Response:
The Dilemma of Validation

John Morton

There is widespread agreement in the scientific community on a number of facts .out memory. It is clear that what is stored in the mind concerning events we have experienced is fragmentary, and that reconstructive processes operate at the time of recall. These reconstructive processes serve to fill out the narrative by inserting routine items which had not been stored at the time (such as the addition of milk to coffee in our memory of yesterday's breakfast), but could also incorporate information from the record of another, similar, event or, possibly, from something read or seen or even imagined. Next time we try to recall the event, it will rarely be possible for us to distinguish between elements which were present in the original and those which were imported during the previous recall.

Given these properties of our cognitive system, it is not surprising that there is agreement that it is possible for suggestible patients to be led to believe falsely that they were sexually abused in childhood. The relevant question concerns the conditions under which this could occur. Lindsay and Read (1994) said in a recent comprehensive review:

> There is little reason to fear that a few suggestive questions will lead psychotherapy clients to conjure up vivid and compelling illusory memories of childhood sexual abuse. (p. 294)

However, it is agreed that sustained pressure by an authority figure on a susceptible person would be likely to lead to false beliefs. It is also agreed that use of techniques such as hypnosis could lead to confusion as to whether the source of a particular thought was reality or imagination.

The scenario characteristic of the recovered memory debate is that an adult in their thirties or forties, in therapy for some reason (the reasons most commonly mentioned are depression, sexual dysfunction or eating disorder), comes to believe that they had been sexually abused as a child by their father. As an illustration, I will summarize a case which was brought to court in Denver and reported in the *Rocky Mountain News* of 2 and 3 November 1995. This report was summarized in the FMS Foundation *Newsletter* of January 1996. The therapist was ordered to pay $120,857 for implanting false memories of incest. The patient, JB, had sought treatment for post-partum depression in 1990. After a year in therapy the depression had deepened. Eventually dim memories, then detailed recollections, of weekly sexual abuse emerged. According to JB, the therapist would get angry when she questioned these memories, saying, `Why don't you just accept this? You want to get better don't you?' At some stage, hypnosis was used. JB subsequently cut off relations with her parents and siblings. We

John Morton is a cognitive psychologist who works on memory. He is director of the Medical Research Council's Cognitive Development Unit and Professor of Psychology in University College London. He was chair of the British Psychological Society's Working Party on Recovered Memories (Morton *et al.* 1995). Address for correspondence: MRC Cognitive Development Unit, 4 Taviton Street, London WC1H 0AH.

British Journal of Psychotherapy, Vol 12(3), 1996

are meant to understand that the therapist believed in the abuse before the client did and that it was the historical truth of the memories that was important.

In this story there are a number of possible sources of distortion from the original events, some systematic. As told, however, it is not as extreme as some. There is no report in this case, as in others, of the therapist having told the patient at the first meeting that it was clear that she had been sexually abused on the basis of symptoms, such as depression, alone.

Such are the political and emotional pressures in the debate in the USA that a respected cognitive psychologist from Yale, John Kihlstrom, wrote recently:

> [T]herapy transpires in a cultural context which is increasingly permeated by unwarranted beliefs about the prevalence of abuse, traumatic amnesia, the clinical consequences of both abuse and amnesia, and the efficacy of recovered memory therapy. Within this socio-cultural milieu, even a few probing questions and suggestive remarks by an authoritative figure such as a therapist may be sufficient to inculcate a belief on the part of a patient that he or she was repressed, and start the patient on the road toward the "recovery" of false memories. (1995, p. 46)

Can such circumstances account for the prevalence of recovered memories? Andrews *et al.* (1995) surveyed therapists who were accredited to the British Psychological Society and discovered that, of the 810 respondents, more than one in five reported that they had at least one client in the preceding year who recovered a memory of childhood sexual abuse (CSA). However, about a third of our respondents said that they had had clients recovering such memories before they had any therapy. Furthermore, nearly a third (a total of 225) had clients recovering memories from complete amnesia of a traumatic experience other than CSA. Such findings would be difficult to account for on the basis of pressure from CSA-oriented therapists.

If one is to believe in the possibility of essentially accurate recovered memories, then one has to believe in the possibility of amnesia for the traumatic events, often extended over time. There is good agreement over this issue as well, at least in principle (Lindsay & Read 1994). What has been attacked is the use of the concept of repression as an explanation. Ceci and Loftus (1994) comment that `repression is almost certainly overused as an explanation of memory failure, with normal forgetting, deliberate avoidance, attentional overfocussing, and infantile amnesia providing both more prosaic and parsimonious explanations of encoding and/or retrieval problems' (p. 352). However, given we accept the existence of amnesia, we need not here be concerned with the plausibility of putative mechanisms.

In her article, Gardner makes a serious attempt to address issues that arise for the therapist when the patient reports remembering something from the past. She focuses on the task of validation. This takes in the contrast between historical and psychic truth, the nature of the therapeutic exercise and the contribution of the therapist.

The first issue is what it is that is being validated. The context of the current debate - that some people who recover memories proceed to accuse their parents and in some cases sue them - is soon dismissed: `positivistic notions of validation have little relevance to the analytic encounter'. But such notions are difficult to keep out. Gardner continues in the next paragraph:

> Verifiable documentation of childhood sexual abuse ... is usually not available and so the assessment and validation of the recovered memories takes place in the consulting-room between patient and therapist.

It would be easy to read such a sentence as implying that the validation referred to had the same status as social service records. But this is not the intention. The object of validation has changed totally. It is no longer the content of the recovered memory but the analytic knowledge, and especially the interpretations, arising from the `shared therapeutic experience', that are validated:

> it is the psychic reality *of both patient and therapist* that is then being considered though there is both a connection and a distinction between the inner experience and the actuality. (my emphasis)

Of course, in the present debate, it is the precise nature of this connection that is at issue. In addition, as soon as the psychic reality becomes joint, the role of the analyst becomes more sensitive as psychotherapists understand and assess material from within their own experience and orientation.

Gardner is properly cautious about this process, and quotes others on the validation function of supervision: `Self-deception and unconscious collusion with the patient to evade reality makes counter-transference unreliable without additional corroboration. Here a third point of view can help the analyst to recognize his blind spots and fortify his judgement.' It sounds here as though we are talking about psychic reality. However, in the following paragraph Gardner refers to what happens to `early memories of documented trauma'. What is not spelled out is the relation of this to any psychic reality of the patient (or, rather, of the patient and therapist combined). Within this framework, do the processes of dissociation and repression have to do with fantasy or with reality? If it is reality, then are we to infer that supervision should be necessary whenever there is a change in cultural context, such as the realization of widespread child sexual abuse, beyond the experience of some, at least, analysts?

In the context of her patient Kate, Gardner discusses an initial belief (without memory) of paternal abuse, followed by a vague memory which Kate herself interpreted. In the context of true vs. false recovered memories, it would have been interesting to have had a more extended discussion of the pressure on the therapist by the patient to accept as historical truth the interpretation the patient had put on the memory, and the methods used by the therapist to assess them. Gardner actually seems to reject the abuse interpretation in part because of a lack of `clear development of the abuser/abused dyad in the transference'. The use of such phenomena as evidence raises the thought that such development would be in part determined by the relevant experience (real and psychic) of the analyst. Such a view is reinforced by the story quoted from the work of Good (1994), where the psychic reality of a memory of clitoridectomy `was confirmed in the manifest and latent content of her repetitive and trauma-laden dreams'. The material truth lay in the gynaecological examination which revealed an intact clitoris. We then have the `vexing possibility that the trauma remembered may not be the same as the trauma that occurred'. `Vexing possibility' is an understatement, particularly when the possibility of serious abuse is being discussed.

Gardner sensitively sketches the dilemma for the therapist. Regardless of the therapist's theoretical predisposition, the patient makes demands concerning the historical past which have to be met some way. Other people in the same tradition take a tougher view. For example, Cohler (1994), writing on memory recovery from a psychoanalytic perspective, draws on a number of authors (such as Anna Freud 1967 and Cooper 1986) in support of the position that `It is not the event itself, but rather

our presently constructed memory of that event that is important in psychoanalytic treatment' (Cohler 1994, p. 369). He goes further: `From a psychoanalytic perspective, the very concept of repression means that it is impossible to "recover" memories beneath the repression barrier which arise out of the effort to resolve the psychological conflict of early childhood' (p. 372). Cohler later observes that `The analytic intervention fosters a collaborative construction of the life story' (along the lines that Gardner admirably illustrates), and concludes that whatever the justification for memory recovery intervention, it cannot be founded in psychoanalysis. In this context, recovering memories seems irrelevant and the objective of the therapy could well be reconstructed as that of creating a memory prosthesis, as it were, through which the past could be comfortably viewed. I do not get the impression that this would be a universally acceptable conclusion, however.

Bloom steps back from practice to purpose: 'a therapy is considered to be effective ... when it does more good than harm ... Memory retrieval just for its own sake is not necessarily helpful.' The reason for this is that reliving traumatic memories can simply be retraumatizing. The reason is that the underlying memory traces are somatosensory fragments without a coherent semantic component. To retrieve such fragments is to re-experience them. Van der Kolk and Fisler lay a great deal of emphasis on the observation that memories of trauma are essentially sensory and affective rather than semantic or narrative, and that post-traumatic stress disorder (PTSD) experiences remain essentially unchanged for many years.

It is not clear what we are to make of this material even if we accept it without question. Bloom, like van der Kolk and Fisler, stresses the difference between memories of traumatic events and those which are merely stressful. Traumatic memories are fixed, and are thus unlike memories of non-traumatic events, which are liable to change. This means that valid conclusions cannot be drawn from laboratory experiments which are merely stressful. However, we cannot, from van der Kolk and Fisler's own analysis, conclude that recovered memories of trauma must also be accurate in detail. A personal narrative will be constructed, but this 'does not necessarily have a one-to-one correspondence with what actually happened' (van der Kolk & Fisler 1995, p. 519).* So narrative recall of such trauma will have all the properties of non-traumatic memory, in particular the changeability, even if the somato-sensory components are experienced as real. In addition, there remain questions as to what gives some traumatic events the power of PTSD and what are the properties of other traumatic events that allow them to be kept from consciousness.

There are further issues that arise. What of a recovered memory, for example, that starts as a vague image and only gains specific features, including affect, later? Within the van der Kolk and Fisler framework, would these be suspect? And what of abuse which is not traumatic at the time, but occurs in a microculture of normality? Would this be unforgettable within the framework?

It is possible that such issues will be resolved in relation to psychic truth but it remains clear that historical truth is not to be resolved by such means. It may well be that highly trained psychoanalysts and psychotherapists can work at validating the joint psychic reality without confusing the patient into thinking that the historical reality was being addressed. And there is no reason why an intellectual climate in

* From the second part of their paper - A.S.

which the fantasy of past incest is more important than the reality of past familial sexual abuse should not flourish behind closed doors. In the context of current concerns, however, such a doctrine should avoid making contact with the world outside the consulting-room, both for the fear of being misunderstood and from the danger of leading others into believing the psychic to be the historical.

References

Andrews, B., Morton, J., Bekerian, D.A., Brewin, C.R., Davies, G.M. & Mollon, P. (1995) The recovery of memories in clinical practice: experiences and beliefs of British Psychological Society practitioners. In *The Psychologist 8:* 209-14.

Ceci, S.J. & Loftus, E.F. (1994) `Memory work': a royal road to false memories. In *Applied Cognitive Psychology 8:* 351-64.

Cohler, B.J. (1994) Memory recovery and the use of the past: a commentary on Lindsay and Read from psychoanalytic perspectives. In *Applied Cognitive Psychology 8:* 365-78.

Cooper, A. (1986) Toward a limited definition of psychic trauma. In *The Reconstruction of Trauma: Its Significance in Clinical Work* (Ed. A. Rothstein). Madison, CT: International Universities Press.

Freud, A. (1967) Comments on psychic trauma. In A. Freud, *The Writings of Anna Freud, vol.* 5. Madison, CT: International Universities Press.

Good, M. (1994) The reconstruction of early childhood trauma: fantasy, reality and verification. In *Journal of the American Psychoanalytic Association 42:* 79-101.

Kihlstrom, J.F. (1995) Letter to *The Therapist 3(4):* 45-6.

Lindsay, D.S. & Read, J.D. (1994) Psychotherapy and memories of childhood sexual abuse: a cognitive perspective. In *Applied Cognitive Psychology 8:* 281-338.

Morton, J., Andrews, B., Bekerian, D.A., Brewin, C.R., Davies, G.M. & Mollon, P. (1995) *Recovered Memories.* Leicester: British Psychological Society.