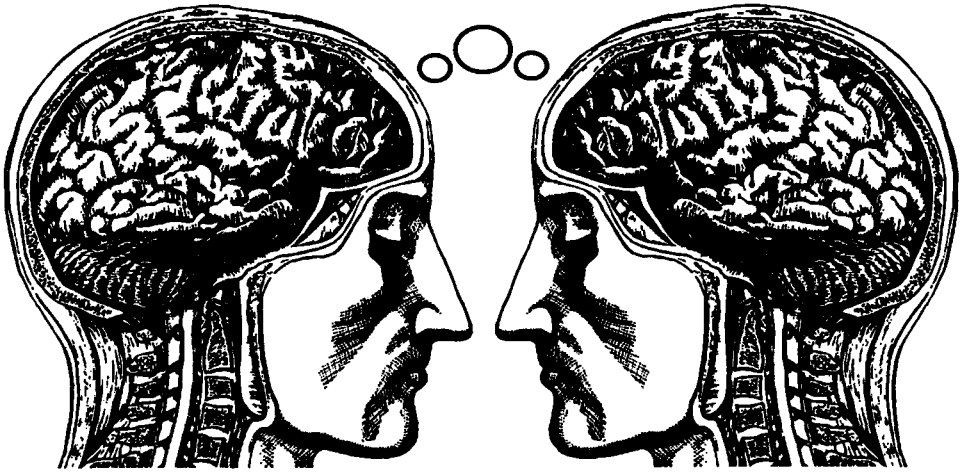
FALSE MEMORIES?



On Delayed Memory

John Rowan

Some years ago, adults discovering that they had been sexually abused in childhood seldom came up in psychotherapy. It was secret, hidden. People didn't mention it, even to their therapists. If they did, many of the therapists explored their feelings and fantasies about it, but did not appear to really believe them — at any rate, they gave no sign of it.

Then came a whole lot of new information, some of it academic and factual (Finkelhor, 1979), and some of it equally well researched but much more emotional (Rush, 1980). One of the most influential voices was that of Alice Miller (1983). She set off a new wave of discovery, among people who had not even heard of the previous work, many of them psychotherapists. Sexual abuse started to appear more and more as people admitted that it might be significant. Instead of being something rare and relatively unimportant, it took the centre stage. The sexual politics of it appeared, too. If male therapists didn't believe women's stories, this was because of a male tendency to protect the father. Jeffrey Masson (1985) came along and claimed that this is exactly what happened with Freud himself. And now Alice Miller (1985) was saying that

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therapists were, in refusing to criticise the father, repeating the abuse. They were subjecting their clients to a regime where they — the therapists — could not be wrong, just as did the original perpetrators. So Miller argued that therapists had to become advocates for the child, not remote observers and facilitators.

In the United States the same sort of thing was happening, but with some interesting twists.

In 1974, Congress had passed the Mondale Act which provided incentives for states to set up programmes for child abuse research, education, prevention, identification, prosecution and treatment. In subsequent years the law was expanded and modified. Programmes would not get federal money unless they undertook (a) to provide immunity from prosecution to all those reporting child abuse, and (b) to make the reporting of abuse mandatory for health care professionals, law-enforcement officials, teachers and school administrators (Gardner, 1993). The figures for sexual abuse went up very substantially through this regime, to the point where alarm was expressed quite widely.

At the same time the various 12-step programmes (based on the work of Alcoholics Anonymous) already in existence and forming during the 1980s began to pay great attention to issues such as co-dependence and the dysfunctional family. This meant an interest in the hurt child within (Bradshaw, 1991), and recovered memories of sexual abuse became prominent in the therapy of such victims and addicts.

Also at the same time, multiple personality disorder was proliferating, and everything seemed to point to sexual abuse as being implicated in most of these cases (Braun, 1986). So we had three extra sources of concern with such matters. In all of them the emphasis was on believing the child or adult, and supporting her (or, more rarely, him) in every way.

We can see from this that there have been two phases: first the phase of ignoring or downplaying sexual abuse; then the phase of paying great and growing attention to it. What now appears to be emerging is a third phase, already very big in the United States, and increasing in this country.

Phase Three

What is this third phase, appearing on the scene of counselling and psychotherapy in this country, emanating from America? A number of therapists working with clients of various kinds are actively looking for and finding early sexual abuse, usually by the father or stepfather, though sometimes by siblings. (This is rather different from the phase two picture, where sexual abuse was just as often perpetrated by neighbours, uncles, family friends, grandfathers, teachers, etc.) And some of these therapists then act as advocates, supporting the clients in going to court to accuse the father (or other adults) of incest.

Now it is obvious that memories of early traumatic experiences of all kinds may return spontaneously to a person, or may also emerge naturally in the course of their therapy. Many therapists, including Balint (1968) and Winnicott (1958), have found such natural emergence. This comes from within the client. But what if it comes originally from the therapist? What seems clear is that once a therapist

is looking for abuse, he or she can always find it, particularly if the definition is drawn widely enough. This is because of the authority situation in therapy, where the therapist's beliefs get communicated very readily to the client, and may often be taken up by the client. This has often been commented on in the standard texts, and all therapists in their training are warned about the power of suggestion. Some authorities argue that not only the therapist's conscious beliefs, but also their unconscious beliefs and attitudes can be communicated to the client (Smith, 1991). This is of course not to deny in any way that sexual abuse is important: we have only to read Florence Rush (1980) or numerous subsequent surveys to know how horrific, and how widespread, it is.

This has raised many questions about regression in psychotherapy — more particularly when it is done hypnotically, but even when hypnosis is not used at all. Are the 'memories' which are recovered real memories, or not? A recent article in *Time* magazine even asked the question — is it not time to abandon the whole idea that childhood events can be responsible for adult problems?

Repression, Dissociation, Amnesia

Murmurings about babies and bathwater can be heard at this point. There are three different questions at issue here. The first is the question as to whether memories can be repressed at all — is there such a thing as repression? The second is the question as to whether the recovery of repressed memories can be therapeutic, in the sense of freeing-up the client. The third is the question as to whether the remembered incidents actually happened. It is quite possible that the first and second questions could be answered in the affirmative without the latter necessarily being true at all. Most therapists of all persuasions have experience of previously warded-off material emerging in quite a dramatic way, and resulting in a diminution or cessation of symptoms and compulsions directly connected with such material. Mahrer (1985) counts this as one of the 'good moments' or 'very good moments' in therapy, in his extensive research on the subject.

My own answer to the three questions is that (a) there is such a thing as repression, (b) the recovery of repressed memories is often therapeutic, and (c) the incidents recalled did not necessarily happen in the way they have been 'remembered'.

But it is not only repression that is involved. We also have to look at dissociation and amnesia. Frank Lake (1980) made a useful distinction between four levels of trauma. Level 1 is totally need satisfying — everything is all right. Level 2 is coping: there are some unmet needs but they are bearable, still within the realm of the 'good enough'. One may even be strengthened by meeting and dealing with such challenges. Level 3 is opposition: pain of this order cannot remain connected up within the organism; it is repressed, and many aspects of the matter are pushed into the unconscious, in the manner suggested by Freud. Level 4 is transmarginal stress (this term is taken from Pavlov's work) and here the pain is so great that the much more drastic defence of splitting has to be used. This is where we get dissociation or amnesia.

Amnesia can also come from actual brain injuries.

If we now ask the question 'Can such early traumas be remembered in therapy?' my answer would again be yes. In fact it is quite common in all forms of therapy for such trauma to emerge, though some specialise in it more than others (Grof, 1985).

Some interesting research has been done in recent years on this issue, using actual records of attested sexual abuse in childhood, and then following up the adults between ten and twenty years later. It is found that a substantial percentage of the respondents had amnesia for the earlier events, some of which were assaults repeated many times (Herman and Schatzow, 1987; Briere, 1992; Williams 1992). Few would doubt that these lost memories could return in psychotherapy, given a sympathetic ear.

Memory

One difficulty here is that we so often have a false view of what memory is. This false view, enthusiastically embraced by many hypnotherapists, is that memory is laid down accurately in files, so to speak. All we then have to do is to find a way of accessing the file, and the memories are all there, in their proper order. For example: 'Thanksgiving at the age of three may consciously be remembered as a fuzzy blur of turkey and cranberry sauce. But stored in the memory, and accessible through hypnosis, are details such as: who was present, their names and how they were dressed, where everyone sat at the table, all the foods that were served and how they tasted (salty, burned, etc.), the time of day dinner was served, how many cars passed the house, topics of conversation and whatever else occurred!' (Anderson-Evangelista, 1980)

Only one exclamation mark seems inadequate for such a remarkable catalogue. But let us listen instead to a more cautious and well seasoned hypnotherapist such as Ernest Hilgard.

Hilgard (1986) has a discussion of what he calls 'fantastic age regressions', including the celebrated case of 'Bridey Murphy' (Kline, 1956), which was shown up to be a complete fabrication. The main point that Hilgard makes is that hypnotic subjects 'will role play an extreme regression on demand' (p.50). He quotes experimental evidence to show that memories may be 'woven into a realistic story that is believed under hypnosis by the inventor of the story'.

Hilgard is of course an able and experienced scientist, as well as a well-known hypnotist, and when he says that in age regression 'the subject creates a hallucinated environment appropriate to the suggestion, combines random memories from the period (and years before and after), and contributes a certain amount of confabulation' (p.55) there is every reason to take him seriously.

If we look up the word 'confabulation' we find this definition: 'the act, conscious or unconscious, of inventing details of memory about oneself, where true memories are lost (and the person may invent them out of embarrassment). It typically occurs in brain damage secondary to alcoholism.' (Feltham and Dryden, 1993)

Of course it is not only in alcoholism that we find this phenomenon. Confabulation is well known in studies of eye-witness behaviour, where it is regu-

larly found that witnesses think they have accurate memories, but are really making sense of what they think must have happened. The memories are not filed images, so much as constructed images.

Hilgard says 'memories revived under hypnosis, no matter how convincing to the subject, cannot be trusted until verified by external criteria (e.g. Kelsey, 1953). The 'will-to-believe' may be so strong in the hypnotist as well as the subject as to give the impression of validity.' (p.59)

The US television programme *20/20* presented the recent research of Cornell developmental psychology professor Steven Ceci on children's memory. Documented on video is the development of a child's elaborate narrative created by simple questions asked over a period of time. The child created a story that never happened. It did not require threats or intimidation or any of the aggressive methods we might think necessary for persuasion. All it took was a trusting and imaginative child who wanted to satisfy the researcher. This is written up fully in Ceci and Bruck (1993).

All this material makes it clear that we have to avoid not only the Scylla of not believing the client (sexual politics does come in here, as we noted earlier), but also the Charybdis of believing the client too much and in the wrong way. What I mean by the wrong way is that it is impossible to take the uncorroborated statements of clients about anything as statements of fact. What is more important from a therapeutic point of view is to take those statements as the best sense the client can make in the here and now, and to work seriously with them as such. They may or may not be factual; that can only be checked by bringing in other evidence. As with all material coming from the client, we have to be discriminating. It has been said that the ideal therapist needs to be thoroughly gullible and thoroughly suspicious at the same time.

And so we come back to the question — what is memory? A rather beautiful and poetic statement comes from the French psychologist Gaston Bachelard: 'In their psychic primitiveness, imagination and memory appear in an indissoluble complex. If they are attached to perception, they are badly analysed. The remembered past is not simply a past of perception. Since one is remembering, the past is already being designated in a reverie as an image value. From their very origin, the imagination colours the paintings it will want to see again.' (Bachelard, 1991, p.44)

More scientifically, we can go to the recent work in academic psychology on connectionism — the idea that memory takes place through parallel distributed processes, rather than through a neat linear process. One feature of such systems is default assignment: missing information about an object or event is filled in on the basis of information about similar objects or events. If there is no information given about particular aspects, the gaps will be filled with plausible information from elsewhere.

Such models also have the property of graceful degradation, with forgetting, or indeed physical damage to the system, leading to a noisier or weaker recall of the original memory, rather than the complete removal of certain fragments and the complete preservation of others (Baddeley, 1990).

One danger of memory, on this connectionist view, is that we should get confabulation occurring — that is, memories would be doctored to suit the present context, and then 'remembered' erroneously.

Actually it has always been the humanistic view that events which remind us of previous events have the power to change our memories of those previous events. We interpret the earlier events in the light of the later events. So we are continually reprocessing the past. This means that the whole notion of storage has to go, and be replaced by a notion of processes which are maintained or transformed in accordance with the values of the person. There is a good discussion of many of these issues in Courtois (1992).

We turn now to some specific issues raised by various writers on the subject, which have a bearing on points which seem more peripheral.

Body Memories

Susan Smith (1993) has written a paper entitled 'Body memories: and other pseudo-scientific notions of "survivor psychology"' and a book entitled *Survivor Psychology: How the mental health missionaries of a pseudo-science cult are raping minds and ruining families*. She quotes from eminent authorities and gives the impression of trying to be factual and objective. One of her targets is the idea that there are such things as 'body memories' — that is, memories of early experience which are held, not in the brain, but in the muscles or cells of the body. One reason why she is so opposed to such a notion seems to be that the proponents of such ideas (or some of them) propose that such memories are infallible. Another reason seems to be that some proponents of such ideas maintain that such body memories are always connected with sexual abuse.

Let us take these things slowly, one by one. First, there do seem to be such things as body memories. It is well known that stigmata of various kinds can come up on the body and be very dramatic in their appearance (e.g. Janov 1977, p.283). In fact, people under hypnosis can often produce them at will, or at the suggestion of the hypnotist. (There was a good TV programme about this in early 1994). If they occur spontaneously they very often do point to some event with which they are connected. And so far as psychotherapy is concerned, the whole Reichian and neo-Reichian school takes the view that memories can be held in the musculature, and that pressure on the relevant muscles can evoke striking memories of traumatic events (Southwell, 1988).

Second, the notion that such memories are infallible is not held by any reputable psychotherapist of any school known to me. Such memories are subject to all the problems of memory mentioned above, and do not escape from any of them. Anyone who believes that they are infallible as to matters of fact just has not considered the matter thoroughly enough. Even a convinced supporter of early memories says that 'errors are always possible', and insists on proper checking wherever and whenever possible (Chamberlain, 1988).

Third, such body memories certainly do not refer only to sexual abuse. They can refer to any traumatic event no matter how caused (Lake, 1980). In my experience they are particularly likely to be laid down at a time when the person is

too young to have access to language, and information therefore has to be stored in the form of images. It is well known that images are generally less precise than language, and such images, physical in this case, are therefore quite suspect in their precision just for this reason. They may be very accurate as to feelings, but by no means so accurate as to the facts surrounding those feelings.

For these reasons, I think that Susan Smith has gone too far in her criticisms, in spite of her effort to be objective.

Court Cases

In some cases therapists have been to court as witnesses supporting the client in cases where parents have been sued or otherwise accused. In an interesting paper on this aspect, Thomas Gutheil, Professor of Psychiatry at Harvard Medical School, says that we must distinguish between a fact witness and an expert witness: 'A fact witness testifies to direct observations through the senses (e.g., what one saw in or heard from a patient) and what one did (e.g., explored an issue). An expert, once qualified by the court, may testify to conclusions to the previously described reasonable degree of medical certainty. Note that the license to testify in this way derives in part from the assumption that the expert has objectively examined the entire database in a given case, including both sides of the matter, and that the expert is willing to acknowledge honestly the limits of the data.' (p.530)

The details of the legal requirements may be different in this country, but the crucial difference is obvious: the fact witness is subjective, while the expert witness is objective. The fact witness says 'I listened', while the expert witness says 'I checked'. What so often seems to happen is that the unfortunate therapist is called in as a fact witness, and is then treated as an expert witness, simply because they have qualifications. However, it is not qualifications that are at issue, but the degree and type of checking that was undertaken.

Another important point is that therapy and law are two very different arenas, with quite different rules. In a court of law it is considered a bad thing to ask leading questions. In psychotherapy we have to ask questions or make other interventions which are perfectly proper in therapeutic terms, but which in a court of law would probably be counted as 'leading questions'. Any attempt at empathy normally involves something like a 'leading question', and psychotherapy without empathy would be a strange creature indeed. The Canadian researcher Alvin Mahrer has suggested that all therapy is prescriptive, and that even the most non-directive therapist is still more prescriptive than one might expect from the label. (All these questions come up in relation to the Ramona case, which hit the headlines last April.)

It goes without saying, perhaps, that it is not part of the therapist's job to advise clients to go to law, or not to go to law. At present there is a Working Party, set up by the UK Council for Psychotherapy, which it is hoped will produce a set of guidelines for practitioners on this whole question.

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