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Recollections of Sexual Abuse: An Introduction to The Recovered/False Memory Controversy

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At the time of this writing, the controversy surrounding delayed and recovered memories of child sexual abuse is entering its sixth year. It has spawned considerable public debate and has had a profound effect on the mental health professions and the practice of psychotherapy. It has also moved beyond the consulting room to the forensic setting. Lawsuits charging therapists with malpractice for suggesting or implanting false memories of abuse through faulty technique and inappropriate influence have been filed in increasing numbers, most often by disgruntled former patients but more recently by third parties as well. A false memory defense is now quite routine in litigation involving any allegations of abuse, whether current or past. The controversy has further extended to the legislative arena. Bills have been introduced (but not passed as of this writing) in several state legislatures that would restrict clinical practice by setting conservative criteria regarding what constitutes a credible memory of past abuse, acceptable conditions for the initial disclosure of such information, and acceptable versus proscribed therapeutic techniques. Although the impact of the controversy has already been enormous, its effect can be expected to continue and possibly to accelerate in the future.

The gist of the arguments that make up the controversy are as follows:

Proponents of the false memory position charge that a substantial number of therapists, on the basis of mistaken notions about the workings of human memory, erroneous theory regarding repressed and recovered memory for trauma, and suggestive therapeutic

technique, have caused the development of recovered but false abuse memories in gullible patients who have no previous recollection of abuse. Patients go on to develop "false memory syndrome" whereby they regress and become dependent on a therapeutic program that actively pursues missing memories of abuse, often of the most bizarre and improbable forms. A number of these patients, in turn, have gone on to accuse their parents (and others) of abuse based on these memories and many have cut off all contact with families and even initiated civil lawsuits, causing further harm and distress to innocent individuals and families.

Proponents of the recovered memory (or traumatic stress) position argue that recovered memories do not automatically equate with false memories and that no data have yet been published to substantiate these serious charges that have nonetheless been sensationalized in the media and presented in the courtroom. They further hold that false memory critics and memory researchers have little, if any, understanding of human traumatization and sexual abuse on which to base their critique. Disturbances of memory have long been identified in traumatized individuals as part of their immediate and/or long-term post-traumatic reaction; therefore, it is not unusual for individuals to have variable recollections of past abuse and trauma, some of which might be expected to emerge during psychotherapy not as false memory and not necessarily as the result of suggestive influence. Traumatic stress advocates also question the asymmetrical emphasis placed on false memories: in the controversy, they apply more to the victim/accuser than to the alleged perpetrator even though research

has consistently documented patterns of denial, disavowal (and false memory) in real perpetrators. Proponents of the traumatic stress position agree with false memory critics that false accusations of abuse are tragic, yet they argue that the denial of real abuse and traumatization is equally, if not more tragic, and the societal focus on the reality of abuse of the last two decades ought not be lost in the debate.

The positions taken in the controversy have often been extreme, overdrawn, and caustic due to the intense politicization of the issues. A rational position that incorporates the legitimate issues of each side has been lacking and is only beginning to emerge. Cognitive memory experts and clinical researchers and practitioners have recently found some common ground and are beginning to engage in collaborative research and clinical efforts. Collaboration and a reasoned middle ground that is responsive to all parties will help on a number of counts:

- It will insure that the relatively new fields of traumatic stress studies and dissociation continue to develop and to incorporate information from other fields of study;
- It will insure that efforts to provide treatment to those reporting recollections of abuse (whether continuous or with variable accessibility) will proceed and become more articulated and sophisticated. Adults abused as children make up a high percentage of patients in mental health caseloads and have historically been underserved, a situation that was changing before the controversy surfaced. It is critical that these advances not be prematurely attenuated or abandoned but rather continue; and,

(continued)

- It will help clinicians by providing a context for their work with this treatment population. Many therapists are confused and scared in the current contentious and litigious climate and are in need of principles and guidelines for clinical

practice.

The guidelines presented below are this writer's attempt to provide, in rather condensed form, such a set of practice recommendations. As noted in the introduction, they are not definitive but

are a consolidation of authoritative writing and research findings along with the recommendations of professional task forces and working groups that have been empaneled to study the issue.