“MEMORY WORK” AND RECOVERED MEMORIES OF CHILDHOOD SEXUAL ABUSE:
Scientific Evidence and Public, Professional, and Personal Issues

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The authors review and critically evaluate scientific evidence regarding recovered memories of childhood sexual abuse and discuss the implications of this evidence for professional psychology, public policy, and the law. The discussion focuses primarily on abuse memories recovered through “memory work” by people who previously believed that they were not sexually abused as children. The authors argue that memory work can yield both veridical memories and illusory memories or false beliefs, and they discuss factors that could be used to weigh the credibility of allegations based on recovered memories. The article offers tentative recommendations regarding public education, training and certification of psychotherapists, guidelines for trauma-oriented psychotherapy, research initiatives, legislative actions, and legal proceedings.

The controversy about psychotherapeutic and self-help techniques used to help clients/readers remember hidden histories of childhood sexual abuse (CSA) is the issue at the intersection of psychology, public policy, and the law in the 1990s. Debate centers on the questions of whether many clients are amnesic for histories of CSA and whether “memory work” (techniques used to recover suspected hidden histories of childhood traumas) can lead people who were not sexually abused as children to believe that they were. This topic bristles with complexities and is charged with political tensions and personal emotions. From any perspective, the stakes are high. Victim advocates understandably fear that charges of iatrogenic pseudomemories of CSA threaten therapists and undermine our society’s fledgling efforts to...
protect children, support survivors, and prosecute perpetrators. On the other side, critics of memory work argue that such techniques have destroyed families and caused clients/readers great and needless harm. Recovered memories have led to court cases by clients against their parents, former clients against therapists, parents against therapists and authors, and parents against their accusing adult children (Bulkley & Horwitz, 1994; Lipton, 1994; Loftus, 1994a, 1994b; Slovenko, 1994). The American Medical Association (1994), American Psychiatric Association (1993), Australian Psychological Society (1994), and British Psychological Society (1995) have released public statements on this issue, and the American Psychological Association has released a brief pamphlet (1995) and empaneled a group to produce a position paper. The debate has received extensive media coverage and is the subject of many recent and pending books, chapters, articles, and special issues of journals. This topic demands our best efforts toward understanding and communication.

This article focuses on recollections and beliefs about CSA developed through memory work rather than on those that arise more spontaneously. This is not meant to imply that all experiences of memory recovery occur through memory work. Briere (in press) argued that psychotherapy that does not involve searches for hidden memories may nonetheless sometimes support recollection of childhood traumas, and two recent surveys of psychotherapists found that memories of CSA are often said to be recovered outside of therapy (although these reports do not indicate whether or how often self-help books and related material played a role in fomenting memory recovery; Andrews et al., 1995; Feldman-Summers & Pope, 1994). Our reading of the memory literature leads us to believe that spontaneous recovery of previously forgotten histories of CSA is a rare phenomenon, but that same literature also leads us to believe that if and when memory recovery is truly spontaneous there are far fewer grounds for concern about false memories. Therefore, we focus on memory recovery techniques and ancillary practices (specified below) used to help clients/readers recover suspected hidden memories. For similar reasons, our comments primarily concern cases in which adults initially believe they were not sexually victimized as children and later come to believe that they were, rather than cases in which people who always knew they survived such abuse as children remember additional details or instances. It must be acknowledged, however, that it is difficult to draw a sharp line between spontaneous and nonspontaneous memory recovery, or between cases in which people always knew that they were abused but only recently confronted that knowledge and cases in which people who previously believed that they were not sexually victimized subsequently believe that they were (see Schooler, 1994).

We have several aims in this article. First, we briefly discuss the cultural context in which the recent popularity of memory work developed. Second, we review scientific evidence of the validity of recovered histories of CSA. Central considerations in this regard include the base rates of CSA and of forgetting CSA, practitioners' ability to discriminate between clients with and without hidden histories of CSA, the susceptibility of memory to suggestion, and factors that increase the difficulty of discriminating between veridical and illusory memories. To anticipate (at the risk of oversimplifying), we argue that memory work can lead both to the recovery of essentially veridical memories and to the development of essentially illusory memories or false beliefs of CSA, and we propose a number of factors that
may be useful when attempting to postdict the validity of alleged recovered memories. Finally, we consider the implications of the best available evidence regarding recovered memories for professional psychology, public policy, and the law.

Our approach to this topic reflects the dual contributions of our training as cognitive psychologists and our concern about the reality of CSA. We hope to reduce use of approaches that may inadvertently lead clients to develop false beliefs and to help fact finders discriminate between accurate and false accusations, without undermining support for survivors of CSA and without impugning psychotherapy in general.

Cultural Context

The debate about memory work can only be understood in its cultural context. A major aspect of that context is the history of sexual victimization of children and women in Western cultures\(^2\) (e.g., Brownmiller, 1975; Brundage, 1993). CSA has a long history, and until recently the predominant cultural response has ranged from passive acceptance to denial and minimization. Over the last century there have been several brief periods during which the sexual victimization of children captured public attention, but these episodes were followed by extended periods during which the existence of CSA was largely ignored. Thanks in large measure to grassroots efforts undertaken as part of the women’s movement, in the past two or three decades our culture has made progress toward a more sustained commitment to protecting children, supporting survivors, and prosecuting and treating perpetrators of CSA (Enns, McNeilly, Corkery, & Gilbert, 1995; Herman, 1992). It is now well established that CSA is much more common than once was thought (e.g., Finkelhor, 1994) and that CSA is associated with psychological problems in adulthood (e.g., Beitchman, Zucker, Hood, daCosta, & Cassavia, 1992). Efforts to combat CSA initially met with resistance from some authorities, who questioned the reliability of child witnesses and minimized the prevalence and impact of CSA, and progress has been hard won (e.g., Hechler, 1988). Heightened sensitivity to the reality of CSA and its association with psychological problems in adulthood helps account for recent interest in psychotherapeutic techniques designed to detect and support survivors (see Conte, 1994). The history of denial and minimization of CSA helps account for the skepticism with which some therapists have reacted to criticisms of memory work in psychotherapy.

An anonymous reviewer of an earlier version of this article suggested that feminism lies at the heart of the promulgation of memory work. Some critics of memory work have made similar arguments in ways that might be characterized as antifeminist (see Enns et al., 1995). Although there are certainly many linkages between feminism and CSA-oriented memory work, we believe it would be incorrect to categorize the latter as peculiarly and uniquely feminist. For one thing, there are striking parallels between memory work and controversial therapies of earlier decades that could hardly be described as feminist (e.g., lobotomy, insulin shock therapy, electroconvulsive shock therapy). Indeed, it can be argued that extreme forms of memory work are antithetical to feminism because they foster codependency between therapist and client and lead clients to define themselves as victims.

\(^2\)Our brief review focuses on Europe and North America because we are not familiar with the history of other cultures with regard to CSA.
(e.g., Haaken & Schlaps, 1991). Finally, Poole, Lindsay, Memon, and Bull’s (1995) surveys of psychotherapists indicated that men and women practitioners equally often reported use of CSA-oriented memory recovery techniques. Feminism is quite properly involved in any debate that touches on the issue of sexual abuse, feminist psychologists have played a major role in promoting memory work, and strong feelings about feminism (on both sides of the issue) have contributed to the politicization of this topic; however, in our view the controversy regarding memory work does not reduce to a debate between feminists and nonfeminists.

It has also been suggested that popular interest in recovered memories of CSA is a symptom of an emerging “culture of victimhood” in which people tend to attribute their problems to the harmful actions of powerful others rather than viewing them as their own responsibilities (e.g., Kaminer, 1992). It may or may not be true that self-identifying as a victim is more common now than in previous decades, but many psychologists have long claimed that childhood traumas precipitate adulthood psychological problems and that analyzing memories of childhood trauma is important for psychological healing. Of course, therapists differ widely in the extent to which they cleave to these views, with many rejecting a focus on childhood trauma in favor of more present-focused interventions (e.g., Madanes, 1990; Minuchin & Fishman, 1981). Nonetheless, beliefs about the role of childhood trauma in causing and treating adulthood problems have deeply permeated our culture over the course of the last century, and many practitioners’ approaches to therapy include an emphasis on exploring childhood trauma (e.g., Andrews et al., 1995).

Because of the prevalence of beliefs about the importance of resolving childhood trauma in treating adulthood problems, various forms of memory work have long been used in some approaches to psychotherapy. For example, in his early article on the “seduction” theory, Freud (1896/1962) described 18 patients whose treatment, he argued, demonstrated that incestuous CSA is often the root cause of psychological problems. This early work of Freud is, in two ways, a caput Nili (source of the Nile) for recent ideas about memory recovery. First, renewed interest in hidden memories of childhood trauma was fueled, in part, by attacks on Freud for abandoning the seduction theory in favor of psychoanalytic theory (according to which these clients had not really been sexually abused as children but instead had fantasized incestuous events during childhood or therapy; e.g., Masson, 1984). Second, many of the recent ideas about hidden memories and memory work are similar to those Freud propounded in his early work. Although secondary sources sometimes imply that Freud’s patients disclosed instances of abuse of which they had always been aware, Freud (1896/1962, p. 204) explicitly stated the following:

Before they come for analysis the patients know nothing about these scenes. They are indignant as a rule if I warn them that such scenes are going to emerge. Only the strongest compulsion of the treatment can induce them to embark on a reproduction of them.

It appears that in this early therapy Freud used highly suggestive techniques, and that in some or all of these cases what the clients produced in response to these techniques were vague thoughts, associations, and images that Freud interpreted as evidence of incestuous CSA, rather than clear recollections of specific events (Powell & Boer, 1994; Schimek, 1987; Tabin, 1993). Freud (1896/1962) likened the therapist to an archeologist who recruits the local people (the patient) to excavate suggestive perturbations in the terrain (symptoms) in the hope of unearthing ancient ruins.
(memories of CSA), and he used a variety of techniques in such excavations. These techniques, and the rationale Freud presented for using them and for viewing their products as memories of actual CSA, are extraordinarily similar to the techniques and rationales offered by recent advocates of memory work in psychotherapy. Similar beliefs about the recovery of hidden memories were widely popularized in sensational books such as *Sybil* (Schreiber, 1973) and *Michelle Remembers* (M. Smith & Pazder, 1980). The “recovery” approach to treating addiction and “codependency” also emphasizes the importance of searching for and resolving childhood conflicts (e.g., Bradshaw, 1988, cited in Pendergrast, 1995; cf. Kaminer, 1992; Yapko, 1994).

Together with increased awareness of the prevalence of CSA and its psychological sequelae, these influences led to the development, promotion, and use of CSA-focused memory-recovery techniques and ancillary practices by some counselors, social workers, psychotherapists, and psychiatrists in the 1980s. There is no formal school or established approach to memory work in psychotherapy, but during the past decade numerous writers have advocated various forms of CSA-focused memory work. Such approaches have been promoted in journal articles (e.g., Claridge, 1992; K. R. Clark, 1993; Courtois, 1992; Ellenson, 1985; Herman & Schatzow, 1987; Maltz, 1990; Olio, 1989; Person & Klar, 1994; Siegel & Romig, 1990), scholarly books (e.g., Courtois, 1988; Dolan, 1991; McCann & Pearlman, 1990; Meiselman, 1990), workshops for therapists (see Pendergrast, 1995), popular self-help books (e.g., Bass & Davis, 1988; Blume, 1990; Engel, 1989; Frederickson, 1992), magazine and newspaper articles, radio and television programs, and novels (see Loftus, 1993, and Pendergrast, 1995, for citations of popular sources). There are important differences among proponents of memory work, and not all advocate prolonged, multifaceted searches for suspected hidden memories. Nonetheless, it is indisputable that CSA-oriented memory work with clients who initially report no CSA history has been widely promulgated in recent years.

In the past few years various “special interest” groups have been formed to represent constituencies affected by the debate about recovered memories. On one side are advocacy groups for people who claim to have been falsely accused on the basis of recovered memories. Of these, the False Memory Syndrome Foundation (FMSF) has been the most active, with 17,000 reported contacts as of October 1994 (FMSF Scientific and Professional Advisory Board, 1994). On the other side, victim advocates have responded in kind, publishing criticisms of the FMSF (e.g., Lawrence, 1993), forming advocacy groups (e.g., Silent No Longer) and, on occasion, staging protests during lectures by critics of memory work (Kristiansen, 1994). Some on each side of this debate have made inflammatory statements about the moral character and motivations of those on the other side and tendered biased accounts of the scientific evidence. This personal and political polarization, understandable in view of the contrasting perspectives of advocates of the truly abused and advocates of the falsely accused, is an important part of the context for discussions of memory work. One of our central arguments, however, is that there is no contradiction between being critical of suggestive memory work and being concerned about CSA.

### Clarifying Criticisms of Memory Work

Criticisms of memory work have focused on approaches that combine several of the following techniques and ancillary practices in a prolonged effort to help clients who initially report no history of CSA recover suspected hidden memories:
(a) directly or indirectly communicating to clients that their symptoms are indicative of hidden memories of CSA, that many survivors do not remember any abuse, and that psychological healing depends on recovering memories; (b) using techniques such as hypnosis, age regression, guided imagery, sodium amytal, and instructions to work at remembering CSA (e.g., giving free rein to the imagination, stream-of-consciousness journaling, use of family photographs as retrieval cues, etc.) to help clients remember CSA; (c) interpreting dreams and physical symptoms (“body memories”) as memories of CSA; (d) recommending that clients suspected of having hidden memories join survivors’ groups, read popular books on remembering CSA, or both; and (e) endorsing all reports related to CSA as accurate memories and countering clients’ expressions of doubt. Again, criticism has focused on extended (although not necessarily overtly coercive) use of a constellation of such techniques. Critics do not claim that all memories experienced through such techniques are false but rather that some—perhaps many—likely are false (e.g., Gardner, 1992; D. S. Lindsay & Read, 1994; Loftus, 1993; Pendergrast, 1995; Schooler, 1994).

Prevalence of Memory Work

In response to criticisms of highly suggestive memory recovery techniques, some have argued that few qualified practitioners actually use such approaches (e.g., Berliner & Williams, 1994; Brown, 1995; Enns et al., 1995; Olio, 1994; Pezdek, 1994). Yet it is indisputable that some counselors, psychotherapists, social workers, and psychiatrists have used suggested memory work in recent years. Individual cases are documented in publications promoting memory work (e.g., Bass & Davis, 1988; Blume, 1990; Claridge, 1992; K. R. Clark, 1993; Ellenson, 1985; Engel, 1989; Frederickson, 1992; Maltz, 1990; McCann & Pearlman, 1990; Meiselman, 1990; Olio, 1989) and in therapy notes and testimony presented in legal cases (see Loftus, 1994a; Ofshe & Watters, 1994; Pendergrast, 1995).

Recent surveys suggest that such practices are not limited to a tiny “fringe” group of poorly trained practitioners. For example, Poole et al.’s (1995) national surveys of certified psychotherapists in the United States (N = 145) and United Kingdom (N = 57) found that 71% (return rate = 40%) reported using techniques such as hypnosis, body work, and dream interpretation to help clients remember CSA. Moreover, 25% reported a constellation of beliefs and practices that led Poole et al. to classify them as “memory focused.” Such respondents indicated that they believe that remembering CSA is important for effective psychotherapy and that some of their clients had hidden memories, that they are sometimes “fairly certain” after an initial session with a client who denies a CSA history that the client has hidden memories of CSA, and that they use two or more techniques to help clients recover memories of CSA. These criteria are too broad to limit this subgroup only to those who use the most suggestive approaches, but the findings are nonetheless interesting. In Survey 1 this subgroup of respondents indicated, on average, that 60% of women clients whom they suspected of hidden histories of abuse eventually recovered such memories, and in Survey 2 they indicated, on average, that 34% of all women clients who initially denied a CSA history eventually recovered such memories. In a survey of Seattle-area practitioners, L. Berliner (personal communication, October 19, 1994) found that although most respondents did not indicate a focus on helping clients recover memories of CSA, a minority did. Andrews et al. (1995), in their survey of certified therapists in the United Kingdom, found that the
10% who reported use of hypnotic regression reported more clients recovering previously unknown histories of CSA than did other therapists. In Yapko's (1994) and S. Smith's (1991) surveys of therapists, a substantial percentage of respondents reported ill-founded beliefs and practices regarding memory recovery techniques such as hypnosis.

Memory work has also been widely popularized through self-help books. Santrock, Minnett, and Campbell's (1994) *The Authoritative Guide to Self-Help Books*, provides evaluative summaries of self-help books, based in part on ratings of 350 books by 500 “experts in clinical and counseling psychology from all 50 states . . . [who] possess the very best psychological knowledge in the United States” (p. 3; all respondents were members of the counseling or clinical divisions of the American Psychological Association). The first chapter of reviews is dedicated to “Abuse and Recovery,” and Bass and Davis's (1988) *The Courage to Heal* received a five-star rating (“strongly recommended”):

> This book gets extremely high marks. Any woman who knows she was sexually abused as a child or has the slightest inkling she might have been abused will benefit from this book . . . [It] can help women recognize if they were sexually abused as a child . . . [A]fter leading women to become aware of a painful past, [it] moves on in positive ways to help them heal and recover. (p. 12)

Consistent with this recommendation, 44% of the U.S. practitioners in Poole et al.'s (1995) survey indicated that they had recommended *The Courage to Heal* to clients. Pendergrast (1995, p. 51) reported that this particular book has sold 750,000 copies. Although *The Courage to Heal* and other self-help books that include an emphasis on recovering memories of CSA may provide much-needed support for survivors of CSA, they are alarmingly suggestive (D. S. Lindsay & Read, 1994; Pendergrast, 1995). In such books, an authoritative source explains that many people have histories of CSA of which they are unaware, that many common psychological problems are evidence of hidden abuse histories, that doubting abuse is often a sign of “denial,” and that recovering memories is a painful but important step toward healing. These books prescribe memory recovery exercises to enhance imagery and lower memory-monitoring criteria and provide vivid personal accounts of people who have recovered memories of previously unsuspected histories of CSA.

In summary, the majority of qualified practitioners do not focus on searching for hidden histories of CSA in their clients, but it appears that a nontrivial minority have taken such an approach in recent years. Given that a very large number of people provide insight therapies of various types under various auspices in North America (Baker, 1994), each with a number of clients, a very small percentage of therapists translates into many thousands of clients. Moreover, it appears that a large percentage of psychotherapists make at least some use of potentially suggestive techniques to help some clients search for memories of CSA. Finally, suggestive memory work has also been widely promoted in self-help books.

**Scientific Evidence Regarding the Validity of Recovered Memories**

**Base Rate of Hidden Memories**

A core premise underlying the use of CSA-oriented memory work in psychotherapy is the belief that a substantial percentage of clients have histories of CSA but are unaware of those histories. The rationale for this premise is that (a) a large
percentage (e.g., 33%) of women are survivors of CSA (e.g., Bass & Davis, 1988; cf. Finkelhor, 1994); (b) a large percentage of abuse survivors (e.g., 50%) have no conscious memories of the abuse (e.g., Blume, 1990; Maltz, 1990); and (c) because CSA causes psychological problems, survivors with hidden memories are overrepresented among psychotherapy clients. If these premises are true, then tens of millions of women in North America suffered CSA but do not know it, and a large proportion of people who seek therapy have hidden histories of CSA. In the following sections, we review evidence on the base rates of CSA and amnesia for CSA histories and then consider evidence related to practitioners’ ability to discriminate between clients with and without hidden CSA histories.

**Base rate of CSA.** As noted in our comments regarding the cultural context of the debate about memory work, in the past two decades it has become clear that CSA is much more common than once was thought. If CSA is defined sufficiently broadly (e.g., to include inappropriate comments, looks, and gestures directed by adults at children under 18 years old), then it is likely that most North American women are survivors of CSA. Even if CSA is defined narrowly (e.g., restricted to sexual contact by an adult), evidence indicates that there are millions of survivors of such abuse in North America (e.g., Finkelhor, 1994).

It is important that our society continue to acknowledge the reality of CSA and take steps against it. The not-so-old belief that only one in a million persons in the United States is an incest survivor (Weinberg, 1955, cited in Russell, 1983) has been soundly rejected. It is also important, however, that prevalence estimates based on vague or broad definitions of CSA (e.g., those that combine offenses ranging from sexual comments to exhibitionism to intercourse) not be misconstrued as estimates of the prevalence of the most extreme forms of abuse. Similarly, prevalence estimates that include survivors of an isolated instance of CSA should not be misconstrued as estimates of the prevalence of repeated abuses. For example, Russell (1983) found that 38% of the 930 women interviewed in her study reported at least one instance of contact CSA by age 18, and 4.5% reported any form of “actual or attempted” contact sexual abuse by their fathers. Burnam (1985, cited by Peters, Wyatt, & Finkelhor, 1986) found that 6% of 1,623 randomly sampled Los Angeles women reported forced sexual contact of any kind before the age of 16 years. Wyatt (1985) found that 75% of retrospective CSA reports in her sample of 248 Los Angeles women involved a single instance of abuse; 1.6% of the respondents reported actual contact CSA of any kind perpetrated by fathers. Finkelhor, Hotaling, Lewis, and Smith (1990), in their national survey of 2,626 U.S. men and women, found that 34.2% of the women reported some form of contact CSA by age 18, but “the majority of the experiences were one-time events” (p. 21) and 2% reported any form (contact or noncontact) of CSA perpetrated by their fathers or stepfathers. In a recent review, Finkelhor (1994) argued that the best evidence indicates that 20% of women in the United States experienced some form of CSA, and that 4 to 5% experienced CSA involving penetration or oral-genital contact. Finkelhor also emphasized that retrospective studies indicate that more than half of CSA is extrafamilial and that approximately a third of offenders are under 18 years of age.

Our point is not to minimize the reality of incestuous sexual abuse of children, and we do not mean to dismiss as trivial other forms of abuse. Even when abuse is defined narrowly, the best data indicate that there are millions of survivors, and even instances of noncontact abuse may be harmful and are to be abjured. Our point is
that prevalence estimates that include reports of noncontact CSA, single instances of
extrafamilial CSA, and so on, should not be misconstrued as prevalence estimates for
repeated, incestuous contact CSA. We focus here on repeated incestuous contact
abuse because (a) evidence indicates that such abuse is most strongly associated with
subsequent psychological problems (e.g., Briere & Conte, 1993; Briere & Elliott,
1992; Conte & Berliner, 1988; Finkelhor & Browne, 1988) and (b) extreme forms of
incestuous abuse have been the focus of writers and practitioners who favor searches
for suspected hidden memories of abuse (e.g., Bass & Davis, 1988; Blume, 1990;
Courtois, 1992; Freud, 1896/1962; Poole et al., 1995; Wakefield & Underwager,
1992). The best available evidence suggests that a very small percentage of North
Americans have experienced repeated, incestuous contact CSA. Even if retrospec-
tive self-report studies underestimate the prevalence of such abuse, and even if the
base rate of such abuse is several times higher in the population of people seeking
psychotherapy (a point on which evidence is mixed: See Briere & Zaidi, 1989; Brown
Poole et al., 1995; Stinson & Hendrick, 1992), people with such histories would still
make up a small minority of clients in most general practices.

Memory for CSA. As noted earlier, a central premise for memory work is the
belief that many adult psychotherapy clients are survivors of CSA who are unaware
that they were sexually abused as children. It is claimed that children “dissociate”
during CSA in ways that impair later conscious recollection or that they later
“repress” memories of the trauma. The secret nature of CSA and the victim’s
powerlessness are also said to contribute to amnesia for abuse. According to some
writers, repression, dissociation, or both, are so effective that children who are
routinely subjected to horrific abuse often show no obvious symptoms and are
oblivious to the abuse until decades later (e.g., Terr, 1994; Walker, 1994). In this
section, we review evidence for and against the idea that memories of CSA are often
hidden from awareness. Perspectives on this issue have ranged from the molecular
and cellular levels (e.g., effects of hormones and neurotransmitters on brain
functioning: Cahill, Prins, Weber, & McGaugh, 1994; LeDoux, 1992; McGaugh,
1992; Siegel, 1995; van der Kolk, 1988) to the postulation of higher level cognitive
processes (Ganaway, 1989; Freud, 1899/1962; Freyd, 1993; Morton, 1994; Terr, 1993,

It is well established that people are unable to recall many of their past
experiences, especially those of childhood, and sometimes do not recollect even
quite memorable adulthood events. For example, Loftus (1993, p. 522) cited
government research showing that adult survey respondents sometimes do not
remember relatively recent automobile accidents or hospital visits. Studies of
“directed forgetting,” in which people are instructed to forget some studied material
and later receive a surprise test on that material, indicate that instructions to forget
can lower later memory test performance (e.g., Bjork, 1989; Vokey & Allen, 1995).
Rehearsing an event (either mentally or aloud) serves to improve later memory for
that event, so it is reasonable to propose that avoiding thinking or talking about an
experience can contribute to forgetting that experience (e.g., Bower, 1990). Memory
performance also sometimes shows context- and state-dependency effects (i.e.,
memory performance sometimes suffers slightly when the environmental context or
mental–emotional state of the person change from study to test; e.g., Davies &
Thomson, 1988; Eich, 1995), and although such effects are often not statistically
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reliable, they might contribute to poor adulthood memory for childhood traumas. Thus, several cognitive processes may contribute to forgetting of CSA (see Freyd, 1993; Siegel, 1995). These processes are opposed, however, by other processes that lessen the probability that a history of CSA will be forgotten: In general, the core details of highly salient life experiences tend to be well remembered (Christianson, 1992; Winograd & Neisser, 1992). Given these competing mechanisms, the likelihood of completely forgetting a history of CSA is an important empirical question. Below we review the seven studies published to date that addressed this question, as well as studies of memory for other traumatic events (see other reviews by Enns et al., 1995; Koss, Tromp, & Tharan, 1995; Pope & Hudson, 1995; Siegel, 1995).

In six studies, people were asked if they had ever experienced a period during which they could not remember CSA that they now remember. In Briere and Conte’s (1993) questionnaire study of 450 women whose therapists were part of a sexual abuse treatment network, 59% of the 100% who reported CSA indicated that there had been a period during which they were unable to remember the first instance of abuse. In Loftus, Polonsky, and Fullilove’s (1994) interview study of 105 women in a drug rehabilitation program, 19% of the 54% who reported CSA indicated a prior period during which they forgot the abuse. In Gold, Hughes, and Hohnlecker’s (1994) intake interviews of an unspecified number of women in a sex abuse survivors’ treatment program, 30% of the (presumably) 100% who reported CSA indicated that there had been at least a 1-year period during which memories of the abuse were “completely blocked out.” In Sheiman’s (1993) questionnaire study of 196 undergraduates, half of the 12% who reported CSA indicated that there had been a period during which they did not remember the abuse. In Feldman-Summers and Pope’s (1994) questionnaire study of 330 therapists, 41% of the 24% who reported CSA indicated that there had been a period during which they could not remember some or all of the abuse. In Williams’s (1994a) prospective study of 129 women with recorded histories of an instance of CSA, 12% of the 62% who reported the recorded instance when interviewed 17 years later indicated that there had been a period when they did not remember that instance of abuse.

The most global criticism of these studies concerns the ambiguity of the question respondents were asked, such as, Was there ever a time when you could not remember some or all of the abuse? (Loftus, Garry, & Feldman, 1994; Ofshe & Watters, 1994). The meaning of affirmative responses to this question is not clear: Were respondents reporting periods during which they avoided thinking of the abuse or periods during which they would have been unable to recall it if asked? Williams (1994a) noted that some of her respondents indicated that they were referring to periods of time during which they avoided thinking about the abuse. The question was phrased in different ways in different studies, but in all cases it is unclear how well the question mapped on to complete amnesia for a CSA history. Even if it is assumed that most respondents were referring to complete amnesia for abuse histories rather than to avoidance, forgetting of details, or forgetting of particular instances, questions can be raised about people’s ability to assess whether they would have been able to remember CSA during a period of time when they claim not to have remembered it (Loftus, Garry, & Feldman, 1994; Ofshe & Watters, 1994; Schooler, 1994).

As a more general methodological comment, an implicit assumption in these studies has been that affirmative responses to questions about forgetting of CSA
reveal magnitudes of memory loss peculiar to traumatic experiences; however, Read, Seelau, and Nicholls (1995) found that 33.1% of a large group of undergraduates affirmed that they had experienced recall of other sorts of autobiographical experiences that had been forgotten for some period of time. In a follow-up study, Read et al. (1995) found that 31% of 204 undergraduates reported having experienced “recovery” of long-forgotten autobiographical memories; the vast majority of these indicated that although they had not thought of the event for an extended period of time, they believed they would have if they had been asked. Finally, questions can also be raised about the representativeness of the samples in studies of reported amnesia for CSA and about the contribution of memory work to reports of prior amnesia: All of the people in Briere and Conte’s (1993) study had been in treatment for sexual abuse, half of Feldman-Summers and Pope’s (1994) respondents who reported a period of being unable to remember some or all of their abuse histories said that they were in therapy when memories returned, and all of Gold et al.’s (1994) respondents had self-selected as clients in a sex-abuse survivor’s treatment program. These points do not entirely vitiate the consistent finding that a substantial percentage of people who report CSA histories report that there were periods when they could not remember some or all of those histories, but they do raise questions about what those findings tell us about the prevalence of hidden histories of CSA in clients presenting for psychotherapy for common psychological problems who initially report no memories of CSA.

Herman and Schatzow (1987) used the reports of 53 adult clients in a 12-week trauma-memory-oriented group-therapy program to estimate the prevalence of forgetting of CSA. All of the clients reported CSA histories. Sixty-four percent of the clients were judged to have evidenced some degree of prior forgetting of CSA because they reported new memories of CSA during the therapy program. Of the clients who reported new memories, 74% subsequently reported corroboration of their abuse histories, but the nature of some of the corroboration appears weak (e.g., clients’ self-reports that family members in some way supported their beliefs), and it is not clear whether the corroboration referred to newly remembered abuse or to never-forgotten abuse.

Williams (1994a) interviewed 129 women who 17 years earlier, during childhood, had been judged by hospital authorities to have experienced an instance of CSA. In the course of a single interview that used no special memory recovery techniques, 88% of these women reported instances of CSA, and 62% were judged (by a lenient criterion) to have described the particular recorded instance in response to questions about their history of CSA. Interviewers did not ask the women about the particular recorded instance—indeed, they were blind to it. Williams did not indicate how many of the 12% who reported no abuse history were under 4 years of age when the recorded instance occurred, so we cannot estimate the extent to which infantile amnesia (i.e., the well-established, normal paucity of adulthood recollections of events that occurred before the age of 3 or 4 years) contributed to these cases. Williams’s results suggest that a substantial minority of victims of CSA do not report a particular instance when interviewed years later and that some survivors of a recorded instance do not report any CSA when interviewed about their CSA histories (probably because they do not recall the abuse). As Williams (1994b) noted,
however, the findings do not support the idea that a large percentage of people with extensive histories of CSA are unaware that they ever experienced such abuse.

To our knowledge, the seven studies just reviewed are the only published investigations of the base rate of forgetting of CSA (excluding a few in the literature on multiple personality disorder [MPD], which suffer from numerous methodological flaws; see Read & Lindsay, 1994, pp. 419–421). Taken together, these studies show that a substantial minority of abuse survivors do not remember a recorded instance of CSA, that a smaller minority of abuse survivors do not report any CSA, and that a substantial percentage of people who report CSA histories indicate that there have been periods during which they could not remember some or all of the abuse. In our view, however, this research does not provide strong support for the belief that a large percentage of people seeking psychotherapy have recoverable hidden histories of CSA. First, all but the Williams (1994a) study relied on retrospective self-reports of a period of time when respondents could not remember CSA that they later remembered. As noted earlier, the meaning of these reports is not clear: Were respondents indicating periods of avoidance or periods during which they could not have recalled abuse if asked? Can people accurately answer the latter question? Were respondents referring to periods of not remembering particular instances or details of abuse or to periods of not remembering that any abuse had ever occurred? Furthermore, respondents in the studies by Briere and Conte (1993), Gold et al. (1994), and Herman and Schatzow (1987) were in therapy for sexual abuse, which suggests that they were not amnesic for all abuse and raises questions about the generalizability of the findings. Finally, the fact that all of Briere and Conte’s (1993) and Herman and Schatzow’s (1987) respondents were in therapy, as were half of Feldman-Summers and Pope’s (1994) respondents who reported prior periods of not remembering CSA, raises the possibility that suggestive memory work may have played a role in some reports of previous periods of not remembering abuse. Other research on memory for traumatic experiences, reviewed later, also does not support the claim that a large percentage of CSA survivors are unaware that they experienced such abuse as children.

In an unpublished dissertation study, Vardi (1994, described by Brown, 1995) found that adults who reported histories of CSA performed significantly more poorly than did control participants (matched on demographic variables with the exception of amount of time in therapy) on measures of memory for names of teachers, schools attended, and significant public events around the time of the reported abuse. This finding is consistent with other evidence, cited by Schooler (1994), that traumata can cause general memory disruptions, but it should not be misconstrued as evidence that abuse survivors commonly forget that they were abused; indeed, we assume that Vardi’s abuse survivors remembered histories of abuse. It must also be emphasized that poor memory for early childhood events is a normal phenomenon, exhibited in most mammals (e.g., Spear, 1979; Usher & Neisser, 1993). Finally, although CSA may impair memory for later childhood events, other factors may also have this effect.

Cameron (1994) surveyed 72 women with reported CSA histories, most of whom were recruited by their therapists, who were asked to recruit clients who had either been totally amnesic for (n = 25) or had always remembered the reported abuse (n = 21). The therapists also recruited 14 clients who reported partial amnesia, and 12 women in a prison program for sexual abuse survivors also participated. Cameron
compared responses of these women with findings of studies of combat veterans with posttraumatic stress disorder (PTSD). One difference was that combat veterans usually sought help 9 to 30 months after their return from Vietnam, whereas the clients entered therapy 20 to 50 years after childhood. A related difference was that the most common symptom among veterans was intrusive memories, whereas among clients the most common symptom was the absence of trauma memories for decades and what Cameron described as strategies for avoiding memories (e.g., alcohol or drug use in 36%, keeping "overbusy" in 75%). Symptoms of anxiety and depression were also reported, but it appears that these symptoms were primarily associated with recovering memories. Cameron did not indicate what proportion of clients who reported amnesia had recovered memories through therapy, but the article is imbued with the beliefs that underlie memory work, and 22% of the sample reported types of CSA that are extremely rare (torture in ritual abuse or childhood gang rapes). Cameron's data document that some clients experience "memory recovery," but in view of the sampling procedure and the likely role of memory work in producing some of the reports of amnesia in her sample, the findings shed little light on the base rate of amnesia for CSA.

Cameron (1994) was not the first to argue that amnesia for CSA is analogous to the amnesia sometimes exhibited by combat veterans (e.g., Herman, 1992). In fact, however, veterans with PTSD rarely if ever forget that they experienced wartime trauma, but rather exhibit emotional numbing, avoidance of combat-related stimuli, symptoms of depression or anxiety, generalized cognitive deficits, and perhaps the hallmark symptom, intrusive memories of their experiences (e.g., Figley, 1986; Sonnenberg, Blank, & Talbott, 1985; Wilson, Harel, & Kahana, 1988). Veterans with PTSD sometimes exhibit amnesia for particular traumatic events, but Silver (1986), in a chapter describing an inpatient program for Vietnam veterans with PTSD, stated that "Complete amnesia may be encountered but it is rare" (p. 221). We know of no case in which a Vietnam veteran believed for years that nothing terrible had happened in Vietnam and then remembered combat traumas. Similarly, survivors of the Holocaust rarely if ever forget that they experienced Nazi concentration camps (Kraft, 1994; Wagenaar & Groeneweg, 1990). In summary, although CSA can cause PTSD (Briere & Runtz, 1990; Rowan, Foy, Rodriguea, & Ryan, 1994), documented cases of PTSD bear little resemblance to cases in which people believe for decades that they were not sexually abused as children and then later come to believe that they were.

Like combat veterans, many adult rape victims experience intrusive memories of their assaults (e.g., Foa, Rothbaum, Riggs, & Murdock, 1991), but there are few reports of victims who forget that they were raped. Christianson and Nilsson (1989) described a rape victim with amnesia for the assault, but the woman did not evidence a smooth and seamless encapsulation of the rape with no obvious signs of psychological impairment; rather, she exhibited a dramatic and general retrograde amnesia (e.g., did not know who she was, did not recognize friends, and was amnesic for her entire history). Such symptoms appear typical of psychogenic amnesia (Schacter & Kihlstrom, 1989). In contrast, as noted earlier, some advocates of memory work claim that sexually abused children often repress or dissociate ongoing abuse yet show no symptoms of trauma or amnesia until years later. That claim also conflicts with data on child victims of sexual abuse, who often exhibit psychiatric problems (e.g., Merry & Andrews, 1994; Oates, O'Toole, Lynch, Stern, & Cooney, 1994), although some victims, while aware of the abuse, are asymptomatic (Beutler,

Research on children's memories for traumatic experiences also sheds light on the plausibility of the claim that children frequently forget traumas, such that they could be repeatedly sexually abused and not consciously remember it later. For example, Malmquist (1986) reported a study of children who had witnessed the murder of a parent. Far from exhibiting amnesia for the tragedy, the children suffered intrusive memories of it. Pynoos and Eth (1984) described 40 children who had witnessed the murder of a parent and reported that these children had exceptionally vivid recollections. Green et al. (1994) assessed 99 survivors of a disaster that had occurred 17 years earlier (when respondents ranged in age from 2 to 15 years) and found no reliable differences between disaster survivors and a control group on any of the measures, including PTSD; although not specifically mentioned, the report implies that none of the survivors forgot the disaster. Dollinger (1985) studied 38 child survivors of a lightning strike that killed three of their playmates; a month later one boy, described as a "side-flash victim who was hospitalized for depression as well as medical problems" (p. 377), was said to have no memory of the event, but there is no indication that any of the other children failed to remember it when assessed 9 months later. Femina, Yeager, and Lewis (1990) found no evidence of amnesia when physically abused children were interviewed at age 24 years. Terr (1988, 1991) studied children who had survived extremely traumatic experiences and reported that those who had experienced a single, unique trauma had vivid recollections of it, whereas those who had experienced repeated episodes of trauma remembered bits and pieces of different experiences rather than each episode as an integrated whole.

Terr (1994) claimed that her studies indicate that unique (Type I) childhood traumas are generally well-remembered, but repeated (Type II) traumas are often entirely forgotten. As others (Loftus & Ketcham, 1994; Ofshe & Watters, 1994) have pointed out, Terr offered no compelling evidence in support of the latter conclusion, which flies in the face of a host of empirical studies demonstrating that although repeated experiences of a given kind often lead to difficulty in recalling details of specific instances, they also lead to excellent memory for the "script" (Schank & Abelson, 1977) of the experience. In fact, Terr's case histories do not include clear evidence of any child being entirely amnesic for traumas that occurred beyond age 3 years. Consistent with cognitive research, evidence from a few highly publicized molestation trials suggests that survivors usually remember the abuse and that the likelihood of remembering increases with the number of incidents (Goleman, 1992; Yapko, 1994). According to psychiatrist S. Grassian (personal communication, January 6, 1995), who surveyed 43 people who alleged CSA by a priest, only 16% indicated that they had not thought about the abuse since it had happened, and none received memory work to remember it. Grassian found that as the reported number of molestation experiences increased, so did the likelihood of reported later thoughts about them; most people who said they had not thought about the molestation since it occurred indicated one-time incidents. In summary, contrary to Terr's claims, evidence indicates that survivors of multiple traumas are more likely to remember they have had such experiences than are victims of an isolated trauma.  

4Closed head injuries, electroconvulsive shock, and similar brain injuries reliably cause retrograde amnesia for events preceding the injury (e.g., Pinel, 1990, pp. 411–412).
Howe, Courage, and Peterson (1994) interviewed children who had experienced physical traumas (broken bones, contusions, etc.) sufficiently severe to require hospital treatment. The children were interviewed a few days after the trauma and a second time 6 weeks later. There was no evidence of unusual forgetting of trauma. Instead, forgetting appeared to follow its usual course, with the children remembering the central aspects of the trauma very well, but forgetting or remembering incorrectly peripheral details over time. Furthermore, there was no relationship between parental ratings of the child’s emotional stress during the trauma or during the hospital treatment (when some children were so hysterical that they had to be physically restrained) and later memory. As Howe et al. pointed out, several other studies have also found little or no evidence of a negative relationship between stress and later memory (Goodman, Bottoms, Schwartz-Kenney, & Rudy, 1991; Goodman, Hirschman, Hepps, & Rudy, 1991; Ornstein, Merritt, & Baker-Ward, 1995; Peterson, Moreno, & Harbeck-Weber, 1993). Goodman, Quas, Batterman-Faunce, Riddlesberger, and Kuhn (1994) studied 4- to 10-year-old's memories of a medical procedure in which the child is catheterized, his or her bladder is filled with radioactive liquid, and the child is required to urinate on the table while being X-rayed. Goodman et al. found that children neither entirely forgot nor perfectly remembered the experience. Pynoos and Nader (1989) interviewed children about a sniper attack near their school and found evidence of forgetting of details and memory errors (including some children who did not witness the event but reported that they had) but not for amnesia for the experience. Stuber, Nader, Yasuda, Pynoos, and Cohen (1991) found that six children who had experienced painful bone marrow transplant operations exhibited PTSD symptoms when interviewed up to 12 months later (e.g., intrusive thoughts, avoidance of topic), but there is no indication in their report that any of the children had forgotten the traumatic experiences. Peters (1991) found that children stressed by the sounding of a fire alarm remembered less about concurrent events than did control children and were also more suggestible, but the decrement was not in memory for the stressful event (i.e., the fire alarm) itself. Parker, Bahrick, Lundy, Fivush, and Levitt (1995) found that Florida children whose homes were most dramatically damaged by Hurricane Andrew reported less information when interviewed about the hurricane than did children whose homes were only moderately damaged. However, the decrement was restricted to reports of storm-related events that had occurred during the days and weeks after the storm (e.g., home and yard repairs), and it is likely that more of the children whose homes took the full brunt of the storm were more often moved to nondamaged areas immediately after the storm. In any case, no child forgot the terrifying experience of the hurricane (J. Parker, personal communication, December 20, 1994).

Studies of corporal punishment of children provide converging evidence for the hypothesis that forgetting of childhood trauma is the exception rather than the rule. Severe corporal punishment at the hands of loved ones can be terrifying to children, as well as physically painful and shaming. In some cases, such experiences overlap with CSA in other ways as well (e.g., being spanked on bare buttocks). Physical punishment—particularly severe punishment—is often meted out in private, away from witnesses. During such punishments, children may “dissociate” to escape mentally, and it seems likely that such punishments are rarely a subject of subsequent conversation. Doubtless, children experience motivations to forget such beatings.
Research suggests that most North American adults not only have such experiences in their histories (Finkelhor & Dzubia-Leatherman, 1994; Wolfner & Gelles, 1993) but remember them (DiTomasso & Routh, 1993). On the basis of research on autobiographical memory, we speculate that people with multiple experiences of this sort are likely to have the sense that memories of details of some events are blended with others and that some specific details and individual events do not come to mind at all; in contrast, people who only once or twice received severe physical punishment are likely to remember the experience in some detail.

Some defenders of memory work claim that neurophysiological research supports the belief that traumas are often entirely forgotten yet could later be recollected under certain circumstances (e.g., Brown, 1995; Enns et al., 1995). In fact, however, the relatively small number of studies do not offer clear and consistent support for this idea. Trauma is associated with changes in electrochemical activity in the brain, and some animal studies indicate that the amygdala can mediate learning of stressful events (Kandel & Kandel, 1994; Siegel, 1995; van der Kolk, 1988), but it is not clear to us whether or how such findings support the notion of recoverable hidden memories. Other research with animals and humans suggests that emotional experiences are associated with increased levels of adrenalin in the brain and that heightened adrenalin leads to better memory (e.g., Cahill et al., 1994).

It has also been argued that task and population dissociations between direct ("explicit") and indirect ("implicit") tests of memory support the idea that people often have recoverable hidden memories of CSA. Indirect tests of memory involve presenting experiment participants with a task that is in some way related to previously studied material (e.g., asking them to solve word fragments, such as R__C__VE__, after exposing them to a list of words that included solutions for some of the fragments). Direct tests, in contrast, instruct participants to remember the studied materials (e.g., recall a previously studied list or make recognition judgments on studied and nonstudied words). People can demonstrate memory for past events on indirect tests when they do not remember or recognize those events on a direct test (see Kelley & Lindsay, in press, and Roediger & McDermott, 1993, for reviews). Such findings show that people's behavior and experience can be affected by events that they do not consciously remember, but they do not support the idea that people could recover episodic recollections of those events. Indeed, many memory theorists have argued that indirect tests reflect use of a memory system fundamentally different from that which supports episodic remembering—that is, "implicit memories" cannot later become "explicit memories" (Squire, 1994).

In summary, some factors likely exacerbate forgetting of childhood traumas, but others likely serve to preserve memories of such experiences. Research on autobiographical memory suggests that people who were sexually abused in the first few years of life are unlikely to remember the experiences as adults and that those who experienced one or a few isolated instances of sexual abuse (especially events that were not extremely salient at the time) may often not remember them as adults. In our reading, however, studies of memory for traumatic events offer little support for the idea that adults with extensive histories of extreme CSA often forget those histories yet could recover memories under the appropriate conditions. Indeed, the evidence reviewed in this section suggests that this is a rare phenomenon, such that most practitioners would encounter few such cases. Of course, the validity of this conclusion depends on (a) the aptness of criticisms of studies presented as evidence
that complete amnesia for CSA is commonplace and (b) the generalizability of studies of memory for childhood trauma, which indicate that people are unlikely to forget the occurrence of highly traumatic childhood events experienced after the age of 3 or 4 years. As Schooler (1994) eloquently argued, at present there are too few studies, and too many differences between the studies and the question of forgetting of CSA, to justify definitive statements. Nonetheless, existing research on children’s and adults’ memory for physical traumas, murders, natural disasters, and so on, suggests that memory for trauma follows the same principles as memories for mundane events, and that, because of their salience, traumatic events are more, rather than less, likely to be remembered. A recent review of research on trauma memories by clinicians Koss et al. (1995) reached the same conclusion. The sole published prospective study of adult survivors of CSA (Williams, 1994a) provides converging evidence that the majority of adults who experienced contact CSA beyond age 3 or 4 years remember that they had such experiences (although they may not remember particular instances).

Summary. In this section, we reviewed evidence on the base rates of contact CSA and forgetting of CSA. We argued that although CSA is much more prevalent than once was thought, a relatively small percentage of North Americans have experienced the most extreme forms of CSA (e.g., repeated contact CSA). We also argued that research indicates that traumatic events experienced beyond the first few years of life tend to be remembered relatively well. We do not claim that it is impossible for survivors of repeated contact CSA to forget that they were abused. Rather, our point is that evidence suggests that such forgetting is rare. Forgetting in ways that enable later remembering is likely rarer still. Together, these findings and arguments imply that only a very small percentage of people have hidden histories of CSA that they could recover through memory work. Awareness of these lower base rates might lead trauma-oriented therapists to be more cautious about attributing clients’ symptoms to hidden histories of CSA, particularly in light of evidence, reviewed in the next section, regarding the difficulty of discriminating between clients with and without hidden histories of CSA.

Reliability of “Indicators” of Hidden Memories of CSA

There is evidence of associations between remembered CSA and a variety of adulthood psychological problems. Some have taken such findings (in the context of the belief that a large percentage of clients have hidden memories of CSA) as support for the idea that clients with certain symptoms likely have hidden histories of CSA (e.g., Gelinas’s, 1983, “disguised presentations”; cf. Freud, 1896/1962). This view reaches its extreme form in self-help books that offer readers checklists of numerous common symptoms said to be indicative of hidden histories of CSA (Blume, 1990; Frederickson, 1992; Ratican, 1992). Bass and Davis (1988) presented a similar variety of “indicators” embedded in prose rather than as a list. Similar beliefs are reported, in less simplistic form, by some highly trained practitioners (e.g., Courtois, 1988, 1992; Herman, 1992; Walker, 1994). Collectively, the 212 respondents in Poole et al.’s (1995) surveys of highly trained therapists listed dozens of “indicators” of CSA, including sexual dysfunction, relationship problems, depression, anxiety, eating disorders, dissociation, substance abuse, and born-again Christianity.

Some ideas about detecting hidden histories of CSA on the basis of symptoms appear to reflect the common logical error of “affirming the consequent” (i.e.,
assuming that if A causes B, then all cases of B must have been caused by A). The fact that CSA is associated with particular symptoms does not mean that those symptoms can be taken as indicators of CSA. This is because it is well established that many other factors are also associated with such symptoms, and some of these other factors have higher base rates than CSA. By analogy, brain tumors are associated with headaches, but this does not mean that all or most people with headaches have brain tumors, because many other factors—some of which have much higher base rates than brain tumors—can also cause headaches.

Some proponents of memory work have emphasized the importance of the simultaneous presence of multiple “indicators” for forming a clinical judgment, hypothesis, or “index of suspicion” about hidden memories (Ellenson, 1985; Ratican, 1992). The underlying idea is that although other factors might account for individual symptoms, clients with multiple indicators (e.g., low self-esteem and suppressed appetite and relationship difficulties and sexual dysfunction and sleep disorders) very likely have histories of CSA. This rationale would be reasonable if each of the symptoms were independent of the others, and if the constellation of symptoms was uniquely diagnostic of CSA, but in fact multiple symptoms are often highly correlated aspects of a particular syndrome (e.g., all of the symptoms listed in the preceding sentence are characteristic of clinical depression, which has multiple etiologies; see Ceci & Loftus’s, 1994, discussion of “incremental validity”). CSA is associated with many adulthood psychological problems, but some people with CSA histories do not have those symptoms, and many people who have those symptoms do not have CSA histories. Thus, there is no well-defined post-CSA syndrome that could be used reliably to identify people with hidden histories of CSA (Beitchman et al., 1992).

Research on the reliability of diagnoses raises further doubts about therapists’ abilities to discriminate between clients with and without repressed histories of CSA. Even highly trained therapists working with well-defined diagnostic categories often disagree about the appropriate diagnoses for particular clients (e.g., di Nardo, Moras, Barlow, Rapee, & Brown, 1993; Herron, Schultz, & Welt, 1992). Because there is no established post-CSA syndrome, clinical judgments regarding hidden memories of CSA are almost certainly less reliable than formal diagnoses. In view of the likelihood that practitioners’ theoretical orientations can bias their clinical judgments (e.g., Sarason & Sarason, 1984, p. 81), there are grounds for concern that those who believe that CSA is a major source of adulthood psychopathology often erroneously form the opinion that nonabused clients have hidden memories. In any case, even if one accepted the claims of proponents of memory work regarding the base rate of complete amnesia for CSA, and even if one assumed extraordinary diagnostic accuracy among such therapists, the likelihood that diagnoses of repressed memories would be erroneous is surprisingly high. For example, if 33% of clients are abuse survivors, if 50% of these are amnesic for the abuse, and if clinical judgments about hidden histories are 90% accurate, then nearly a third of all positive judgments about hidden memories would be wrong (assuming symmetry between positive and negative diagnoses). As any of these parameters is lowered the likelihood of false-positive judgments increases dramatically (see D. S. Lindsay & Read, 1994; Read & Lindsay, 1994).

5As C. J. Dalenberg (personal communication, February 2, 1995) pointed out, checklists purporting to evidence that respondents were not sexually abused as children are equally suspect.
“Dissociability” appears to be emerging as the symptom most often mentioned as an indicator of childhood trauma (e.g., Sheiman, 1993). In our view, there are grave risks associated with using dissociability as an indicator of hidden memories of CSA. First, Brenneis (1994) cited several studies and reviews indicating that symptoms of dissociability may arise for numerous reasons. Second, dissociability is closely related to suggestibility (Piper, in press). Thus, dissociability may in fact be a measure of clients’ susceptibility to suggestive memory recovery techniques. Consistent with this possibility, dissociability is a hallmark of MPD (dissociative identity disorder); many critics have argued that MPD may be an iatrogenic phenomenon that arises from suggestive therapies used with suggestible clients (e.g., Piper, in press; Spanos, 1994).

Memory Work and Memory Illusions

The research reviewed in the previous section suggests that adulthood recovery of previously forgotten histories of CSA through memory work is likely a rare phenomenon. Yet both proponents and critics of memory work have offered evidence indicating that in recent years many thousands of North Americans have reported memory recovery in psychotherapy or through self-help books, survivors’ groups, and so on. This section reviews evidence relevant to the possibility that some such reports reflect iatrogenic illusory memories or false beliefs developed in response to suggestive influences.

Memory and suggestion. Psychologists and sociologists have long been interested in memory errors and distortions. We and others have recently reviewed relevant aspects of this literature (D. S. Lindsay & Read, 1994; Loftus, 1993; Loftus & Ketcham, 1994; Ofshe & Watters, 1994; Read & Lindsay, 1994; Schacter, 1995), so we confine this discussion to a brief recapitulation and mention of some new studies.

The picture that emerges from this large and varied literature is a strikingly coherent one: Memory is largely accurate but far from perfect, people are susceptible to suggestive influences that can lead them confidently to misremember past events, and the likelihood that suggestive influences lead to memory errors is jointly determined by (a) the clarity of memory for the period and events about which suggestions are given and (b) the strength of the suggestive influences. Quite weak suggestions often lead to memory errors when they concern trivial details in a passively witnessed event (e.g., Loftus, Miller, & Burns, 1978), but stronger suggestions are usually needed to create illusory memories of memorable, personally experienced events (e.g., Hyman, Husband, & Billings, 1995). Factors that lead to poor memory for the events or time period about which suggestions are given (e.g., delay) and those that increase the strength of suggestions increase the likelihood that people will experience illusory memories or false beliefs in accord with suggestions (e.g., Loftus et al., 1978). The overall strength of suggestive influences is determined by a multitude of factors, including perceived authority and trustworthiness of the source of suggestions, repetition of suggestions, perceived plausibility of the suggestions, imagability of the suggestions, and memory-monitoring response criteria (i.e., the amount and kind of cognitive evidence people require before they accept an image or idea as a memory; see Ross, Read, & Toglia, 1994, for recent review chapters).
As explained in more detail in D. S. Lindsay and Read (1994) and Read and Lindsay (1994), the important point is that extreme forms of memory work in psychotherapy combine virtually all of the factors that have been shown to increase the likelihood of illusory memories or beliefs: (a) a trusted authority communicates a rationale for the plausibility of hidden memories of long-ago childhood trauma (that many clients have hidden memories, that the client’s psychological symptoms, physical symptoms, and dreams evidence them, and that doubt is a sign of “denial”) and (b) a trusted authority provides motivation for attempting to recover such memories (that healing is contingent on retrieving hidden memories); (c) the client is repeatedly exposed to suggestive information from multiple sources (anecdotes in popular books, other survivor’s stories, comments and interpretations offered by the therapist, etc.), providing a “script” for recovering memories as well as suggestions about particular details; and (d) techniques such as hypnosis and guided imagery enhance imagery and lower response criterion such that people are more willing to interpret thoughts, feelings, and images as memories.6 In the most extreme forms of memory work, these converging suggestive influences unfold gradually over a period of weeks or months of therapy sessions, sometimes supplemented with homework exercises, self-help books, and survivors’ meetings. Immersion in such a program may provide material for troubling dreams and intrusive “flashbacks.” Through such memory work, thoughts and images (which may at first be experienced with considerable doubt) may become detailed and convincing pseudomemories.

Memory recovery techniques likely do not need to be overtly coercive to be strongly suggestive—indeed, overt coercion may inoculate people from suggestive influences to some extent (Bowers, 1984). Instead, therapists who use long-term, multifaceted, suggestive forms of memory work may be viewed (and view themselves) as sympathetic and supportive guides through unchartered territory. Rosenthal’s (1994) recent review of 30 years of research on expectancy effects is particularly germane here: This research shows that expectations held by teachers, managers, judges, nursing-home caregivers, and others can affect the behavior of those with whom they interact. For example, when caregivers are led to believe that certain patients should do better than others, those patients do in fact tend to do better. Rosenthal argued that these expectancy effects are mediated primarily by subtle nonverbal behaviors. The applicability of such effects to psychotherapy is supported by the observation that therapists with particular orientations often find that their clients fit their orientation (e.g., MPD-oriented therapists find that many of their clients have MPD; Piper, in press).

Of course, not every client who receives suggestive memory work develops false beliefs or illusory memories of CSA. First, these techniques might enable some clients with hidden histories of CSA to remember actual abuse. We have argued that research on autobiographical memory suggests that such cases are rare, not that they

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6Hypnosis, guided imagery, age regression, and other visualization and relaxation techniques appear to have therapeutic value in other respects (e.g., Kirsch, Montgomery, & Sapirstein, 1995) but not as memory recovery techniques. Dozens of studies have shown that although these techniques lower response criterion and may enhance imagery (and consequently often increase both accurate and inaccurate reports, and inflate confidence in both accurate and inaccurate reports), they do not in themselves increase ability to remember (e.g., American Medical Association, 1994; Steblay & Bothwell, in press). The belief that hypnosis or age regression can reliably enable people accurately to recapture early childhood experiences has been debunked (e.g., Frankel, 1993; Nash, 1987; Spanos, Burgess, & Burgess, 1994).
are nonexistent. Second, there appear to be individual differences in suggestibility (Brown, 1995; Piper, in press), which may be understood in terms of the factors listed earlier. For example, individuals with vivid imagery and high trust in authority may be especially susceptible to suggestion (cf. Hyman & Billings, 1995; Schooler & Loftus, 1993). Thus, some clients are likely more at risk of developing illusory beliefs through memory work than others.

It must also be emphasized that approaches to memory work vary considerably, from those in which a single technique is used on one or two occasions to "explore the possibility" that a selected client has hidden memories to approaches that combine all of the suggestive elements described earlier. Research on suggestibility indicates that few clients are likely to develop full-blown illusory memories or false beliefs regarding CSA solely in response to a few suggestive questions; as the frequency, number, duration, and social power of suggestive influences increases, so too does the risk that clients who were not abused as children will come to believe that they were.

Generalizability of research on memory illusions. Some writers have objected that studies of memory illusions cannot be generalized to traumas remembered in therapy (e.g., Berliner & Williams, 1994; Brown, 1995; Courtois, 1995; Enns et al., 1995; Olio, 1994; Pezdek, 1994). One argument is that evidence from laboratory studies of eyewitness suggestibility, in which suggestions typically refer to minor details in a passively witnessed slide show, video, or staged event, cannot be generalized to cases in which people report memories of traumatic childhood experiences. This claim is challenged by several recent studies that have shown that suggestive influences can indeed lead people to experience illusory memories of dramatic life experiences (e.g., spending a night in the hospital for an ear infection at age 5 years; being sexually abused as a child in a past life), provided that the suggestive influences are sufficiently strong (Hyman, 1994; Hyman & Billings, 1995; Hyman et al., 1995; Loftus & Pickrell, in press; Spanos et al., 1994; for similar findings with children, see Ceci & Bruck, 1994; Poole & Lindsay, 1995). Importantly, the same sorts of factors that laboratory studies have shown determine the strength of suggestive influences (e.g., authority, repetition, lowered response criterion, etc.) appear to be involved in producing illusory memories and false beliefs of autobiographical experiences. For example, Loftus and Pickrell (in press) asked 24 people to recall four childhood events, three of which had actually happened and one of which had not; 25% indicated that they remembered the suggested nonevent. Similarly, Hyman and his colleagues conducted a number of studies in which undergraduates were asked to remember childhood events that they were told their parents had reported. In fact, the to-be-remembered events included one or two events that parents' reports indicated had never happened (e.g., knocking over a punch bowl at a wedding reception). Few participants claimed to remember a suggested event the first time they were interviewed, but up to a quarter of them did so in a second interview, and a substantial minority provided detailed descriptions of a suggested event. Hyman and Billings (1995) found that participants with high scores on the Dissociative Experiences Scale (Bernstein & Putnam, 1986) were particularly likely

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7In view of evidence that childhood traumas are associated with adulthood problems and with elevated scores on the Dissociative Experiences Scale, it may be that, on average, people seeking psychotherapy are more susceptible to suggestion than the broader samples on which most of the suggestibility research has been conducted.
to "remember" the suggested event. Finally, sociologists have documented cases in which suggestive influences led suspects to confess to crimes that they evidently did not commit (e.g., Gudjonsson, 1992; Ofshe, 1989, 1992).

Of course, there are differences between these studies and memory work. Given that ethics bar researchers from testing the hypothesis that suggestions can give rise to false memories of CSA, there will always be room to argue that studies demonstrating false memories of other kinds cannot be generalized to memories of CSA. Yet anecdotal and correlational evidence from real-world cases supports generalization from such studies to memory work. Some "memories" recovered through memory work are demonstrably false (Read & Lindsay, 1994, pp. 413–414), and some clients working with fringe therapists who believe in UFO abductions, past life regression, and intergenerational satanic cults recover memories that are difficult to credit (e.g., Bottoms, Shaver, & Goodman, in press; Ryder, 1992; Spanos et al., 1994). Coons (1994) reported that of 29 patients who had entered a dissociative disorders clinic between 1984 and 1993 and eventually reported histories of satanic ritual abuse (SRA), 17 admissions were within 2 years after a Geraldo Rivera television show about SRA, and 10 admissions were within 1 year after a local workshop on SRA. Hence, 92% of the SRA cases during this 10-year period occurred shortly after one of these two programs. Coons noted that reports of SRA were elicited through hypnosis in 14 patients, dreamwork in 10, and regressive therapies in 8; for only 2 patients was there no evidence of the use of memory recovery techniques. Coons noted that despite attempts to corroborate the reports, none of the memories of SRA was supported (cf. Bottoms et al., in press).

In view of the wealth of converging evidence, we believe it would be foolhardy to contend that illusory memories or false beliefs of CSA cannot be created by long-term, multifaceted, suggestive memory work. It should be emphasized that it is the principles underlying suggestibility that we believe can be generalized to the therapy situation (i.e., effects of poor memory for the time period about which suggestions are given; perceived authority and trustworthiness of the source of suggestions; repetition, plausibility, and imagability of suggestions; and low response criterion), not the absolute size of the suggestibility effect. The size of the suggestibility effect is determined by a multitude of factors that likely interact in complex ways. Thus, we can say with confidence that approaches to memory work that combine many or all of these factors put clients at substantial risk, but we cannot predict exactly how many nonabused clients receiving a particular form of memory work would come to hold false beliefs about CSA.

Another argument advanced against generalizing from the research literature on suggestibility to memory work is that participants in research studies do not always genuinely believe the suggestions they report under hypnosis or in misinformation studies (e.g., Pezdek, 1994). It is true that research indicates that some people who report witnessing suggested details or events realize (or at least are capable of realizing when asked) that their reports are based on postevent suggestions rather than on memories of the to-be-remembered event itself (for review, see Lindsay, 1994). It is also true that in studies in which hypnotized people give false reports, some later indicate that the suggested event they reported under hypnosis was imagined rather than real (Spanos, 1992; cf. Lynn, Rhue, Myers, & Weeks, 1994). These findings should not be misconstrued, however, as evidence against generalizing from the research literature to cases of recovered memories of CSA. First, there
are ample demonstrations that under some conditions people given misleading suggestions confidently believe they are remembering actually experienced events when they report things that were suggested to them (e.g., Ceci & Bruck, 1994; Lindsay, 1994; Loftus & Ketcham, 1994; Zaragoza & Lane, 1994). Second, anecdotal accounts and statements presented by proponents of memory work indicate that clients too often initially worry that the thoughts and images they are experiencing are products of imagination or suggestion rather than accurate memories of childhood experiences (e.g., Bass & Davis, 1988; Frederickson, 1992). Third, in our opinion no laboratory study has come remotely close to matching the overall strength of the suggestive influences of extreme forms of memory work.

A third argument against generalization advanced by some defenders of memory work is that trauma memories are immune to suggestion (e.g., Brown, 1995; Enns et al., 1995). This argument misses the point, which is that people without trauma histories are not immune to suggestive influences. If therapists were perfectly accurate at discriminating between clients with and without hidden trauma histories and used memory recovery techniques and ancillary practices only with the former group, there would be much less basis for concern about such techniques (although one might still have concerns about traumatized individuals being led to “remember” traumas in addition to those they actually experienced). Unfortunately, as noted in a previous section, there are good reasons to believe that practitioners are far from perfect at discriminating between clients with nonreported CSA histories and clients without CSA histories. Furthermore, as argued later, there are scant grounds for the belief that memories of traumatic experiences are immutable and accurate and that trauma survivors are immune to suggestion.

Proponents of the belief that trauma memories are inviolable and entirely accurate cite evidence from two sources. First, there are case studies and anecdotal accounts of people recovering detailed and vivid memories of childhood trauma, often through therapy. People having such experiences often evidence intense emotional anguish, sometimes behaving as if the trauma were occurring at the very moment (see Levitt & Finnell, 1994, and Siegel, 1995, for discussions of such “abreactions”). We suspect that first-hand experience with such cases is a major source of the confidence and belief evidenced by practitioners who use memory recovery techniques in their therapies (cf. Andrews et al., 1995; Wylie, 1993). As noted earlier, however, memories of CSA recovered in therapy are not always accurate, and the emotional intensity of the experience of remembering cannot, in our opinion, be taken as evidence of the accuracy of the memories. Experiencing memory-like images of being sexually abused by a loved one, and accepting those images as accurate memories, would be an emotionally wrenching experience regardless of whether the images were veridical memories. Consistent with this argument, people who experience recovery of memories of UFO abductions, intrauterine trauma, or human sacrifices in satanic cult ceremonies also evidence great distress in the process (e.g., Ryder, 1992; Shaffer & Cozolino, 1992; Spanos, 1994).

The second body of evidence cited in support of the belief that trauma memories are peculiarly accurate and immune to suggestion comes from studies of combat veterans with PTSD (e.g., van der Kolk, 1988). As argued in a previous section, such cases provide a poor analogy to clients who initially report no knowledge of childhood trauma and later experience memory recovery; even the subset of combat
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veterans with PTSD who are amnesic for particular events are aware that they experienced combat. In any case, studies of combat veterans do not document the claim that their memories, flashbacks, or dreams are invariably accurate (although they are very vivid and intense). Finally, because delayed-onset PTSD is trauma-oriented practitioners’ diagnosis of choice for adult clients suspected of having hidden histories of CSA (e.g., Claridge, 1992), one might expect frequently to see years-delayed onset of PTSD symptoms among those known to have experienced war trauma. However, although PTSD symptoms often emerge over a period of months following return from combat (e.g., Sonnenberg et al., 1985), and although there are some cases in which veterans who appeared to have adjusted to peace-time life suddenly demonstrate dramatic PTSD symptoms years after the war, evidence suggests that years-delayed onset of PTSD is a rare phenomenon in combat veterans (Burstein, 1985; Helzer, Robins, & McEvoy, 1987).

Brenneis (1994) provided an informative discussion of research on combat veterans’ memories. He noted that although some have claimed that recurrent dreams reported by veterans duplicate the actual traumatic events, the study most often cited to support this claim (van der Kolk, Britz, Burr, Sherry, & Hartmann, 1984, cited in Brenneis, 1994) collected neither dream reports nor documentation regarding the traumatic events; the claim that dreams mirrored past reality was based solely on dreamers’ statements to that effect. Moreover, Brenneis argued that there is no empirical evidence for the claim that people who have no conscious recollections of past traumas have dreams that duplicate those forgotten traumatic experiences (although people who do remember traumas often dream about them, and people whose waking life is dominated by searches for hidden trauma memories are likely to have trauma dreams; cf. Nielsen & Powell, 1992). Brenneis also described Boulanger’s (1985) study of 275 Vietnam veterans 6 to 16 years after their return to the United States, which found that 36% of the combat veterans met criteria for PTSD but that 17% of noncombat and non-war-zone veterans did as well. This finding is reminiscent of Yapko’s (1993) description of a man with symptoms characteristic of Vietnam veterans with PTSD who turned out never to have been in Vietnam.

Flashbacks and abreactions are sometimes described as though they were vivid relivings of past experiences, and hence necessarily veridical (e.g., K. R. Clark, 1993; Person & Klar, 1994). Clinical evidence does not support this belief. According to Frankel (1994), Maloney (1988) found that the spouses of some Vietnam veterans experienced some of the same imagery that figured in their husbands’ flashbacks. Similarly, Brenneis (1994) described a study by Rynearson and McCreery (1993) of 18 family members questioned about their memories of the murder of another family member; all but one of them reported vivid, intense, and intrusive images of the murder, even though only one of them had witnessed it. Thus, there is little reason to believe that trauma memories are always accurate. Moreover, people can have “trauma memories” of events they never experienced. Finally, given that “dissociability” is often cited as a symptom of childhood trauma, and given that people who score high on measures of dissociability also tend to score high on measures of

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8McHugh (1994) noted that people often have troubling dreams associated with daily life stressors (e.g., dreaming of failing an exam at school); his point was that although such dreams may be vivid and distressing, they often do not reflect reality (e.g., one did not really fail the exam).
suggestibility (Piper, in press), it is difficult to understand the argument that trauma survivors are immune to suggestion. The evidence supports the opposite claim.

**Differences between recovered and never-forgotten memories.** Bottoms et al. (in press) sent questionnaires to American Psychological Association clinicians who, in response to an earlier survey, had reported one or more cases of clients reporting satanic ritual abuse or what Bottoms et al. referred to as “religion-related abuse” (e.g., beatings to exorcise devils). In a subanalysis, Goodman, Qin, Bottoms, and Shaver (1993) compared practitioners’ descriptions of 43 recovered memories with 447 reports of never-forgotten abuse. Abuse reported in newly recovered memories was much more extreme (i.e., more instances, more perpetrators, more severe abuse, and more ritual abuse, with a younger age of onset and an older age of termination) than were never-forgotten abuses. Despite the extreme nature of the alleged events in recovered memory cases (which often involved multiple murders, torture, etc.), almost none of the cases was supported by any evidence. These findings led Goodman et al. (1993) to question the validity of the recovered memory claims. Nonetheless, most respondents indicated belief in their clients’ reports, with equal confidence in never-forgotten and newly remembered abuse. This is consistent with research demonstrating that observers—including clinicians—often cannot discriminate between accurate and inaccurate reports that are products of suggestive influences (e.g., Ceci & Bruck, 1994).

A striking difference between recovered and never-forgotten memories of CSA concerns the role of women as perpetrators. According to the FMSF Scientific and Professional Advisory Board (1994), 30% of the cases in their records include allegations that mothers sexually abused their children. Similarly, the clinicians in Bottom et al.’s (in press) survey reported that clients who remembered ritual abuse typically reported multiple perpetrators, with more than 40% of them women. This contrasts with other evidence, which suggests that women rarely sexually molest children (cf. Finkelhor, 1994).

Consistent with these views, Abrams and Abrams (1994) reported that polygraph examinations of 300 people accused of CSA in cases that did not involve recovered memories indicated that 78% were deceptive in denying the allegations, whereas polygraphs of 46 people accused of CSA on the basis of recovered memories indicated that only 4% were deceptive in denying the abuse. Polygraphy can be criticized on several grounds, and Abrams and Abrams's study is open to methodological criticism (e.g., the alleged offenses were much less recent in cases that involved claims of repressed memories), but this is nonetheless a striking finding.

**Shades of gray.** The foregoing discussion may appear to imply that adults can neatly be assigned to groups of those who were and those who were not abused as children, and that abuse survivors can be dichotomized into those who do or those who do not remember their abuse. As Harvey and Herman (1994) and others have pointed out, the reality is less clear-cut than this. Most people have had childhood experiences that might be defined as “trauma,” and most children and adolescents suffer offenses that might be defined as CSA. Furthermore, remembering is not an all-or-none phenomenon: adults recollect some childhood events vividly, others only vaguely, and yet others not at all. Similarly, it would be simplistic to assume that recovered memories are always 100% accurate or that they are always 100% illusory: Essentially accurate autobiographical recollections are rarely perfect and complete (e.g., Neisser & Winograd, 1988), and essentially inaccurate ones often blend
veridical memories with products of suggestion, imagination, and interpretation (e.g., Hyman & Loftus, in press).

As noted previously, critics of memory work have focused on cases of recovered memories in which clients initially believe that they were not sexually abused in any way during childhood. Of course, many cases do not fit this mold. For example, some clients may initially report a few isolated instances of high-base-rate forms of CSA and later experience recovery of memories of multiple instances of extreme and low-base-rate forms of contact CSA. Such cases, in our view, warrant the same concerns as memories recovered by people who initially remembered no CSA history at all; if suggestive influences were involved in generating the new-found memories, then in our opinion they should be treated with a substantial degree of skepticism. In contrast, other clients may always have known that they experienced multiple instances of extreme forms of contact CSA, enter therapy with fragmentary memories of the abuse, and come to reveal or remember more details or additional instances of such abuse. Cases of this sort raise far fewer concerns, especially if the additional recall did not rely on suggestive influences, because this pattern is consistent with what is known about autobiographical memory. Research on autobiographical memory suggests that clients who were repeatedly abused are likely to have difficulty remembering details of specific instances and that cues and attempts to remember could help them retrieve some details and fill in others. Although one would expect errors of omission and commission in such cases, memory research indicates that the central events will typically be accurately remembered. Note, however, that such cases differ importantly from those on which criticisms of memory work have focused (i.e., clients who initially remember no history of CSA but later believe that they were grossly sexually abused as children).

Biases and heuristics in clinical judgment. Several well-established and robust biases of human judgment may lead some trauma-oriented therapists to have undue confidence in the reliability of “indicators” of abuse, the accuracy of their clinical judgments, and the efficacy of their treatments. For example, the availability heuristic (the tendency to judge probabilities on the basis of the number of exemplars that can be brought to mind) and confirmation bias (the tendency to look for and focus on hypothesis-confirming information) conspire to make humans vulnerable to “illusory correlations” (i.e., they believe that one variable predicts another when in fact there is no relation between the two). Illusory correlations are a robust phenomenon and have been demonstrated in situations closely analogous to therapy (e.g., Chapman & Chapman, 1967; Dawes, 1989; Dowling & Graham, 1976; Shweder, 1977). In a classic study by Smedslund (1963, cited in Shweder, 1977), nurses studied 100 “case histories” that specified (a) whether each patient had a particular symptom and (b) whether the patient had a particular disease. Statistically, there was absolutely no relationship between the symptom and the disease, yet 85% of the nurses reported that there was such a relationship and justified that conclusion by noting that there were many cases in which the patient had both the symptom and the disease (not noting that there were also many cases in which the patient had the symptom but did not have the disease).

The representativeness heuristic, a tendency to judge the degree of relationship between variables on the basis of their surface similarity, may also lead to ill-based beliefs about the diagnosticity of particular symptoms (Shweder, 1977; Tversky & Kahneman, 1974). As a possible example of the representativeness heuristic, the only
“indicator” of CSA mentioned by more than 16% of the respondents in each of Poole et al.’s (1995) three samples of highly trained psychotherapists was adulthood sexual dysfunction. There is evidence that CSA is associated with adulthood sexual dysfunction, but the relationship is not strikingly strong (Briere & Elliott, 1992), and adulthood sexual dysfunction is also associated with a variety of other factors, some of which likely have higher base rates than the kinds of CSA associated with this symptom (e.g., Sutker & Adams, 1993). Poole et al. suggested that therapists’ beliefs about the reliability of adulthood sexual dysfunction as an indicator arose less from reality than from their susceptibility to the representativeness heuristic.

Confirmation bias, the availability heuristic, and the representativeness heuristic make people susceptible to illusory correlations unless they take systematic steps to avoid them (e.g., keeping and reviewing records that allow an objective assessment of the relationships between predictor and outcome variables). Unfortunately, this is difficult for therapists because of the large number of variables of interest, because outcome measures are rarely well-defined, and because disconfirming evidence is often hard to come by (i.e., it is difficult to know when clinical intuitions are wrong; Marsh & Hunsley, 1993). Typically, therapists do not have access to control groups, and many judge the success or failure of their judgments and interventions on the basis of “clinical judgment” rather than through formal pre- and posttreatment measures. This may account for startling evidence that although confidence in diagnostic accuracy increases as a function of years of clinical experience, accuracy of diagnoses often does not (Dawes, 1994).

The difficulty of assessing the efficacy of therapy (Marsh & Hunsley, 1993) is likely to be especially great in treatments, such as memory work, in which symptoms dramatically escalate during therapy (e.g., McNulty & Wardle, 1994). Regardless of whether all, some, or none of the CSA events a particular client remembers in therapy actually occurred, the experience of “remembering” is likely to be a traumatic one, leading to numerous psychological symptoms (e.g., depression, anxiety, relationship difficulties, sleep disturbance, etc.). Such increases in symptoms during memory recovery have been remarked on by most proponents of memory work (e.g., Frederickson, 1992), and some critics have claimed that recovering memories sometimes culminates in suicide (e.g., Ofshe & Watters, 1994; Pendergrast, 1995). However, many clients gradually heal, to some extent, from the trauma of recovering CSA memories (veridical or illusory). Whether recovery of mental health ever attains pretherapy levels would, we posit, be difficult to ascertain without objective pre- and posttreatment measures.

Social influence. Research demonstrates that people’s beliefs and expectations can greatly influence the behavior of other persons with whom they interact (e.g., Ceci, Leichtman, & White, 1995; Rosenthal, 1994). For example, Ceci et al. found that interviewers working with child witnesses often pose suggestive and leading questions even when they try to avoid doing so. Moreover, people often underestimate their influence on others and often do not appreciate the extent to which their own behavior is influenced by others (e.g., Bowers, 1984). Thus, a therapist’s or client’s retrospective introspections about the extent to which the client’s reconstructions of childhood traumas were influenced by the therapist should be viewed with caution.

As a real-world example of the difficulty of perceiving one’s influence over others, consider recent research on “facilitated communication” (a procedure
believed by some to allow severely autistic children to communicate by typing on a keyboard with the assistance of a trained facilitator). Research reviewed by the American Psychological Association, Division 33 (1994) confirms that severely autistic children’s typing is coherent and relevant only when the facilitator knows what is to be typed, even though facilitators vehemently deny influencing the children’s typing. The example is particularly germane because numerous autistic children have reported CSA through facilitated communication (see Jones, 1994, for the introduction to a special issue of Child Abuse and Neglect on this topic).

**Progress toward consensus on suggestive memory work.** There is increasing unanimity among researchers and therapists regarding the riskiness of highly suggestive forms of memory work (i.e., those that combine multiple techniques in a prolonged search for hidden memories). Many of those who have expressed concerns about memory work are clinical psychologists or psychiatrists (e.g., Beutler & Hill, 1992; Brenneis, 1994; Brown, 1995; Campbell, 1992, 1994; Dalenberg, 1994; Frankel, 1993; Ganaway, 1995; Gold et al., 1994; Haaken & Schlaps, 1991; McHugh, 1994; Piper, 1993, in press; Siegel, 1995; Wakefield & Underwager, 1992; Yapko, 1993, 1994). Two recent articles by trauma-oriented practitioners published in clinical journals (Brown, 1995; Enns et al., 1995) discussed the importance of avoiding highly suggestive memory work (see also Siegel, 1995), and several writers whose contributions to this debate have focused on countering criticisms of memory work have acknowledged that some approaches may lead some clients to develop illusory memories or false beliefs (e.g., Berliner & Williams, 1994; Olio & Cornell, 1994; Pezdek, 1994). This position is clearly articulated in statements by the American Medical Association (1994), the American Psychiatric Association (1993), and the Australian Psychological Society (1994), and cautions about suggestive memory work were also offered by the British Psychological Society (1995). Bass and Davis (1994), coauthors of an extraordinarily popular self-help book that includes an emphasis on recovering hidden memories of CSA, have toned down their claims and recommendations in the most recent (3rd) edition (although not sufficiently to quell our alarm about its suggestiveness). Progress toward consensus on this issue is perhaps best exemplified by guidelines proposed by trauma-oriented psychotherapist Courtois (1994) for working with adult clients suspected of having hidden abuse memories—guidelines that we would endorse with only minor modifications.

Unfortunately, it will likely take time for these messages to be disseminated sufficiently broadly and clearly to overcome the effects of the widespread promulgation of CSA-oriented memory work. Thus, some practitioners probably will continue to use multiple suggestive techniques in prolonged searches for hidden memories. Perhaps more important, evidence suggests that the much larger population of practitioners who use selected memory recovery techniques with selected clients are often unaware of the potential risks of those techniques. This point was dramatically evident in many of the responses to Poole et al.’s (1995) surveys of highly trained psychotherapists: 91% agreed that clients can develop false memories, and many wrote comments indicating a concern about this issue, but 90% indicated that few or none of their own clients had ever experienced illusory memories, regardless of the memory recovery techniques used (see Andrews et al., 1995, for similar findings). A number of Poole et al.’s respondents reported use of techniques that most researchers view as risky, but wrote comments such as “I don’t use suggestive techniques” (see also D. S. Lindsay & Poole, in press). Similarly, Yapko (1993, 1994)
found that 19% of the practitioners in his sample of therapists attending conferences and workshops reported cases in which they believed a client had developed illusory memories through working with another therapist, yet these same respondents reported truly alarming misconceptions about human memory and about the safety and efficacy of hypnosis as a technique for remembering childhood events yet were confident in the validity of their own clients' recovered memories.

Criteria for Weighing the Validity of Recovered Memories

In the absence of clear corroborating or disconfirming evidence, neither practitioners nor cognitive researchers can say with certainty whether any particular case of a recovered history of CSA is or is not veridical. On the one hand, there likely are cases in which people with abuse histories are unaware of them for years but later remember the abuse when given appropriate cues (see Loftus, 1993, Schooler, 1994, and Williams, 1994a, for some compelling cases). On the other hand, evidence on the base rate of CSA and memory for childhood trauma suggests that such cases are rare. Recent prospective research by Henry, Moffitt, Caspi, Langly, and Silva (1994) revealed that even without suggestive influences, memory for childhood events is often strikingly in error, and research on suggestibility amply supports concern that searches for hidden memories can lead some clients to experience compelling but illusory memories and firmly held but false beliefs about CSA.

In our view, allegations of CSA based solely on recovered memories should be treated with a considerable degree of skepticism if there is evidence of exposure to suggestive information or memory recovery techniques. This is not to say that such allegations should be dismissed out of hand. The likelihood of claims based on recovered memories being valid can only be rather crudely estimated by weighing evidence regarding (a) how memories were recovered (the more evidence of a prolonged, multifaceted, socially influenced search for memories, the greater the degree of skepticism); (b) the nature and clarity of the recovered memories (with more credence given to detailed recollections than to vague feelings, beliefs, dream images, or “body memories”); (c) the plausibility of the alleged events being forgotten (e.g., research indicates that people are particularly unlikely to forget repeated contact CSA extending into late childhood or teenage years); (d) the plausibility of recovering the memories (e.g., research shows that claims of recovering recollections of events before age 2 years should be treated with great skepticism); and (e) the base rate of the alleged type of abuse (the lower the base rate, the greater the degree of skepticism).

This approach to estimating the veracity of allegations based on recovered memories will sometimes lead one to view as unlikely accounts that are in fact true and to sometimes view as credible accounts that are not true. This is unfortunate, and it is to be hoped that future research will establish additional bases on which to estimate the credibility of allegations (e.g., along the lines of Briere & Elliott’s, 1992, and Briere & Runtz’s, 1990, Trauma Symptom Checklist; improved techniques for detecting deception; or relevant normative measures of individual differences in suggestibility). At present, however, in our view the just-mentioned considerations are the only ones in the domain of psychology on which assessments of credibility can be based. This is intended to be a two-edged sword. Delayed accusations should not be dismissed as implausible merely because the accused perpetrator is a pillar of the community who seems sincere, because of a lack of corroborating evidence, or
because the accuser has been in psychotherapy. Pillars of the community sometimes sexually abuse children, perpetrators can appear wonderfully sincere, corroborating evidence is more the exception than the rule in cases of CSA, and psychotherapy does not necessarily involve suggestive memory work. Similarly, accusations based on recovered memories should not be accepted as valid merely because of the presence of certain symptoms, because of the emotional intensity and sincerity of the accuser, or because of the confidence a therapist holds in the accuser's memories. Such factors are not probative.

Memory Recovery, Psychotherapy, Public Policy, and the Law

The use of memory recovery techniques and ancillary practices to recover suspected hidden memories of CSA thus raise numerous issues for public policy and the law. In this section we discuss four large categories of issues: (a) training and certification of psychotherapists, (b) professional guidelines for trauma-oriented psychotherapy, (c) public policy initiatives to support research relevant to the recovered memories debate, and (d) issues related to legal actions in cases involving alleged recovered memories of CSA.

The goals of professional psychology, public policy, and the law with regard to this topic can be stated quite simply: We must maximize support for survivors of CSA while simultaneously minimizing the risk of iatrogenic illusory memories and false beliefs. There is a tension between these two goals, but we reject the claim that progress toward one goal must necessarily be offset by movement away from the other (Pezdek, 1994). Psychologists in other domains have demonstrated that it is not necessary to decrease "hits" (in this case, identification of and support for survivors of CSA and prosecution of perpetrators) in order to reduce "false alarms" (in this case, creation of illusory memories or beliefs and false accusations). For example, in studies of suspect identification, R. C. L. Lindsay and Wells (1985) found that sequential lineups, in which witnesses view mugshots one at a time, dramatically lower false identifications of innocent people relative to simultaneous lineups, without reducing correct identifications of perpetrators. Conversely, Fisher and Geiselman (1988) developed a "cognitive interview" that can increase eyewitnesses' correct recall without increasing errors. We believe that the risks of iatrogenic illusory memories and beliefs can be dramatically reduced without lessening sensitivity to and support for survivors of abuse; indeed, we believe that it is an exclusive focus on one goal or the other that leads to undesirable trade-offs and that progress can only be made by pursuing both simultaneously.

We are cognitive psychologists, with limited knowledge and expertise in clinical psychology, public policy, and the law. Consequently, the following discussion is limited to identification of some of the central issues in these domains, citations of statements by experts in these fields, and tentative recommendations that we offer for further consideration.

Training and Certification of Psychotherapists

As noted previously, in recent years some therapists have used potentially risky memory recovery techniques and ancillary practices. Because these practices were used without benefit of empirical evidence of their effectiveness, and because there are grounds for concern about potential ill-effects of such approaches, we view the widespread promulgation and use of memory work as an important failing on the
part of psychology. Such problems are common in the history of the healing arts and sciences (e.g., indiscriminate and excessive use of electroconvulsive shock, psychosurgery, radical mastectomy, multiple bypass surgery, etc.). In the case of memory work in psychotherapy, however, the failing seems particularly egregious because existing scientific evidence, well known within the discipline of psychology, clearly contraindicated this approach to treatment. Several factors related to the training and certification of practitioners may have contributed to this problem: (a) the prevalence of unqualified therapists, (b) poor public education regarding differences in the qualifications of people offering mental health care services under various auspices, (c) inadequacies in training provided by graduate programs in clinical psychology and in ongoing education of practitioners, and (d) limited opportunities for many practitioners for ongoing supervision and consultation with qualified peers.

One challenging aspect of the debate regarding memory work in psychotherapy arises from the number and variety of North Americans providing various types of therapy under various auspices. In addition to substantial percentages of the tens of thousands of licensed psychiatrists, psychotherapists, and registered counselors, insight therapies are offered by unknown percentages of the tens of thousands of social workers (with master’s or bachelor’s degrees), clergy, chemical dependency counselors, and free-lance “therapists” with little or no advanced training in clinical psychology. Within each of these broad categories, there is wide variation in the amount and nature of formal training in relevant skill areas (e.g., diagnosis, treatment, ethics, scientific reasoning) and specific content areas (e.g., sequelae of CSA, treatments for depression).

Thus the term therapist, as we and others have rather loosely used it, covers a large and heterogenous population. This fact has several important implications. First, as noted in a previous section, because there are many tens of thousands of North Americans who regularly conduct psychological therapy with adults, a small percentage of this population translates into a substantial number of practitioners, each working with a number of clients. Second, this heterogeneity may have hampered communication between critics of memory work and practitioners; critics have sometimes painted psychotherapy with a broad brush and have not identified the targets of their criticisms with sufficient clarity, which may in turn have led some practitioners to dismiss the criticisms as unjustified because neither they nor their professional acquaintances fit the critics’ descriptions of therapists. Third, it is likely that many people who seek psychotherapy are unfamiliar with the meaning of the various formal degrees, titles, and certifications for providers of mental health care and hence cannot select between qualified and unqualified caregivers.

Unqualified therapists. Because there is no protection of title for therapists in most jurisdictions, anyone can refer to himself or herself as a therapist and advertise as such with whatever specialization is considered desirable. Some evidence suggests that untrained or undertrained practitioners have made a disproportionately large contribution to the problem of risky memory work (Wakefield & Underwager, 1992; Yapko, 1994). Our own experience is consonant with this evidence; the extreme cases brought to our attention by lawyers or accused parents have usually involved therapists with little formal training (although this may reflect differences in base rates rather than differences in use of memory recovery techniques in these two populations). Of course, certification is a general issue, and the popularization of
memory work has only incrementally added to opportunities for incompetent and unqualified individuals to influence clients in potentially harmful ways.

It is not immediately clear what the response to the prevalence of unqualified therapists should be. At minimum, there is a need for better public understanding of the varieties of psychological therapy and therapists, their training, practices, and credentials. With such information, the public may make more informed choices regarding therapists and therapeutic approaches. In view of the concerns raised in this and other articles about the risks of memory recovery techniques, professionals and professional groups who do not advocate such techniques may decide actively to distance themselves from those who do, thereby enhancing the public's ability to differentiate among therapists.

In addition to improved public education, increased financial support for people seeking psychological treatment might lessen reliance on less expensive unqualified therapists. Of course, the public's failure to discriminate between practitioners with and without advanced formal training may not entirely be a matter of ignorance or financial restriction. As Dawes (1994) has noted, studies of clinical expertise and outcome effectiveness have not always shown a relationship between amount of formal training and effectiveness of treatment. A recent meta-analysis by Stein and Lambert (1995) indicated that formal training is sometimes related to therapeutic success, but the relationship is surprisingly weak. The recommendations made below regarding improvements in formal training, certification, and use of empirically validated treatments would, if followed, increase the difference between licensed or certified mental health care providers and those who offer "therapies" without benefit of advanced formal education.

Formal training of psychotherapists. Even within the relatively narrow confines of practitioners with advanced degrees in clinical psychology, there appears to be a wide range in the amount, nature, and quality of training. Of course, graduate programs in clinical psychology cannot provide advanced training in all content areas of potential relevance to practitioners. For example, it would be unreasonable to demand that clinical programs ensure that all graduates master research and theory in the cognitive psychology of human memory (although such knowledge might have protected graduates from using suggestive memory recovery techniques). Programs quite appropriately vary, both across universities and over time, in the content areas on which they focus. Thus, for example, it is to be hoped that in coming years clinical training programs will reflect the increased awareness of CSA (cf. Enns et al., 1995). It may nonetheless be reasonable to propose that all clinical graduate programs accredited by the American Psychological Association demand a high level of mastery of basic principles of scientific reasoning and methodology, particularly as they apply to making diagnoses and evaluating treatment. These programs would be in the spirit of the scientist-practitioner model (O'Sullivan & Quevillon, 1992), which emphasizes the mutuality of research and practice (Hoshmand & Polkinghorne, 1992).

In our opinion, graduate programs in clinical psychology should also strive to help students develop a degree of skepticism regarding the accuracy of their clinical judgments and observations. Toward this end, clinical psychology programs might require training regarding the cognitive biases and heuristics that lead human reasoners to violate principles of science and logic. For example, it would be useful for all graduates of such programs to know that a high rate of co-occurrence of two
characteristics does not constitute evidence that those two characteristics are correlated (see Shweder, 1977). Similarly, people with advanced degrees in clinical psychology should understand such things as the relationship between base rates and the likelihood of erroneous diagnoses, or the fact that causal effects cannot be inferred from correlational evidence. No doubt many programs do successfully teach such topics, but it appears that some do not.

We echo the recent American Psychological Association (1993) Division 12 Task Force report in calling for an improved correspondence between which treatment approaches are taught in clinical graduate programs and which treatment approaches have been empirically validated (cf. Campbell, 1992). The report indicated that about 20% of the association accredited programs surveyed taught little or nothing about 75% of the empirically validated treatments known to clinical psychology. (It is worth noting that memory work was not identified as an empirically validated treatment.) The task force also recommended directed supervision in empirically validated treatment methods, noting that many programs either do not provide supervision or do provide supervision in treatments that have not been validated. The report argued that, at a minimum, a period of directed supervision by a certified psychologist or psychiatrist is essential prior to undertaking the treatment of others.

Ongoing training. A major goal of the Division 12 Task Force (American Psychological Association, 1993) report was to increase the effectiveness of psychotherapy by promoting the kinds of training and supervision that will encourage practitioners to use therapeutic techniques that have proven effective in controlled studies. Beutler, Williams, and Wakefield (1993) reported that most respondents in their survey of certified clinicians indicated that their therapeutic approaches drew on empirical research, but Poole et al.'s (1995) data indicate that the majority of psychotherapists sometimes use techniques such as hypnosis, guided imagery, and dream interpretation as tools to help clients recover suspected hidden memories of CSA: To the best of our knowledge, there are no published controlled studies testing the efficacy of these approaches to treatment.

What accounts for the disparity between practitioners’ self-reported reliance on scientific research and evidence of widespread use of therapeutic interventions for which scientific justification is absent? We suspect that one explanation is that memory recovery techniques have been promoted in numerous books and workshops advertised as “professional upgrading” or continuing education, offered by practitioners (and endorsed by respected professionals and organizations) who are convinced of the techniques’ effectiveness (see also Beutler et al., 1993). As Dawes (1994) has emphasized, testimonials of this type are not useful for determining the value of therapeutic techniques.

In their survey of certified clinicians, Beutler et al. (1993) found that a surprisingly high percentage (33%) belonged to no professional organization and, of those affiliated with such organizations, only 30% reported attendance at discipline-specific research presentations. When asked about sources of information for their therapeutic knowledge and practices (beyond degree or diploma education), only 35% identified primary research journals as a source. Major sources of information included “professional practice-oriented books” (51%), “popular lay books written by nonacademic scholars” (33%), and “workshops and seminars led by nonacademic professionals” (40%). Surveys by Feld (in press) indicate that MSW programs also
often rely heavily on nonscientific information sources. Without entirely discounting
the potential value of these sources, we suggest that practitioners be trained and
encouraged to place greater reliance on refereed research publications and that
clinical researchers and journal editors ensure that research journals include many
articles of relevance and use to practitioners (cf. Beutler et al., 1993).

Ongoing supervision and consultation. Scientific research is an inherently public
activity, in which the procedures and results of studies are subjected to peer review
and truth value is gauged in large part by the replicability of publicly presented
findings. In contrast, most of what transpires in therapy is treated as private, and
therapeutic success is usually assessed by therapist and client, and perhaps often by
the therapist alone, without benefit of objective measures, control groups against
which to compare effects of therapy, or external review (Marsh & Hunsley, 1993).
We believe that therapy would benefit in many ways if it were a more open enterprise
(cf. Loftus & Rosenwald, 1993). For example, ongoing supervision and consultation,
conducted in ways that protect the confidentiality of the therapist–client relationship
yet provide real opportunities for therapists to receive critical feedback from
qualified others, could be very beneficial (as recommended by Courtois, 1994, Enns
et al., 1995, and Holloway & Neufeldt, 1995, among others). As evidence that
ongoing supervision is not yet normative, the American Psychological Association
(1993) Division 12 Task Force noted that of programs advertising training in new
treatment techniques or theories in the APA Monitor, only 10% required directed
supervision prior to the awarding of continuing education credit or certificates of
competence in the new technique.

Summary: Training and certification. Our recommendations regarding training
and certification of mental health care providers are similar to those made by many
others over the years. We suggest public education efforts on the part of professional
organizations to improve the public's knowledge of the differences between service
providers with varying amounts and kinds of formal training. We also suggest that
graduate programs in clinical psychology increase the extent to which their
approaches are grounded in science, and we recommend improved standards for
ongoing education. Finally, we propose that the quality and efficacy of psychotherapy
might be improved if practitioners were to have greater opportunities for ongoing
supervision and consultation with well-qualified peers.

Guidelines for Trauma-Oriented Psychotherapy

The past year or so has brought suggestions from many clinicians regarding the
need for caution and care in the treatment of suspected adult survivors of CSA and
calling for the development of guidelines for trauma-oriented psychotherapy (e.g.,
Bloom, 1994; Brown, 1995; Courtois, 1994; Enns et al., 1995; Yapko, 1994). We are
optimistic that continued efforts in this direction will raise the standard of care and
reduce the likelihood of false memories without undercutting support for survivors
of abuse. Refinement of guidelines for professional conduct in this area will rely on
future research of the sorts described in a subsequent section (Research Initiatives),
but the outlines of such guidelines can already be specified. We expect that
important components will include the following instructions: (a) Keep an open
mind about the client's history—do not assume that current symptoms can be taken
as reliable indicators of CSA, and do not assume that clients who disavow an
abuse history are "in denial"; (b) avoid suggestive questions or statements (e.g., that hidden memories of childhood traumas may underlie the client's problems, or that healing may rely on recovering such memories); (c) obtain the client's informed consent before using memory recovery techniques; (d) do not use hypnosis, guided imagery, sodium amytal, interpretation of dreams, or "body memories" to help clients recollect CSA; (e) be judicious in recommending self-help books, survivors' groups, and workshops; (f) keep careful records, especially of sessions involving memory work; and (g) do not suggest that clients who recover memories in therapy take legal action against alleged perpetrators. The rationale for most of these recommendations has been amply reviewed in the foregoing; in the following we briefly discuss our recommendations regarding informed consent, record keeping, and legal action.

Informed consent. A survey of 97 San Diego doctoral-level psychotherapists by E. Stein and C. J. Dalenberg (personal communication, February 2, 1995) indicates that clients frequently are not given an opportunity to give truly informed consent prior to therapy. The American Psychological Association's (1992) Code of Ethical Conduct (Ethical Standard 4.02) requires that clients be informed of the potential risks of therapeutic techniques and be told whether the approach to be used has been empirically validated or is experimental (cf. S. Simpson & Baker, 1994). In turn, informed consent requires that practitioners be aware of the potential risks of their interventions (Ogloff, 1995).

Record keeping. Some practitioners whose work includes a focus on CSA-oriented memory work do not make or retain records of their interventions. For example, an Ontario trial judge recently suspended proceedings in a case against a teacher accused of having committed gross indecency 30 years earlier, because the sexual assault crisis center that had provided psychological counseling for the plaintiff destroyed the files pertaining to the case ("Rape-crisis Centre," 1994). Reportedly, this center has a policy of shredding files whenever there is police involvement, and the newspaper account indicated that many other Canadian centers are following a similar policy as a self-described act of civil disobedience. There are also cases in which individual trauma-oriented practitioners have decided not to keep records; in some cases the therapists cited a concern that the records would be misused in the defense of perpetrators, in others that the records put them and clients at risk for reparation from satanic cults (e.g., Reagor, 1991; cf. Gould & Cozolino, 1992).

Record keeping in cases in which adult clients report CSA is a difficult and complex issue. On the one hand, it is easy to appreciate that those who work to support CSA victims are appalled when therapy records are misused in the defense of suspected abusers. Furthermore, detailed note-taking during a session may detract from attention to the client. Finally, most practitioners believe that client-therapist confidentiality is crucial for good psychotherapy, and recording therapy sessions may be seen as threatening confidentiality. On the other hand, the principle that people accused of crimes have a right to information that may exonerate them is a central premise of our judicial system (although therapy records have statutory privilege in some jurisdictions; Cram & Dobson, 1993). Therapy records regarding reported sexual abuse can also serve the interests of survivors (e.g., in custody disputes or in legal defenses of survivors accused of assaulting or killing their abusers). Walker (1994) cautioned that in the absence of therapy records,
judges may bar therapists from testifying on behalf of clients. Furthermore, the challenges of providing good psychotherapy to numerous clients over extended periods of time are such that we suspect that competent practice requires careful record keeping. Finally, in some cases practitioners' self-interest may contaminate decisions not to keep notes of questionable interventions. On balance, professional ethics demand that practitioners keep careful records of therapy sessions (American Psychological Association, 1992, Ethical Standard 1.23; Courtois, 1994). The level of detail and the manner of taking records is up to therapists or their employers. Whether or not such records are released to the courts is perhaps an individual moral question (cf. Walker, 1994), although therapists are subject to court subpoena to testify.

**Recommending legal action.** Some advocates of memory work recommend that clients who recover memories of CSA consider legal action against alleged abusers as a way of seeking validation and healing (e.g., Bass & Davis, 1988). Recently, however, some clinical psychologists have suggested that legal actions against alleged perpetrators more often harm than help clients who have recovered memories (Brown, 1995; Campbell, 1994; Mould, 1994). Courtois (1994) pointed out that supporting or participating in legal actions compromises the therapist's role. It has also been argued that therapists who recommend legal action are obliged to warn clients about the risks of memory recovery techniques and seek corroborative evidence to support the allegations (Brown, 1995; Courtois, 1994; Schneider, 1994; Yapko, 1994). For example, clients should be informed that allegations arising from hypnotic procedures are typically not admissible in court. It goes without saying that these cautionary statements should be provided early in therapy.

**Summary: Guidelines for trauma-oriented psychotherapy.** As a way of reducing the risk of false memories and beliefs, Ceci and Loftus (1994) suggested that therapists doing memory work engage in a "disconfirmation" strategy in which they test the historical accuracy of memories as they are reported, doing so in a manner that neither questions the client's veracity nor stifles disclosure. Several practitioners have offered similar advice: Bloom (1994), Brown (1995), Courtois (1994), Enns et al. (1995), and Yapko (1994) all recommended that therapists adopt a scientific attitude, continually check hypotheses, encourage clients to tolerate ambiguity, and challenge premature closure. Guidelines are already available for forensic child-victim assessment, and construction of guidelines for memory work should not be difficult (see Elliott & Briere, 1994; Rogers, 1994).

Professional guidelines are intended to help both clients and therapists. It is exciting to envision the development of psychotherapy as a profession widely known for providing safe, reliable, and effective ways of helping people cope with or overcome psychological problems. Pending this development, a well-established standard of care could reduce the risks of therapy and protect therapists who follow such standards from spurious lawsuits.

**Legislative Actions to Regulate Therapists**

Others have proposed that more drastic steps than those just described are needed to protect the public from untested and potentially harmful therapies. For example, Campbell (1994) argued that it is naive to hope that practitioner-oriented professional organizations such as the American Psychological Association will speak to the central issue of whether scientific evidence supports the safety and
efficacy of searches for hidden memories of CSA. Campbell noted that the association’s Council of Representatives voted 55 to 52 against obtaining input from its own Board of Scientific Affairs regarding who would be appointed to the task force empaneled to produce a policy statement on memory work, and he argued that for the association to challenge the core premises of memory work would be to challenge the “agenda of the guild.” These arguments imply that psychology, as a profession, may be incapable of setting standards that will adequately protect the people it attempts to serve. Sechrest (1994) noted that if the professional organizations are unable to take decisive steps to improve standards of training, efficacy, and safety, such steps “will be imposed from the outside, perhaps in Draconian fashion” (p. 1). For example, a group called The National Association for Consumer Protection in Mental Health Practices is lobbying for legislation requiring that all psychotherapy paid for with federal funds follow specified procedures for obtaining informed consent (C. Barden, personal communication, September 6, 1994).

Research Initiatives

As reviewed in previous sections, existing evidence indicates that (a) the base rate of recoverable hidden histories of contact CSA is low, (b) people with hidden histories of CSA cannot reliably be identified on the basis of symptoms, and (c) memory recovery techniques pose risks for nonabused clients and their families. Nonetheless, many questions remain concerning these and related issues, and further research is desperately needed. Next, we identify some of the areas in which the need for research is most keen.

Memory for trauma. As noted earlier, some psychologists argue that traumas tend to be remembered better than mundane experiences, whereas others claim that traumas are often repressed or otherwise forgotten. The former position is more strongly supported by scientific research, but the two claims are not necessarily mutually exclusive (i.e., it could be that traumas are usually well remembered but sometimes are repressed or dissociated), and at present there are too few studies to justify conclusive statements. Additional studies of children who have experienced trauma, with long-term follow-up measures, are needed. Enns et al. (1995) and Siegel (1995) have suggested a large variety of useful directions for research on memory for trauma.

Efficacy of memory work. Clinical psychologists who believe that memory work is an important therapeutic tool should support research designed to test the hypothesis that clients who present with the psychological problems identified as indicators of hidden histories of abuse (e.g., depression, sexual dysfunction, anxiety, eating disorders), but report no abuse history in response to direct questions, have better outcomes if they receive therapies that include a focus on recovering memories of CSA than do matched control clients who receive other treatments. Beutler and Hill (1992), Brown (1995), Enns et al. (1995), Haaken and Schlaps (1991), Levitt and Pinnell (1994), and Siegel (1995) have all emphasized the importance of studies of outcome effectiveness, but we are aware of only one modest, unpublished assessment of memory work (Spiegel, 1994, cited in Ceci & Loftus, 1994). According to Ceci and Loftus, Spiegel found no gains of memory work over a present-focused comparison treatment. Of course, even if differences in favor of memory work had been obtained, further research would be needed to determine which components of the approach were effective. A first step that would provide an
essential foundation for such research is the development of treatment manuals for memory work in psychotherapy (American Psychological Association, Division 12 Task Force, 1993; Beutler & Hill, 1992; Holloway & Neufeldt, 1995; Stein & Lambert, 1995). The control condition against which clients receiving memory work are compared should be whatever alternative low-risk treatment for the particular presenting symptoms is best supported by empirical research. Ideally, such studies would include long-term follow-up of clients.

If such studies demonstrate that memory work has differentially beneficial effects, additional follow-up research could be designed to explore corollary issues: Can procedures be developed to identify which clients are more or less likely to benefit from memory work? Which memory recovery techniques are associated with favorable outcomes and which are not? Are memory recovery techniques still effective if steps are taken to reduce risks (e.g., informed consent, limited number or duration of techniques)?

A related question for future research concerns therapists' ability to discriminate between clients with hidden histories of CSA and those with no history of CSA. This is a methodologically challenging research topic, but the difficulties are not insurmountable. For example, in Williams's (1994a) study of women with a recorded history of an instance of CSA, 12% reported no such history when interviewed 17 years after the recorded abuse (i.e., they reported neither the recorded instance nor any other instance of CSA). Such cases could be randomly mixed with a matched control group of people who also report no CSA history but for whom there is no record of such abuse, and trauma-memory-oriented therapists could attempt to discriminate between the two groups (cf. Ceci & Bruck, 1994).

Treatment for effects of recovering memories of CSA. Many people who recover histories of CSA report that memory recovery was a traumatic experience (e.g., Bass & Davis, 1988; Frederickson, 1992). Some critics of memory work have argued that symptoms characteristic of PTSD observed in clients who experience memory recovery often stem not from CSA but from horrifying illusory memories and false beliefs developed through suggestive memory work (Ofshe & Watters, 1994; Nelson & Simpson, 1994). In any case, a substantial minority of clients who recover memories of CSA in therapy subsequently confront their alleged abusers (typically their parents), break off communication with them, or both (Poole et al., 1995). This is, of course, painful for all parties. The literature promoting memory work addresses the need for healing from sequelae of recovering memories, including developing alternative forms of social support for people who recover histories of CSA and consequently terminate contact with family members and sever friendships with those who doubt the accusations (e.g., Bass & Davis, 1988; Frederickson, 1992). Further development of effective supports for people who recover memories may benefit from systematic research.

Some people who recover memories later come to doubt or even reject the belief that they were sexually abused, and it is likely that this process also involves considerable psychological stress. Pendergrast (1995) provided anecdotal reports of seven individuals who retracted allegations based on recovered memories, and the FMSF claims to have been contacted by 300 families in which the accuser has retracted allegations (FMSF Scientific and Professional Advisory Board, 1994). Individuals who now believe that their recovered memories were false provide unique opportunities for research on memory (deRivera, 1994; Lief & Fetkewicz,
Parents accused on the basis of recovered memories of CSA evidence psychological suffering, largely attributable to the destruction of their families but also sometimes to stress associated with public humiliation, legal actions, and so forth. Of course, the suffering of accused parents may be genuine even when accusations are partly or entirely valid. There is a need for research on effective psychotherapies for such individuals, as well as for the development of ways of helping families cope with disintegration and, where appropriate, reintegration.

_Cognitive research on memory recovery techniques._ Clinical studies could be complemented by further cognitive research on memory recovery techniques. Experimental research is constrained by ethical guidelines, which may raise questions about generalizability (e.g., researchers could not test the hypothesis that memory recovery techniques can lead people to develop illusory memories or beliefs of CSA). However, principles of memory discovered in laboratory research have proven to be largely consonant with evidence obtained in more naturalistic field studies, and laboratory research has some important advantages (e.g., Banaji & Crowder, 1989). One advantage is that experimenters can know exactly what did and did not happen in the to-be-remembered events. Such studies could differentiate between techniques that reliably improve recall versus those that merely lower response criterion or facilitate imagery and hence increase false recall (cf. Fisher & Geiselman, 1988). Research could also explore interactions between individual-difference measures and effects of memory recovery techniques (Hyman & Billings, 1995; Schooler & Loftus, 1993). It would be important that cognitive psychologists undertaking such research educate themselves regarding relevant aspects of the clinical literature, so as to design studies that will be of relevance and use to clinical psychologists and practitioners (cf. Beutler & Hill, 1992; Beutler et al., 1993; Brown, 1995).

**Summary: Research initiatives.** Previously, we sketched the outlines for professional guidelines for trauma-oriented psychotherapy with individuals who may have been sexually abused as children but who report no such history in response to direct questions. The research initiatives mentioned in this section would allow for more detailed recommendations that could improve therapeutic gains while minimizing the risk of illusory memories and beliefs. A more general recommendation is that researchers and practitioners work collaboratively, so that knowledge deficiencies in both camps can be mitigated and useful knowledge created.

**Legal Issues**

The vast majority of people who experience recovery of memories of CSA do not take formal legal action against the alleged perpetrator or perpetrators. Psychotherapists responding to Poole et al.'s (1995) surveys indicated, on average, that only 6% of their clients who recovered memories of CSA took any legal action against the alleged perpetrator or perpetrators. The FMSF ("Legal actions against parents," 1994) claimed that legal actions against alleged perpetrators were reported by only 7% of those who had contacted the organization. Presumably, only a fraction of the cases in which legal action is taken end up in court; often the action is restricted to filing a police report or having an attorney send a letter threatening legal action unless certain conditions are met (e.g., a financial settlement, agreement to cease
attempts at communication). Thus, formal legal action is a rare outcome of memory work. Nonetheless, Lipton (1994) reported that the FMSF is following 800 legal cases (most of which are civil suits) in which people who recovered memories have taken the alleged perpetrator or perpetrators (most often their fathers) to court, and a smaller but growing number of suits against therapists or authors by people accused of CSA on the basis of recovered memories or by former clients who claim that therapy led them to hold harmful false beliefs.

Criminal and civil actions concerning delayed accusations of CSA have increased dramatically in recent years (Ewing, 1992). The increase likely results from (a) greater acceptance of the reality of CSA and its potential long-term effects (Enns et al., 1995); (b) increased use of CSA-focused memory work in psychotherapy and through self-help; and (c) changes to relevant statutes of limitations that have increased opportunities for legal actions based on delayed accusations (Bulkley & Horwitz, 1994; Ernsdorff & Loftus, 1993; S. Simpson & Baker, 1994). Regulations in some jurisdictions that provide for state funding of psychotherapy when adult clients file charges against alleged abusers may also have contributed to the increase in legal actions.

Historical context and recent changes. A thorough discussion of the history of legislation and legal precedent related to the current controversy about recovered memories of CSA is well beyond the scope of this article (and beyond our expertise), but it is important to acknowledge the outlines of that history. Until the last few decades, successful prosecution of CSA was rare. Nowadays, although approximately 50% of reports of current or recent child sexual abuse are classified as “unsubstantiated,” and only some substantiated cases are prosecuted, the number of reported cases has increased dramatically, and approximately 90% of prosecutions are successful (Finkelhor, 1994).9 There is little reason to believe that these increases in reports and successful prosecutions are due to an increase in the base rate of CSA (Finkelhor, 1994). Rather, in the past several decades there have been a number of important advances in public policy and legislative initiatives that have improved detection of CSA and facilitated prosecution of such cases (e.g., Hechler, 1988). Although there have been some problems with implementation of these changes (Fincham, Beach, Moore, & Diener, 1994), in our view they constitute much-needed progress.

Legislative changes in the past several years have enhanced opportunities for memory recovery claims (and other delayed accusations) to come forward to the courts in many parts of the United States and Canada. For criminal charges of CSA, there has been no need to change the statutes in some U.S. states or in Canada, because in those jurisdictions there has been no limit on the time period in which such charges may be brought. In many other states, statutes of limitations have been tolled on criminal charges until alleged victims reach the age of majority (Bulkley & Horwitz, 1994; Ernsdorff & Loftus, 1993; Hayes, 1994). Similarly, for civil actions, most U.S. states and Canada have either extended or are considering tolling statutes of limitations (although there is considerable variation across jurisdictions in the number of years beyond the age of majority for which the tolled statutes runs—Bulkley & Horwitz, 1994; Ernsdorff & Loftus, 1993; Hayes, 1994—and pretrial

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9Criteria for substantiation are generally high, so unsubstantiated does not necessarily mean false (see Finkelhor, 1994).
hearings must be held to determine whether tolling is appropriate in each case; Lipton, 1994, and S. Simpson & Baker, 1994).

At the heart of public and legislative willingness to alter statutes of limitation is an acceptance of the concept of “delayed discovery.” As Bulkley and Horwitz (1994) noted, there are at least three bases for delayed discovery in cases involving CSA. Two of these are not relevant to the concept of recovered hidden memories but instead recognize circumstances in which complainants, now adults, have always known that they were abused but either were prevented from disclosing the abuse by the abuser’s threats or were unaware of the harmful consequences of the abuse until many years had passed. It is the third basis for application of the delayed discovery rule to cases involving CSA that is most relevant here: Legislators and courts apparently have been convinced that conscious recollections of CSA are often not available to victims until many years after the abuse occurred (Boland & Quirk, 1994; Lamm, 1991). Indeed, according to Lamm (1991), some courts have ruled that statutes of limitation should be tolled only for claims that arise following a period of total repression of CSA memories, on the grounds that existing statutes already provide sufficient opportunity for complainants who always had knowledge of their abuse to come forward with the allegations. Bulkley and Horwitz (1994), Ernsdorff and Loftus (1993), and Lamm (1991) cited cases in which this “repression” argument for delayed discovery was successfully advanced, and Spiegel and Schefflin (1994) and S. Simpson and Baker (1994) claimed that courts have often found recovered memory allegations more credible than delayed allegations in which the complainant claimed always to have remembered the abuse. In one particularly intriguing Canadian case (Regina v. Norman, 1993), the court apparently gave additional weight to the complainant’s recovered memory testimony because a friend of the victim testified that she witnessed the alleged rape and claimed that she also repressed and then recovered memories of it.

Science, politics, and legislative change. As previously indicated, in our view research does not support the belief that complete amnesia for recoverable histories of CSA is a common occurrence, nor does it support the idea that delayed recollections are necessarily accurate. Given the speed and apparent ease with which statutes of limitation have changed since 1988, it seems that beliefs rather different from ours have guided the actions of legislators in the majority of states and of justices in the Supreme Court of Canada (Bulkley & Horwitz, 1994; Lamm, 1991; Loftus & Rosenwald, 1993; Loftus, Weingardt, & Hoffman, 1993; Schneider, 1994). Erroneous beliefs about memory have a long history. At present, there appears to be a widely accepted belief that the details of all life experiences are stored in memory in such a way that they can reliably be recalled years later with high levels of accuracy and completeness (Bower, 1990; Loftus & Loftus, 1980; Roediger, 1980). These high expectations for human memory are woven into the fabric of our culture and are reflected in literature and film. Such beliefs have also been played out in war-crime trials in which Holocaust survivors have been expected to recall with accuracy and detail persons and events they witnessed 50 years earlier (e.g., Wagenaar, 1988; Wagenaar & Groeneweg, 1990) and in media-event court cases involving recovered memories of CSA (e.g., Loftus & Ketcham, 1994; Terr, 1994). The publicity surrounding these cases and their outcomes have likely served to reinforce the views that concern us here. Survey research has revealed very optimistic views of memory capabilities among lay people (Garry, Loftus, & Brown, 1994; Loftus & Loftus, 1980;
S. M. Seelau, personal communication, January 5, 1995). Loftus and Loftus (1980), Yapko (1994), S. Smith (1991), and Poole et al. (1995) discovered similar beliefs among psychologists, psychotherapists, hypnotherapists, and social workers. For example, 31% of the respondents in Yapko’s survey of 860 practitioners agreed with the statement, “When someone has a memory of a trauma while in hypnosis, it objectively must actually have occurred,” and 54% said that hypnosis enables people to remember actual events “as far back as birth.”

It seems clear that psychological scientists have been unsuccessful in correcting widely held but erroneous views about memory functioning. One reason for our lack of success may be researchers’ reluctance to wander into the fray of public debate; another may be a disinclination on the part of the public and their representatives toward critical or scientific thinking. Many commentators have referred to the “crisis in science education” in North America, which is reflected in the documented decline of skills in mathematics and other sciences (e.g., Sagan, 1990; Schatzman, 1993). Thus, it is not surprising that the public is not well prepared for scientific argument. Unfortunately, most politicians are equally unprepared (Schatzman, 1993). In North America the normal educational background for career politicians is a degree in law, not science. Thus, legislators are often ill-equipped to evaluate scientific evidence and may fall easy prey to uninformed beliefs and vigorously argued positions. Furthermore, even if legislators did have the appropriate background, it is not clear that they could resist the politics of the situation. As Haney (1993) put it in a more general discussion of the pervasiveness of incorrect notions about psychological concepts, “Even a reasonably ‘informed’ judiciary can be made responsive to a largely ‘uninformed’ public” (p. 389). Given acceptance of the idea that a large percentage of adults in North America have completely repressed histories of CSA that can be accurately recovered through therapy, taking legislative steps to allow such people to press charges against abusers would appear to be a right and just course of action.

Future public policy regarding statutes of limitation. Liberalization of statutes of limitation was intended to provide opportunities for legitimate delayed claims of CSA to be brought forward. Unfortunately, such liberalization may also lead to erroneous accusations about alleged events in the distant past (Loftus, 1994b). Such charges are difficult to try, because they often reduce to the word of the accuser against that of the accused. As Ernsdorff and Loftus (1993) pointed out, there may also be grounds for concern that tollings may be extended to cases involving alleged recovered memories of other kinds of childhood events or to events alleged to have occurred after the age of majority. In consideration of these issues, Ernsdorff and Loftus (1993) and Bulkley and Horwitz (1994) enumerated some potential changes to legislation and judicial procedure in cases involving alleged recovered memories. Potential alterations of the tolling mechanism included (a) complete exclusion of cases based on claims of recovered memory; (b) establishment of a finite number of years beyond the statute of limitation during which claims may be filed; (c) requirement of corroborating evidence; (d) imposition of a higher burden of proof in civil cases; and (e) provision of a criminal law remedy only (because of its higher burden of proof and greater protection for accuseds). With respect to changes in judicial procedure that could be adopted as special safeguards against wrongful

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10Issues similar to those discussed here apply to recent uses of multiple personality disorder diagnoses in criminal defences (Piper, 1994).
accusations, Ernsdorff and Loftus discussed (a) use of fictitious names for accusers and accuseds; (b) a more stringent limitation on introduction of “similar act” evidence than presently exists; (c) development of jury instructions regarding recovered memories (akin to the Telfaire instruction regarding eyewitness testimony, U.S. v. Telfaire, 1972); and (d) admission of expert evidence regarding memory recovery.

Extensions of the statutes of limitations are being reconsidered in some states. For example, Schneider (1994) reported that the Illinois Senate recently passed legislation that essentially caps the limitation period at the age of 30 years, a reconsideration that Schneider attributed to the Cardinal Bernardin case. The State of New Hampshire Superior Court (State of New Hampshire v. John Morahan, 1995), in a joint judgment in a pretrial hearing on the admissibility of recovered-memory testimony in the cases of State v. Joel Hungerford (1995) and State v. John Morahan (1995), ruled as follows:

The phenomenon of memory repression, and the process of therapy used in these cases to recover the memories, have not gained general scientific acceptance in the field of psychology, and they are not scientifically reliable. (p. 1)

**Mandatory reporting laws and protection of third parties.** At present, many individuals in the U.S. and Canada are legally mandated to report incidents of known or suspected child sexual abuse to authorities (although many of those mandated do not always report abuse when they observe or suspect it; Brooks, Perry, Starr, & Teply, 1994). It is not clear whether mandatory reporting always, never, or sometimes applies to cases in which adult clients report or are suspected of CSA by an identified perpetrator who may be a continuing danger to identifiable children. In any case, it appears that therapists rarely report recovered memory cases to authorities, even if they believe clients who identify alleged satanic murderers allegedly still active in a cult (see Bottoms et al., in press).

Mandating the reporting of recovered memory cases would likely have multiple effects. On the one hand, mandated reporting might further increase legal actions based on questionable recovered memories, with numerous ill-effects. Mandatory reporting might also threaten the confidentiality of the therapist–client relationship. On the other hand, mandatory reporting would lead to the provision of an early record of what was remembered and (perhaps) of the steps taken to obtain such recall (cf. Courtois, 1994; Enns et al., 1995), and it might encourage therapists to be more cautious about forming the opinion that a client had been abused as a child (e.g., seek collaborative and potentially disconfirming evidence, request advice from colleagues, etc.) because it requires therapists to go on public record regarding their beliefs about clients’ memories. We raise the issue of mandatory reporting in recovered memory cases not because we think it is a good policy but rather because considering this issue helps drive home the gravity of the consequences of using memory work to help clients recover suspected memories of CSA.

**Jurors’ beliefs about recovered memories.** To what extent do jurors accept recovered memories? Loftus et al. (1993) found that mock jurors (university students, members of the public, and practicing lawyers) viewed accusations of CSA

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11It might also be argued that a therapist who believes that a client who has recovered memories poses a risk to an identifiable person (e.g., intends to assault the alleged perpetrator) has a duty to warn that person (as in the Tarasoff ruling; Monahan, 1993).
more skeptically when they were described as recovered memories (as opposed to never-forgotten memories). However, moderate degrees of credibility were assigned to allegations in both conditions. Clark and Nightingale (1994) and A. Warren (personal communication, December 15, 1994) found that undergraduates' assessments of the credibility of abuse allegations did not significantly differ for cases based on repressed versus never-forgotten memories. The content of recovered memories may not greatly affect credibility either, as Schutte (1994) found no difference in mock jurors' verdicts when allegations were of recovered memories of incest versus SRA (cf. Rind & Harrington, 1994). Other research has shown that jurors have undue confidence in memories recovered with hypnosis (e.g., Wagstaff, Vella, & Perfect, 1992). Further research in this area is needed, but these findings suggest that potential jurors find recovered memories as or nearly as credible as never-forgotten memories of CSA.

Certification for giving expert evidence. Expert psychological testimony has been the subject of much recent debate (e.g., the 1992 special issue of Law and Human Behavior; Melton, 1994; Moen, 1994). It has sometimes been suggested that only clinicians have the requisite knowledge and experience to inform courts about repressed memories (Begley & Brant, 1994; Terr, 1994). In contrast, Sales, Shuman, and O'Connor (1994) argued that expert testimony based solely on clinical experience and intuition raises numerous problems of evidentiary reliability. Read and Lindsay (1994) argued that the lines do not necessarily divide as neatly along practitioner and researcher specialties as implied by Sales et al., because there are many individuals with both scientific research skills and clinical experience. In any event, Sales et al. argued that the recent U.S. Supreme Court decision in Daubert v. Merrell Dow Pharmaceuticals, Inc. (1993), which articulates standards for the admissibility of expert testimony, may affect future access to federal (and some state) courtrooms by both psychological scientists and practitioners, because expert scientific testimony will no longer be judged by the Frye standard (United States v. Frye, 1923). The Frye standard requires "general acceptance" of the substance of expert evidence within the expert's professional community, whereas the more recent Daubert decision allows consideration of a number of other bases for accepting expert scientific evidence (e.g., whether or not the theory on which testimony is based is falsifiable and whether or not it has been subjected to scientific tests and is relevant to the task at hand). Questions as to whether and when clinical judgments have a scientific basis gain new importance in light of Daubert (Melton, 1994).

As we previously argued, the current state of psychological science does not allow psychologists to discriminate with certainty between veridical and illusory memories in individual cases. Rather, the credibility of recovered memories claims can only be estimated by considering various factors. Thus, in our opinion, experts on both sides of this issue should be modest in their claims regarding specific cases. Experts should also be careful in their use of terminology. By analogy, consider the legal battles that arose over prosecutors' attempts to have expert witnesses assign children the diagnosis of "child sexual abuse accommodation syndrome" (CSAAS; Bulkley, 1992; Stewart & Young, 1992; Summit, 1983, 1992b). CSAAS is not an established psychiatric condition and hence did not meet the Frye standard. Nonetheless, it was apparently not unusual for psychologists admitted as expert witnesses to provide a CSAAS "diagnosis" (Bulkley, 1992; Stewart & Young, 1992). Summit (1992a) stated that, in retrospect, he wishes he had used the term pattern
rather than syndrome, because he had intended only to claim that a pattern of allegation and recantation is common in CSA, not that such a pattern verifies the presence of CSA. The terms false memory syndrome and repressed memory syndrome present the same dangers, as revealed in lawyers' requests to us (and, we assume, many others) that we "diagnose" accusers as suffering from false memory syndrome.

Because courts have an interest in obtaining accurate and representative scientific testimony, it might be appropriate to develop a registry of blue-ribbon experts from which courts could call for expert psychological testimony (cf. Hayes, 1994). Such a group of experts could develop standards and criteria regarding the nature and quality of the research cited in their courtroom presentations (cf. Committee on Ethical Guidelines for Forensic Psychologists, 1991). If members of the profession cannot agree on a representative group of experts, perhaps psychologists should not be considered qualified to give expert evidence.

Agreement on who qualifies as an expert psychologist is likely to be difficult, but having experts agree with one another may be more difficult still. Courts are reluctant to allow battles of experts over scientific evidence because jurors are likely to have difficulty integrating and evaluating the information presented. As one way to avoid the tendency toward such battles (a tendency likely to be particularly pronounced in cases involving alleged recovered memories), a recent Royal Commission in the United Kingdom advocated changes in procedure for criminal trials such that both prosecution and defense provide pretrial disclosures of scientific evidence and argument so that, as far as possible, pretrial agreement can be reached on such evidence (Roberts, 1994).

Despite the limitations of expert psychological testimony, it seems essential that legal professionals be educated about memory functioning, memory work in psychotherapy, self-help, and related issues (cf. Simmons, 1994). There are a variety of ways in which this can be done, choices that social scientists have debated frequently (Melton, 1994; Roesch, Golding, Hans, & Reppucci, 1991). In addition to serving as an expert witness, these include (a) presenting research findings in outlets accessible to members of the legal profession (e.g., law reviews and informal professional networks); (b) collaborating with other psychologists to develop "amicus" briefs that provide summaries of social science data to the courts (e.g., Maryland v. Craig, 1990; New Jersey v. Margaret Kelly Michaels, 1993); and (c) working with legal professionals to design research directly relevant to the law.

Consequences of criminal and civil proceedings for accuser and accused. In adult recovered memory cases, it is the accuser's decision whether to pursue redress through the courts. If the accuser lives in a jurisdiction in which both criminal and civil options are open, consideration of the costs and benefits of each is important (see Bulkley & Horwitz, 1994, and Enns et al., 1995, for discussions of the advantages and disadvantages of these two types of legal action). From the accuser's perspective, a criminal trial has the advantage that the case rests in the state's hands and thus the state's resources may be brought to bear by the prosecution. Furthermore, the retributive and deterrent consequences of a guilty verdict for the accused may meet the accuser's original goals in filing a charge. On the other hand, the likelihood of a criminal court conviction is relatively small, because the burden of proof falls on the prosecution and that burden is high ("beyond a reasonable doubt"). Finally, because the prosecution is managed by the state and not the accuser, accusers may more often feel victimized than validated by the procedure (Ewing, 1992).

Accusers are more likely to succeed with civil actions than with criminal charges,
because the burden of proof is lower for civil suits ("the preponderance of evidence"). Also, a civil court, unlike a criminal court, necessarily provides an opportunity for the accuser to confront the accused directly, which may have therapeutic benefits for survivors of abuse (Mallia, 1993). For these reasons, individuals seeking redress for a recovered history of CSA have been advised by the self-help literature (e.g., Bass & Davis, 1988, p. 128) and by legal opinion (e.g., Clute, 1993) to pursue a civil rather than a criminal action. Clute, as well as Lamm (1991) and Walker (1992), suggested that a successful litigation provides an opportunity to gain closure and validation of one's injuries. Financial settlements are often reached before cases are tried (Williams, 1988, cited in Bass & Davis, 1988), thus precluding public presentation of the charges, but such settlements may still be seen as a positive outcome for the accuser (Lamm, 1991).

There are potential risks of both types of legal action for accusers (see Enns et al., 1995; Ewing, 1992; Penelope, 1992; Simmons, 1994; Walker, 1992, for differing perspectives on this issue). Not surprisingly, no systematic research has been done to test the hypothesis that suing alleged abusers has therapeutic benefits, and some experts have cautioned against legal action. Ewing, for example, recommended against legal action of either form when much time has elapsed since the alleged abuse, no corroboration from other individuals exists, and the litigation is to be funded by the accuser. In these circumstances, Ewing argued that successful litigation will be highly unlikely, and if litigation is unsuccessful the accuser must deal with the experience of losing the case.

From the accused's perspective, a criminal charge may often be seen as more threatening than a civil suit. Whether the accused is convicted or not, criminal charges can lead to widespread publicity. If convicted, the accused faces possible incarceration and a criminal record. However, a criminal trial provides a higher level of due process and greater protection against erroneous guilty judgments than does a civil trial and may therefore be the preferred option for the accused in many recovered memory cases.

Other legal actions. As noted in the introduction to this article, actions filed against alleged perpetrators or their estates are but one of several kinds of cases involving memory recovery now being heard in the courts (Loftus & Rosenwald, 1993; Schneider, 1994; Spiegel & Schefflin, 1994). Other permutations of clients, alleged abusers, and therapists and authors have also been involved in legal proceedings, such as actions by accuseds against therapists for defamation or for neglect of duty of care, against authors of self-help books, or against accusers for defamation of character, and actions by former clients against therapists for negligent and injurious practices (for examples, see Loftus & Rosenwald, 1993; Nelson & Simpson, 1994; Schneider, 1994; S. Simpson & Baker, 1994). As yet, the U.S. Supreme Court has not dealt with issues arising from recovered memory cases, but given the level of legal activity and political tension in this area, Supreme Court decisions are likely and will perhaps lead to very rapid and dramatic changes in psychotherapy (Slovenko, 1994).

Alternative forms of dispute resolution. It may be possible to develop alternative dispute resolution (ADR) procedures that may be preferable to formal criminal trials or civil litigations for dealing with charges based on recovered memories of CSA. If those who allege CSA based on recovered memories were provided a forum other than a court of law in which their complaints could be heard, perhaps a number of the goals of legal action could be met (conflict resolution, presentation of charges
and confrontation of the accused, and validation for the accuser) without revictimization by an adversarial court system. ADR has often proved successful in cases of tort liability and criminal law (see review by MacCoun, Lind, & Taylor, 1992). One option reported to have reasonable success in recovered memory cases is mediation by a qualified, mutually acceptable mediator (cf. Craig, 1994). Agreements reached as a result of mediation are binding and preclude further action based on additional delayed discoveries, and if a settlement is mediated it often includes coverage of the accuser’s medical and counseling bills as well as future therapy with a mutually acceptable therapist. Courts are likely to be pleased with the mediation process, because it removes cases from their cluttered dockets. Taxpayers may also support mediation, because it is much less expensive than criminal or civil hearings. Los Angeles County has made mediation mandatory in cases of delayed accusations of CSA if either party requests it.

From a therapeutic point of view, mediation may offer most of the benefits and few of the risks of civil or criminal proceedings and may help shift clients’ focus from the past to the future. From a pragmatic standpoint, ADR procedures may be appealing because the considerable sums of money spent by both parties on a litigation could instead be directed to more constructive ends (e.g., therapy for accusers and accuseds).

Summary: Legal issues. Legal actions involving delayed accusations of CSA have increased dramatically in the last decade. The increased litigation can partly be attributed to improved support for survivors, acknowledgment of the potential lasting ill effects of CSA, and consequent relaxation of statutes of limitations, all of which enhanced opportunities for legitimate delayed accusations to be brought to court. Unfortunately, it appears that many delayed accusations brought to the courts involve alleged histories of CSA recovered through suggestive influences in therapy or self-help, and the evidence and arguments reviewed earlier suggest that many such accusations are ill-founded. The possible applicability of mandatory reporting laws to adults’ accounts of CSA, the possible extension of tollings of statutes of limitation to recovered memories of childhood events other than CSA or to postchildhood events, and publicity about successful suits against therapists may further increase litigation in this area. Moreover, popularization of false memory syndrome is likely to lead to widespread use of claims of false memories in legal defenses of people accused of sex crimes (including cases in which there is no basis for such a claim).

From a legal perspective, the central issue is how triers of fact can discriminate between veridical and false delayed accusations. In most cases there is no material evidence, and often there is no corroborating evidence of any kind. In these circumstances, it is critical that triers of fact be informed of evidence regarding the likelihood of accurately recovering previously unavailable histories of CSA and the factors that affect the likelihood of false memories or beliefs. At the same time, expert witnesses must acknowledge the limitations of current psychological science with regard to the veracity of recovered memories in individual cases. In view of the drawbacks of criminal and civil actions, those seeking redress for recovered histories of CSA may wish to consider ADR.

Summary and Conclusion

We began this article by briefly reviewing the historical and cultural context in which the debate about recovered memories of CSA arose. The history of denial and
minimization of CSA and the belief that successful psychotherapy often relies on resolving childhood traumas illuminate the rationale for using memory recovery techniques and help account for skepticism regarding criticisms of those techniques.

The first half of our article reviewed evidence that indicates that allegations of CSA based solely on recovered memories should be viewed with caution. We clarified criticisms of memory work in psychotherapy, emphasizing that concerns have focused on long-term, multifaceted (although not necessarily coercive) searches for hidden memories in clients who initially disavow abuse histories, and described evidence of the prevalence of memory recovery techniques in psychotherapy. We then critically reviewed evidence regarding the base rate of recoverable hidden memories of CSA. In our view, this evidence indicates that only a small minority of psychotherapy clients have recoverable hidden histories of CSA. Furthermore, research on supposed “indicators” of CSA indicates that it is likely difficult for practitioners to identify clients with hidden memories. We argued that, in the context of research on the suggestibility of memory and evidence that clinical judgments are subject to various biases and heuristics, these findings justify grave concern that memory work may sometimes lead to iatrogenic illusory memories or false beliefs regarding histories of CSA in clients who were not abused as children. The claim is not that all memories recovered through suggestive memory work are false but rather that some—perhaps many or even most—likely are. We also offered criteria for weighing the validity of allegations of CSA based solely on recovered memories.

The second half of the article considered implications of scientific evidence regarding recovered memories for psychology, public policy, and the law. The section on training and certification of mental health care providers discussed issues related to the prevalence of unqualified therapists and offered recommendations regarding psychotherapists’ training and ongoing education, supervision, and consultation. Many of these recommendations drew on the American Psychological Association (1993) Division 12 Task Force report, which called for improved training in scientific thinking and methodology, greater emphasis on empirically validated treatments, and higher standards for ongoing supervision, education, and consultation. Next, we discussed the need for well-considered and widely disseminated professional guidelines for practitioners whose treatments include explorations of clients’ memories of childhood traumas. Here too, our recommendations drew on those others have offered (e.g., American Medical Association, 1994; American Psychiatric Association, 1993; Australian Psychological Society, 1994; Brown, 1995; Courtois, 1994; Enns et al., 1995). We emphasized the importance of (a) avoiding high-risk memory recovery techniques and ancillary practices, (b) obtaining informed consent, (c) keeping records, and (d) being circumspect about recommending that clients take legal action against alleged abusers.

The penultimate section of the paper called for field research on memory for trauma, clinical research on the efficacy of memory work and on treatment for sequelae of recovered memories, and cognitive research on memory recovery techniques. The final section offered a discussion of legal issues related to recovered memories. We sketched the historical backdrop for recent changes in laws regarding civil and criminal actions against alleged perpetrators of CSA and briefly discussed the roles of science and politics in fostering changes of the statutes of limitation for delayed accusations of CSA. We then speculated about the applicability of mandatory reporting laws to cases in which therapists believe an adult client was
abused by an identified perpetrator who may be a continuing risk to children. Next we reviewed recent studies of mock jurors' decisions in recovered memory cases and discussed issues related to expert psychological testimony. Finally, we considered the consequences of civil versus criminal legal actions for accusers and accuseds, enumerated the variety of kinds of legal actions involving recovered memories that are currently being tried, and discussed alternative forms of dispute resolution that both accusers and accuseds may find preferable to civil or criminal actions.

The sexual abuse of children is an important problem. CSA is much more common than once was thought, and there is ample evidence documenting an association between CSA and adulthood psychological problems. The reality and importance of this social problem is not diminished by the evidence and arguments presented here.

Trauma-oriented therapies vary, from approaches that most experts would agree are dangerously suggestive to those that most would agree are not dangerously suggestive. Likewise, people who recover memories through memory work vary, from those who initially claimed that their childhoods involved no CSA to those who have always remembered CSA but initially did not view the abuse as particularly important and had forgotten some details and instances. Finally, the conditions that lead to recovered memories also vary, from cases in which memory recovery follows a highly suggestive search to cases in which memory recovery occurs more spontaneously. In our reading, scientific evidence has clear implications for cases at the extremes of these continua: Memories recovered through suggestive memory work by people who initially denied any such history should be viewed with skepticism, but there are fewer grounds on which to doubt spontaneously recovered memories of common forms of CSA or recovered memories of details of never-forgotten abuse. Between these extremes lies a gray area within which the implications of existing scientific evidence are less clear and experts are likely to disagree.

We noted at the outset of this article that the stakes are high for all parties in the debate about memory work and recovered memories. It is perhaps inevitable that there is tension between those who emphasize the importance of supporting survivors of CSA and those who emphasize the importance of avoiding false beliefs. As noted earlier, the history of denial and minimization of CSA understandably predisposes victim advocates to be suspicious of claims that some recovered memories of CSA are false. The intensity of that response is likely heightened by the claim that illusory memories and beliefs can be caused by practitioners' interventions. It is not surprising that the reaction to this charge is angry denial, sometimes taking forms that might be described as "counterbacklash" (e.g., stating that critics of memory work are motivated by a desire to protect perpetrators, as in Enns et al., 1995, Herman & Harvey, 1993, or Walker, 1994).

For therapists who have used suggestive techniques to help clients remember horrific histories of CSA perpetrated by loved ones, the cost of considering the idea that such techniques can lead nonabused clients to develop false beliefs may be great. In our view, however, the evidence for this possibility is too strong to ignore, and trauma-oriented therapists will eventually realize that extensive use of memory recovery techniques is ill-advised. Painful as such an acknowledgement is likely to be for those who have used and prescribed such techniques, they can take comfort in the fact that abandoning risky memory recovery techniques in no way denies the reality and importance of CSA.
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