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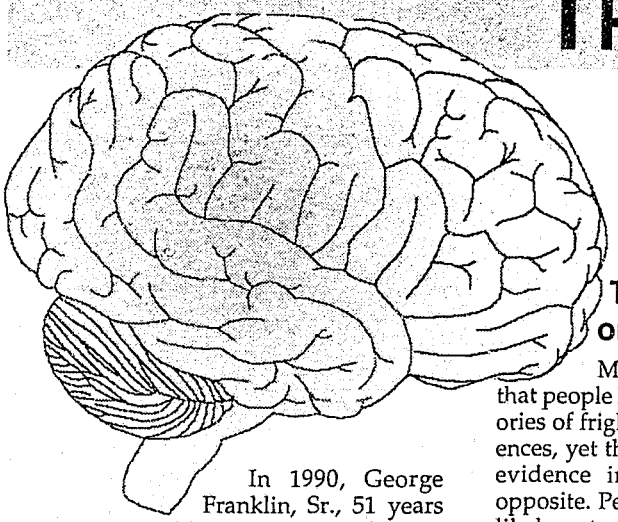
THE CONTROVERSY OVER



In 1990, George Franklin, Sr., 51 years old, was convicted for sexual assault and murder of Susan Nason, an 8 year old friend of his daughter. What was unusual about the conviction is that the murder took place 20 years earlier, on September 22, 1969. Eileen, his daughter, provided the primary evidence against Franklin. Her memory of the murder, which took place in her presence, had been repressed for 20 years. In 1989, while playing with her children, Eileen had her first flashback. Subsequently, she became convinced that her father was guilty of murder. Largely on their belief in Eileen's recovered memory, a California jury convicted her father (Searlman and Hermann, 1994).

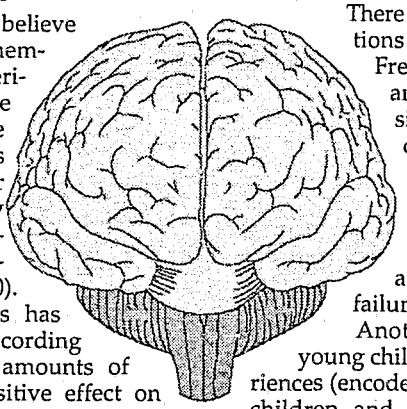
How is this possible? How do people repress traumatic events only to have the memories emerge many years later? Why do some people repress and not others? How can one be certain that repressed memories are accurate? These questions are surrounded by controversy.

Repression

What is repression? While Freud was the first to use the term as one of many defense mechanisms he described, it was Janet, in 1889, who discussed the concept as it relates to traumatic events (van der Kalk, 1994). He suggested that traumatic events interfered with typical memory functions. The intense emotions that accompany trauma, he said, caused the memory of a particular event to be dissociated from the conscious mind. The unpleasant memories or events were not allowed to reach conscious awareness. They became stored, then, as emotions such as anxiety and panic or as visual images. This lack of conscious memory of events is what Freud called repression.

The Effect of Trauma on Memory

Many adults believe that people have vivid memories of frightening experiences, yet the bulk of the evidence indicates the opposite. People are less likely to remember events accurately if they were extremely frightened or emotional during the events (Kail, 1990).



The effect that stress has upon memory varies according to its intensity. Small amounts of stress often have a positive effect on alertness and facilitate memory. However, intense stress can over-arouse the individual, cause high anxiety and hinder memory functioning (Searlman and Hermann, 1994).

One response to high stress is to concentrate only on major details. For example, a person threatened by a man with a knife may focus on the knife and be unable to recall facial features or what type of shoes were worn.

The effects of anxiety or stress may not be simple or easily explained. For example, one theory, the action decrement theory, proposes that high stress causes memory for both central and peripheral details to be inhibited shortly after the event, but claims that both types of details become easier to remember later. An alternative view states that core features of highly emotional events are remembered especially well, although peripheral details may be missed. Findings of several studies (ranging from memories of medical procedures to memories of the space shuttle explosion) show that distress is associated with more complete recall and greater resistance to suggestion (Batterman-Faunce & Goodman, 1993).

Others suggest a psychodynamic cause of repression of memories. Amnesia, memory deficits and dissociation are characteristic defensive maneuvers a person utilizes as a trauma response in the interest of defense and protection (Courtois, 1992; Olio, 1989). "Such defenses usually become so ingrained that they function in a semi- or wholly autonomous fashion and may be largely unconscious" (Courtois, 1992, p. 16).

Infantile Amnesia

The inability to remember events from early in life is apparently universal, both for humans and other animals. Most people can recall little prior to age 3 and only a few select events from ages 3 to 5 years. After age 5, retention increases steadily (Kail, 1990).

There are a number of explanations for infantile amnesia. Freud thought infantile amnesia was due to repression. The experiences were coded in the child's memory, but the individual could not gain access to them. Modern researchers would term repression as an instance of retrieval failure.

Another possibility is that young children may not store experiences (encode stimuli) as well as older children and adults. This would be termed inadequate storage. Thus, information is missing because it was not stored properly and is not there to be retrieved.

A third hypothesis suggests that memory storage in infants and very young children is similar to storage in older children and adults. The early memories, however, are disrupted by the child's development and neurological changes and are, thus, "lost". This theory has been termed disrupted storage.

Others think that the retrieval cues are radically different when the child tries to remember events from infancy, and thus, these are not accessible. Theoretically, if the child or adult could reconstruct the context (for example, being small while the environment is very large), then retrieval might be possible.

Regardless of theoretical basis, there is agreement that very early memories (before age 3) are generally not available to older children and adults.

Research with Children

Research on the effects of trauma or stress on children's memory is difficult. It is unethical to subject a child to severe stress for the purposes of experimentation. However, a few studies have attempted to gather data about children's memory of stressful events using events that have occurred already.

Goodman, Hepps and Reed (1986, reported in Kail, 1990) compared the memories of children visiting a clinic to have a sample of blood drawn to memo-

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ries of children who visited the clinic and were given a washable tattoo. The two groups of 3 to 7 year old children had similar recall of what actions were performed by clinic staff (91 percent accuracy versus 83 percent) and similar performance on ability to identify the technician (53 percent versus 67 percent accuracy).

Another study that utilized children receiving inoculations (Goodman, Aman and Hirschman, 1987 reported in Kail, 1990) rated the amount of stress caused by the procedure, then compared high- and low-stress children. In this group of 3- to 6-year-olds, performance did not differ significantly with differing stress. In contrast, Peters (1987, reported in Kail, 1990) found that children with less anxiety about their dental visit performed significantly better in recognition of the dentist and staff.

Research with Adults

Herman and Schatzow (1987) conducted a study of 53 women treated by them in a short-term therapy group for incest survivors. One of the goals of the study was to "lay to rest, if possible, the concern that . . . recollections might be based on fantasy" (p. 2). They rated the victim's recall as "full recall," (meaning they had always remembered their abuse in detail and that no other memories were recovered in the course of treatment), "mild to moderate memory deficits" (those who had not been aware of major gaps in memory but who reported recent recall of new memories or who recovered some additional memories during group treatment), and "severe memory deficits" (could recall very little from childhood, reported recent eruption into consciousness or memories that had been entirely repressed).

Twenty-eight percent of the subjects reported severe memory deficits. "A strong association was observed between the degree of reported amnesia and the age of the onset and duration of the sexual abuse. Women who reported no memory deficits were generally those whose abuse had begun or continued well into adolescence. Mild to moderate memory deficits were usually associated with abuse that began in latency and ended by early adolescence. Marked memory deficits were usually associated with abuse that began early in childhood, often in preschool years, and ended before adolescence. "In addition, a relationship was observed between frankly violent or sadistic abuse experiences and the resort to massive repression as a defense. Nine of the twelve women who suffered overtly violent abuse reported that they had been amnesiac for these experiences for a prolonged period of time" (Herman and Schatzow, 1987, p.5).

Were the memories true or fantasy? According to the researchers, 74 percent of the subjects were able to confirm the sexual abuse. Forty percent obtained corroborating evidence either from the perpetrator himself, from other family members, or from physical evidence such as diaries or photographs. Thirty-four percent discovered that another child, usually a sibling, had been abused by the same perpetrator. An additional nine percent reported statements from other family members indicating a strong likelihood that they had also been abused, but did not confirm their suspicions by direct questioning.

Briere and Conte (1989) reported similar findings in their study of 450 subjects who were in therapy and who reported some amnesia for abuse which occurred before age 18. They found amnesia for abuse (partial or otherwise) was reported by 59 percent of abuse subjects. The variables of abuse most related to repression were: 1) the abuse occurred at an early age with a fairly long duration; 2) an increased number of psychological symptoms; and, 3) violence such as physical injury or fears of death if the abuse was disclosed.

Linda Williams (1992, reported in Batterman-Faunce & Goodman, 1993) interviewed women who, as children, were treated at a hospital emergency room for alleged sexual assault. Approximately 38 percent of the women evidenced no memory for the emergency room visit or for the sexual assault.

While preliminary evidence in this brewing controversy, the high degree of concurrence between these three studies results in strong face validity. The studies suggest that repressed memories of sexual abuse are probable and that the degree of repression depends on several distinct variables.

Loftus (1993) has challenged the Briere and Conte study based on two concerns. First, the questions on the questionnaire required a yes/no response and were worded in such a manner so that interpretations by the test-taker could be different that those assumed by the researchers. Secondly, all subjects were in therapy, leading to the possibility of their being influenced by therapists' belief that repression of sexual abuse memories is common. She called for a "further examination of the issue with a different eliciting question" (p. 521).

Gold, Hughes and Hohnecker (1994) reported the results of their study which was similar to that of Briere and Conte but which used an interview format allowing for a range of alternate responses representing degrees of forgetting. In addition, the study minimized the likelihood of treatment effects by administering the questionnaire at intake (87 percent of subjects) or as early in the intervention process as possible. The results were similar to Briere and Conte in terms of the reporting of complete repression, but different as to the numbers who reported it (30 percent as opposed to Briere and Conte's 59 percent). The authors suggest this difference is due to the offering of responses as to degrees of repression rather than a yes/no choice.

Loftus (1994) while acknowledging the effort Gold, Hugher and Hohnecker put into controlling for tests and therapy effects, countered that the researchers had no knowledge of the contact these subjects may have had with self-help books and the greater media, all of which could have effected their responses at intake.

Authenticity

Are repressed memories authentic? Therapists seem to believe they are. Loftus reports two studies which reveal a high level of faith by therapists in

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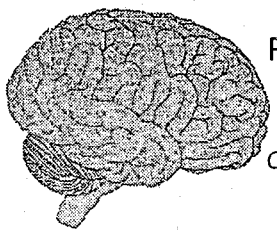

Repressed Memories

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repressed memories. Shaver and Goodman (1991) found 93 percent of clinicians always believed clients who reported amnesiac periods of ritualistic abuse. Loftus and Herzog (1991) found that most therapists (81 percent) invariably believed their "repressed memory" clients and often used symptomology as evidence.

There are those who question the authenticity of repressed memory, partially because of the intensity of the denial by the accused person. A group in Philadelphia, False Memory Syndrome Foundation, coined the phrase "false memory syndrome", believing memories of abuse are the result of therapy and that the memories victimize both the "primary victim" (the person experiencing the memory) and the "secondary victim" (the person falsely accused).

Loftus (1993) is one researcher who questions the authenticity of repressed memories. One source of support is research by herself and her colleagues on the malleability of memory of being lost in a shopping mall at age five. Chris, the 14 year old subject, was convinced by his older brother, Jim, that Chris had gotten lost at age five and was found being led down the mall by an oldish man. Chris was crying and holding the man's hand, Jim said. Two days after Jim provided the scenario to Chris, Chris began reporting his feelings when he was lost ("That day I was scared I would never see my parents again. I knew I was in trouble.") Two weeks later, Chris reported the event in much detail, expanding significantly on the report given by Jim. When later asked to guess which memory discussed during the study had been false, Chris guessed an authentic memory. He had difficulty believing his memory of being lost at the mall was false and induced by his sibling.

How Can Inaccurate Memories Occur?

Suggestion appears to be one cause of inaccurate memory. Suggestion can come from reading, talking to others, viewing media or adopting the viewpoint of an authoritative person. According to Loftus (1993), therapists may also be responsible for some cases of faulty memory. There are a number of ways therapists can influence clients to create false memories, according to Loftus. One method is direct suggestion. Some therapists are alleged to tell patients "merely on the basis of a suggestive history or symptom profile, that they definitely had a traumatic experience. Even if there was no memory, but merely some vague symptoms, certain therapists will inform a patient after a single session that he or she was very likely a victim of a satanic cult" (p. 526).

The possibility of molestation may also be suggested through more tentative statements, such as "Your symptoms sound like you were abused as a child. What can you tell me about that?" Some therapists have been said to be unwilling to take "no" for an answer to questions about abuse, leading clients eventually to disclose. Finally, therapists may interpret dreams or other symbolic material as evidence of abuse. Loftus suggests that even if clinicians are not the first to bring up sexual abuse, they will often reinforce "what begins as a mere suspicion" (p. 527).

In a recent issue of Family Therapy Networker, Yapho (1993) summarizes her concerns by writing "Clients are not only encouraged to believe that were abused, but patiently exhorted to return again and again to whatever fragments of dream, imagination, or memory they can dig up, building a story and a case elaborate enough to satisfy a therapist. The client bold enough to reject the diagnosis of incest survivor is said to be 'in denial,' and unwilling to confront the truth. The rejection of the diagnosis is prima facie evidence in its favor. In other words, if the client admits the abuse happened, it happened; if the client doesn't admit it, it still happened" (p.34).

The use of hypnosis to retrieve memories has also been cited as a possible contamination of memory. Unfortunately, hypnosis is one technique that may allow a person access to hidden memories, putting a client and therapist in a bind. The technique that might allow the memory to be uncovered can also contaminate it.

Whether memories are recovered or buried, therapists might send their clients to support groups. There are questions about this practice unless there are solid memories of childhood sexual abuse. Do support groups foster the development of constructed memories? Possibly. Loftus (1993) reports a study by Shaffer and Cozolino (1992) which found that many clients who, in the course of therapy, revealed victimization through ritual abuse had previously participated in support groups.

Loftus (1993) also indites "checklists" of symptoms that are supposed to indicate the presence of past abuse. Common problems such as low self-esteem, suicidal thinking, depression, poor work performance, and sexual dysfunction are mentioned as indicators of past victimization.

Clients with such symptoms who have no memories of abuse may be exhorted to "try" to remember. "Readers who wonder if they might be victims of child sexual abuse are provided with a list of possible activities ranging from the relatively benign (e.g., being held in a way that make them uncomfortable) to the unequivocally abusive (e.g., being raped or otherwise penetrated). Readers are then told 'If you are unable to remember any specific instances like the ones mentions above but still have a feeling that something abusive happened to you, it probably did'" (Loftus, 1993, p. 21). The client is encouraged to progress from suspicion to confirmation by talking about what is remembered.

Loftus is not suggesting that therapists and writers encourage "false" memories with malicious intent. On the contrary. She suggests they may be attempting to help the client reclaim a traumatic past, a widely held purpose of therapy. Or, therapists may be unwittingly suggesting ideas to clients because they have fallen prey to confirmatory bias. Loftus reports a study by Baron, Beattie and Hershey (1988) which suggested that "people in general, therapists included, have a tendency to search for evidence that confirms their hunches rather than search for evidence that disconfirms" (p. 530). Or, possibly, Loftus suggests, therapists are helping construct a social reality by asking questions that "tend to elicit behaviors and experiences thought to be characteristic of someone who had been victim of childhood trauma . . . " (p. 530).

Others are not so generous. The False Memory Foundation suggests false allegations of sexual abuse to be the third great wake of hysteria to sweep the continent, the first being the Salem Witch trials and the second the McCarthy hearings on communist activity. Therapists, they say, are engaging in a cult-like conspiracy to implant false memories of abuse. (Moving Forward, 2, (4).

Do repressed memories exist? If so, what are the causes? How many "repressed" memories are really "false memories"? There appears to be no definite answer to these questions. Without validation by outside confirmation, there currently is not any way to know whether a recovered memory is accurate or not.

The controversy about repressed memories will continue. Whatever position is taken however, all writers and researchers agree that a great deal more research is needed. Proponents and opponents need to work together to analyze and address the issue with a critical eye.

References Available Upon Request