How Much are Therapists to Blame For False Memories of Childhood Abuse?

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In 1993 the British Psychological Society convened a working party in response to the concern that some psychologists might be inadvertently implanting false memories of child sexual abuse in their clients. The working party's conclusions that both genuine recovered memories and false memories were likely to occur were endorsed in a subsequent article by Wright, Ost, and French, published in The Psychologist in June 2006, and a series of guidance documents have since been made available to members. The concerns reflected in these publications remain current, as accusations of historic child sexual abuse continue to increase in the wake of the revelations concerning Jimmy Savile and the setting up of the Independent Inquiry into Child Sexual Abuse by the U.K. Government in 2015.

There is now widespread agreement on the existence of false memories of sexual abuse and on the immense harm they can cause. In our work both for the defence and prosecution, however, we have noticed that the events featuring in these cases by no means always support the original account that primarily identifies therapists as actively setting out to suggest or implant false memories of abuse. In this article we revisit the evidence and ask whether it is time to adopt a broader understanding of the issues involved.

The original view of false memory creation (Loftus, 1993) proposed the following typical scenario: Clients with no suspicion of having been abused enter treatment with a therapist who suggests their problems are likely to stem from repressed memories of child sexual abuse and sets about encouraging them to recover the memories using hypnosis, guided imagery, or related techniques (so-called "recovered memory therapy"). The clients are persuaded by the therapist to treat the resulting material as fact, and typically go on to create ever more elaborate 'memories' based on suggestion or fantasy. According to this account, prominent on the websites of false memory societies (e.g., www.bfms.org.uk), and which we have often heard repeated by experts in court, genuine abuse is rarely forgotten and therefore accounts of recovered memories are usually false and the product of inappropriate

therapy. Three claims are typically made to support this argument: Experimental studies show false memories of childhood events are easily created in the laboratory; there is no scientific evidence for a repression mechanism in memory; surveys show that therapists typically have little understanding of memory and many use inappropriate suggestive techniques with their clients to recover memories. But to what extent are these claims valid? Here we now briefly review the research conducted by ourselves and others to address each of these issues.

Suggesting False Childhood Events in the Laboratory

Three types of study have been used to assess the ease of experimentally suggesting complete childhood events. The paradigms used and the results obtained are described in detail in our review article (Brewin & Andrews, 2016). In the imagination inflation paradigm participants are typically given a checklist of distinctive events that might have happened in childhood (such as putting one's hand through a window) and rate how confident they are that each one occurred. The original 1996 study by Maryanne Garry and colleagues asked participants to imagine events they rated as unlikely to have occurred, to answer questions about the events as if they had happened, and then to re-rate their confidence that they had experienced the events. This mimics the guided imagery thought to be used by some therapists. In the false feedback paradigm, participants rate the confidence with which they believe they experienced certain childhood events (for example, that they got sick after certain foods). They are then provided with false feedback that the particular experience was likely to have happened to them at that time and re-rate their confidence that they experienced it. This mimics therapists telling clients that their problems are likely to stem from repressed abuse memories.

The most well-known of the three paradigms involves what has come to be known as memory implantation. In these studies the experimenter targets a particular event (such as being lost in a shopping mall in the original 1995 study by Elizabeth Loftus and Jacqueline Pickrell) which a parent indicates did not happen, and then encourages participants to recall over two or three sessions the details of the false event they are misleadingly told the parent has confirmed as happening. In some cases they may be shown a doctored photograph that supposedly illustrates their presence at the false event. These accounts are then rated for their correspondence to a complete memory by the investigators.

In our review, which is accompanied by commentaries from experts in the area, we followed numerous cognitive psychologists in distinguishing beliefs that an event happened (which may be present without any memory) and recollective experiences of the event, noting that such experiences are not necessarily accepted as real. We reasoned therefore that in order for participants to be judged as having fully accepted a false memory of a childhood event, they must report a recollective experience usually consisting of a visual image, and be confident as well that this experience corresponds to a real event. The imagination inflation and false feedback studies often succeed in increasing the belief that the suggested event occurred by a statistically significant amount that is typically small in absolute terms, but rarely assess the nature of any recollective experiences. Only 8 of the 22 memory implantation studies we reviewed assessed whether a false recollective experience was accepted as real, and on average about 15% of participants appeared to fully accept a false memory. Studies by researchers such as Henry Otgaar suggest that self-report ratings of accepting a memory as real are more conservative than the observer ratings of false memories that the studies report, so it is possible that the actual figure may be lower than this.

After and during the recall attempts participants in these implantation studies are instructed to provide accounts of the false event and sometimes of comparison true events

that have actually been confirmed by the parent. In the majority of studies they are also guided to imagine the false events as if they had happened. Rather than childhood memories being easy to implant, therefore, a more reasonable conclusion is that they can be implanted in a minority of people given sufficient effort. We also question whether the use of family members pretending to be eyewitnesses to the event (an integral part of all studies) and doctored photographs (additionally used in some) - also makes these experiments unlike the therapeutic situation, in which there is scope for suggestion but not deception on this level. Finally, we note that while researchers have been able to implant single false childhood memories, we are not aware of them implanting memories for repeated events, which often feature in abuse allegations.

Does Repression Exist?

Although the original false memory account relied heavily on the lack of any scientific evidence for unconscious repression as an explanation for the forgetting of traumatic events, there was little discussion of alternative mechanisms that might offer a plausible account of how people could forget what appeared to be memorable events. For example, can people choose to forget? Even Freud could not make up his mind whether repression was a deliberate or unconscious process and used the term in both senses.

While evidence for repression as an unconscious mechanism is not yet forthcoming, there is a substantial body of evidence concerning the effectiveness of deliberate strategies of forgetting and their neural underpinnings. Anderson (Benoit & Anderson, 2012) has distinguished between direct suppression, the attempt to not think about something (analogous to conscious repression), and thought substitution, its replacement with an alternative thought. Direct suppression makes it harder to retrieve a memory through the mechanism of activity in the prefrontal cortex inhibiting memory formation in the

hippocampus. Thought substitution, in contrast, involves occupying the limited focus of awareness with a substitute memory. These findings underscore that memory is not a passive process, and that forgetting can be influenced by at least two separate control mechanisms.

Just as experimental research on false memory implantation cannot prove what happens in the clinic, the presence of these control mechanisms in the forgetting of childhood abuse has not yet been examined. Nevertheless, it is clear that the principle of the mind inhibiting unwanted memories, as described in psychoanalytic theories of repression and dissociation, is in no way scientifically implausible and there is evidence that it may occur in response to stress. A related phenomenon is 'dissociative amnesia' which involves a more widespread reversible deficit in memory retrieval that is not attributable to brain damage. It typically affects autobiographical memory for events occurring prior to a stressful event and is well recognized in the context of exposure to trauma (Staniloiu & Markowitsch, 2014). Recent evidence suggests that the underlying neural mechanisms may be similar to those involved in direct suppression (Kikuchi et al., 2010). Finally, it is important to take a developmental perspective, considering for example how memories change qualitatively with age and how early trauma may affect memory by leading to a fragmented sense of self (Brewin, 2012).

Beliefs and Practices of Psychological Therapists

Around 11 surveys since 1994 have questioned therapists about their beliefs concerning the validity of recovered or repressed memories and/or the possibility that such memories could be false. Caution is needed in their interpretation and generalisability as response rates in most surveys are very low - the 3 surveys since 2000 have not achieved rates above 17%. The vast majority of clinical psychologists and licensed psychotherapists believed that repression existed in the two studies that asked the question. Two surveys that

questioned qualified clinical practitioners who were also BPS members about the general accuracy of recovered memories found that almost all believed they were accurate at least sometimes (Andrews et al., 1995; Ost, Wright, Easton, Hope, & French, 2013), although few believed they were always so. Forty-three percent of clinical psychologists in a U.S. survey agreed that "repressed memories can be retrieved in therapy accurately" although none strongly agreed (Patihis, Ho, Tingen, Lilienfeld, & Loftus, 2014). Because the survey questions did not specify whether they referred to the unconscious or deliberate forms of repression, we have questioned whether these results really mean, as Patihis et al. suggested, that there is a science-practice gap with clinicians being poorly informed (Brewin & Andrews, 2014).

The vast majority of therapists participating in surveys also believed that false memories are possible. The earliest study included family therapists and hypnotherapists and found at least 79% endorsed this possibility, rising to 89% among trained hypnotherapists. More recently, over 95% of clinical psychologists in the US agreed (Patihis et al., 2014). Of the studies reporting lower rates of belief in false memories, two included the already mentioned surveys of BPS members where the question was qualified by asking about the possibility of false memories of *repeated* childhood sexual abuse. Comparing like with like, this was endorsed by 67% of the chartered clinical and counselling psychologists and the psychotherapists in Andrews et al.'s (1995) survey (all of whom were BPS members), and 68% of the subsample of BPS chartered clinical psychologists participating in Ost et al.'s (2013) survey (our calculation, factoring in 27% who didn't answer the question). This is in contrast to another subsample of BPS chartered clinical psychologists included in Poole et al.'s (1995) study of whom 88% endorsed false memory possibility in response to the same question without the 'repeated' qualification (Poole, Lindsay, Memon, & Bull, 1995).

Therapists' responses to false memory questions seem to depend crucially on specific wording and can change if they are given options beyond the usual yes/no choice or a chance to elaborate. BPS member practitioners from Andrews et al.'s (1995) survey who had seen clients with recovered memories participated in a subsequent in-depth interview study. While 47% of them had originally stated in response to a yes/no question that false memories of repeated abuse were not possible, with extra response options just 15% thought they were not possible, with 73% believing they were possible but unlikely, and 12% that they were possible and likely (Andrews, 2001). This study also provided insight into the reasons behind BPS therapists' beliefs - although half of those who made further comments attributed false memories to therapists and their practices, the other half also implicated the symptoms and difficulties experienced by highly vulnerable and disturbed clients.

Deeper understanding also emerges from the few surveys that have asked therapists whether they actually use particular techniques to help clients remember child sexual abuse. The most highly cited paper-and-pencil survey reported that 71% of U.S. and U.K. respondents had used at least one therapeutic technique from a specified list for this purpose (Poole et al, 1995). It is difficult to reconcile this substantial rate with the fact that over 90% of all these respondents also believed that false memories were possible. A number of commentators have argued that the necessarily brief survey items could not capture the stage at which therapists used such techniques and whether they were used with clients who had actually forgotten their reported abuse. One aim of our in-depth study described above was to address these issues. We found that our sample of BPS member practitioners had used techniques to aid recall in 42% of their recovered memory cases. This rate reduced to 21.5% when they were used *before* any memory recovery started, with a further reduction to 16% when they were used with clients who did not have *any* prior memory of abuse (Andrews et al., 1999), Andrews, 2001). These figures suggest that while the prevalence in the 1990s of

inappropriate memory techniques was probably less than had been claimed, there was still a significant minority of qualified practitioners who lacked knowledge about good practice.

A Broader Perspective on False Memory Creation

Although we agree that the original account of false memory creation remains valid, we think that there are other explanations for many instances of false memories of abuse occurring today. False memories of childhood events can be implanted in the laboratory but this is difficult to do, it relies on procedures such as deception that make it different from therapy, and only a minority of people appear susceptible. The focus on unconscious repression has been superseded by greater understanding of how trauma impacts on the developing self and of how neural mechanisms underpin the deliberate exclusion of unwanted material from consciousness. It appears that many recovered ‘memories’ first occur outside therapy or in the absence of suggestive techniques. The vast majority of practitioner psychologists now have views that are consistent with professional guidelines, although less qualified therapists are still a major source of concern as they appear to be less well informed about memory than psychologists (Brewin & Andrews, 2014).

Our experience in the courts is consistent with these findings in that we have only comparatively rarely come across examples of therapists setting out from the start to recover memories of abuse. We have much more frequently come across complainants who, when they began therapy, had already recovered their ‘memories’ or had started to, or who appeared to recover ‘memories’ spontaneously during a period when they were receiving therapy. As noted by the BPS therapists interviewed in our study, this places greater weight on factors such as reality monitoring, the need to distinguish the products of thoughts, imagination, and dreams from what has actually occurred (Johnson, 2006). From this

perspective it is important to appreciate how convincing, as well as disturbing, apparent recovered ‘memories’ of traumatic events can be.

Recovered ‘memories’ are often involuntary and can involve repeated reliving of the event, accompanied by marked sensory detail and emotional arousal. High levels of sensory detail are normally associated with true rather than false recollection, but if the apparent recollections are in fact false, the occurrence of this feature increases the likelihood that they are incorrectly labelled as true (Brewin, Huntley, & Whalley, 2012). Clients may also assume that the intensity of their emotional response signifies that the ‘memory’ must correspond to reality.

As has been described in the reality monitoring literature, judgements about whether mental experiences reflect imagined or real events can also be influenced by the person’s cognitive characteristics (e.g., hypnotisability or creative imagination), prior knowledge of similar events, beliefs, cultural factors, repeated imagining, and the influence of other people (Johnson, 2006). We think the same constellation of internal and external factors, singly or in combination, contribute to those situations in which people have compelling, yet false, memories of abuse. When disclosed within therapy to a qualified psychologist, these interpretations of experience are likely to meet with a neutral response that preserves the therapeutic alliance and at the same time permits the client to explore the experience in more depth, considering all possible explanations.

We suspect that a minority of less qualified and experienced therapists may still uncritically endorse the client’s interpretations without careful consideration of other possibilities, for example because the therapist shares erroneous assumptions about memory or because the therapy is exclusively non-directive and supportive. Other therapists may use techniques involving an element of free association without educating the client about the

possibility of false memories. We have commonly found that clients have questioned the veracity of their experiences at some point but often lack the relevant knowledge about how misleading memory may sometimes be. In the context of the disbelief and scepticism that only too often surrounds abuse disclosures, it is perfectly understandable that some clients convinced their memories are true may seek out therapists who do not question their beliefs.

Recovered memories lie on a spectrum from being plainly false, being plausible but lacking in corroboration, to being independently corroborated. In seeking to explain those false memories that do arise within therapy, our account in no way excludes the possibility of therapists acting inappropriately, but places more weight on pre-therapy reality monitoring and on the interactions between a therapist and a client struggling to make sense of what are often distressing and confusing experiences. The risks of uncritically accepting false memories, or disbelieving genuine recovered memories, both have the potential to do immense harm. It is therefore essential that the BPS continues to encourage debate and education around these contentious issues.

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