient without their consent other than in very limited circumstances. False memory advocates recommended the establishment of a regulatory body to consider and determine complaints from third parties. Most practitioners and survivors reported that some third party complaints might have a place, but complaint processes should not disempower the patient, who is already vulnerable and experiencing distress. In considering third party complaints, the importance of patient confidentiality, the sensitive and controversial nature of the trauma area and the vulnerability of the patient all need to be taken into account and balanced with the concerns of the third party.

It was not the Commissioner's role to make judgements about individual cases. In families involved in this debate, some sort of dysfunction exists, whether the problem is the occurrence of CSA, denial or secrecy, or whether it is a problem of mental illness, or an individual looking for an answer or cause for their problems. In any case, groups of people are reportedly suffering, including family of individuals who have undergone unprofessional practice and survivors of CSA. If both parties (the accused and the accuser) wish to recommence a relationship or simply want to discuss the accusations, there are many counselling services that offer mediation and family therapy. For example:

- The Dispute Settlement Centre of Victoria offer mediation services for families at no charge.
- Jesuit Social Services offer a range of social service programs that provide assistance to vulnerable families.
- Mackillop Family Services provides support services for families in Melbourne and Geelong regions.
- Victorian Association for the Care and Re-Settlement for Offenders assists offenders and their families before, during and after sentencing.
- Bouverie Centre offers family therapy where there is a significant behavioural, emotional or psychiatric difficulty.
- Relationships Australia provides counselling and mediation services in Victoria.

9 CONCLUSIONS AND RECOMMENDATIONS

The nature of the area of false and recovered memory is one of controversy, conflict and intense emotion. This was reflected in the scientific literature, as the evidence for the existence of these phenomena is primarily indirect and heavily criticised. It was also reflected in the submissions that were made to the Inquiry, as expert and lay groups are profoundly divided on the issue. On the one hand, the accusation of CSA can be devastating for families who are unable to know how the allegations arose or to respond to them or discuss them with the accuser. On the other hand, individuals reporting CSA are also suffering, and CSA causes serious long-term affects.

It was concluded that reports of the practice of RMT are often based on speculation. Therefore, at present there is no reliable evidence base for the practice of RMT in Victoria. Respondents assumed some inexperienced or underqualified practitioners inadvertently or intentionally might contribute to the creation of false memories of CSA. The extent to which this occurs is unknown. The Commissioner recommended:

1. The government undertake a review of the risks and examine any need for further regulation of unregistered providers of counselling and psychotherapy services.

Respondents reported it was important to ensure practitioners are appropriately trained in the area of trauma in order to avoid the creation of false memories. As practitioners assumed that inexperienced or underqualified therapists might be causing harm by using inappropriate techniques, the Commissioner recommended:

2. Collaboration between universities and professional bodies to review the adequacy of training regarding trauma, with a view to ensuring practitioners are being adequately trained.

Respondents agreed what constitutes professional practice. However, there was some concern that some professional bodies have not established guidelines to assist practitioners working with patients recovering memories of CSA. In addition, some practitioners reported that many guidelines outline what not to do, such as how to avoid contributing to the creation of false memories, but fail to document what to do, such as how to effectively and safely facilitate the recovery of memories in ways

that prioritise patients' interests, including the patient's right to decide the extent and timing of recovery. The Commissioner recommended:

3. Professional bodies (including those for registered and unregistered practitioners) and registration boards which have not established best practice guidelines related to recovered memories do so.

Best practice guidelines, in general, and specifically related to recovered memories of CSA, include a number of systems, such as:

- The establishment of a code of ethics
- The establishment of ongoing peer supervision and ongoing professional training
- Mandatory member participation in ongoing peer supervision and ongoing professional training
- Training in maintaining adequate patient records
- Training and support of members whose patients are involved in legal processes in order to prevent patient re-traumatisation

Some therapeutic practises raised concern such as some unregistered practitioners completely and unreservedly encouraging early or preverbal memories (before the age of two) of CSA without educating patients about memory. There appears to be increased scepticism about preverbal recovered memories, and there is a danger in encouraging such memories, as they may be false. Professional guidelines advise therapists to keep an open mind and allow patients to come to their own conclusions. However, there is also a danger in completely discouraging any recovered memories of CSA, as there is the risk of pushing a needy individual away, and of overlooking a real memory of abuse. In order to ensure that unregistered practitioners maintain ongoing professional training in the area of trauma, and continue to practice in an ethical and professional manner, the Commissioner recommended:

4. Any unregistered providers of trauma counselling and psychotherapy services become a member of the Psychotherapy and Counselling Federation of Australia.

Individuals reporting CSA and patients with mental health issues are vulnerable and easy prey to charlatans. To assist vulnerable groups in finding appropriate treatment and making informed decisions the Commissioner recommended:

5. The Department of Human Services take a leadership role with professional bodies, registration boards and advocacy groups to conduct a community education campaign aimed at ensuring members of the public have the information needed to choose appropriately qualified practitioners.

As confidentiality is the cornerstone of the therapeutic relationship, the Commissioner cannot demand patient and practitioner cooperation in order to deal with third party complaints concerning RMT, while maintaining the confidentiality of the patient. To further investigate the extent of third party complaints related to the current practice of RMT the Commissioner recommended:

6. The OHSC considers ways to receive and record new third party complaints relating to RMT for the purpose of further review of this issue.

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11 APPENDIX A: LITERATURE REVIEW

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1 Introduction and the Nature of the Evidence

The loss of memory for a particular event and its subsequent recovery has usually been associated with episodes of trauma. Sivers, Schooler and Freyd (2002, pp. 169) define “recovered memory” as, “The recollection of a memory that is perceived to have been unavailable for some period of time.” A number of authors have defined “false memories” as cases in which one seems to experience a memory of an event that did not take place (Brandon, Boakes, Glaser & Green, 1998; McDermott, 1996; Robinson & Roediger, 1997). False memories are not a simple memory error, which are often characterised as the absence of a memory, but involve a memory for a relatively complete episode that does not correspond with objective reality. The concepts of recovered and false memories have been examined since the 1800s.

The first major acknowledgments of forgotten and recovered memories were by Pierre Janet, Sigmund Freud, and Freud’s colleague, Josef Breuer, in the 1800s (Alpert, Brown & Courtois, 1998; Brown, Schefflin & Hammond, 1998; Gleaves, Smith, Butler & Spiegel, 2004; Merskey, 1996). All three physicians independently understood the concept of altered consciousness, or a splitting off of aspects of consciousness used as a defence against psychological trauma. Janet labelled the notion ‘dissociation’, and Freud and Breuer used the term ‘double consciousness’. They also recognised the altered state induced by hypnosis was comparable to that induced by trauma, and they believed bringing these memories into consciousness would initiate recovery. Recovered memories of trauma have continued to receive attention, particularly in the literature on wartime trauma (for example, Bremner, Southwick, Brett, Fontana, Rosenheck, & Charney, 1992; Brown, et al., 1998; Fisher, 1945; McNally, Lasko, Macklin & Pitman, 1995; Valent, 1993; 1995) and more recently on childhood sexual abuse (CSA) (for example, Briere & Conte, 1993; Herman & Schatzow, 1987; Painter, 2002; Terr, 1994; Valent, 1993; 1995) (For a detailed review of the history and professional discussion on psychological traumatisation refer to Lamprecht & Sack, 2002).

In recent years, the recovery of traumatic memories, particularly memories of childhood abuse, has been the subject of an increasingly heated debate within professional and lay circles. Few topics have provoked such a high degree of polarised discourse. There have also been numerous reviews of the literature (for example, American Psychological Association Working Group on Investigation of

Memories of Childhood Abuse, 1998; Brandon et al., 1998; Gleaves et al., 2004; Pezdek & Banks, 1996; Roth & Friedman, 1997; Schooler, 1994). However, most research has been criticised for presenting an unbalanced view, either downplaying the evidence for recovered memory and exaggerating the data on false memories, or *visa versa*. Therefore there is little consensus among researchers.

It appears clear that most researchers, including critics of recovered memory, acknowledge childhood trauma can be forgotten (Lindsay & Read, 1994). However, much remains unknown or unclear, such as the frequency with which memory loss occurs (Femina, Yeager, & Lewis, 1990; Williams, 1994), the extent to which forgotten memories can be retrieved accurately, and the mechanisms underlying such processes (Ceci & Loftus, 1994; Lindsay & Read, 1994; Loftus, 1993). Nevertheless, the finding that forgetting early trauma sometimes occurs makes the accurate recovery of such memories at least a possibility. In addition, both sides of the debate argue there is little direct evidence for the claims of the opposing view. Schooler (1994) states that in the absence of direct evidence, one must be careful in drawing conclusions of 'no evidence'. Rather the implications of the available indirect sources of evidence should be considered.

Some researchers have suggested the concepts of blocked and recovered memories of traumatic events have only become controversial since their association with memories of CSA (Cossins, 1997; Leary, 1996). It has been suggested that at the centre of the controversy is the issue of the prevalence of CSA (Brown et al., 1998; Gawenda & Gurvich, 1995), about which there is no agreement. A recent study by Fergusson and Mullen (1999) has reviewed recent population studies of the prevalence of CSA published in the English language since 1990. Based on a range of behaviours where children are used for someone's sexual gratification, the prevalence rate is one in three women and one in six men.

Recently, the report *Childhood Abused: The Pandemic Nature and Effects of Abuse and Domestic Violence on Children in Australia*, a joint initiative of the Alannah and Madeline Foundation and La Trobe University, stated that in 2002-2003, there were 198,355 child abuse notifications in Australia and more than 40,000 cases were substantiated (Brown & Endekov, 2005). Of those cases, emotional abuse was the most common, accounting for 34% of reports, with physical abuse and neglect both at 28% and sexual abuse accounted for 10% of claims (Brown & Endekov, 2005). Gawenda and Gurvich (1995) state regardless of what constitutes sexual

abuse, if these alarming figures are accurate, they strongly suggest that in a large proportion of families, children are unsafe. There are also other related concerns, for instance many therapists working with victims of sexual abuse are concerned the media coverage of the recovered memory debate has been too sensational and there is a danger people who have genuine memories will be disbelieved (Gawenda & Gurvich, 1995). An American study of 113 adult survivors of CSA found although many of the women had confirming evidence for their memories, over 50% had been accused of having false memories. The women reported that exposure to the false memory debate led to increased feelings of anxiety and depression, increased self-doubt about their memories, and an overall slowing of the progress of therapy (See Dallam, 2002).

In this literature review the position of Gleaves et al. (2004), Schooler (1994), Sivers et al. (2002) is adopted, by refraining from making absolute judgements on the topic, and instead, reviewing briefly the empirical and theoretical evidence for both the phenomena of recovered and false memories. This literature review is not intended to be a comprehensive research review, but a summary of the scientific understanding of recovered memory and false memory. Specifically, the review begins by discussing the conceptualisation of memory, followed by a brief outline of the factors which may interfere with the accurate recall of memory. It then discusses briefly the empirical and theoretical evidence for blocked and recovered memories, possible cognitive mechanisms for blocked and recovered memories, and the clinical and empirical evidence for false memories. The review then summarises the psychotherapeutic techniques associated with recovering forgotten memories, and concludes by outlining various government responses, and guidelines issued by professional bodies concerning the issue of recovered memory, specifically the recovery of memories of CSA.

2 Conceptualising Memory

Memory researchers have conceptualised memory as comprising four stages: attention and selection, encoding, storage and retrieval (Intelegen Inc., 2003; Matlin, 1998). Regarding the first process of attention, there is much more information in the environment than one can process, therefore one must make choices (conscious and unconscious) regarding the information which is addressed. When information is selected, it must be encoded to be remembered. Encoding refers to interpreting

incoming information into a meaningful mental representation that can be stored in memory (Intelegen Inc., 2003; Matlin, 1998). Information can be encoded into several different ways, such as according to its sound (acoustic encoding), what it looks like (visual encoding), and its meaning (semantic encoding). Encoding is important to memory, as the manner in which one encodes can affect what is remembered and how it is subsequently recalled. For example, if a list of terms is encoded acoustically and visually, they may be recalled relatively easily however there may be some difficulty in explaining the meanings of each term (Intelegen Inc., 2003; Matlin, 1998). On the other hand, if the terms are encoded semantically, the meanings may be recalled, but there may be some difficulty in remembering the order in which they were listed on the page (Intelegen Inc., 2003; Matlin, 1998).

Storage is the process of keeping information in memory (Intelegen Inc., 2003; Matlin, 1998). A distinction is made between short-term and long-term memory: Short-term or working memory is brief and transient and only contains the small amount of information which is actively being used. Memories in short-term memory are somewhat fragile and can be lost from memory within approximately thirty seconds unless they are in some way repeated or rehearsed (Intelegen Inc., 2003; Matlin, 1998). Long-term memory has a large capacity and contains old and new memories. Memories in long-term memory are reasonably permanent. According to some researchers (Atkinson & Shiffrin, 1968), material which has been rehearsed or repeated passes from short to long-term memory, for example, repeating someone's name over and over again. Elaborating on the information can also help to transfer it from short to long-term memory. Elaboration refers to making the information meaningful, and drawing connections between the new information and that which is already familiar (Intelegen Inc., 2003; Matlin, 1998).

Retrieval is the process of recalling information at the time it is needed. The retrieval process is closely related to encoding and storage. For example, if information was encoded visually, but one is attempting to retrieve it acoustically, it will be difficult to remember. Therefore, like encoding, information can be retrieved through imagining the sound, visualising it, and thinking about the meaning (Intelegen Inc., 2003; Matlin, 1998). In addition, as information has to be stored in order to be retrieved, knowing how it was stored can help this process. This is where the process of elaboration becomes relevant because it helps to think about related ideas when attempting to retrieve information (Intelegen Inc., 2003; Matlin, 1998).

Consider the scenario of a student attempting to recall a mathematical formula during an exam, although he/she is able to visualise the page in the textbook, he/she cannot recall the exact formula but can remember the class in which the formula was used and as he/she thinks about this class, the formula comes to mind (Intelegen Inc, 2003).

In summary there are four stages of memory which involve selection, encoding, storage and retrieval. One can consciously or unconsciously select and attend to information in the environment. The information is then coded for storage where it can simply be rehearsed or processed more deeply, such as elaboration. Later, when needed, information can be retrieved by using a search strategy that parallels the way the information was encoded and stored (Intelegen Inc., 2003; Matlin, 1998).

3 Determinants of Accuracy

Within this conceptual framework memory failure can be attributed to a breakdown at any one of the four stages. There may be many factors in the selecting and attending stage that affect the accuracy of recall of events. One factor concerns the situational conditions at the time of the event (Thomson, 1995). For example, the extent of the opportunity to perceive events is essential to what can be recalled. If the event in question appeared quickly or if there were poor lighting conditions, it is unlikely the observer would be able to recall many accurate details of the visual features of an event (Thomson, 1995). Aspects of the observer in the attention stage are also important to what can be recalled and the degree of accuracy of the memory. For example, a person's perception will be different depending on their level of stress when the event is occurring. Research suggests observers under extreme stress may be inaccurate in the details they are able to recall about the event in question (Brown, Salmone, Pipe, Rutter, Craw & Taylor, 1999; Chiles, 1958; Idzikowski & Baddeley, 1983).

Research has shown the storage stage is also affected by a number of factors. One factor is time. For example, recall is likely to be less detailed and accurate if there is a greater period of time elapsing since the event was observed (Powell & Thomson, 1996; Thomson, 1995). The events that occur in the intervening time can also have an impact on what is retained about the event in question. For example, the greater the number of events which occur, the greater the difficulty in remembering any specific event. This finding is particularly true when many of the events are

similar to one another and/or occur at similar times or places (Powell & Thomson, 1996).

Remembering is also a function of factors occurring during the retrieval stage. As previously discussed, recall is better if the retrieval context is similar to the encoding context (Begg & White, 1985; Geiselman & Glenny, 1977; Tulving, 1983), and may be hindered when the two contexts do not match (Thomson, Robertson & Vogt, 1982; Thomson & Tulving, 1970; Tulving & Thomson, 1973). This is particularly true for visual material such as human faces, and when context is created through mental imagery. For example, several psychologists have demonstrated that the context in which human faces are observed can influence the ability to remember the faces (Davis, 1988). Smith (1988) suggests trying to imagine the context in which the original memory was encoded can enhance memory. For example, trying to create a mental image of a page from a textbook to help reconstruct the answer to a question on a test (Matlin, 1998). However, there are inconsistencies in the context-effects research, and at times context has no influence on recall (for an explanation of the inconsistencies see Smith, 1988).

Research on mood also emphasises the importance of context (Matlin, 1998). For example, positive information is processed more efficiently than negative information (for experimental evidence refer to Matlin & Stang, 1978; Walker, Vogl, & Thompson, 1997). Memory is also better when the nature of the material to be learned is congruent with a person's current mood, otherwise called mood congruence (Blaney, 1986; Bower, 1987; 1992; Gara, Woolfolk, Cohen, Goldston, Allen & Novalany, 1993; Gotlib, 1992; Haaga, Dyck & Ernst, 1991; Mineka & Sutton, 1992; Nasby, 1994; Ruiz-Caballero & Gonzalez, 1994). Some studies also show people often remember material better if their mood during encoding matches their mood during retrieval. However this group of articles also show inconsistencies.

Memory can be explicit (also referred to as declarative or semantic) or implicit (also referred to as non-declarative or somatic), and this can affect recall. Explicit memory is intentional or conscious recollection of information whereas implicit memories tend to occur without conscious awareness, but they have an affect on performance and behaviour. These two types of memories are encoded differently, and when memory measures match the type of encoding, memory performance is better (Cozolino, 2002; Matlin, 1998).

In summary, memory performance is enhanced when the retrieval context

resembles the encoding context. Memory performance is also influenced by the emotional tone of the material, by the match between the material and a person's mood, and by the match between the mood during learning and the mood during recall. The advantage of matching contexts also applies in both explicit and implicit memory tasks. Within this theoretical context and the determinants of inaccuracies, the next section examines the empirical and experimental evidence for false memories.

4 False Memories

4.1 Experimental Evidence of False Memories

The experimental evidence for false memories originates from laboratory studies that show that the production of images or impressions can be sufficiently vivid to enable them to be confused with reality. The evidence supports indirectly the conclusion individuals can be made to remember events that did not occur. The evidence includes studies of the misinformation effect, hypnotic pseudomemory, failure of reality monitoring, intrusions in schema-guided recall, and intrusions in recall of list words.

4.1.1 Frontal lobe damage and confabulation

Several studies have provided evidence that patients with frontal lobe damage exhibit memory distortions resembling source amnesia, confabulation and false recognition (for a review see Schacter, Kagan & Leichtman, 1995). Source amnesia occurs when people recall a fact or occurrence from the past but fail to remember the source of their knowledge (Craik, Morris, Morris & Loewen, 1990; Glisky, Polster & Routhieauz, 1995; Schacter, Harbluck & McLachlan, 1984). Schacter and colleagues (1984) conducted experiments with patients with amnesic syndromes caused by different kinds of brain lesions. The researchers found the amnesiac patients could often learn and successfully recall new fabricated stories but they failed to remember the correct source. Indeed they frequently failed to remember the experimenter had told them the story, and insisted they had acquired the story from a source separate to the experiment, such as television or radio. The observation that prefrontal regions are specifically related to deficits in source memory is particularly relevant to the experimental evidence of false memories because research with normal adults reveals that when people fail to recollect the source of their knowledge, they are likely to

exhibit various kinds of memory illusions and distortions, such as confusing real and imagined events (Johnson, 1991; Johnson & Raye, 1981), and failing to remember whether something actually happened or was only suggested (for a review see Johnson, Hashtroudi & Lindsay, 1993).

Confabulation is a symptom that occurs in a range of neurological and psychiatric syndromes (See Schacter et al., 1995). The distinguishing feature is an inaccurate account of an event. Several investigators agree frontal lobe damage is strongly associated with confabulation (Johnson, 1991). However, some also believe frontal lobe damage may not be sufficient to produce confabulation (Dalla Barba, 1993; DeLuca, 1993). Confabulation is observed more readily when patients are asked about personal experiences and it is observed relatively rarely when patients are asked about general knowledge (Dalla Barba, 1993). In addition, investigators examining confabulation in neurologically impaired patients have revealed two manifestations of confabulation: a memory distortion where real events from the past are confused in time, and a strange confabulation of events that contains impossible occurrences and is based on figments of imagination (Johnson, 1991).

In a typical laboratory experiment, recognition memory is examined using a variation of a procedure in which participants initially study a list of words or objects. After a period of time, participants are again exposed to the items plus a new distracter or a lure item, and they are asked to indicate which items had appeared in the first list. Several patients with frontal lobe pathology exhibit a distinct tendency toward false recognition, that is, a tendency to report that distracter or lure items, which they had not previously encountered, appeared on the first list (See Schacter et al., 1995). The evidence considered above suggests patients with frontal lobe damage can be susceptible to source amnesia and false recognition and can occasionally show confabulatory memories.

4.1.2 Source monitoring failures

Source monitoring refers to the process involved in making attributions about the origin, or source of memories (Johnson et al., 1993). Source refers to a variety of information that collectively specifies the conditions under which a memory is acquired, for example, the spatial, temporal and social context of the event and the means through which it was perceived (Johnson et al., 1993). Reality monitoring is one example of source monitoring. It refers to differentiating memories of internally

generated information from memories of externally derived information, such as distinguishing memories for thoughts and imagination from memories for perceived events (Johnson et al., 1993).

Research, which supports the concept of false memories, shows individuals can confuse real thoughts or actions with imagined thoughts or actions so they remember events they only imagined (For example, Johnson, 1988; Johnson & Raye, 1981). For example, people can remember they have had dreams that were recounted by others (Johnson, Kahan & Raye, 1984). These memory failures occur when people confuse the origin of information, misattributing an experience to perception when in fact it was only imagined. Jacoby's (1991) explanation of misattribution is based on a distinction upon implicit and explicit memories. When a memory is automatically stimulated without conscious thought of its source, the resultant memory might be attributed to an incorrect source.

4.1.3 Associative-memory illusion

The associative memory illusion involves asking participants to study a list of words, all of which are related to an unstudied target word, known as the critical lure. For example, thread, pin, eye, sewing, sharp and point are all strongly associated with the word 'needle'. The associative memory illusion occurs when participants, who have studied the list of words, falsely remember having studied the critical lure, in this case, needle (Deese, 1959a, 1959b; Roediger & McDermott, 1995).

One explanation (Roediger & McDermott, 1995) for the occurrence of the associative memory illusion is that when participants study a list of words they automatically think of related words, and memories of the related word or critical lure are later mistaken for the actual list words. This explanation is similar to the source monitoring explanation of false memories as it supposes that the memory for the associative word and the actual list words are not adequately distinguished and therefore the source of memory is confused.

There is some evidence that patients with post-traumatic stress disorder (PTSD) and people with histories of self-reported CSA and other traumas show elevated levels of associative-memory illusion (Bremner, Shobe & Kihlstrom, 2000; Clancy, Schacter, McNally & Pitman, 2000). Clancy and colleagues (2000) have recently reported women with recovered memories of CSA showed greater levels of false recognition than women who always had such memories. Bremner and

colleagues (2000) revealed similar findings in a sample of women with self-reported histories of CSA. Those women who also had a diagnosis of PTSD showed significantly higher levels of false recognition than control women who did not have a diagnosis of PTSD or a self-reported abuse history. These studies are not claiming self-reports of abuse are illusory, however, they do suggest individuals with a history of trauma may show higher levels of associative-memory illusion. These findings imply that the credibility of self-reported trauma and abuse would be increased if they were corroborated.

Clancy et al. (2000) commented that it is unknown whether findings pertaining to false recognition of semantic associates in a laboratory paradigm can be generalised to recovered memories of childhood trauma. Researchers have suggested that to the extent some false memories reflect the essence of past experience, illusory memories of CSA may be accurate representations of some aspect of a person's past. Memories can be correct in the sense they refer abstractly to an experience, yet can contain many details arising from memory failures rather than from experience (Schacter, Norman, & Koutstaal, 1998).

4.1.4 Misleading post-event information: The misinformation effect

Research on the effects of post event information has demonstrated people can integrate misleading suggestions into memory. Specifically, the misinformation effect is generated in three steps: presentation of the original event, intervening events intended to mislead the participant, and a memory test (Garry, Loftus & Brown, 1994). The original explanation of the misinformation effect was based upon the belief that related events are not stored independently, but rather the individual events are used to construct an integrated memory trace that represents the general meaning of the episode (Bransford & Franks, 1972).

In a famous example (Loftus & Palmer, 1974) of the misinformation paradigm, participants were given an account of a car accident and then asked what speed the car was travelling when it 'bumped' (in one condition) or 'smashed' (in the other condition) into another car. Participants who were asked the smashed question estimated the cars were travelling at a greater speed than those who were asked the bumped question. While the misinformation paradigm has been influential in the eyewitness literature, a study by McCloskey and Zaragoza (1985) casts doubt upon the paradigm, as the researchers suggest the results are a consequence of response

bias¹.

In another example, Loftus (1997) explored the task of planting false childhood memories. She enlisted the help of family members to suggest to participants that they witnessed a particular event. Using this method, Loftus succeeded in convincing adult participants that as children they had a variety of experiences such as being lost in a shopping mall. The findings show the resulting memories can be described in great detail, and are as likely as real memories to be maintained in the face of contradictory information. The generalisability of this study has also been questioned (for example, Brown, 1995), in part because the misinformation was of a relatively common, plausible and non-traumatic experience. In addition, in the above study, it was the family members rather than the experimenter who convinced the participants of false memories. Gleaves et al. (2004) question the significance of the study. For example does it show that parents or other family members can deceive their children? If so, does the study support the idea that false memories actually occur in therapy? Pezdek, Finger and Hodge (1997) replicated the findings to the extent that three of the 20 participants accepted a similar suggestion. However, when a suggestion of a more unusual and possibly more traumatic memory (such as a rectal enema, an event more analogous to sexual abuse) was given, none of the subjects adopted the suggestion. Nevertheless, some recent studies (Mazzoni, Loftus & Kirsch, 2001; Porter, Yuille & Lehman, 1999) show false memories for unusual or infrequent events can be implanted.

The willingness of some participants to modify childhood memories in favour of the parents or family members' recollections shows a neglected area of research on memory and suggestibility (Fish, 1998). Kluft (cited in Dallam, 2002) stated that such experiments show that, as family or parents are considered authority figures, they have a good chance of inducing false reports of not having been abused.

4.1.5 Hypnotic pseudomemory

A number of researchers have described hypnotically regressed patients who have reported a range of traumatic experiences such as abduction and sexual abuse by space aliens (Fiore, 1989; Hopkins, 1987; Jacobs, 1992; Mack, 1994), satanic ritual

¹ Response bias has the potential to exist in any study in which responses of some sort are required of participants and the participants are more likely to respond in one way than in another. It occurs independently of the effect of any experimental manipulation.

abuse (Shaffer & Cozolino, 1992; Young, Sachs, Braun & Watkins, 1991), early childhood events (Ceci & Loftus, 1994; Loftus & Pickrell, 1995), past lives (Fiore, 1989; Wambach, 1979), traumatic foetal experiences (Van Husen, 1988), and experiences occurring on the day after birth (Spanos, Burgess, Burgess, Samuels & Blois, 1999).

Exploring additional components of hypnotically created pseudomemories, such as hypnotisability, confidence in and accuracy of the memory has extended this line of research. Research (Barnier & McConkey, 1992) has found one's degree of hypnotisability, rather than hypnosis *per se*, is more likely to create a pseudomemory. Also, some findings indicate that hypnotic procedures cause participants to feel overconfident in their incorrect recall than do non-hypnotic procedures. However, this research shows many inconsistencies (for example, Spanos et al., 1999). Some, research (Erdelyi, 1994; Steblay & Bothwell, 1994) suggests that hypnotic procedures are no more effective than non-hypnotic procedures at facilitating accurate recall or recognition, instead they are likely to decrease accuracy. For example, Erdelyi (1994) and Steblay and Bothwell (1994) reviewed studies comparing hypnotic and non-hypnotic conditions, and found hypnotic recall is no more accurate than non-hypnotic recall.

4.1.6 Schema-guided remembering

Some researchers (Brewer & Treyens, 1981; Rabinowitz & Mandler, 1983) exploring false memories have observed schema-guided recall and recognition. A schema refers to general knowledge about an object or an event that has been acquired from past experiences (Cohen, 1989). Schemas are developed from a large number of specific life events, and it essentially is a summary of the important characteristics about the event. For example, most people will have a schema for 'eating dinner' and generally it is likely to be at approximately the same time of the evening where one sits in a particular area and eats a meal. Brewer and Treyens (1981) examined undergraduates' recognition of objects that fit in schemata of a graduate student's office. The participants were taken into the office and were later tested for memory of the room. They found memories that were consistent with participants' schemata of an office were more likely to be falsely recalled and recognised than inconsistent schemata. These findings are consistent with Pezdek et al.'s (1997) findings that plausibility and typical experiences are more likely to be suggestively implanted in

memory.

4.1.7 Limitations

The experimental research on false memories shows some people can be made to report remembering events that did not occur. However, Gleaves et al. (2004) call attention to the limitations of this research such as response biases and generalisability. The researchers ask the question ‘do research participants reporting false memories genuinely believe what they are reporting or are their reports due to the demand characteristics of the research?’ For example, Barnier and McConkey (1992) showed participants slides of a thief stealing a purse, and subsequently suggested false aspects of the incident such as the attacker wore a scarf and helped the victim pick up flowers. The researchers collected qualitative data regarding participants’ feelings about the study and found evidence for some behavioural compliance. One participant noted, “I knew he didn’t have a scarf. I felt pressured, so I put a scarf on him to give an answer” (Barnier & McConkey, 1992, pp. 525).

In relation to the issue of generalisability, some researchers (Gleaves et al., 2004) suggest the majority of laboratory research on false memories has involved suggesting mundane memories to non-clinical participants, and eliciting false reports with no long-term personal consequences, such as family disruption or a jail sentence for a family member. In addition, laboratory research may have limited generalisability as it may underestimate the degree of influence and suggestion that may occur in therapy. Contact between the experimenter and participant is normally brief in comparison to therapist and client contact. Studies suggest participants are more likely to report false childhood memories with increasing contact with the experimenter (for example, Hyman, Husband & Billings, 1995; Zaragoza & Mitchell, 1996). Gleaves et al. (2004) state the possible effects of repeated exposure to suggestion have not been experimentally studied.

Although there are limitations associated with experimental research on false memories, the findings show people can report inaccurate or fabricated memories. The research (for example, Brandon et al., 1998; Shobe & Kihlstrom, 2002; Spanos & Bures, 1994; Spanos et al., 1999; Weekes, Lynn, Green & Brentar, 1992) suggests the circumstances under which false memories can, or are likely to occur, include:

- in the presence of an authority figure,

- who believes in the suggested memory;
- communicates these ideas to the patient with conviction;
- uses suggestive techniques to recover memories.

The existence of false memories does not contradict the possibility that forgotten and accurately recovered memories can also occur.

4.2 Empirical Evidence for False Memories

Primary clinical evidence for the existence of false memories comes from anecdotal evidence from people known as ‘retractors’ (See De Rivera, 1997, 2000), letters from people reporting to be falsely accused of sexual abuse (See Loftus, 1993), legal cases, investigations conducted by the Commissioner and media reports.

4.2.1 Legal cases

“Little case law as yet exists in Australia and New Zealand in relation to the admissibility of expert evidence about the processes of recall by adults or children of assaults, sexual or otherwise, perpetrated upon them. Expert evidence has been admitted in Canada ... This enables the evidence potentially to pass through the doors of the common knowledge² rule for those jurisdictions where it still exists” (Freckelton & Selby, 1993, 13.290). In other words, if the expert evidence is thought to be common knowledge it is inadmissible. Cases, which have set a legal precedent, in relation to the admissibility of expert evidence about recovered traumatic memories are summarised below (See Freckelton & Selby, 1993 for a thorough review of case law in relation to recovered memories).

4.2.1.1 *Canadian authority: R v Norman*

In the Canadian case of *R v Norman* (1993) 87 CCC (3d) 153, the Ontario Court of Appeal expressed concerns about the risks posed by evidence from complainants in sexual abuse cases where memories are retrieved by therapeutic techniques. Namely, the techniques might draw out false memories, but the patient believes they are real memories of the sexual abuse. The court said that a mistake might be made in such situations by placing too much weight on the appearance of

² Expert witnesses may not give evidence on matters considered to be common knowledge to the jury, because it is believed the jury will not benefit from expert assistance (Freckelton, 1993).

honesty and confidence on the part of the patient who has engaged in therapy to recover memories.

In *R v Norman* the Court of Appeal did not rule authoritatively on the admissibility of expert evidence about memory. However, it placed considerable weight on the evidence of an expert on recovered memories of sexual abuse, who emphasised that a memory may arise from a therapist's suggestions. The court found that in historical sexual assault cases, expert evidence was important and helpful, as courts may not be familiar with the processes of recall by individuals of sexual assault. However, it said that the possibility that a psychiatric condition could be responsible for lack of memory does not lessen the responsibility of the court to ensure that the Crown has presented its case beyond reasonable doubt.

4.2.1.2 New Zealand authority: R v R

In the case of *R v R* (1994) 11 CRNZ 402, a single judge of the New Zealand High Court was called to rule on the admissibility of expert evidence relating to recovered memories of sexual abuse. The accused was charged with the sexual abuse of his two daughters (aged 21 and 18 years at the time of the trial), which was reported to have occurred between 1983 and 1990. The elder daughter had her first memory of the alleged abuse in 1990. It was reported that the memory was recovered during counselling. The younger daughter had her first memory of the alleged abuse in 1991.

The Crown sought to call an expert to give evidence about the way in which memories are created, reconstructed and retrieved. The expert was also going to describe the different types of memories, such as explicit and implicit memory, and the psychological defences against trauma, such as dissociation, denial and repression. The Counsel for the accused objected that the evidence was not relevant and could be detrimental to the credibility of the complainant. However, the judge found the evidence was relevant and believed the expert evidence in this particular case was both necessary and admissible as he considered the issues were beyond the knowledge of a Judge or jury.

4.2.1.3 Australian authority: R v Bartlett

The main Australian authority on recovered memories and the admissibility of false memory evidence is the Victorian Court of Appeal decision in *R v Bartlett*

[1996] 2 VR 687. The decision of *R v Bartlett* established the legitimacy, in certain circumstances, for the defence in criminal trials to adduce suitably qualified expert evidence, such as from a psychologist, about the unreliability of recovered memories (See Freckelton, 1997). In that case, the accused was convicted of indecent assault and false imprisonment of a nine-year-old girl, which was reported to have occurred 13 years before the trial. The complainant gave evidence that her memories of abuse were recovered during therapy.

The accused sought to call expert evidence from a psychologist regarding recovered and false memories, but the trial judge rejected it on the basis that there was no scientifically accepted body of knowledge concerning memory, and persons without knowledge in the area of memory and trauma would be able to form a sound judgement without expert evidence. The court found this ruling to be incorrect and found that the phenomena in question were beyond the general knowledge of the layperson. As the expert evidence was able to convince the jury that the events described by the complainant were false memories, the Court of Appeal decided that the convictions of the accused should be quashed.

At present, in national and international courts, profound controversy still exists about the dangers posed by evidence that is therapeutically recovered. Given the profound disagreement within the expert communities regarding whether a particular recovered memory is true or false, and the lack of controlled studies into traumatic recovered memories, in most cases expert evidence is likely to be inadmissible as it is unlikely to assist the tribunal to better understand the issues or dispel falsehoods (Freckelton & Selby, 1993).

4.2.2 An investigation into Recovered Memory Therapy by the Health Services Commissioner

In March 1999 a complainant contacted the Commissioner because of concerns about the wellbeing of her sister. Her sister was living in a Victorian country town and was attending the medical clinic where she was being treated for, amongst other things, depression. She was also receiving psychotherapy from a psychologist. The complainant was concerned about the possible financial and sexual exploitation of her sister. She was also concerned about her sister's medication, and counselling sessions, which lasted for hours. She mentioned a "blackmailing" letter demanding money that had been sent to her father by the psychologist. The

complainant was told that as the Commissioner had no complaint from the patient (her sister), the OHSC could not intervene. In November 1999, the Minister for Health requested the Commissioner to undertake a formal investigation of the medical clinic to assess the accuracy of the complainant's allegations under section 9(m) of the *Act*. The patient gave her consent for her health services to discuss her care with the Commissioner.

After extensive inquiries the Commissioner found no evidence of financial exploitation by the medical clinic, but she noted that the clinical management of the patient by the general practitioner and the psychologist raised a number of concerns. The psychologist was conducting late night counselling sessions with the patient, her prescribed medication was a concern, and she was in a state of exhaustion. The general practitioner was aware of these issues, but did nothing to stop the occurrences, and appeared instead to have encouraged it. Eventually it was the nursing staff that put a stop to the psychologist's late night removal of the patient. The Commissioner recommended that the general practitioner's management of the patient be referred to the Medical Practitioners Board of Victoria for action.

The Commissioner had serious concerns about the psychologist's conduct and considered he put the health and safety of his patient at risk. As a registered psychologist he had a duty to uphold the standards of his profession and behave in an ethical manner. The Commissioner decided there was *prima facie* evidence that the psychologist either created the illness in his patient, or contributed to its longevity and seriousness. There is evidence in the form of the letter to the patient's father that he did this for financial gain. The letter "requesting" payment of \$30,000 in fees also contained a threat that legal action would be taken if the money were not paid. The Commissioner considered it was inappropriate for the psychologist to seek fees from the patient's father in this way. The Commissioner noted, "The area of repressed memory therapy is fraught with controversy and the psychologist's treatment regime with the late night visits, the exhausted state of his patient, the claims of thousands of memories recovered from the age of two years following therapy sessions lasting for hours could not be described as professional. The psychologist himself told the Commissioner that the recovery of so many memories was, amazing, incredible and difficult to believe." The Commissioner recommended that the psychologist's management of the patient be referred to the Psychologists Registration Board for action.

4.2.3 Media reports

Recent media reports about recovered memories of CSA are reviewed and compared to the legal proceedings relating to the cases. In December 2000, an article appeared in Brisbane's *Sunday Mail* (Taylor, 3 December 2000) reporting on the case, *R v Kenward* [2000] QCA 482, of a Queensland man, Robert Kenward, who was jailed on child sex charges. In the mid-1980s, the complainant, her sister and their mother lived in Kenward's home. In April 1995, the complainant started attending the Royal Brisbane Hospital for a work related shoulder injury. At the time an occupational therapist and a psychologist assessed her to ascertain whether her chronic pain might have a psychological basis. On 18 June 1997, to obtain relief from her shoulder pain the complainant gave the Royal Brisbane Hospital her personal history. In the course of the assessment at the pain clinic, she made the allegations of CSA against Kenward to her psychologist. She reported this was the first statement she made to any person implicating Kenward in any form of sexual misconduct with her. The complainant said she had always remembered the abuse, but for approximately 20 years was too afraid to speak about it. However, the newspaper article reported that Kenward believes it was a false memory created in counselling.

In April 2000, Kenward was arraigned on sex charges and found guilty at trial of one count of rape and one of indecent dealing, but was acquitted on four others. He was sentenced to six years in prison and spent several months behind bars before being allowed bail pending his appeal. In *R v Kenward*, Kenward's convictions were quashed on appeal. The Appeal Court judges said the contradictory evidence plus the complainant's behaviour, such as her emotional outbursts in court, warranted the quashed convictions.

On 26 April 2001, reporter Simon Royal from the ABC's *7.30 Report* gave an account of Robert Kenward's story. The report involved Kenward, Anton Maher (Kenward's barrister), Brian Hazell (a psychologist), Liz Mullinar (founder of Advocates for Survivors of Child Abuse), a survivor of CSA, and Professor Gina Geffen (board member of the Queensland Psychology Board). Maher stated that in trials dealing with a complaint, which occurred many years ago, the central feature is the reliability of the memory. Maher stated that in cases where the defence believes the memory has been altered by therapy, the defence has to find evidence that the complainant has undergone therapy that has changed his/her memory; otherwise,

there is no basis upon which to make an application to the court to exclude the evidence. In Kenward's case, the defence could not examine the complainant's counselling records, as they could not be located. Brain Hazell and another psychologist examined the complainant's psychological and counselling history for the defence and believed that therapy may have altered her memory. Royal, from the *7.30 Report*, reported the complainant denied this. It was also reported the judge ruled that Hazell could not be heard because the defence lacked the documentary evidence for its argument.

Recently, articles appeared in the *Sydney Morning Herald* (Lamont, 6 July 2005; Maley, 9 July 2005) reporting on the case of *AW & Ors v State of New South Wales* [2005] NSWSC 543. These proceedings arose out of events in 1994 in which charges were laid against a mother, father and grandmother alleging they had committed sexual offences against their four children. In 1993, in the course of counselling from a Family Planning Association, the eldest child (known as SW) said that a number of physically violent boyfriends had previously raped her and that her father had sexually molested her. In subsequent counselling sessions, SW said her father had raped her. The *Sydney Morning Herald* newspaper articles reported that some of the claims allegedly came from repressed memory counselling sessions however, the case, *AW & Ors v State of New South Wales*, did not discuss claims of RMT.

SW reported the alleged abuse to the police where she provided a statement detailing a history of abuse by her father commencing at five years of age. At subsequent police interviews, SW also made allegations against her mother and grandmother. Police questioned the SW's three siblings who initially denied the abuse but over time came to make allegations of ritual sexual abuse against one or both parents and the grandmother. In 1994, police arrested the mother, father and grandmother.

In November 1995, the three youngest children retracted their statements and a Children's Court Magistrate ruled their allegations were untrue due to the many inconsistencies between the children and within each child's statements. However, he found there was inadequate supervision of the children, there had been inappropriate sexual touching between the children, and ordered they be taken into care. In 1996, after a committal hearing, a magistrate dismissed charges against the parents and grandmother involving the four children.

On 5 July 2005, the Supreme Court ruled the mother, father and grandmother had been wrongfully arrested and suffered malicious prosecution, awarding them \$165,000 in damages. *AW & Ors v State of New South Wales* at 611 commented: “I have concluded that MOD (the investigating officer) lacked a degree of objectivity in the conduct of the ... investigation. He appears to have accepted the accounts offered by SW (eldest daughter) and EW (13 year old daughter) notwithstanding features of them that were improbable and to have concluded that AW (father) and LW (mother) were likely to be members of a paedophile ring. However, I do not find that MOD’s motive in instituting the prosecution of charges against AW and LW on 23 June on the strength of the unsupported and in some instances implausible allegations made by their children was the product of any motive other than a desire to see them brought to justice.”

Julia Limb (6 July, 2005) from ABC Radio also reported on the above case and she spoke to the Director of the New South Wales Institute of Psychiatry, Louise Newman. Newman made an important distinction between the use of recovered memories, which are used as evidence in court, and those in therapy. She stated that recovered memories do make unreliable evidence but are important in therapy. She said, “Sometimes in clinical practice we don't ever know the truth, which means if someone is looking at a legal proceeding it's actually very difficult because the court is in the position of trying to determine whether something was true or false.” As patients who recover memories may only recover partial memories of the event, “In many clinical situations that (the veracity of memories) becomes less of an issue and we're really trying to help people live with their beliefs and some memories of what's happened to them without necessarily wanting them to reconstruct in an active way a whole story of abuse.”

Newman also discussed the uncertainty that comes from working with patients who may not know how accurate their memories are and patients who cannot recall the entire event: “So it's always extremely difficult to know with any degree of certainty about the veracity of someone's memories. And I think that really becomes quite a complex clinical issue when we see people who have questions that they would like the answers to about what actually happened to them and we need to work with those individuals to help them reconstruct or put together a story of what might have been particularly negative experiences.” Newman also said that recovered memories have not always been used appropriately and should be dealt with by

experienced and appropriately trained professionals: “Children have falsely in some cases, it appears, as adults, accused parents. So the consequences of this sort of therapeutic approach in unskilled hands or in overenthusiastic hands are very serious. Certainly working with repressed memories or working with people who've survived abuse is not the sort of therapy that should be undertaken by people without a lot of experience working in this area.”

The above media reports do not show reliably that RMT exists in Australia. The reporters appear to have reported inaccurately on the legal cases by stating that the allegations of CSA arose from RMT, when in fact the complainants have denied such allegations and the judge's summations did not mention RMT. The reports also highlight issues such as the differences between the objectives of therapy versus legal proceedings in relation to the issue of recovered memories. The objective of therapy is to help patients live with their experiences of abuse, and uncertainties about their experiences. In contrast, the objective of a legal proceeding is to determine whether the memory is true or false. All persons, including police and therapists, working with allegations of CSA need to be mindful of the impact of suggestion, their position of authority and their own beliefs on patients or complainants.

4.2.4 Limitations

Some researchers have criticised anecdotal evidence for false memories for a number of reasons, such as they do not believe that false allegations of CSA are a common occurrence, and there may be alternative explanations of why those accused of CSA or retractors may be denying the abuse occurred. These criticisms are outlined in more detail.

Much of the literature supports the notion that false allegations occur in a small proportion of total allegations of sexual abuse. For example, a recent review of false allegations of sexual abuse in the Family Court in South Australia concluded that approximately nine per cent of allegations were false (Brown 2003, cited in Crime and Misconduct Commission, 2003). False allegations of CSA do not appear to be a common occurrence.

Rubin (1996) suggests it is important to consider the source of the report of false memory, especially of CSA. For example, Rubin (1996) stated that when the source of the report is the person accused of abuse, there might be several interpretations of what actually occurred. Rubin noted that guilty persons might deny

they are guilty of sexual abuse for a number of reasons, such as denial, secrecy, alcohol-induced blackouts, and dishonesty. In addition, some researchers believe that just as victims of CSA report forgetting or blocking of the abuse, so can perpetrators (Resneck-Sannes, 1995).

When the source is an individual who has retracted accusations of CSA, it is important to consider that people with verifiable histories of abuse are known to alternate between accepting and denying their memories. A victim may also be more susceptible to suggestions their memories are false (Gleaves, 1994).

5 Memory Blocking and Recovery

This section examines briefly clinical and experimental evidence for blocked and recovered memories and the theoretical explanations of such cognitive mechanisms.

5.1 Experimental Evidence for Blocked and Recovered Memories

This section reviews several areas of experimental research for memory blocking and recovery (for a more extensive review refer to Gleaves et al., 2004). The experimental evidence includes spontaneous recovery from retroactive interference, tip of the tongue research, implicit memory research, recovery from posthypnotic amnesia, output interference and recovery, retrieval induced forgetting and suppression. In each of these cases, the memory blocks continue for a substantial amount of time.

5.1.1 Recovery from retroactive interference

Retroactive interference is when the event in question is stored in memory and subsequently, similar experiences are stored, and the first event is forgotten (Bootzin, Bower, Crocker & Hall, 1991; Freyd, 1996). Brown (1976) found the greater the length of time which the event is stored in memory, the greater the likelihood the memory will become accessible. Gleaves et al. (2004) suggested two explanations for this finding: memory traces for the event in question may weaken and somehow subsequently gain strength in time, or memory traces always remain intact but the storage of similar memories cause temporary inaccessibility (for example, Postman, Stark & Fraser, 1968). Wheeler (1995) found memories can become temporarily inaccessible and can be recovered at a later time, however this research did not

determine the mechanisms involved in the recovery.

5.1.2 Tip of the tongue research

The tip of the tongue experience is where a word or name cannot be recalled, but one feels recall is imminent. Experiments have shown that when a word is on the tip of the tongue, individuals have some clues to its identity, such as what it sounds like (Brown & McNeill, 1966). Studies have found that after a delay most tip of the tongue experiences are likely to be resolved (Burke, MacKay, Worthley & Wade, 1991).

Brown (1991) and Smith (1994) state one cause of the experience is a temporary memory block. For example, Jones and Langford (1987) revealed that when participants heard a word phonologically similar to the target word, they reported tip of the tongue experiences. In addition, Meyer and Bock's (1992) research showed an increase in tip of the tongue experiences was accompanied by an increase in recall after a period of time.

5.1.3 Implicit memory research

As previously discussed, implicit memories tend to occur without conscious awareness. Smith and Tindell (1997) examined blocking by using a typical implicit memory test: the word fragment completion task. A word fragment task is where a participant is asked to read a list of words and some time later is given a word completion task where word fragments are provided. Participants are asked to complete the word fragments with an appropriate word. Typically, they are more likely to provide the words from the previous list than words that had not been on the list. Smith and Tindell gave participants two lists of words, one that was orthographically similar and another that was different to the correct solutions. They found if orthographically similar words to fragments were used, word completion was worse. For example, if the related word was 'analogy' and the unrelated word was 'unicorn', and the fragment was 'a_l__gy', it would be more difficult to complete the word fragment due to some sort of blocking. Similar to most other bodies of evidence for memory blocking and recovery, researchers have found word fragments are more likely to be resolved correctly after a delay (Smith, Carr & Tindell, 1993, cited in Gleaves et al., 2004).

5.1.4 Recovery from posthypnotic amnesia

Hypnotic or posthypnotic amnesia shows when participants are hypnotised and given suggestions to forget an experience, memories of the experience become inaccessible (Kihlstrom, 1979; Kihlstrom & Evans, 1979). The research also shows the memories can be recovered if the participants are given a prearranged signal to cancel the amnesia.

Gleaves et al. (2004) suggest the characteristics of hypnotic amnesia most closely resemble blocked and recovered memories of naturally occurring traumatic events for two reasons. First, the memories can be recovered subsequently and are thus accessible. Second, just as some researchers suggest blocked memories can affect behaviour, similarly during posthypnotic amnesia, inaccessible memories may affect indirectly experiences and behaviour. However, some researchers (Spanos, 1986) have criticised the evidence from posthypnotic amnesia arguing the degree to which reports of amnesia are due to compliance is unclear.

5.1.5 Output interference and recovery

When participants recall a list of items, the act of recalling can have the effect of blocking other items that have not yet been recalled. This interference is referred to as output interference. Rundus (1973) and Nickerson (1984) provide support for output interference caused by experimenter-provided items from a learned list. The researchers used a part-list or part-set cuing procedure which means participants were shown a list of words, and some time later, participants were asked to recall the list of words, and were given some of the words as cues. Consistent with the hypothesis, part-list cuing interferes with recall of the remainder of the list.

According to some researchers (Estes, 1955; Mensink & Raaijmakers, 1988), recovery from initial blocking in recall, may occur on subsequent tests because blocks caused by output interference weaken over time. This concept challenges the idea that forgetting increases over time, because more is recalled on subsequent tests. Many other experimenters have provided evidence that part-list cues causes memory blocking on an initial recall test, and increased recovery on later recall tests (Basden & Basden, 1995; Basden, Basden & Galloway, 1977).

5.1.6 Recovery from intentional forgetting

Another body of evidence supporting the phenomenon of blocked and

recovered memories is that of intentional forgetting or motivated forgetting (Basden, Basden & Gargano, 1993; Bjork & Bjork, 1996; Freyd, 1996). Researchers have conducted experiments where participants are given a list of words to remember and are subsequently asked to forget the list of words. Participants are then requested to concentrate on a second list of words. The results show that the first list is poorly recalled and the second list is better recalled if participants are given instructions to forget, presumably due to decreased interference from the forgotten list. In addition, research has shown the forgotten list can be recovered if participants are re-exposed to some of the forgotten material on a recognition test (Bjork & Bjork, 1996).

5.1.7 Limitations

Similar to experimental evidence for false memories, the experimental research on recovered memories is also subject to the limitation of generalisability. The research largely examines blocking and recovering for routine memories, which may be different to memories of naturally occurring trauma. For ethical reasons, researchers cannot traumatise participants and then assess the degree to which memories are blocked and subsequently recovered.

An important limitation of recovered and false memory research is whether accurate and false memories can be distinguished from one another, either by the client who is remembering or the observer. Some researchers state that memories for true events are likely to be expressed with more words, comprise greater clarity of perceptual details, and are held with greater confidence than are false memories (for review see Oakes & Hyman, 2000; Pezdek & Taylor, 2000). However, there is also contradictory evidence as other researchers state that traumatic events, which have been forgotten and subsequently remembered, are often explained as unclear, fuzzy or dream-like (See Williams, 1995). Research has not thoroughly addressed whether there is a distinction between the characteristics of false as opposed to accurate memories.

Although the available evidence remains primarily indirect, there is nevertheless a reasonable foundation for the existence of both recovered and false memories. A sceptical view about the frequency with which one or the other of these occurrences actually takes place should be tempered by the importance of their potential existence (Schooler, 1994).

5.2 Clinical Evidence of Blocked and Recovered Memories

Memory loss with subsequent recovery or recall of the complete or partial memory has been documented in relation to many traumatic experiences, such as, natural disasters or accidents (Madakasira & O'Brian, 1987), war (Bremner et al., 1992; Fisher, 1945), kidnapping and torture, concentration camps (Neiderland, 1968; Goldfield, Mollica, Pesavento & Faraone, 1988; Kinzie, 1993), and physical and sexual abuse (Bagley, 1990; Briere & Conte, 1993; Cheit, 1998; Feldman-Summers & Pope, 1994; Herman & Schatzow, 1987; Loftus, Garry & Feldman, 1994) (Refer to van der Kolk, 1996, for a comprehensive review of traumatic memory). This section examines key retrospective and prospective empirical studies exploring the likelihood and prevalence of delayed recall for a history of trauma, specifically childhood sexual or physical abuse. A retrospective study is a study that looks backwards in time, and a prospective study looks forwards in time.

5.2.1 Retrospective studies

There have been many retrospective studies assessing the possibility of forgetting and subsequently recovering memories of CSA (Elliott & Briere, 1995; Briere & Conte, 1993; Gold, Hughes & Swingle, 1996, 1999; Herman & Schatzow, 1987; Loftus, Polonsky, Fullilove & Thompson, 1994). These studies have used clinical samples, mainly of women, who had reported histories of CSA. The methodology generally involved individual structured interviews, and the results revealed 30 to 70% of participants reported memory loss for the abuse, which ranged from partial to complete memory loss. Independent corroboration for the abuse was sought in only one of the aforementioned studies (Herman & Schatzow, 1987). Herman and Schatzow (1987) obtained confirmation for 74% of the sample from many different sources including the perpetrator, family members, physical evidence, and finding that another child, usually a sibling, had been abused by the same perpetrator.

Some retrospective researchers have also distributed surveys regarding memory for traumatic events to large random non-clinical community samples (Elliot, 1997; Epstein & Bottoms, 2002; Feldman-Summers & Pope, 1994). For example, Feldman-Summers and Pope (1994) surveyed a random national sample of male and female psychologists regarding history of childhood abuse before the age of 18 years whereas Epstein and Bottoms (2002) examined college women. Approximately 30%

to 40% of participants, who reported a history of abuse, reported partially or completely forgetting the abuse for a period of time. A major common finding was that a variety of traumatic events, including murder or suicide of a family member, sexual abuse and combat, were subject to periods of forgetting (Elliot, 1997; Epstein & Bottoms, 2002; Feldman-Summers & Pope, 1994; Spiegel, 1998). Elliot (1997) highlighted that memory loss is especially high for traumatic events involving interpersonal victimisation.

Some of the studies examined how memories were triggered (Elliot, 1997; Feldman-Summers & Pope, 1994). Triggers generally included media reports, being informed by someone who knew about it, or an experience similar to the original trauma. Although participants reported therapy was often associated with recollection, therapy by itself was reported to be a least likely trigger.

Feldman-Summers and Pope (1994) found approximately half of those who reported memory loss also reported corroboration for the abuse. The sources of corroboration ranged from someone who knew about the abuse told the participant, the abuser acknowledged the remembered abuse, someone else reported abuse by the same perpetrator, participants' own journals or diaries, that had been forgotten, described the abuse, and medical records describing the abuse.

Severe memory deficits were generally associated with abuse that began at an early age, extended abuse and more violent abuse (Briere & Conte, 1993; Elliot, 1997; Feldman-Summers & Pope, 1994; Gold et al., 1999; Herman & Schatzow, 1987). Herman and Schatzow (1987) also found participants with severe memory deficits reported limited access to childhood memories in general, which is consistent with recent research on autobiographical memories of combat soldiers with PTSD (McNally et al., 1995; Wessel, Merckelbach & Dekkers, 2002). This finding may suggest the experience of a childhood trauma not only affects memory for the traumatic experience, but memory for that period of life in general.

Many of the empirical studies have been criticised for methodological flaws. For example, studies that only use clinical samples have been criticised as the degree of amnesia regarding abuse memories may have been overestimated due to the composition of the group, and therefore the results may not be generalisable to the general population (Loftus et al., 1994). In addition, Loftus et al. (1994) suggests when samples of participants who are in therapy are utilised, the therapists may have influenced the data by, for example, communicating their beliefs and ideas about

recovered memories to their clients.

Other methodological flaws include the manner in which the degree of memory loss is assessed and corroboration of abuse reports. For example, participants in Gold et al.'s (1996) study assessed their own memory, which may have led to different results if another method of assessing degree of memory had been used. Other researchers have criticised the wording of questions pertaining to memories of childhood abuse for being too vague (Loftus, 1993). Studies of sexual abuse have also been criticised as reports are often uncorroborated, and the possibility of misrepresentation of either the abuse reports or the amnesia could not be discounted.

Alpert and colleagues (1998) noted some studies (for example, Feldman-Summers & Pope, 1994; Loftus et al., 1994) did not distinguish between different degrees of forgetting, or did not gather detailed information about the circumstances of abuse (such as age of onset, duration of abuse and severity of abuse) and its treatment, all of which are important in determining whether, and to what extent, memories of the abuse are likely to be forgotten.

Some researchers have responded to criticisms of retrospective studies. For example, Paivio (2001) addressed the concern of relying on the often noted inaccuracies of retrospective reports. Certain types of psychopathology associated with child abuse are also associated with memory impairments. For example, research on the associative memory illusion shows people with histories of trauma may show higher rates of false recognition in comparison to others (Deese, 1959a, 1959b; Roediger & McDermott, 1995). This further reinforces some researchers' doubt of relying on retrospective accounts. Paivio examined clients' psychopathology and self-reports of CSA prior to and after undergoing six months of emotionally focused therapy. Analyses revealed significant reductions in psychopathology from pre- to post-therapy. Specifically, clients showed reduced: self-blame, negatively biased memories, avoidance and minimisation of the abuse. Reports of abuse remained stable from pre-to post-therapy. The stability of self-reports in the context of significantly reduced psychopathology contributes to evidence supporting the accuracy of retrospective self-reports of childhood abuse.

5.2.2 Prospective studies

There have been few prospective studies assessing memories for trauma.

Well-known publications in this area have examined memories for CSA (Bagley, 1990; Williams, 1992, 1995). Bagley (1990) and Williams (1992) published similar studies investigating longitudinal data from samples of women who, as children, had previously disclosed sexual abuse. Participants had been abused 16 to 18 years prior to the studies, and the abuse had been corroborated by medical or social services. Bagley's study revealed 26% of participants were either unable to clearly remember details of the abuse or could not recall the verified abuse. Williams' study revealed 38% did not recall abuse or chose not to disclose it. In addition and consistent with the aforementioned retrospective studies, Williams revealed participants were less likely to remember the abuse if they were young when the abuse occurred, had a close relationship with the perpetrator (such as a family member), and were subjected to other physical force during the sexual abuse.

Williams (1995) also reported that some of the women who remembered the childhood abuse were often very unsure about their memories and stated they resembled dreams. Williams recognised these are the types of statements which arouse cynicism. However, she points out that perhaps such cynicism should be tempered as her study shows feeling uncertain about recollections of abuse does not mean they are false. Clinicians have stated adults who report childhood abuse frequently report doubts about the reliability of their memories, whether recovered or not (Davies & Frawley, 1994).

Yovell, Bannett, and Shalev (2003) followed six people who experienced different types of trauma, ranging from having fingers torn off, being stabbed in the chest, and motor vehicle accidents. There were clear similarities across all participants: they all reported gaps in their memory of the event, and the gaps occurred at the moment they experienced the greatest fear. For example, the woman who had her fingers torn off reported a memory gap when she realised she had lost her fingers. The man who was stabbed by his father did not remember the moment he was stabbed, and those participants who were involved in car accidents reported memory loss at the moment of collision.

Yovell et al. (2003) found differences between those participants who developed PTSD and those who did not. Participants who developed PTSD reported larger and expanding memory gaps which were potentially reversible. These participants reported further memory loss each time they were interviewed after the initial event, but could recall some of the missing details when they were primed.

This type of memory loss may be due to difficulties in the retrieval of information that was previously encoded and stored. It may also be linked with avoidance, as these participants experienced extreme difficulty talking about their trauma. Alternatively, those participants who did not develop PTSD reported brief and stable memory gaps. This type of memory loss may raise the possibility of a failure of registration or initial encoding. Another possibility is that the release of stress hormones, which might occur at times of extreme fear, could interfere with the initial encoding of the event.

Andrews and colleagues (Andrews, Brewin, Ochera, Morton, Bekerian, Davies & Mollon, 1999; 2000) questioned members of the British Psychological Society who were practising psychologists by using qualitative and quantitative research methods to investigate the prevalence of patients who recovered memories of trauma and the characteristics of the memories. Andrews et al.'s (1999) findings were consistent with other studies showing people recover memories of non-sexual traumatic events, as one third of the recovered memories reported in therapy involved traumas other than sexual abuse. The recovered memories were also generally independently corroborated. The researchers concluded therapy is not always the basis for memory recovery, as the findings indicated approximately one third of the patients had recovered memories before entering therapy.

The psychologists reported the most common triggers for memory recovery for all patients were events and circumstances involving their own children and other events involving physical threat and danger to themselves. Memories were less commonly triggered by books and media reports on CSA or by therapy. Andrews et al. (2000) found the degree of amnesia prior to seeking therapy varied widely. For example, the psychologists reported some patients had prior amnesia, others had a prior vague sense of the existence of a traumatic memory and others had prior partial memories. It was also found the features of the traumatic memories were similar, for example psychologists reported they were fragmented but detailed, accompanied by high levels of emotion, such as fear, and experienced as reliving the original event.

Research examining recovered memories from different viewpoints, such as by speaking to patients and to therapists is useful. By seeking various forms of information from different sources, researchers seek to draw conclusions that are corroborated in a number of ways. The conclusions that can be drawn from the above research include, memory loss is not only associated with sexual abuse, some patients recover memories, or are at least aware that a trauma occurred prior to seeking

therapy, and memories are triggered by a range of circumstances.

5.2.3 Limitations

The findings described in this section lend support to the empirical evidence that a substantial proportion of adults reporting childhood abuse or trauma have experienced a period of forgetting with regard to all or some of the abuse. A drawback of the above empirical studies is they do little in clarifying the specific mechanisms for memory loss. However, they suggest that decreased accessibility to traumatic memories may also be related to feelings of fear or shame, as experiences of veterans and survivors of childhood abuse generally connote such feelings. The findings also show that features of memory loss appear to be age and degree related. That is, the younger the person's age at the time of the traumatic event or the more prolonged the traumatic event, the more likely the person will experience memory loss. There also appears to be some evidence to suggest traumatic amnesia for CSA is more likely to occur if the child depends on the perpetrator for survival (See Freyd, 1996, for more information regarding betrayal trauma theory, which explains the conditions under which a betrayed or abused person does not have conscious awareness, or memory, of the betrayal or abuse). More methodological consistencies are needed to compare adequately studies for blocked and recovered memories, such as type of study (retrospective versus prospective), type of sample (clinical and non-clinical), method of assessing memory, details of abuse, corroboration, and type of corroboration of memories.

The clinical evidence for blocked and recovered memory has limitations. Some researchers have criticised the large number of clinical reports that are retrospective. When memories are recalled from long ago, inaccuracies may be a problem. In addition, recovered memories of trauma are rarely subject to independent corroboration, and it may be that such memories are misleading or false. In instances of corroboration, studies have been criticised for the type of supporting evidence. Reports of war related trauma have also been criticised. Kihlstrom (2004) states that many studies involving memories of war are not adequately analysed, as researchers were unable to exclude organic amnesia associated with head injury or disease as causal factors of forgetting.

5.3 Theoretical Explanations for Blocked and Recovered Memories

Some researchers believe there is confusion about the reported mechanisms of memory loss for traumatic events (for example, McNally, 2004a, 2004b). They believe traumatic amnesia is often confused with a variety of other phenomena, such as everyday forgetfulness, organic amnesia, non-disclosure and not thinking about the event for a long period of time. Schooler (1994) states traumatic memories may in fact be completely unavailable for a period of time. Another possibility is that once access to memory is increased, rebound effects may be experienced where there is a flooding of the traumatic experience. The ensuing prevalence of thoughts about the trauma may contrast powerfully with the prior relative absence of such thoughts. From this perspective, the previous relatively reduced accessibility of the memory may be construed as a complete unavailability, however this does not necessarily have to be the case. There are many other mechanisms that might contribute to the decreased accessibility of the traumatic memory, such as infantile amnesia, processes more specific to trauma such as dissociation, repression, and suppression, as well as situations where the retrieval cues do not match the encoding context, and interference. The following brief review of theoretical mechanisms that could cause memory blocking and recovery reveal a number of potential causes that can occur even in laboratory situations.

5.3.1 Infantile amnesia

It has been reported that most adults, adolescents and older children are unable to recall events from infancy or early childhood (Cossins, 1997; Joseph, 2003). This condition is referred to as infantile amnesia. Theories about infantile amnesia have been divided into two broad categories: memory loss is due to storage difficulties (early experiences are not adequately transformed into long-term memories) versus memory loss is due to retrieval failures (early memories exist but they are difficult to recollect) (Schaffhausen, 2000).

The idea that infantile amnesia may be caused by inadequate memory formation originates from studies that show that neural circuitry of the brain is not fully functional in infants and myelination (which is the process of insulating nerve fibres in the nervous system) in much of the brain surface is not complete before two years of age. There is some argument about when different brain structures are developed and mature, and thus, which brain structure is responsible for inadequate

memory formation. Some assert the hippocampus, which is important for many types of memory formation, is not entirely developed at birth. Others do not believe that hippocampus development is at the heart of infantile amnesia as they assert it is nearly mature at birth. Alternatively, they believe the maturation of the infereotemporal cortex and prefrontal cortex corresponds with the improvement on many memory tasks and therefore may be the key to early memories (Schaffhausen, 2000).

Some researchers believe that the acquisition of language, which generally coincides with when most people report their earliest memories, allows more adequate rehearsal of the event and better storage in long-term memory (Schaffhausen, 2000). However, there is disagreement, as some researchers believe that the evidence that preverbal babies can demonstrate functional memories suggests that language is not necessary for long-term storage or retrieval (See Gaensbauer, 2002; Hayne & Rovee-Collier, 1995; Meltzoff, 1995). Some researchers believe part of the brain called the hippocampus, which involves explicit memory (See Bremner, Krystal, Southwick & Charney, 1995), does not develop in children until the age of approximately three. Therefore, memory for children under the age of three is regulated by the implicit memory system, which involves the more primitive parts of the brain, which do not store conceptual, factual and verbal material. Therefore, neurologically, children may not be able to store an explicit memory in a verbal form (Cozolino, 2002). This suggests that memory failure may be a function of retrieval rather than storage.

The *Diagnostic and statistical manual of mental disorders* (4th ed.: DSM-IV) also acknowledges that traumatised children are more likely to re-enact traumatic events than to describe them verbally (American Psychiatric Association, 1994). This statement is consistent with research in infant memory which suggests that it is manifested as non-verbal and behavioural expressions of remembered experiences. For example, Terr (1988) explored the stories of children who had been sexually assaulted before the age of five. All cases were externally corroborated with photos of the events. Terr evaluated the children's behavioural memories of the sexual assault and the corroborating evidence and found them to be comparable. For example, some of the children's behaviours involved acting out aspects of their experience which accurately corresponded to pornographic photos of the event (Refer to Cossins, 1997 and Gaensbauer, 2002 for clinical observations of children who experienced trauma in the preverbal period and who showed forms of memory of their trauma at subsequent time points).

Research suggests that infant memory retrieval might be highly dependent on contextual cues. As adults, appropriate retrieval cues for early memories may not be accessible and/or may not correspond to the way in which memories are encoded as a child. Schaffhausen (2002) states that an adult's perception of the world may differ from a child's so much so that cues associated with early memories may be unavailable, and the connection with infant memories may be lost.

Elliot (1997) attempted to determine if infantile amnesia was the cognitive mechanism causing memory loss of traumatic experiences in childhood. The study showed that the memory loss was not a result of infantile amnesia as when the participants reporting trauma before the age of five were removed from analyses, memory loss continued to be associated with young age at the time of trauma.

5.3.2 Dissociation

Dissociation is used to describe the disconnection or lack of connection between things usually associated with each other. Dissociated experiences are not integrated into the usual sense of self, resulting in discontinuities in conscious awareness (The International Society for the Study of Dissociation, 2004). Dissociation is a key concept in a range of disorders such as PTSD and dissociative identity disorder. In the DSM-IV dissociative amnesia is defined as "a reversible memory impairment in which memories of personal experiences cannot be retrieved in verbal form" (American Psychiatric Association, 1994, pp. 478). The experiences that cannot be retrieved are "usually of a traumatic or stressful nature" (American Psychiatric Association, 1994, pp. 478) and the memory impairment is "too extensive to be explained as normal forgetfulness (American Psychiatric Association, 1994, pp. 478). Acute dissociative responses have been identified in survivors of overwhelming traumas such as combat, sexual abuse, accidents and natural disasters (Brown, & Endekov, 2005; Sivers et al., 2002). Additionally, trait dissociative tendencies appear to be higher in individuals with a traumatic history (Sivers et al., 2002). It has also been noted that dissociation is more common in younger children and in females - individuals who frequently feel or are powerless (Perry, Pollard, Blakely, Baker & Vigilante, 1995) (For more extensive reviews on the study of dissociation refer to Hall & Powell, 2000, Klein & Doane, 1994, Lynn & Rhue, 1994, Putnam, 1993, Scaer, 2001, Spiegel & Cardena, 1991, Terr, 1994, and van der Hart & Nijenhuis, 1995). Sivers et al. (2002) explain that present understandings of dissociation describe three

components to an acute dissociative response: derealisation (alteration in one's perceptions), depersonalisation (alteration in one's sense of self and connection to one's own body), and memory disturbances. Research has recognised a persistent, dissociative personality trait that appears to lie on a continuum throughout the general public (Sivers et al., 2002).

It is claimed that acute dissociative states lead to poor encoding of a traumatic event. One possibility is at the time of the event, the various sensations and perceptions fail to be integrated as a conscious memory (van der Kolk, 1996; van der Kolk & Fisler, 1995). However, later these experiences can become integrated as a memory. Another possibility is a dissociative state may be functionally different from a 'normal' state. Dissociation occurs in situations of terror, this state causes the event to be encoded in terms of snapshot pictures, smells and sounds (Cozolino, 2002). Memory failure occurs because the dissociated information is only available when one enters the dissociative state (Sivers et al., 2002). When individuals encounter similar sounds, smells and sensations to the original trauma (in other words, when the encoding and retrieval contexts match), it is likely to produce feelings of terror and trigger the memories.

Neurological research on dissociation (Everly & Lating, 1995) shows that the traumatic event will result in fragmented, emotional and sensory memories without the person being aware of the events originally responsible for the memories, so there will be no verbal component to the memory. Researchers suggest that trauma results in the arousal of the autonomic nervous system, producing a flight/fight response, which also results in the increased activation of the limbic system and the inactivation of Brocca's Area. The limbic system is a part of the brain that helps to control emotions and species typical behaviours such as mating and fighting (Bootzin, et al., 1991). One structure of the limbic system, the amygdala, is involved in regulating fear, anger and aggression as well as memory. A second part of the limbic system, the hippocampus, is also involved in memory and emotion (Bootzin et al., 1991; Cozolino, 2002). Brocca's Area is the part of the brain related to language. The traumatic circumstances render the storage of information to be completed under conditions of biological turmoil such that the event is stored as visual images, sensorimotor modalities and somatic sensations (For more information on somatic sensations and memory see Rothschild, 2000; Scaer, 2001). Under these circumstances, memories are encoded in terms of snapshot pictures, smells and

sounds. When individuals encounter similar sounds, smells and sensations to the original trauma, it is likely to arouse the autonomic nervous system, again producing the flight/fight response (Cozolino, 2002). For more information on the neurobiology of fear see Catherall (2003). Catherall discusses that individuals in a state of fear or terror undergo a dramatic shift from explicit or semantic memory to implicit or somatic memory formation, in which access to conceptual-linguistic thought processes is severely restricted, and involves actual neurological changes in the limbic system (Also, refer to Rothschild, 2000, who has developed a therapy that manages implicit or somatic memory and the fear state).

Some researchers (See Anderson, Ochsner, Kuhl, Cooper, Robertson, Gabrieli, Glover & Gabrieli, 2004; Wagner, Schacter, Rotte, Koutstaal, Maril, Dale, Rosen & Buckner, 1998) have used magnetic resonance imaging (MRI) to examine how brain activity differs for forgotten and subsequently remembered verbal experiences. They found that the ability to later remember a verbal experience is predicted by the extent to which the left prefrontal cortices and the hippocampus are activated during that experience. These findings provide direct evidence that left prefrontal regions promote memory foundation for verbalised events. They also suggest that prefrontal cortical and hippocampus activations predict the magnitude of forgetting.

Additional neurological evidence shows traumas, such as child abuse and war, can cause structural abnormalities in the brain (See Bremner, 2002; De Bellis, Keshavan, Clark, Casey, Giedd, Boring, Frustaci & Ryan, 1999; Read, Perry, Moskowitz & Connolly, 2001). Electroencephalograms (EEG) and MRIs show that physically, sexually and psychologically abused children and adults and combat veterans have reduced left-sided hippocampal volume. As stated above, the hippocampus is very important for learning and memory and is very sensitive to stress activation. Additionally, danger or threat changes the ability of the hippocampus and connected cortical areas to store certain types of information (such as verbal), while effectively storing others (such as non-verbal) (See Bremner, 2002; Read, Perry, Moskowitz & Connolly, 2001).

5.3.3 Repression

Traditionally, repression is defined as the unconscious defence mechanism where the contents of the unconscious are kept hidden from conscious awareness, thereby protecting the individual from psychological threat (Bootzin et al., 1991;

Thomson, 1995). It is also said that unconscious repressing of thoughts can adversely affect conscious thoughts and actions. Gleaves et al. (2004) suggest the repression of thoughts may or may not be the result of unconscious mechanisms, depending upon the practitioner's theoretical orientation.

Thomson (1995) states memories that have been repressed can become accessible under limited circumstances such as in altered states of consciousness (for example, when the person is asleep and under hypnosis) or in circumstances where the person feels sufficiently safe to allow memories to become conscious. In these circumstances there is a relaxation of the defence mechanism, which allows the relaxation of repression, thereby causing memories to seep into consciousness.

Many researchers (Loftus, 1993; Thomson, 1995) state it has been difficult, if not impossible, to obtain experimental evidence for the existence of repressed memories. In contrast, Erdelyi and Goldberg (1979) present a range of clinical and non-clinical sources as evidence that people recall events previously excluded from consciousness to avoid psychological threat. However, the cognitive mechanisms for this phenomenon have not been determined conclusively. In addition, Reisner (1996) undertook a literature review of theoretical and experimental studies regarding recovered repressed memories and concluded there exists an experimental paradigm involving perceptual defence and facilitation which provides a "sort of construct validity for the concept of repression and for the differential operation of defence mechanisms in different types of neurosis" (Reisner, 1996, pp. 565).

5.3.4 Suppression

Blocking painful memories may also occur through conscious and deliberate processes (Bootzin et al., 1991; Thomson, 1995). People may deliberately try not to think about unpleasant experiences; in this way people do not rehearse the events, which results in the formation of weak memory traces and poor retention. Some studies examining suppression (Koutstaal & Schacter, 1997; Anderson & Green, 2001) suggest voluntary attempts to keep certain memories out of awareness may result in difficulties in subsequent recall due to the number of times the unwanted memory was triggered and then avoided. In addition, people may deny to themselves that the negative event actually occurred, or tell themselves the event was not as bad as it appeared. With repetition, such denial may become well learned and automatic, and the adverse memories can be forgotten.

Experiences of veterans and survivors of CSA generally connote feelings of embarrassment or shame, which suggests that individuals may be reluctant to talk about their experiences. Much research suggests telling one's story to oneself and others help to integrate them into one's life narrative, thereby increasing its potential accessibility (Nelson, 1993). On the other hand, the absence of such processing may reduce the accessibility of these experiences. Also, embarrassment and shame may particularly prompt individuals to actively avoid or suppress thoughts about these experiences which may result in their temporarily reduced accessibility. As a result of this decreased accessibility, individuals may experience a period of time where they do not show extrinsic evidence of possessing the memory. However, when a situation is encountered that shares some essential similarity with the original traumatic experience with respect to context or affective/physiological state, the accessibility of the traumatic memory may also increase.

5.3.5 Retrieval cues and contextual dependence

There is a large body of evidence which shows memories may appear to be lost, but when the right retrieval cues are given, those memories can become accessible (Thomson & Tulving, 1970; Tulving & Thomson, 1973). Memories are easiest to retrieve if the retrieval situation is the same or similar to the one in which the information was originally learned. Alternatively, some researchers believe that encoding specificity or state dependency theories are well-established non-trauma-specific memory forgetting mechanisms, and may not apply to traumatic memories (Sivers et al., 2002).

Mood-dependence may be one explanation as to why traumatic memories are unable to be retrieved. For example, if the traumatic event were associated with an extreme or atypical mood, it would be unlikely for the memory to be recalled due to the low probability of re-experiencing that mood state (Gleaves et al., 2004). Alternatively, Thomson (1995) believes loss of memory of childhood events is likely to reflect the fact that the cues which adults use in recall and recognition may not match the way in which a child stores information, which would make it difficult to recall details of a particular event.

5.3.6 Interference

One common memory failure is interference, the confusion of one memory

with occurrences preceding or following it, that are similar to it, and which compete with its retrieval (Anderson, 1983) or alternatively become incorporated as part of the memory (Thomson, 1995). For example, Bruck, Ceci, Francoeur and Barr (1995) assessed children's recollections of a medical examination, which occurred 12 months earlier. In the intervening time, researchers gave the children misleading information. It was found the children's reports of their medical examination included the misleading suggestions. Mechanisms that may explain interference include competition between memories: the retrieval of one associated memory delays or interferes with the retrieval of another memory, or alternatively the strength of competing memories causes the loss of the original memory (Gleaves et al., 2004). It should be noted that some researchers believe that interference is a well documented but a non-trauma-specific memory forgetting mechanism (Sivers et al., 2002).

Research on recovery from interference provides the best evidence that interference does not necessarily cause memories to be permanently inaccessible. Essentially, interfering memories can decay with the passage of time, and as there is less interference or competition between memories, originally blocked memories become less inaccessible, which in turn increases the chances of their recovery (See Smith, 1994).

Lindsay and Read (1994) listed five characteristics associated with interference: (1) memory suggestibility increases the longer the time period between the event and the recall of the event, (2) acceptance of the misleading information by the observer is directly related to the status of the person providing the information, (3) repetition of the misleading information increases the likelihood that the memory will be distorted, (4) the more believable the misleading information, the more likely it will be incorporated into the memory, and (5) the more ambiguous or confusing the misleading information, the more likely that it will contaminate the memory.

In conclusion, it seems likely that forgetting and recovery of traumatic memories involves many cognitive processes occurring simultaneously. Future research should reflect the complexity of this area rather than reducing it to whether trauma can be forgotten or whether they can be accurately retrieved.

6 Clinical Techniques Associated with Recovered Memory

The critics of the recovered memory phenomenon describe clinical techniques, which are used by therapists in therapy sessions, which they believe have been used to

recover memories of traumatic events, especially those of CSA (See Lindsay & Read, 1994). The most controversial of these techniques include hypnotism, guided imagery / visualisation, dream interpretation and interpretation of body memories (Lindsay, 1994; Lindsay & Read, 1994). Critics of recovered memory also report that some therapists tell patients who report no history of CSA, that their symptoms indicate repressed memories of CSA, that many patients cannot recollect their abuse, but healing depends upon recovering memories of abuse (Lindsay, 1994).

It has been suggested hypnosis increases the risk of recollecting inaccurate memories. One way by which inaccurate memories are produced under hypnosis is because clients' criteria for the kinds of mental images they will report as memories is often lowered. Vague or weak images, which people would not rely on in their waking state may be reported as real memories in a hypnotised state (Lindsay & Read, 1994; Wakefield & Underwager, 1994). Researchers have documented many concerns associated with hypnosis, such as it can increase an individual's confidence in memories arising from the hypnotic state, and hypnotised individuals are more susceptible to suggestion (See American Medical Association Council on Scientific Affairs, 1985; Coons, 1993; McConkey, 2001; Spanos, Burgess & Burgess, 1994; Spanos et al., 1999). Lindsay and Read (1994) and Frankel (1993) suggest that hypnosis may be an effective tool, however, it appears ineffective in recovering memories of accurate events. Other researchers disagree and believe alleged problems associated with hypnosis have been exaggerated, and it is a helpful tool that allows clients to work through traumatic memories (Spiegel, 2003). See Yapko (1995) for strategies in how to deal with recovered memory and hypnosis.

Guided imagery is where a client is asked to close their eyes and to relax and allow their imagination to play out scenarios suggested to them by their therapists (Lindsay & Read, 1994; Wakefield & Underwager, 1994). Researchers caution that guided imagery can induce a similar dissociative state as hypnosis and therefore may increase the risk of suggestibility, and of recovering false memories (Lindsay & Read, 1994; Wakefield & Underwager, 1994).

Dream interpretation is another alleged recovered memory technique however, there appears to be no evidence to suggest that dream interpretation reliably shows accurate recollections of long-forgotten events (Lindsay & Read, 1994). In fact, most publications reveal that dreams are a product of 'daily residue', concerns and events of present daily life (Nielsen & Powell, 1992). Lindsay and Read (1994) suggest that

therapists should take care when interpreting dreams, as interpretations may reflect therapist's own biases and beliefs (Lindsay & Read, 1994).

It has also been reported that some clinicians believe certain physical symptoms can be interpreted as unconscious memories of CSA (Lindsay & Read, 1994). For example Frederickson (1992) claimed fear of dental visits is an indicator of oral sexual abuse. It is unclear how such statements could be accurately generalised to every client who exhibits a certain physical symptom. It is important to note that although it is possible that unconscious memories can influence behaviour (for example, Jacoby, Lindsay & Toth, 1992; Rothschild, 2000), it is difficult to determine in any particular case whether physical symptoms should be attributed to unconscious or conscious memories.

Critics also believe the book titled *The Courage to Heal: A Guide to Women Survivors of Childhood Sexual Abuse* by Ellen Bass and Laura Davis (1994), has been used by therapists to assist them in recovering memories of CSA. This book is a self-help book for women who have been sexually abused as children. The book explores the effects of CSA (including blocked memory of the abuse), the stages common to the healing process, strategies for partners and family members, and stories from women who have been abused. The book also has an accompanying workbook titled, *The Courage to Heal Workbook* by Laura Davis (1990). This workbook describes exercises which women can work through to help them deal with the sexual abuse. The book was written in the 1980s and some practitioners have reported the book is dated and over-represents the extent of recovered memories of CSA amongst patients. However, other practitioners have reported that some patients continue to find it helpful. Some practitioners believe that if patients want to read it or if practitioners suggest the book to patients, therapists should provide the patient with some preliminary education about current research on memory and trauma or a discussion placing the book in context.

The literature review found no research on the incidence of use of such techniques to recover memories or empirical or experimental research examining techniques used to recover memories of trauma. However, Yapko (1994) stated that it is necessary to distinguish between professional and unprofessional practice. He stated it is necessary to distinguish (1) those cases in which someone knows and has always known that he or she was abused, from (2) those cases in which someone independently remembers forgotten memories, from (3) those cases in which a

therapist facilitates recall of forgotten memories, from (4) those cases in which a therapist suggests memories of abuse. He reported that unprofessional practice would be classed in the latter phenomenon. Brown, Schefflin and Whitfield (1999) state the issue is not whether a particular therapeutic technique is used, such as guided imagery or hypnosis, rather whether the therapist's questions or comments which accompany the use of the techniques are excessively suggestive and the therapist has supplied much of the content about fabricated abuse related themes in and across sessions.

7 Government Responses and Professional Bodies: Guidelines Addressing Recovered Memories

A search of the literature found that a number of professional bodies have responded to concerns surrounding recovered memories of CSA. These include the American Psychological Association (1998), American Psychiatric Association (2000), Canadian Psychological Association (2001), British Psychological Society (1984, cited in Royal College of Psychiatrists, 1996), and the Australian Psychological Society (2000). There have been few responses from international and national governments. An examination of the international literature revealed the Netherlands' Government issued a series of reports from 1997 to 2004 (Mak, 2004) regarding recovered memories and allegations of CSA. An examination of the national literature found in 2003, the Crime and Misconduct Commission³ also examined the way in which sexual offences were handled in Queensland.

7.1 International professional bodies

7.1.1 American Psychological Association

The American Psychological Association's Working Group on the Investigation of Memories of Childhood Abuse issued a report in 1998. The six-member group was divided in their views but did agree on the following conclusions.

- “Controversies regarding adult recollections should not be allowed to obscure the fact that child sexual abuse is a complex and pervasive problem in America that has historically gone unacknowledged.
- Most people who were sexually abused as children remember all or part of what

³ The Crime and Misconduct Commission is an independent law enforcement commission set up to combat major crime in Queensland, including organised crime and paedophilia, and official misconduct in the Queensland public sector.

happened to them.

- It is possible for memories of abuse that have been forgotten for a long time to be remembered.
- It is also possible to construct convincing pseudomemories for events that never occurred.
- There are gaps in our knowledge about the processes that lead to accurate and inaccurate recollections of childhood abuse” (American Psychological Association, 1998, pp. 933).
- The American Psychological Association’s Working Group (1998) advised therapists:
 - To exercise caution when working with patients who believe they are recovering memories of trauma.
 - To exercise special care in dealing with patients and other groups who are affected by recovered memories, such as family members and the wider community.
 - Give patients information about possible treatment strategies, including the risks and benefits of each strategy.
 - Do not ask leading questions.
 - Avoid imposing beliefs and values on the patient
 - It would not be wise to initiate a search for memories.
 - To be aware of the ways in which they can influence their patients’ memories, such as the questions they ask or the statements they make during the session.
 - To allow the patient to direct the therapy session, to be open to discussion of abuse, but nevertheless, cautious in interpreting the patient’s response.
 - Provide ample opportunities for clarification and discussion.
 - Obtain informed consent in relation to the details of the therapeutic process and possible consequences.

The major difference of opinion within the Working Group related to the extent to which recovered memories are accurate or false. The Guidelines neither support nor deny the accuracy or inaccuracy of recovered memories, but do highlight that memory in general is unreliable, and the accuracy of memories can be affected by many variables. The Guidelines also acknowledge there is inconclusive experimental evidence regarding recovered memory, and whether traumatic memory is processed, stored and recalled differently to non-traumatic memory. The Working Group

concluded that more research is needed to determine:

- The mechanisms by which accurate and inaccurate memories of events may be created.
- The techniques which lead to the recovery of accurate and false memories.
- The impact of trauma on memory.
- If there are client groups who are more susceptible to memory suggestions, and if so, what characterises them from other client groups.

Additionally, on the website of the American Psychological Association (<http://www.apa.org/pubinfo/mem.html>), questions and answers about memories of childhood abuse have been released, which is partly based on the work of the Working Group. This web page includes guidelines for patients in choosing a psychotherapist to help deal with a childhood memory and what can be expected from a competent psychotherapist.

7.1.2 American Psychiatric Association

In March and May of 2000, the American Psychiatric Association approved a Position Statement on ‘Therapies Focused on Memories of Childhood Physical and Sexual Abuse.’ The Position Statement stressed:

- Psychiatrists must not allow the confusion and controversy surrounding recovered memories, particularly in regard to CSA, to discredit the reports of patients who have memories of abuse.
- Memory in general is not always accurate and certain variables, such as severe or prolonged stress and suggestion, may interfere with accurate recall.
- The report concluded with recommendations to psychiatrists.
- “ ... maintain an empathic, non-judgemental, neutral stance towards sexual abuse.
- As in the treatment of all patients, care must be taken to avoid prejudging the cause of the patient’s difficulties, or the veracity of the patient’s reports.
- A strong prior belief (on the part of the therapist) that physical or sexual abuse, or other factors, are or are not the cause of the patient’s problems is likely to interfere with appropriate assessment and treatment” (American Psychiatric Association, 2000, pp. 1).

It was also recommended when there is no supporting evidence for patient’s reports of new memories of childhood abuse, “treatment may focus on assisting

patients in coming to their own conclusions about the accuracy of their memories or in adapting to uncertainty regarding what actually occurred. The therapeutic goal is to help patients to understand the impact of the memories/abuse experience on their lives and to reduce the impact of these experiences and the detrimental consequences in the present and future” (American Psychiatric Association, 2000, pp. 1). It concluded more research is needed in this area. The Position Statement did not address the possibility of imaginary or false memories.

7.1.3 Canadian Psychological Association

The Canadian Psychological Association also updated its ‘Guidelines for Psychologists Addressing Recovered Memories’ (2001). The Guidelines acknowledged:

- There are “... many theoretical approaches to counselling and therapy, many of which support the existence of repressed memories which, in entrenched emotional disturbances, may need to be brought to consciousness to address the past painful experiences more realistically” (Canadian Psychological Association, 2001, pp. 1).
- Psychologists need to remain up-to-date with the latest literature in the area.
- Psychologists are required to continue professional training throughout their career.
- Psychologists must be familiar with and acknowledge the benefits and limitations of therapeutic techniques.
- Psychologists should be aware of their own personal values and beliefs which they bring to the therapy session.

7.1.4 British Psychological Society

The Working Party of the British Psychological Society released a review of the scientific basis for recovered memories (British Psychological Society, 1984, cited in Royal College of Psychiatrists, 1996). The review reported:

- Complete or partial memory loss is a frequently reported consequence of experiencing certain kinds of traumas, including CSA.
- Memories may be recovered within or independent of therapy and recovered memories may contain errors, which may be dependent on the age at which the

event occurred.

- Pressure or persuasion by an authority figure could lead to the retrieval of false memories.
- At the time of publication, there was no reliable evidence to suggest this was a concern in Britain.

7.2 National professional bodies

7.2.1 Australian Psychological Society

The Australian Psychological Society (2000) revised special Guidelines for its members relating to recovered memories. “Amid the controversy ... there is general agreement about the following points:

- Childhood trauma involving physical, sexual and/or emotional abuse is not uncommon;
- Children who are subjected to such experiences are likely to be adversely affected, and evidence exists that varying degrees of psychological damage can be attributed to a child's experience of such abuse;
- Child sexual abuse should not be retrospectively assumed solely on the basis of presenting symptoms;
- Memories of such experiences may be incessant, intrusive, complete, selective, fragmented, distorted or absent depending on the context and nature of the abuse and the survival strategies available to the individual as a child or later in life;
- All memories are susceptible to revision and influence from the time of encoding up to and including the time and context of retrieval, as well as in the disclosure and reporting process; and

The percentage of child sexual abuse experiences that (a) are recalled for the first time during therapy and (b) are the subject of litigation, is very small in comparison to those that are remembered but unreported, and whose effects may or may not require treatment (Australian Psychological Society, 2000, pp. 1)”.

7.3 International government reports

7.3.1 Netherlands Health Council

The Netherlands’ Government commissioned a series of reports from 1997 to the 2004 (See Mak, 2004; Netherlands Health Council, 2004) examining the issue of

false sexual abuse allegations made to police. The conclusions included:

- Memory is reconstructive, and remembering is affected by the social context in which it occurs. Forgetting and recovering memories are normal occurrences involving a range of different mechanisms.
- It is also plausible that memories for traumatic events can become inaccessible, either partially or temporarily, albeit sometimes in fragmentary form.
- The cognitive mechanism involved in forgetting and recovering traumatic memories is unknown.
- Individuals can experience imaginary or false memories.
- Influencing memories by suggestion must be avoided.
- The theory that certain symptoms, such as bulimia, were indicators of forgotten childhood trauma was heavily criticised.
- The risk of creating false memories is increased when an individual, who has certain personality traits, psychological disorders, vague memories or symptoms that are difficult to explain, is exposed to an influential authority figure (such as a police officer or therapist) who believes in the theory that certain symptoms are indicators of CSA, who employ suggestive techniques and who impose firmly their personal convictions on the individual. The reports did not specify the personality traits or psychological disorders that place individuals at increased risk.
- Professionals should produce a pamphlet outlining the benefits, limitations and potential risks of various therapeutic techniques.
- The importance of continued education in the field of memory.
- Further research into the underlying mechanisms of memory phenomena associated with traumatic experiences (Mak, 2004; Netherlands Health Council, 2004).

7.4 National government reports

7.4.1 Crime and Misconduct Commission

In 2003, the Crime and Misconduct Commission released a report, *Seeking Justice: An Inquiry into how Sexual Offences are Handled by the Queensland Criminal Justice System*. Public concern about the issues arose during the investigation, prosecution and discontinuance of charges against swimming coach Scott Volkens in September 2002 prompted the Crime and Misconduct Commission to

conduct a general Inquiry into how the Queensland criminal justice system deals with sexual offences. With regard to recovered memories, the Inquiry examined disclosures of sexual abuse and concluded:

- Disclosures of sexual abuse can be brought about by, but are not limited to, recovered memories.
- There is much evidence that experiences of sexual abuse can be forgotten.
- The validity of recovered memories has been the focus of much controversy within the criminal justice system.
- Leading and suggestive questioning could be generating false allegations.
- The findings of the Inquiry did not support concerns about disclosures of sexual abuse based on recovered memory. To enhance understanding of the full implications of the disclosure of sexual abuse, the Commission recommended specialist sexual offence training for all officers and police prosecutors who are working with sexual offences.

7.5 Summary

The responses of national and international bodies to recovered memories of CSA show many similarities. For example, each professional body reported:

- Memory in general is not always accurate and the degree of accuracy can be susceptible to a range of variables, such as stress.
- Traumatic experiences, including CSA, could be partially or completely forgotten, and subsequently triggered and remembered later in life.
- The difficulty with recovered memories is the ambiguity about the accuracy of the recollection.
- It is possible to create false memories for events that never occurred.
- Considering the possibility of creating pseudomemories, the professional bodies have advised therapists to use caution when working with patients who believe they are recovering memories of trauma. Their advice is:
 - To avoid assumptions and drawing premature or unfounded diagnoses based on symptoms, to remain non-judgemental, acknowledge personal beliefs and avoid imposing them.
 - Avoid leading questions and avoid initiating a search for memories.
 - There is a need for more research in the area of traumatic memory.

8 Summary of the Literature Review

Memory in general is a reconstructive process, that is, memory is reconstructed by using one's current knowledge, understanding and life situation. All memory, including continuous and forgotten memories, has the potential for inaccuracy. A search of the literature found experimental evidence for both recovered and false memories. The available evidence for both phenomena has been criticised for being primarily indirect and having limited generalisability to real life situations. The literature also shows empirical evidence that memory for a range of traumatic events can be unavailable or forgotten for a period of time and subsequently retrieved. There are also anecdotal reports and legal cases indicating evidence for false memories of CSA. There is a range of mechanisms for explaining memory blocking and recovery processes, but generally, researchers agree the likely process involves many cognitive mechanisms occurring simultaneously. In conclusion, there seems a reasonable foundation for the existence of both recovered and false memories.

Recovered memory critics believe there are a variety of memory recovery techniques, for example, hypnosis and dream interpretation. The use of such techniques has been criticised for placing patients at an increased risk of suggestibility, and of contributing to the recovery of false memories. The literature review found no research on the incidence of use of such techniques to recover memories. The issue may not be whether a particular therapeutic technique is used but whether it is used in an ethical and professional manner.

Similar to the research, there is much disagreement on the issue, but the reports and guidelines from professional and government bodies show many similarities. They acknowledge traumatic experiences, including CSA, can be partially or completely blocked for a period of time, and subsequently recovered. They also acknowledge it is possible for therapists to create pseudomemories. In addition, professional bodies also agree on ideas of good professional practice, such as supporting the patient, keeping assumptions to oneself, and remaining non-judgemental.

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