

## Recovered Memory and Adult Disclosure of Child Sexual Assault

**Public Defenders  
Annual Criminal Law Conference  
3rd & 4th March 2007**

Paper by Dr Brent Waters, Consultant Child Psychiatrist

In some circles, recovered memory as an explanation for adult disclosure of child sexual assault is still controversial, but in others the argument is over – in one direction or the other. I am a skeptic who relies on empirical research. Perhaps the simplest way to deal with the science of this issue is to indicate that most peak psychological and psychiatric professional bodies in the English-speaking world have issued memoranda to their members outlining the lack of scientific evidence for the concept of repressed memory. This is usually coupled with a caution against the use of forceful, leading or otherwise persuasive interviewing techniques intended to reveal evidence of past sexual abuse because of concern that techniques such as this can lead to false affirmation. These memoranda were largely issued in the mid to late 1990s and as far as I am aware, no scientific evidence has come to light since then which has caused them to be withdrawn or substantially modified.

In a nutshell, several decades of research has been unable to demonstrate the validity of the notion of repressed memory, not just in respect of child sexual abuse, but in other situations. On the other hand research has demonstrated with great clarity what had been well established by the advertising and marketing industry. People are extremely malleable and suggestible, and once persuaded, they can hold to a false notion with incredible tenacity. This has been demonstrated in people of all ages except the extremes of the age spectrum – children under about the age of 3 and the elderly, the former because there would be ethical concerns with some studies and the latter because of the problem of dementia confounding interpretation of results.

Several weeks ago an article was reprinted from the New York Times of February 2nd 2007 reporting a study by Harvard Professor of Psychiatry Dr Harrison Pope published in the Journal Psychological Medicine. He reported that a team of psychiatrists and literary scholars could not find a single account of repressed memory, fictional or not, before the year 1800. This cut off was chosen because in the 19th century a genre of romantic literature developed in which what amounts to repressed memory was used as a plot device. The authors had specific criterion for this - that a healthy person blanks out a specific traumatic event, only to retrieve it a year or more later.

While this may not appear to be a particularly scientific approach to an issue, it was not really an attempt to validate the concept, but more an effort to understand the evolution of the concept.

His data are consistent with repressed memories for sexual abuse being a culture bound phenomenon – a behavioural phenomenon of time and place like witch trials, ritual abuse, repetitive strain injury and dare I say it, alien abduction.

Social science lies in a domain between objective and subjective reality, and the subjective in particular is as susceptible to fashion and imperial pretensions as any other area of human enterprise. Yet at the same time, particularly in the Courts, there is strong pressure to create a sharp demarcation between objective and subjective knowledge which has the effect of forcing categorical decisions about matters which are intrinsically non-categorical in nature. That is to create black and white out of a domain which is naturally in shades of grey.

In psychiatry in particular, arising as it does out of medicine, there has always been a strong focus on a diagnosis and therefore on diagnostic categories or diseases. A valid classification of diseases has a number of important purposes, two of the highest being that it creates a language for effective communication and that it allows the definition of groups of people with particular conditions which in turn permits reproducible research into aspects of a condition, everything from causes to treatment.

The problem with the push for disease classification in psychiatry and the social sciences is that in the absence of external and unambiguous measures of a disease, such as the abrupt line of black tissue which defines the edge of gangrene, or high levels of creatinine which demonstrate the failure of the kidneys to do their function, one has to look for other parameters to define conditions. This is a particularly acute problem in behavioural science and psychiatry where the major phenomena are observed behaviours and reported feelings. Reported feelings in particular are highly subjective, but observed behaviours can also be subjective as well. To take political example, the diagnosis of paranoid psychosis applied to political dissidents in the USSR during the 1980s. There is good evidence that this was not entirely a cynical exercise by Soviet psychiatrists as there was also a significant body of practitioners who seemed to genuinely believe in what they were diagnosing.

In the 1950s and 1960s in the United States, attempts at psychiatric classification rested partly on observed behaviour. This is perhaps best exemplified by the diagnostic criteria for alcoholism, dementia and schizophrenia. However, in the areas of more common and less debilitating disorders such as those associated with anxiety, the classification rested less on behaviours and reported emotions than it did on theoretical constructs of what was going on psychologically underneath.

It is here that we come back to the notion of repressed memory. As I indicated earlier, the notion of partially or fully repressed memories was an attractive plot device in romantic novels of the 1800s. At the end of that century, Freud and very soon a group of his disciples began to develop ideas about a variety of subtle processes which shaped behaviour. One thing which evolved from this was the concept that because of early childhood experiences troubled people had developed individualised yet repetitively employed ways of dealing with life's challenges which were inherently dysfunctional. The individuals were regarded as unaware of the actions of these psychological habits, although through their repetitive use, their presence could be inferred. These were referred to as ego defence mechanisms against anxiety. They were the methods which the person used unconsciously to avoid being overwhelmed by anxiety.

Sigmund Freud described a number of these defence mechanisms and they were later codified by his daughter Anna. She sorted them into some which were extremely primitive or immature, reflecting very early childhood trauma, and some which were somewhat more mature. She also added a third group of quite mature defence mechanisms which are seen among normally functioning individuals. For instance rationalisation, or the capacity to talk oneself around a problem in the least confrontational way. Among the most primitive defence mechanisms was repression, which was basically pushing an issue so deeply out of consciousness that it is extremely difficult to bring it back into consciousness. Among the more mature defences was suppression, which amounts to conveniently distancing oneself from anxiety-provoking memories, although no so far that they cannot be retrieved with a little effort.

The psychoanalytic movement spawned by Freud held sway in American psychiatry well into the 1960's, when a transition occurred in around 1970 towards a more objective approach to psychiatric classification. A system of classification was developed which relied much more heavily on observed behaviour and where that was absent or to complement it, reported emotions.

The American Psychiatric Association did not have a stranglehold on psychiatric classification around the world, at least at a formal level. For instance in the English speaking world, the World Health Organisation had created a comprehensive classification known as the International Classification of Diseases which included medical as well as psychiatric conditions, and if that was not accepted in other particular countries, those countries generally had their own classifications as well, although the practise was usually to appropriate either the American or the WHO classification. However particularly since the 1970's in psychiatry, the American psychiatric classification has increasingly held sway. For instance, even though technically in Australia we adhere to the WHO classification, the reality is that the teaching of psychiatry is largely organised around the American classification. There are significant differences between the major classifications, and of course a number of areas of substantial agreement. Some argue that this has been a form of psychiatric imperialism, and there has been a very interesting interplay between the popularization of various of the American diagnostic groups and the marketing of pharmaceuticals, particularly with depression, but that is another story, as are the reasons for psychology and behavioural sciences in general jumping on the same psychiatric diagnosis bandwagon.

The relevance of it though is that the United States has been an incredible powerhouse for the promulgation of behavioural syndromes and simple solutions, and it is where the notion of repressed memories of childhood sexual abuse was really kick-started and from where it spread.

It is relevant in terms of disease or disorder identification to be able to identify conditions which have been reported across diverse cultures as well as throughout the historical record. Conditions which appear in some cultures and not in others, or which appear at some times and not at others, suggest that cultural and historical factors are at play, and I would like you to assume that account is taken of descriptive and rhetorical differences. So for instance, melancholic depression, the so-called "black dog", has been described in the Greek and Roman records and can be found in every contemporary culture. The same is the case for schizophrenia and also substance abuse or addiction.

Returning now to Professor Pope's study, I would emphasise that repression of childhood sexual abuse is not a psychiatric disorder *per se*. It is a phenomenon associated with a particular hypothesised ego defence mechanism. Dr Pope tells us that cases of repressed memory of childhood sexual abuse have not yet been found before 1800, and that they first started to be seen in 19th century romantic fiction, although in a more oblique form than we see now. Freud thought that he had discovered this, but then he famously recanted, and later in his career he held to the view that mostly, inferences of sexual inappropriate behaviour by a parent towards a child were imagined and reflected even more deeply repressed Oedipal or Electral wishes. Of course he has been heavily criticised for this recantation by Jeffrey Masson when he briefly had charge of the Freud archives, and he expressed views which resonated strongly with the rising tide of repressed memory rhetoric in the 1980's in particular.

In my view, Pope has provided strong, though not definitive, evidence that repressed memory of childhood sexual abuse is a new phenomenon. The historical record provides abundant records not just of rates of child sexual abuse in historical but recorded times, but also of the same individual responses to this form of predation – shame, depression, alienation etc.

Now I would like to briefly review how reports of abuse repression may have become so prevalent. Unfortunately, these types of mechanisms are not open to satisfactory scientific study, not the least reason being that people who report repressed memories of sexual abuse by and large are ideologically strongly opposed to science which tests hypotheses about causation rather than simply accepting wholeheartedly what they may believe has happened to them and the mechanism by which it occurred.

What there is though, as I have inferred earlier, is a very large body of data which demonstrates how people's minds can be manipulated and false ideas be implanted, not just in the laboratory but of course in the form of propaganda etc. Obviously however it is completely unacceptable to implant as potentially dangerous and distressing ideas as having been sexually abused, so the ideas implanted in scientific studies tend to be of a more benign variety, although not necessarily entirely innocent. For instance children have been able to be persuaded about burglars getting into their homes, being abducted by people at shopping centres and things of that sort, ideas which I would have to say that I am not courageous enough to put in children's minds because the studies also show that once in there, these ideas can be quite hard to dislodge and there is also a risk that implanted false ideas might cause people to have enduring heightened levels of vigilance based on something which they thought happened, but never did.

Closer to home are what amount to single case studies, situations where there is very clear documentation of a person not have a particular idea at time A and the idea being gradually planted in their head. The earliest and probably best documented of these are cases in which therapists have kept very detailed notes and in some cases even audiotapes of sessions where a person attends the therapist for some type of emotional malaise and the therapist asks increasingly leading and often quite forceful questions about sexual abuse, then when an affirmation is obtained, forced choice questions follow – did he do A or did he do B? – and other persuasive or leading techniques lead to increasing detail being added until a so called clear picture emerges. I have been involved in some cases where the documentary evidence provides a clear indication from where an aspect of an allegation has arisen during well intentioned interrogation by a therapist or more alarmingly, by people who's brief it was to investigate a complaint.

It is not clear why these cases started to emerge in numbers in about the 1970's, but it was rather like a snowball when it happened. I believe it was because child sexual abuse was at last being recognised. Very quickly victims groups emerged and also coalitions of professionals, many of whom did not have what would be regarded as comprehensive training in psychological intervention, but certainly many of the leaders of these groups have been fully qualified psychiatrists and clinical psychologists. By this point a popular literature was also starting to develop which made these concepts much more widely accessible. One construction would have it that books like "The Courage to Heal", in which it is basically declared that if you believe you have been abused, then you have, found a very receptive audience. With the notion being taken up by popular mass culture such as talk-back shows etc., no one even had to go to enthusiastic therapists any more to be provided with persuasive information, even peer pressure, and for people to generate their own stories.

As an audience comprised largely of legal practitioners who work with defendants, I imagine that you see in what I have said a cogent basis for understanding probably well intentioned but nevertheless false accusations, and take heart from the absence of scientific evidence for the existence of this mechanism, as well as the presence of a body of incomplete but nevertheless strongly suggestive evidence that it is a sociocultural epiphenomenon. It can be satisfying to not only be able to demonstrate that your client did not do it, but also that what he is accused of doing almost does not happen anyway.

However I want to also highlight another very serious problem which this situation has caused. At this point I want to introduce a term which you have probably wondered why I haven't used already - False Memory Syndrome. As a behavioural scientist, I have a lot of problems with anything that has the term syndrome tacked on the end, because it generally shrieks over-simplification, but False Memory Syndrome also carries with it connotations of malice and retribution, which I happen to believe is present in only a minority of cases. If this is a false syndrome, in my view these are not people that deserve to be repudiated, but rather that the reasons that they seized on this explanation bears some understanding. In my experience most are emotionally needy people who are vulnerable to suggestions from some well intentioned other that the reasons for their unhappiness can be blamed on childhood sexual abuse, the memory of which they have repressed. In the small group of cases that I have seen, their early lives have typically been unsettled and potentially distressing, some extremely so.

A final point that I believe has to be made is that the whole repressed memory/false memory debate has had an unintended but quite catastrophic effect in that it has clouded peoples thinking about childhood sexual abuse. The debate has tainted the perception of genuine victims of childhood sexual abuse and in many cases has provided a life raft for offenders who have tried to make the defence that the victim was suffering from False Memory Syndrome, whereas in fact they have had distressing, although not always completely clear, memories of what happened to them and that the effects continue to reverberate through their lives. False memories which create what we call false *positives*, or people thought to have suffered a harm who haven't really, have created a problem in the community of over-identification of false *negatives*, or people who have been genuinely harmed but who are dismissed as just trying to harm to somebody else.

What the historical record does provide, particularly in the previous century, but earlier as well, is that people who have suffered horrendous circumstances, not so much repress their memories of what happened and are unable to recall them, but rather suffer because they wish they could forget and are not able to. Childhood victims of war and dislocation provide eloquent evidence of this. Similarly, the reportage of the horrors of international conflict

and imprisonment have shown two peaks in documentation – the first not long after the event when some people want to talk about it, and the second five or six decades later when these people who have never talked about these things with their families and might only talk about on ANZAC Day after a few beers with the battalion, seem to lose their inhibitions, perhaps because they are never going to get another chance and also importantly as the first subtle changes of dementia start to appear in the form of various types of disinhibition. To use the Freudian term, these people have suppressed their memories. They have been able to go on with their lives by compartmentalising it, perhaps being able to reflect privately on it when something pushes it into their mind or when they feel the need, perhaps being able to release a little with others who have gone through the same experience, but generally putting it in a place where it doesn't cause trouble.

*Suppression* of memories is what often happens to victims of childhood sexual abuse, and research shows that these memories can be quite easily retrieved as reliably – or unreliably as any other memories. Life events will often make the memories bubble to the surface as well – first desired sexual experience, marriage, birth of a child etc. But the sense these people have is of an experience that is within reach of recall, though usually not voluntarily thought about.