

**FINAL CONCLUSIONS OF THE APA WORKING GROUP  
ON INVESTIGATION OF MEMORIES OF CHILDHOOD ABUSE**

**FINAL CONCLUSIONS OF THE APA WORKING GROUP  
ON INVESTIGATION OF MEMORIES OF CHILDHOOD ABUSE**

In this concluding section, we seek to bring the preceding documents together by summarizing our points of agreement and disagreement. We also articulate some of the implications of our deliberations for clinical practice, forensic practice, research, and training. Finally, we conclude with a plea for unity within our discipline.

**WHERE DO WE STAND?**

Inspection of these reviews and commentaries indicates that we are in agreement concerning a number of key points. Indeed, as indicated in the Working Group's Interim Report, we agree on the following:

1. Controversies regarding adult recollections should not be allowed to obscure the fact that child sexual abuse is a complex and pervasive problem in America that has historically gone unacknowledged.

2. Most people who were sexually abused as children remember all or part of what happened to them.

3. It is possible for memories of abuse that have been forgotten for a long time to be remembered.

4. It is also possible to construct convincing pseudomemories for events that never occurred.

5. There are gaps in our knowledge about the processes that lead to accurate and inaccurate recollections of childhood abuse.

As important as these areas of agreement are, it is equally if not more important to acknowledge frankly that we differ markedly on a wide range of issues. At the core, the clinical and research subgroups have fundamentally differing views of the nature of memory. These contrasting conceptions of memory have led to debate concerning (a) the constructive nature of memory

and the accuracy with which any events can be remembered over extended delays; (b) the tentative mechanisms that may underlie delayed remembering; (c) the presumed "special" status of memories of traumatic events; (d) the relevance of the basic memory and developmental literatures for understanding the recall of stressful events; (e) the rules of evidence by which we can test hypotheses about the consequences of trauma and the nature of remembering, (f) the frequency with which pseudomemories may be created by suggestion, both within and outside of therapy; and (g) the ease with which, in the absence of external corroborative evidence, "real" and pseudomemories may be distinguished.

#### **WHERE DO WE GO?**

Given this characterization of our understanding of the critical issues, how do we proceed from here? And what are the implications of these documents for research, practice, training, and forensic psychology? As suggested above, one of the most consistent observations emerging from our deliberations has to do with the very divergent epistemologies and definitions utilized by psychologists who study memory and those who study and treat the effects of trauma. Although there are exceptions, we frequently do not speak the same professional language or define phenomena in the same manner; we read different journals and books, and attend different specialty meetings; and each group finds useful and compelling studies that the other group sees as problematic and questionable. Many of the difficulties that we have encountered in attempting to achieve consensus reflect these profound epistemological differences, a phenomenon which has been previously documented in studies comparing psychological scientists and psychological practitioners (Kalinkowitz, 1978; Caddy, 1981; Dawes, 1994). If we are to go forward toward the development of productive research that will be found to be credible by both scientists and practitioners, and toward the promotion of clinical practice that is truly rooted in psychological science, some steps must be taken to resolve these

epistemological differences and develop consensual definitions about what is being studied and discussed.

To begin, it is essential to address fundamental differences between the two subgroups in terms of basic definitions of the issues under investigation. Thus, for example, it is necessary to consider the two groups' contrasting views of the nature of early trauma and the young child's representation of various types of sexual abuse. Accordingly, one important implication of our deliberations is that psychologists who work in the field of trauma and those who study memory would benefit from working collaboratively to (a) develop paradigms for research; (b) search for consensual definitions of constructs that speak to the issue of how trauma affects memory; and (c) develop models that will be scientifically sound while being well-grounded in the realities of clinical practice. No matter how well designed, a study that equates stressful experiences that are socially sanctioned with those involving pain, betrayal and loss of safety will be found less credible by those who treat the survivors of the latter, just as texts on treatment, no matter how therapeutically useful they may seem based on the author's anecdotal observations, will lack credibility to scientists when what is clinically suggested violates the data available through research.

Some studies of therapists (Yapko, 1994, Poole, Lindsay, Memon, & Bull, 1995) have criticized practitioners for their lack of knowledge of the workings of memory and their willingness to endorse techniques that might implant suggestions. An alternative view of this state of affairs might be that based on their experience, which is a powerful source of data for practicing clinicians, many therapists have developed beliefs about techniques that they feel are clinically effective in reducing the distress of trauma survivors. Future research is needed to evaluate the validity of these beliefs and to better inform both practitioners and researchers as to the characterization of "useful" as opposed to "risky" approaches to interventions.

The epistemological foundation from which one evaluates clinical outcomes or research findings affects the meaning given to those outcomes/findings. Because the entire Working Group converges on the belief that a science-informed practice will be the most effective strategy for treatment, we believe that practice-informed research will enhance the integration of knowledge about memory into the overall field of trauma treatment. This direction in research may also help us to answer the still unclear questions about the nature of various observed human behaviors in response to trauma.

### **IMPLICATIONS FOR PRACTICE**

The deliberations of the Working Group strongly underscore the importance of a careful and science-based preparation for professional practice in psychology. Many possible errors in working with adult survivors, or with clients who present as recovering memories of childhood abuse, could be avoided if the therapist were well-grounded in developmental psychology (particularly developmental psychopathology and cognitive development), cognitive psychology (especially the study of memory), and research on trauma (with an emphasis on the range of responses to interpersonal violence). Both the scientist-practitioner (Ph.D.) and scholar-practitioner (Psy.D.) models of training embrace this necessity. Given the very high rates of histories of some kinds of interpersonal violence among the patient population (Jacobson & Richardson, 1987), all doctoral level training programs in professional psychology, including those whose primary focus is the training of clinical researchers, should insure that students are exposed to formal course work and supervised practica in which the role of interpersonal violence as a risk factor for psychopathology is central. Currently practicing psychologists, if lacking in these knowledge bases, should be encouraged to pursue formal continuing professional education on these topics. Care should be taken to insure that instructors (and course curricula) reflect a science

knowledge base as well as high-quality clinical practice.

A second important implication of our findings for clinical practice is that care, caution, and consistency should be utilized in working with any client, and particularly one who experiences what is believed (by either client or therapist) to be a recovered memory of trauma. Moreover, clients in all circumstances must be given information about possible treatment strategies and should in turn provide informed consent for treatment. As with any intervention, clients have the right to know both risks and benefits of procedures used by a therapist. Careful histories should be taken from all clients, and questions about the entire range of risk factors, including but not limited to a history of sexual abuse, must be asked of all new clients, not only those whose symptoms arouse suspicions of abuse in a clinician. This is because such suspicion may be unfounded, while genuine experiences of interpersonal violence may never be volunteered by clients with such histories whose symptoms do not conform to a clinician's beliefs about the sequelae of abuse. Questions should be phrased in a non-leading manner, and in the most open-ended way possible, in order to promote a more behaviorally descriptive and less affectively-laden introduction of this difficult topic into the history-taking process.

When clients report what they phenomenologically experience as memories of previously unreclected trauma, therapists should take a number of steps to avoid imposing a particular version of reality on these experiences and to reduce risks of the creation of pseudomemories. If these materials are intrusive and create problems for the client's functioning, the first goal of treatment should be stabilization and containment following the recommendations of many experts in the field of trauma treatment. It is important to remember that the goal of therapy is not archeology; recollection of trauma is only helpful insofar as it is integrated into a therapy emphasizing improvement of functioning. Therapists should avoid endorsing such retrievals

as either clearly truthful or clearly confabulated. Instead, the focus should be on aiding the client in developing his or her own sense of what is real and truthful. Clients can be encouraged to search for information that would add to their ability to find themselves credible (e.g., contemporaneous writings, reports of third parties), and to carefully weigh the evidence. Therapists should carefully consider all alternative hypotheses, including: (a) that the retrieved material is a reasonably accurate memory of real events; (b) that it is a distorted memory of real events, with distortions due to developmental factors or source contaminations; (c) that it is a confabulation emerging from underlying psychopathology or difficulties with reality testing; (d) that it is a pseudomemory emerging from exposure to suggestions; or (e) that it is a form of self-suggestion emerging from the client's internal suggestive mechanisms.

Clients who seek hypnosis as a means of retrieving or confirming their recollections should be advised that it is not an appropriate procedure for this goal because of the serious risk that pseudomemories may be created in trance states and of the related risk due to increased confidence in those memories. Clients should also be informed that the use of hypnosis could jeopardize any future legal actions they might wish to take. Moreover, in those situations in which hypnosis is employed, it is necessary to interpret the client's responses in light of parallel measures of suggestibility and proneness to fantasy.

As indicated above, it can be helpful to seek corroborative evidence for claims of sexual abuse. Nonetheless, denials by alleged perpetrators should also not be taken as evidence that the client is experiencing other than an accurate recollection. Indeed, known perpetrators of child sexual abuse can also deny and lie about their behaviors, even in the presence of physical evidence that incontrovertibly links them to the abuse, and sometimes tell their victims that the abuse "never happened" or should be forgotten. Finally, while there are no statistics available on its prevalence, it is known that on occasion adults

who report recovering memories will lie, particularly when the constellation of motives (fear, embarrassment, desire to protect loved ones, desire for revenge) outweigh the incentives to tell the truth.

In some states, persons who have recovered memories of childhood sexual abuse are eligible for crime victims' compensation if they report the alleged abuse to the police in a timely fashion. They are then treated as any other victims/witnesses of a crime. When resources for treatment are in short supply, this course may be attractive to both client and therapist as a means of insuring payment for therapy. However, both parties need to be especially cautious in making assertions to legal authorities as to the factual basis of recent recollections. Such actions may prematurely commit both therapist and client to a particular interpretation of the information reported by the client, and may commit a client in some instances to testifying in a resulting criminal case, should the report fall within statutory limits. Thus, therapists should explore a variety of other alternatives with the client before embarking on this particular course.

In short, a responsible path for therapists to pursue is one in which clients are empowered to be the authority about their own lives and reality, where the emphasis is on recovery and function, and where memories of trauma are viewed within the context of what one might tentatively assume to be a post-traumatic response. This approach, however, may mean that clients occasionally reach conclusions about what may have happened to them that we find difficult to accept. Nonetheless, respect for the dignity of adults who seek treatment must inevitably temper therapists' efforts at reality testing. Therapists need to eschew the roles of advocate, detective, or ultimate arbiter of reality, unless the veracity of the material being constructed/retrieved becomes important for either therapeutic or legal reasons.

## **IMPLICATIONS FOR FORENSIC PRACTITIONERS**

The role of the forensic psychologist is that of an educator to the triers of fact, the judge and jury. In that capacity, forensic psychologists, in general, should avoid attempting to speak to the ultimate issue (i.e., guilt or innocence) in a case, because that they usually are not in a position to know the truth. Forensic psychologists should always exercise caution, temper the degree of certainty with which they offer their testimony, and be aware of both the problems and the strengths of their methodologies. How then, can forensic experts practice responsibly in cases where questions of recovered memories of childhood abuse are involved?

First, whenever possible, therapists should avoid serving as expert forensic witnesses in the cases involving clients whom they are treating. This is consistent with APA ethical standards, and with guidelines published by the Division 41 of APA (Psychology and Law -- AP/LS) for forensic practice. Experts, moreover, should confine their testimony to their specific areas of expertise and knowledge. For example, questions of the appropriate standard of care would ordinarily be the purview of those trained in the fields of professional psychology; this might be distinguished from expert testimony about risks of a specific therapeutic technique when the technique or practice being considered is one in which scientists' findings could be applicable (e.g., the risks of using hypnosis to bolster a memory). When evaluating a person who alleges having recalled memories of childhood abuse, forensic experts should utilize all possible sources of information, and not rely solely upon the self-report of either plaintiff or defendant. Possible sources of suggestion and contamination should be explored rigorously. Because there is no one syndrome or symptom pattern associated with a history of childhood sexual abuse, care should be utilized in making inferences from the symptoms to the credibility of a plaintiff's report.

In cases involving complaints against therapists who are alleged to have created pseudomemories of sexual abuse, similar care should be taken by forensic psychologists to rely on a variety of sources of information and to search for the convergent validity of data. Reports by clients of what has occurred in therapy may or may not be accurate; reports by therapists about what transpired in therapy may or may not be accurate; and reports by third parties who were not present at the treatment may or may not be accurate. When feasible, expert clinical opinions should be based upon direct or videotaped observation, and not simply reviews of written or audiotaped materials.

#### **IMPLICATIONS FOR RESEARCH AND TRAINING**

Just as the Working Group has endorsed the value of a scientifically-informed approach to practice, its members also endorse the value of a practice-informed approach to research. There is much to be gained by both researchers and practitioners when their respective insights cross-fertilize each other's professional activities.

For researchers, this means incorporating into their designs as many of the ingredients of real-world trauma as is ethically and practically permissible, and learning from clinicians about the those phenomena that require further study. In this regard, in recent years there has developed a large body of naturalistic empirical research that stands at the interface between the domains of memory and trauma. Examples include Wagenaar and Groeneweg's (1990) study of Dutch concentration camp survivors' memories of victimization; Parker, Bahrick, Lundy, Fivush, and Levitt's (1995) study of child survivors of Hurricane Andrew; both Merritt, Ornstein, and Spicker's (1994) and Goodman, Quas, Batterman-Fraunce, Riddlesberger, and Kuhn's (1994) explorations of children's bladder catheterization; and Eisen, Goodman, and Qin's (1995) study of the susceptibility of sexually abused children to sexual suggestions. More recently, there have also

been studies of the neurobiological substrates of memory for traumatic events (Bremer, et al., 1995; Yehuda, et al., 1995). Nonetheless, there is a clear need for more of this sort of research, particularly as it applies to the phenomenon of repetitive boundary violations within the family setting, in which a number of complex person-situation variables are at play.

For practice-oriented students, cross-fertilization means that training faculty need to insure that they are well grounded not only in the substance of scientific psychology but also in its core values (e.g., the pursuit of "proof by disproof" as the strongest means of knowing). For research-oriented students, this means some degree of orientation to the limitations of generalizability of research findings to clinical applications, and a familiarity with clinically observed phenomena that require further study. In an ideal world, all graduate trainees, whether in practice or scientific research, would be exposed to each other's ideas, readings, and experiences, and would thus acquire a common vocabulary and shared knowledge base.

Too often, members of each group develop in what amounts to a culture of isolation from the other group's knowledge and experiences. To some extent, this is the unhappy consequence of increased specialization and the need for increasingly prolonged and focused apprenticeships to acquire the tools of each of these psychological trades. Presently, the sheer amount of domain-specific knowledge that must be learned to be considered competent in science or practice is enormous, and enjoinders to learn even more may seem unrealistic in view of the real limits of time and resources. Fortunately, there are ways of solving this dilemma that can expose each group to phenomena without requiring additional curricula, but merely a reorganization of what is already in place in many programs. What we have in mind is the use of critical case studies in training that bridge both groups' interests.

As an example, the issue before us -- the recovered memory debate -- is a window through which the generic chasm can be

bridged. Both clinical and research trainees can be exposed to the type of argument and data contained in this Working Group Report as a means of not only acquainting them with the specifics of this particular debate, but far more importantly of inculcating a sense that the world is full of phenomena that require a consideration of both groups' perspectives. Clinical students, as well as those studying both cognitive and developmental psychology, would benefit from a consideration of the issues that have animated this debate, and it could be couched in the context of existing course work.

This case study approach, moreover, can also serve to teach valuable lessons about professional behaviors that are and are not consistent with standards of good practice or good science. From our perspective, there are signs everywhere of psychologists making public pronouncements on matters of importance, based on anecdotes and impressions rather than on systematic empirical evidence, challenged by alternative explanations. When researchers and clinicians espouse views in public, including courtrooms, they have the highest responsibility to make clear to their audiences the limits to generalization of their conclusions, all known threats to the external validity of their information-gathering procedures and/or clinical interpretations, and the results of attempts to test alternative explanations. These professional behaviors can be illustrated readily in the context of this and other important debates.

#### **A FINAL STATEMENT**

We wish to end on a note with which we can all agree. The members of the Working Group, individually and collectively, bemoan the increasing "Balkanization" of psychology, a development that has surely made our tasks more difficult as we have attempted to bridge across powerful gaps of understanding. Our discipline has spawned many psychologies, often disconnected from each other, and both the cortical and ethical glues that ought to have connected them seem to have been neglected. We are

fast becoming a collection of psychologies, each uninformed by the data and epistemologies of the others; in short, we are pluribus, but not unum. And most critically, we need to change dramatically if psychology as a discipline seeks to lead the way in avoiding harm to all those who are affected by the consequences of both accurate and false recollections of abuse.

## References

- Bremer, J. D., Randall, P., Scott, T. M., Bronen, R. A., Seibyl, J. P., Southwick, S. M., Delaney, R. C., McCarthy, G., Charney, D. S., & Innis, R. B. (1995). MRI-based measurement of hippocampal volume in patients with combat-related posttraumatic stress disorder. American Journal of Psychiatry, 152, 973-981.
- Caddy, G. R. (1981, June). The development and current status of professional psychology. Professional Psychology, 12(3), 377-384.
- Dawes, R. M. (1994). House of cards: Psychology and psychotherapy built on myth. New York: Free Press.
- Eisen, M. L. & Goodman, G. S., & Qin, J. (1995, May). The impact of dissociation and stress arousal on the suggestibility and memory of abused or neglected children. In F. J. Morrison (Moderator), Children's memory: Implications for Testimony. Invited symposium at the meetings of the Midwestern Psychological Association, Chicago.
- Goodman, G. S., Quas, J. A., Batterman-Faunce, J. M., Riddlesberger, M. M., & Kuhn, J. (1994). Predictors of accurate and inaccurate memories of traumatic events experienced in childhood. Consciousness and Cognition, 3, 269-294.
- Jacobson, A., & Richardson, B. C. (1987). Assault experiences of 100 psychiatric inpatients: Evidence of the need for routine inquiry. American Journal of Psychiatry, 144, 434-440.
- Kalinkowitz, B. (1978, Fall). Scientist-practitioner: the widening schism. Clinical Psychologist, 32(1), 4-5.
- Merritt, K. A., Ornstein, P. A., & Spicker, B. (1994). Children's memory of a salient medical procedure: Implications for testimony. Pediatrics, 94, 17-23.
- Parker, J. F., Bahrick, L. E., Lundy, B., Fivush, R., & Levitt, M. J. (1995, July). Children's memory for a natural disaster: Effects of stress. In Parker, J. (Moderator), Eyewitness memory: Effects of stress and arousal upon children's memories. Symposium at the meetings of the Society for Applied Research in Memory and Cognition, Vancouver, BC.

- Poole, D. A., Lindsay, D. S., Memon, A., & Bull, R. (1995) Psychotherapy and the recovery of memories of childhood sexual abuse: U.S. and British practitioners' opinions, practices, and experiences. Journal of Consulting and Clinical Psychology, 63, 426-437.
- Wagenaar, V. A., & Groeneweg, J. (1990). The memory of concentration camp survivors. Applied Cognitive Psychology, 4, 77-87.
- Yapko, M. D. (1994). Suggestibility and repressed memories of abuse: A survey of psychotherapists' beliefs. American Journal of Clinical Hypnosis, 36, 163-171.
- Yehuda, R., Kahana, B., Binder-Byrnes, K., Southwick, S., Mason, J. W., & Giller, E. L. (1995). Low urinary cortisol excretion in Holocaust survivors with posttraumatic stress disorder. American Journal of Psychiatry, 152, 982-986.