

Guidelines relating to recovered memories

Introduction

The Australian Psychological Society has developed the following Ethical Guidelines in relation to an issue that has involved public controversy, therapeutic uncertainty, scientific conflict and debate, and on occasions, litigation. While the Guidelines are primarily directed towards psychologists working with clients who report memories of abuse, it is recognised that a range of people may be involved in or affected by such reports. The Guidelines are intended to safeguard all clients, and to assist in dealing with reports of recovered memories in therapeutic, forensic and scientific contexts. The aim is to produce a balanced document offering some clarity without compounding the distress and confusion of those most affected by the issue.

Complete or partial memory loss is a frequently reported consequence of trauma, particularly childhood trauma and, most commonly, child sexual abuse. Recovered memory, also known as repressed traumatic memory, refers to the full or partial recovery of such memories after a gap of some years. Amid the controversy surrounding the validity of treatments designed to recover traumatic memories, there is general agreement about the following points:

- Childhood trauma involving physical, sexual and/or emotional abuse is not uncommon;
- Children who are subjected to such experiences are likely to be adversely affected, and evidence exists that varying degrees of psychological damage can be attributed to a child's experience of such abuse;
- Child sexual abuse should not be retrospectively assumed solely on the basis of presenting symptoms;
- Memories of such experiences may be incessant, intrusive, complete, selective, fragmented, distorted or absent depending on the context and nature of the abuse and the survival strategies available to the individual as a child or later in life;
- All memories are susceptible to revision and influence from the time of encoding up to and including the time and context of retrieval, as well as in the disclosure and reporting process; and
- The percentage of child sexual abuse experiences that (a) are recalled for the first time during therapy and (b) are the subject of litigation, is very small in comparison to those that are remembered but unreported, and whose effects may or may not require treatment.

Given that this is a controversial area, and that no source of truth can be taken as absolute, it is essential that psychologists continually examine their own values and take account of the wider contexts in which debates may arise. Such debates may involve divisions between scientist, clinician and consumer perspectives, or between advocates of false memory and recovered memory theories, research on cognitive memory, body memory and traumatic memory processes, conflicting forensic and therapeutic concerns, and issues related to gender, power and the repercussions of the widespread exposure given to childhood trauma in recent years. Questions are raised around the empirical basis for particular trends in psychological treatment, and the different contexts in which retrieval for research, litigation and therapeutic purposes can take place.

I. Scientific issues

Members should recognise that reports of abuse long after the alleged events are difficult to prove or disprove in the majority of cases. Independent corroboration of the statements of those who make or deny such allegations can be difficult. Accordingly, members should exercise special care in dealing with clients, their family members, and the wider community when allegations of past abuse are made.

Memory is a constructive and reconstructive process. What is remembered about an event is shaped by how that event was experienced, by conditions prevailing during attempts to remember, and by events occurring between the experience and the attempted remembering. Memories can be altered, deleted, and created by events that occur during and after the time of encoding, during the period of storage, and during any attempts at retrieval.

While there is a great deal of evidence for inaccurate memory in the context of eye-witness and other non-clinical research, there is currently less evidence for the creation of false memories in clinical contexts. Research about memory in non-traumatised people may not necessarily apply to the experiences of people who have been abused or traumatised. As there is evidence of selective memory, particularly autobiographical memory, in the context of mood disturbance, there is a need to consider what is cause and effect in dealing with recovered memories.

Memory is integral to many approaches to therapy. Repression and dissociation processes are also central to some theoretical and therapeutic approaches which propose that memories of traumatic events may be blocked out, such that a person has no recall of the events, although they may become accessible at some later time. Although clinical observations offer some support for the possibility of repressed memories, experimental research on memory is inconclusive. Moreover, the question of whether traumatic memory is processed, stored and recalled differently from normal memory is unresolved. Current scientific evidence does not allow predictive statements to be made with great certainty about any relationship between trauma and memory.

Memories that are reported either spontaneously or following the use of special procedures in therapy may be accurate, inaccurate, selective, fabricated, or a mixture of these. The level of belief in memory or the emotion associated with the memory does not predict the accuracy of the memory. The scientific and clinical evidence currently available does not allow accurate, inaccurate, and fabricated memories to be distinguished from one another in the absence of independent corroboration.

II. Clinical issues

Members should seek to meet the needs of clients who report memories of abuse; this responsibility exists quite apart from the truth or falsity of those reports. Members should always recognise that the needs and wellbeing of individual clients are paramount, and should design their therapeutic interventions accordingly.

Members should always evaluate critically their assumptions or biases about attempts to recover memories of trauma-related events. Equally, psychologists should facilitate exploration of clients' own assumptions about repressed or recovered memories. Assumptions that adult problems may or may not be associated with repressed memories from childhood are difficult to sustain on the basis of available scientific evidence.

Members in caring, assessment and therapeutic roles need to be open to the emergence of memories of trauma that may or may not have been previously available to a client's consciousness. Recovered memories are only one way in which experiences of abuse may surface or be disclosed within and beyond the therapeutic context. Disclosure is typically an emerging process rather than a one-off event, and delays in reporting may reflect the difficulties of this process rather than being attributable to a recovered memory phenomenon. The establishment of trust within the therapeutic relationship is central to the client's choices regarding disclosure.

Members should be alert to the ways that they can influence the reporting or non-reporting of memories by clients through the expectations they convey, the comments they make, the questions they ask or do not ask, and the responses they give to clients. Members should be aware that clients may be susceptible to subtle suggestions and reinforcements, whether those communications are intended or unintended. Equally, members should be alert not to dismiss memories that may be based in fact, and should provide a context in which it is safe to disclose material about abuse.

Members should recognise that the context of therapy is as important as the content. At all times, psychologists should be empathic and supportive towards clients, while also ensuring that clients do not form premature conclusions about the truth or falsity of their recollections of the past. They should also ensure that alternative causes of any reported problems are explored.

Members should not avoid asking clients about the possibility of sexual or other abusive occurrences in their past, if such a question is relevant to the problem being treated. However, members should always be sensitive in the way that they ask such questions, and cautious in interpreting any response that is given. Members should **not** assume that a report of no abuse is necessarily indicative of either repressed or dissociated memory or denial of known events. They should neither assume that a report of abuse indicates necessarily that the client was abused; nor assume that a report of no abuse is indicative that no abuse occurred.

Members should not initiate a search for memories of abuse, as abused (and non-abused) clients may be further traumatised or overwhelmed by material that has not arisen spontaneously. On the other hand, whilst taking care about

the implications of active investigation and suggestion, members should not seek to manage these risks simply by refusing to deal with past events and 'working in the present' where this actively denies the client's experience or wishes. The decision to deal with, or not deal with, past events should always be made in the interests of the client's welfare.

Members should understand the distinction frequently made in the literature between narrative truth and verifiable truth, and the relevance of this distinction within the therapy context and outside that context. Members need to tolerate, and help their clients tolerate, uncertainty and ambiguity regarding the client's early experiences, as eventually it may have to be accepted that the truth cannot be verified, and that helping clients to make sense of their lives may not be the same as discovering objective facts. However, to be accepted for legal purposes, reports must be shown to be substantially accurate.

Finally, members should note that there is no standard procedure for verifying recovered memories in individual cases, and that clients may want to draw their own conclusions about whether or not they were previously traumatised, and about the specific details of such events, insofar as they wish to recall or reconstruct them.

III. Ethical issues

Members treating clients who report recovered memories of abuse are expected to observe the Principles set out in the *Code of Ethics* (1999) of the Australian Psychological Society, and in the *Code of Professional Conduct* of the Psychologists Registration Board in the State(s) and/or Territory(ies) in which they are registered as psychologists. Psychologists should be mindful of General Principle I of the *Code of Ethics*, which relates to the personal responsibility they hold for the foreseeable consequences of their actions.

At the beginning of therapy members should provide opportunities for clarification and discussion, and obtain informed consent in relation to the details of the therapeutic process and its possible consequences. Where hypnosis is to be used, informed consent should include information about its likely effect on litigation cases, whereby information gathered under hypnosis may not be accepted as evidence. (See also the *APS Guidelines on the teaching and use of hypnosis*).

Members should be prepared to discuss with any client who recovers a memory of abuse the nature of that memory: that it may be true or false, partly true, distorted, selective, thematically true, metaphorically true, or a blend of accurate, distorted and symbolic material. Members should explore with the client the meaning and implications of the memory for the client, rather than focus solely on the content of the reported memory. Members should explore with the client ways of determining the accuracy of the memory, if appropriate. Discovering that some aspects of a memory are displaced, metaphorical or inaccurate should not lead members to immediately discount all of that memory. Given the acknowledged difficulties in distinguishing 'false' from 'true' memories, an open mind is essential.

Members should be particularly alert to the need to maintain appropriate skills and learning in this area, and should keep abreast of relevant scientific evidence and clinical standards of practice. Members should guard against accepting approaches to abuse and therapy that are not based on scientific evidence and appropriate clinical standards. Nor is it the role of members to instruct or pressure clients to take a particular course of action with accused offenders and/or family members during the course of therapy for childhood abuse.

IV. Legal issues

Members should in no way tolerate, or be seen to tolerate, childhood or adult sexual abuse, or abuse of any kind. They should ensure that their psychological services are used appropriately in this regard, and should be alert to problems of deciding whether allegations of abuse are true or false. They should be alert especially to the different demands and processes of the therapeutic and legal contexts in dealing with such allegations, including laws relating to the reporting of child abuse.

Members should be aware that some approaches and writings concerning abuse and recovered memories urge clients to engage in legal action against the alleged abuser and any others who may question the accuracy of any recovered memories. Given that the accuracy of memories, which is the focus of the courts, cannot be determined without

corroboration, members should exercise caution when responding to questions from clients about legal action. Members may explore the implications of taking legal action in terms of the potential impact on the client's wellbeing, including the possibility of their being further traumatised by the legal process. Members working in a therapeutic context should recognise that their responsibilities are to the needs of their clients, and not to issues of legal or punitive action. Nevertheless, the therapeutic need of clients might include support through a litigation process.

Members should be aware that their knowledge, skills, and practices may come under close scrutiny by various public and private agencies if they are treating clients who recover memories of abuse. Members should always ensure that accurate records are maintained about their sessions with clients recovering memories of abuse. Members should consider the implications of any records they keep, should they be the subject of a subpoena, and familiarise themselves with laws relating to confidentiality in various legal jurisdictions in their State. Where the role of members is to assist in obtaining evidence that is reliable in forensic terms, they should restrict themselves to procedures that enhance reliability (such as the cognitive interview), and avoid techniques that are known to reduce reliability (such as hypnosis or leading questions). When negotiating informed consent in such circumstances, the member should be aware that the techniques they use might be called into question, and therefore might discuss the option of documenting sessions by audio or videotape. Reports for forensic purposes may include comment on the availability of any corroborative or contradictory evidence.

While there are currently no standard protocols for the determination of the validity of individual reports of recovered memories, the scientific and clinical knowledge available can provide consensual and balanced information, which can be utilised in forensic contexts.

V. Research issues

Members should be aware that further research is needed to understand more about trauma-related memory, techniques to enhance memory, and techniques to deal effectively with childhood sexual abuse. Members should support and contribute to research on these and related issues whenever possible. Clinicians need to recognise the limitations of anecdotal reports or data collected solely from clinical populations; memory researchers need to examine and acknowledge the limitations of laboratory-based data and non-traumatised samples.

References

Australian Psychological Society (1999). *Code of Ethics*. Melbourne.

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