Executive summary

Health Council of the Netherlands. Disputed memories. The Hague: Health Council of the Netherlands, 2004; publication no. 2004/02.

The Minister of Health, Welfare and Sport requested advice from the Health Council concerning the scientific situation with regard to therapies involving recovered memories of traumatic childhood experiences, especially of sexual abuse. The Committee, which was established to respond to the request for advice, formulated the sub-questions as follows: ‘could the stored memories of traumatic events be inaccessible and, if so, what might account for this? Under what circumstances might inaccessible memories become accessible once again? Is it possible to recall memories of traumatic events which were never experienced and, if so, what might account for this? What part might psychotherapy play in retrieving such memories?’. The Committee’s findings, which are set out below, provide answers to these questions.

Traumatic childhood experiences are major risk factors

Sexual abuse and other traumatic childhood experiences are major risk factors for psychological problems and psychopathology in adults. There is every reason for caregivers to be alert for certain memories of traumatic childhood experiences which people find difficult to discuss. However, the relationship is neither specific nor imperative. On the basis of a clinical picture it is impossible to draw conclusions about the occurrence of specific traumatic events in a patient’s history.

Memories are reconstructions with a present-day function

Experiences were long thought to be recorded and stored as discrete memories. This view is now known to be incorrect. Experiences are stored in multiple memory systems. This means that the various aspects of an experience are stored in different places, and that they are linked together by associations. Recalling a memory always involves reconstruction rather than instant portrayal. This reconstruction is linked to the current situation. It is influenced by the social context, which can either stimulate or obstruct certain memories. Even though a memory may be perceived as a reliable and authentic portrayal of a past event, its content may differ substantially from those of the actual event.

Forgetting and recovering are normal occurrences

Events that have not been stored in the memory can not be recalled, forgotten or recovered. If it becomes difficult to access a stored memory, then that memory gradually will be forgotten. A forgotten memory can, in theory, be recalled if the right cues are provided. These help subjects to recall the correct associations, provided that there are no processes which might counteract the conscious perception of the recalled memory. Forgetting and recovering are normal, functional occurrences, which can involve a range of different mechanisms.

Important emotional or traumatic experiences (and certainly specific elements of these experiences) are more strongly recorded than everyday experiences. As a result, they are generally well remembered, albeit sometimes in fragmentary form. It is remarkable, yet plausible, that these memories too can become inaccessible. This may be partial or complete, temporary or context-dependent. Furthermore, they may eventually be recovered. It is not clear to what extent this occurs. It has been shown that excessive anxiety and stress can have a marked influence on memory function, affecting coding, storage and retrieval. The exact nature of the mechanisms which cause humans to forget traumatic experiences is not known.

It is difficult to interpret a failure to report, denial and self-reports of forgetting and recovering

The non-reporting or denial of having experienced sexual abuse is quite common. This is not necessarily associated with forgetting or with special mechanisms of memory. Something that is particularly difficult to interpret is when someone reports that they initially forgot a memory of a traumatic experience only to recall it at a later date. It is not

always clear what the subject means by ‘forgot’ or the extent to which the memories in question were genuinely inaccessible. In practice it is not always easy to distinguish between not telling, not wanting to remember and not being able to remember.

Imagined memories are more common under certain circumstances

Everybody experiences imagined memories. The most common explanation is that the subject has confused the source of recalled images and thoughts, which can be fantasies, the power of imagination, dreams, stories recounted by others and their own experiences. The meaning of a memory can also change, through reinterpretation, reassessment or reattribution. It has also been shown that individuals can experience imaginary, false memories as dramatic personal events. There is an above-average risk of this when subjects with certain personality traits or psychological disorders are exposed to the suggestive influence of authority figures or other important sources.

Psychotherapy can enable memories to be accessed and recalled

There are many reasons why some patients will only broach the subject of certain feelings and memories in the context of psychotherapy. Such settings usually offer safety and the acceptance of negative emotions such as anxiety, aggression, guilt, shame, vengeance and forbidden desires. Within this safe environment, subjects may feel at liberty to verbalise painful memories. In many cases, these individuals are subsequently able to discuss these memories with others.

During psychotherapy, the discussion always centres on certain aspects of the patient's ability to function. This facilitates the retrieval of related memories. Special cues can occur in therapeutic situations. These may help subjects to recall details or events that had previously been inaccessible.

Psychotherapy stimulates the reinterpretation of memories

Virtually all forms of psychotherapy focus, to some extent, on changing the meaning of symptoms for patients, so that they will find them less of an impediment in their day-to-day functioning. This changed meaning is, of necessity, coupled with a changed view of aspects of the patient's history, and a reinterpretation of memories. The new interpretation is primarily one which is easier for the patient to deal with, it is not necessarily a more accurate reflection of reality. The aim of discussing the past is not to uncover the truth, it is to assign a meaning to memories.

The reinterpretation of memories changes the substance of an individual's life history. Accordingly, it may also cause subjects to revise their relationship with significant

individuals from their past. This process can have both positive and negative repercussions. The relationship in question can improve or become more distant, and the new version of history may be more in keeping with other people's experiences or it may conflict with them.

Influencing memories by suggestion must be avoided

Therapists who adopt a suggestive approach when the patient tries to recall memories, are at risk of creating false memories whose content is related to the suggestion used. This is particularly true of situations in which the therapist is trying to account for a patient’s symptoms in terms, for instance, of a possible trauma in their past. The risk is greater in certain cases. These include patients with certain personality traits and psychiatric disorders, vague memories and symptoms that are difficult to explain, as well as therapists who tend to firmly impose their personal convictions. The risk of false memories is exacerbated by the use of certain methods for stimulating memories.

In therapy, memories that are perceived as authentic are a given, but they are not always historically accurate

Memories that are perceived to be authentic are seen as being 'true'. The sense of authenticity is reinforced by factors such as sensory details and accompanying emotions. False memories can also be perceived as authentic, and as having the same intensity as genuine memories. In therapy, the story told by the individual seeking assistance is an important factor. However, unless he is acquainted with the historical facts, the therapist has no way of knowing whether the story is historically accurate.

Those providing treatment must inform patients about the relevant aspects of the proposed treatment. Particularly in situations where it may be important to discuss emotional memories, it is appropriate to provide information about the purpose of discussing memories in therapy. It should be emphasised that the focus is on the current meaning of such memories, and not on uncovering the actual course of events. Here, also, it should be pointed out that, in the absence of further supporting evidence, memories are unreliable when it comes to finding out what really happened.

The professionals involved must speak out

The current consensus within the field of experimental and clinical scientific research into certain aspects of memory pertaining to emotional experiences is sufficient for the formulation of judgements and guidelines for clinical practice. This in no way detracts from the fact that empirical research into the underlying mechanisms of memory phe-

nomena associated with traumatic experiences in particular has still left many questions unanswered, and that further research is needed. Current knowledge of the scientific situation regarding the memory is extremely relevant to the conduct of therapy. In practice, however, it appears to have had insufficient impact in this area. Professionals in this area are registered under the Individual Health Care Professions Act (BIG). The Committee feels that this group can and should speak out about the findings in contemporary memory research that are discussed in this advisory report, and the repercussions for the conduct of therapy. This is particularly applicable to the opportunities and risks implicit in dealing with the memories of traumatic childhood experiences during a course of therapeutic treatment. The Committee cites several specific quality conditions in the area of requisite expertise, diagnosis and treatment, file handling, therapeutic stance and a possible legal context.

At a more general level, the professionals involved should produce a kind of 'instruction leaflet' containing general information about the various forms of psychotherapy. This would contain details of their effectiveness, drawbacks and alternatives, and of the procedures used.

In view of the part that memories play in all forms of psychotherapy, judgements and guidelines in this area could be most relevant. The Committee expects that the guidelines for those professionals who are registered under the Individual Health Care Professions Act (BIG) could serve as an example for professionals working in the areas of psychosocial and social care who are not registered under the BIG. It takes the view that those offering alternative therapies should also take such findings into account.

Educational programmes must not become outdated

It is enormously important that newly trained professionals in various fields be fully informed about the implications of contemporary memory research. Universities and institutes of higher vocational education (HBO) should openly incorporate these developments into vocational courses on the provision of care to individuals with psychological symptoms and psychosocial problems.

Therapy can conflict with the course of law

Sexual abuse is an unlawful act or criminal offence. Memories of such experiences that are retrieved during therapy can sometimes lead to claims for damages or to incidents being reported to the police, possibly resulting in a prosecution. However, memories, although perceived as authentic, do not qualify as social or legal facts. It is not the attending therapist's task to assist the criminal justice system in arriving at the truth. On scientific grounds and for reasons of professional ethics, therapists should refrain from

commenting on the reliability of statements made by a patient. Regarding the retrieved memories of possible unlawful acts or punishable offences, the therapist should – if at all possible – raise the issue of the relationship between therapeutic and legal processes during his interview with the patient. He should not encourage the patient to take legal action. Instead, he should point out that therapy and jurisdiction are sometimes mutually exclusive, albeit temporarily.