The Quality of False Memories


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Professor Guiliana Mazzoni was explicit about her bias in presenting information, which had a bearing on the delayed memory controversy. Guiliana had been working closely with Dr Elizabeth Loftus. Dr Loftus holds a position on the scientific advisory board of the “False Memory Foundation” in North America. Dr Loftus has written extensively on the delayed memory controversy and has been frequently criticised for the lack of balance and objectivity in her work. Dr Loftus appears to repeatedly attempt to undermine the credibility of traumatised people who disassociate aspects of their experiences and involves herself in highly emotive attacks on the credibility of mental health practitioners who work with such clients.

In contrast, Professor Mazzoni clearly and carefully articulated many of the pertinent issues which have a bearing on our understanding of memory for traumatic and more ordinary life events including the diverse biological processing of implicit versus explicit memory. Guiliana discussed the effect of mood on the recall of life events and outlined some of the factors, which may increase the likelihood of people experiencing illusory memories. I believe Professor Mazzoni is to be congratulated for this aspect of her presentation.

However, I had major difficulties with the way Guiliana selectively cited relevant empirical research. Guiliana openly acknowledged her lack of familiarity with many other studies. Guiliana described an experiment she had conducted on dream interpretation. The experiment was specifically designed to demonstrate the power of a therapist to influence the creation of illusory memories. The “therapist” involved imposed his views and interpretations of the authenticity and meaning of dreams on unwitting undergraduates. Such an approach is contrary to the ethical guidelines, which inform psychologists working with any client. Ethical practices are especially pertinent in working with clients who may have disassociated memories for life events. The study described by Guiliana did not address traumatic life events and used a small sample of students. The experiment
did demonstrate that the “therapist” involved could misuse his professional power to influence the memories of some vulnerable students.

During the past few years there has been considerable controversy regarding the validity of adult’s previously disassociated but recently recovered memories of childhood abuse. The line of debate falls roughly between clinicians, trauma researchers and survivors who argue that most recovered memories are true and some experimental cognitive psychologists, alleged perpetrators, sociologists and people who recant previous allegations of child abuse who say that many recovered memories are false. The False Memory Syndrome (FMS) is a term coined by the latter group who refer to a hypothesised process whereby people, usually women in their mid-30s, enter therapy with one problem such as depression, insomnia, or an eating disorder, and as result of the therapist’s suggestion leave therapy erroneously believing they were abused in childhood.

I believe this controversy as been artificially polarised and oversimplified. It has flourished in environments characterised by ignorance of child abuse and traumatisation and where there is an inadequate knowledge base with which to critically appraise the information that is presented in the scientific and popular literature. Unsubstantiated claims are made by various writers and then frequently cited and recited as evidence for particular viewpoints in later publications. Most studies in this area are not only theoretically bereft but many are scientifically unsystematic. There is often a lack of conceptual clarity in defining trauma, child sexual abuse, memory or disassociation. These concepts have been classified in many different ways thereby limiting the comparisons that can be made between findings. There is often a focus on selected populations coming to the attention of mental health professionals or the membership of the False Memory Foundation. The samples are frequently biased, unrepresentative and very small. This severely curtails the generalisability of such results. The widespread failure to use control groups and take account of possible confounding variables largely invalidates many investigations. Studies frequently do not statistically evaluate stated differences between groups and there is repeated and serious violation of the fundamental assumptions of various statistical tests. An exclusive reliance on self-report inventories or unsubstantiated observer inference without recognition of the limitations of such approaches often leads to erroneous conclusions. Cross-sectional rather than longitudinal designs have predominated and studies have been limited by the retrospective analysis of relevant variables. Inappropriate causal inferences have frequently been drawn about the relationships between multiple variables.
It is in these contexts that a number of dangerous myths have arisen which appear to be exerting considerable influence on the attitudes and behaviours of the judiciary, the police, health professionals and the general public. The myths include: 1) there is no such thing as recovered memories of child abuse; 2) people frequently do develop false memories of childhood sexual abuse; 3) there is no experimental evidence for delayed memory; 4) infantile amnesia makes memories before age three impossible to believe; 5) disassociated memories for traumatic events are rare; and 6) recovered memories are unsubstantiated. I am of the view that Professor Mazzoni may have inadvertently further perpetuated some of these myths because she did not appear to be familiar with some of the pertinent information. I will now briefly address each of these myths.

**Myths Surrounding The Delayed Memory Controversy**

**There is no such thing as recovered memories of child abuse**

Harold Lief is a psychiatrist and a member of the FMS Scientific Advisory Board. He has argued that 25% of recovered memories of child abuse are false. Strong advocates for the veracity of survivors’ memories argue that there is no scientific evidence of false memories among survivors of child sexual abuse. They say there is only very weak anecdotal evidence provided by a small numbers of well-publicised recanters. This recanter evidence is considered weak because of the repeated clinical finding that survivors of severe and prolonged traumatisation often fluctuate between acknowledgment of the horror of their experiences and considerable self-doubt. One study found that nearly 90% of recanters re-disclosed the abuse later. Another study found that 27% of children recanted their abuse and 5% recanted twice. The essence of the debate is not about whether a large percentage of recovered memories are true. Even the False Memory Foundation is saying that 75% of recovered memories are likely to be true. The debate is about these percentages and the factors that influence the truth of recovered memories.

**People frequently do develop false memories of childhood sexual abuse**

The evidence for the “implanting” of false memories is based on anecdotal statements, single and repeatedly publicised case studies of recanters, experimental studies for memory of non-traumatic events, studies on hypnotically influenced memory and conclusions based on erroneous comparisons with the literature on false confessions. The process of having false memories “implanted” is based on a crude analogy. The process of implantation is said to occur through the pathogen host process of internal medicine. The pathogen is said to be
created by reading popular child sexual abuse recovery books, attending support
groups with other survivors, and by unethical, destructive and inappropriate
therapeutic practices. The pathogen is said to be maintained by untrained and
unskilled therapists, writers and survivors. These people are said to be motivated
by financial gain, the need for simplistic explanations for complex constellations
of symptoms and a desire to exact revenge. Some pathogen maintainers are said
to be man hating separatist feminists whilst others may be well intentioned but
vacuous individuals who are instrumental in destroying ideal families.

My own perusal of the literature has revealed little scientific or forensic evidence
for the “implanting” of memories of child sexual abuse. The research that is cited
in support of this case is about other life events that may or may not have been
personally traumatising. It is characterised by highly selective reporting which
simply leaves out studies demonstrating the essential accuracy of traumatic
memory (Norris & Kaniasty, 1992; Neisser et al, 1991, Terr, 1994). There is also a
serious logical flaw in inferring the existence of phenomena from the contention
that there may be an explanation for it (Pezdek, 1994). The FMS cannot
justifiably claim that false memories of childhood traumatisation exist because
they have conceived a clumsy explanation for a hypothesised process. This
position also ignores evidence that trauma survivors can and do recover memories
prior to seeking therapy, reading self-help books or joining survivor groups. Much
of the alleged support for the implanting of false memories comes from studies
on highly hypnotisable subjects and is associated with memory for normal life
events. There is robust scientific evidence that only 10% of the population is
highly hypnotisable. Despite this evidence, Kevin McConkey in his 1995
presidential address to the APS focused his discussion of recovered memories
almost exclusively on hypnotically influenced memory. Research on the effects of
hypnosis on memory shows that hypnosis can lead to an increase in recalled
material but it also increases errors in recall. It is argued that hypnosis may also
be implicated in making people more confident that incorrect recollections are
accurate (McConkey & Sheehan, 1992). However, the bottom line is that research
clearly indicates that only 5% of recovered memories occur under hypnosis
(Felton, 1994; Hovdestead et al, 1994). The 1995 working party of British
Psychological Society on recovered memories caution against the used of
hypnosis in recovering disassociated memories. This same working party also saw
problems in comparing false confessions to so-called false memories because
many such confessions are coerced and there is often little suggestion that the
confessor actually believes they committed the confessed crime. The confession
is made to escape the coercion. Even voluntary confessions are usually quickly
abandoned in the face of contradictory evidence, whereas recovered memories are frequently persistent and survive despite repeated denials by others of the reality of the events. The working party concluded, “There are a number of significant differences between false confessions and false recovered memories which preclude generalising from one to the other”.

In one study, Loftus (1994) deliberately tried to implant false memories in 24 adults. Ten percent of the 24 participants came up with a specific elaborated memory of having been lost in a shopping mall as a small child, 15% said they had a vague sense of being lost but only after repeated questioning and 75% of the participants did not manufacture a memory even in response to the repeated suggestion of the veracity of this memory by a close relative. Loftus has shown us that even trusted family members are usually unable to “implant” a memory of about a relatively benign and highly conceivable experience. None of these studies on normal life events speak to our understanding of truly traumatic memories. The common denominator of traumatisation is a feeling of intense horror and helplessness, a threat of physical and psychological annihilation, and speechless terror. Any experimental research in this area has serious problems with external validity because of the obvious and important ethical difficulties in manipulating people’s exposure to traumatic events.

There is some evidence for distortions in recall and confabulated memories for non-traumatic events involving explicit memory processes. These memories are malleable by being re-worked, re-organised and re-framed. Memories for normal events have been shown to be influenced by expectations and beliefs, mood and emotional states (Lindsay & Read, 1994, Lynn & Nash, 1994; Ward, 1995). Factors that influence the degree of reconstruction include the personal significance of the event, its emotive content, the length of delay between the event and recall, the reasons why the person is remembering the event and the circumstances of recall. The 1995 report of the working party of the BPS on recovered memories concluded, “normal event memory is largely accurate but may contain distortions and elaborations”.

There is no sound empirical evidence that people can and do develop false memories of traumatic child abuse and there is evidence that even minor details from highly significant events can be reproduced with little distortion. There is also very strong evidence that traumatisation occurs co-morbidly with many other psychological problems. The most common include substance abuse, depression, social adjustment, other anxiety disorders and obsessive-compulsive disorder. Traumatised people have also been found to commit suicide eight times more
frequently than a non-traumatised person even after the influence of depression is statistically controlled (Davidson et al., 1991). Traumatised people also have more difficulties in their sexual functioning (Resick, 1993) and more physical problems (Davidson et al., 1991). In this context, I would strongly argue that any ethical and professional practitioner must obtain information on previous traumatisation as part of a comprehensive psycho-social history. Studies have shown that between 20 to 50% of psychiatric patients suffer from Dissociative disorders (Chu & Dill, 1990; Saxe & van der Kolk, 1992). There are over 40 empirical studies demonstrating that traumatisation precipitates alterations in attention and consciousness. The most common alteration is dissociation (van der Kolk, 1994, Van Dyke, 1994).

**There is no experimental evidence for delayed memory**

As a cognitive psychologist, Dr Loftus (1993, 1994) argues that there is no controlled experimental support for the process of repression. This is indeed true! However, the failure to have this evidence does not mean that it does not exist. Even more importantly Loftus and her colleagues seem to have missed a crucial point. Recent trauma researchers are not arguing that delayed memories occur through the process of repression but through the process of disassociation (Higgins, 1995; 1997; Van der Kolk, 1994; van der Kolk & Van der Hart, 1991). Repression is a Freudian concept that suggests a vertical process where traumatic events are pushed down into the unconscious. Disassociation involves a horizontal model of memory. When a person cannot remember a traumatic life event, the memory exists, but is inaccessible because it is contained in an alternative but parallel memory system (Kihlstrom & Schachter, 1992). Various forms of disassociation can occur not only after, but also during a traumatic event. People appear to disassociate along a continuum depending on the psychological proximity of particular life events. People may disassociate certain behaviours associated with a traumatic event for example; the Vietnam veteran who couldn't initially recall that it was he who repeatedly shot the small bundle, which he later discovered, contained a tiny helpless baby. Some people may have always had comprehensive visual recall of a particular event but have disassociated their feelings for example, the holocaust survivor who describes the gas chambers and the selection process for murder in detail but does so in a monotone voice. Some people may need to go the extreme of creating dissociated identities to survive certain traumatic events for instance, the woman who experienced corroborated organised sadistic abuse and created 60 disassociated identities each holding memories of horrific abuse. While the process of repression has not been
documented an increasingly large literature from neuropsychology, clinical, cognitive and developmental psychology supports the process of disassociation.

**Infantile amnesia makes memories before age three impossible to believe**

The support for the concept of infantile amnesia in relation to traumatic events is at best tenuous. Loftus (1993) used a study by Winograd and Killinger (1983) and concluded that adults aged younger than three when JFK was assassinated couldn’t remember where they were when they heard about this event. She concluded that this means they had infantile amnesia. As the parent of two children, I find it highly conceivable that a child of three would not even know what a “president” means, let alone find the event personally significant or memorable. Infantile amnesia is hypothesised to occur because the neurones of the hippocampus are not sufficiently mylenated to process semantic or factual information. However, the hippocampus is not required to process the implicit sensorimotor memories associated with traumatisation. In fact, the subcortical structures necessary for implicit sensorimotor memory namely, the amygdala, the cerebellum and the autonomic nervous system appear to mature much earlier. It is therefore physiologically possible that adults may recall sensorimotor memories of trauma experienced during infancy and that such recall may have significant biological survival value (Le Doux, 1992; 1994). This assertion is also consistent with the research conducted by Lenore Terr (1991). She studied 150 children who had experienced a variety of traumas. Even those children who were toddlers or infants at the time of the traumatic event were able to play out, draw or re-see visual elements of their traumatic experiences. While adults may not recall personally meaningless events before the age of three or four, they may well be able to recall trauma experienced during infancy although such recollections may not appear in semantic form.

**Disassociated memories for traumatic events are rare**

This is contention is simply not supported by the available prevalence data on disassociated memory for child abuse. The are four retrospective studies in this area, three conducted on clinical samples and one on students (Belicki et al. 1994 (55.4%n=68); Briere & Conte, 1993 (59.3% n=450), Gold et al, 1994 (69%n =105); Herman & Schatzow, 1987 (64% n=58); They all demonstrate rates of disassociated memory for child abuse of over 50%. The only disparate finding is a study conducted by Loftus and her colleagues (1994) that showed that 19% of her sample reported disassociated memory for child sexual abuse. Loftus’ figure is really 31% if you include the women who disassociated all or some of their abuse.
Despite this evidence, Loftus and her colleagues (1994) still attempt to say that delayed memories are rare and they say that the range of prevalence rates for delayed memory is very large and therefore the prevalence findings are of questionable reliability. Her own study differs from other prevalence research in several important respects. Loftus and her co-workers were working with a clinical sample of only 57 substance abusers that only had to be drug-free for a week to be included in the sample. They defined violent abuse in a totally different way to other researchers in the area. The study is methodologically weak in many other respects severely limiting its relevance to our understanding of delayed memories and their correlates.

There is only one prospective study in this area and it provides evidence for the prevalence of disassociated memory of child sexual abuse (Williams, 1994). In this study 38% of 129 women known from hospital records and documented research data to have been sexually abused seventeen years earlier did not recall this episode of abuse. This lack of recall was not a function of their age at the time of the abuse. The women who had been abused by someone with whom they had a close psychological relationship were more likely to have disassociated the memory of the abuse even when abuse severity and age at the time of the abuse were controlled. The women who did not recall the abuse were more likely than those who did recall the abuse to have medical evidence of genital trauma (Williams, 1994).

**Recovered memories are unsubstantiated**

Loftus (1993) claims there is only one case study substantiating recovered memories for child sexual abuse but in doing so she ignores one of the major findings of a study conducted by Herman and Schatzow (1987). These workers found that 83% of the survivors who tried to obtain corroboration for their recovered memories were able to obtain such corroboration. This substantiation was in the forms of admission by the perpetrator, corroboration from another family member and diaries and photographs from the time of the abuse. About a third of these survivors later discovered the same perpetrator had abused a sibling. The ability to obtain corroboration was totally independent of the degree of memory loss. Belicki et al (1994) found that 60.3% of their sample of survivors was able to find corroboration of their memories and that their ability to get evidence was independent of their degree of amnesia for the abuse. Feldman-Summers & Pope (1994) conducted a study on 500 North American psychologists. Twenty five per cent of the women psychologists reported being sexually abused as did 16% of the male psychologists. Half of those psychologists
who had been abused were able to find outside corroboration from relatives, medical or court records, journals or diaries or from the perpetrators’ admission of the abuse. They found that those who recovered their memories through therapy were just as able to find corroboration as those whose memories returned in other ways. Delayed memory was associated with the severity of the abuse and with the degree of violence. Other research strongly indicates that survivors are more likely to minimise rather than to exaggerate their abuse (Famina et al 1990). In her prospective study Williams (1994) found that the women with recovered memories had no more discrepancies in their accounts than did those women who reported that they had always remembered the abuse.

In concluding my invited commentary, I would like to thank Professor Guiliana Mazzoni and the people who helped to make her presentation possible. Giuliani’s talk helped to further alert me to the important role psychologists can play in conducting methodologically sound and theoretically informed research on the processes of traumatisation, disassociation and memory. We really need high quality research to understand what accounts for the partial versus the complete disassociation of memories of traumatisation and to evaluate explanations for lengthy as opposed to short periods of disassociated memory.

Dr Jeannie Higgins