The Construction of False Memory Syndrome: A Transactional Model

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The process of developing false memories (also called pseudomemories or illusory memories) mystifies many mental health workers who cannot imagine how an adult could claim she had been molested by a parent many years, perhaps decades ago, unless it were true. Why would someone make up stories so horrendous, often involving satanic ritual abuse (SRA), incorporating satanic symbols, murder, cannibalism, dismemberment, baby breeding, and sacrifice? When SRA is involved, we know ipso facto that the accusations are untrue, for over a decade of study by the FBI (Lanning, 1992), The Center for Child Abuse and Neglect (Goodman, Qin, Bottoms, & Shaver, 1996), and groups in Great Britain and other countries have failed to document a single verified case of SRA (LaFontaine, 1994). (Ritual abuse by psychotic individuals occasionally occurs, but no evidence exists of any organized cult practicing SRA.)

Even when SRA memories are not involved, we have reason to be concerned about the illusory nature of many recovered memories. For example, in a pilot survey of parents accused of sexual abuse (Freyd, Roth, Wakefield, & Underwager, 1993) approximately 40% reported that their adult children had recovered memories of abuse beginning before age 3. In a follow-up survey of 426 parents accused of sexual abuse (Freyd, 1995), about 35% indicated that the accusers remembered abuse beginning between birth and age 2. Memories for events from before age 3, a reasonable cut-off point for the brain to have developed the cognitive capacity to store such memories, should be evaluated with extreme caution, particularly in the absence of any external corroboration.

Even if researchers can demonstrate that some of the memories recovered after a period of amnesia, sometimes three or four or more decades after the events, are valid historically, the process of psychogenic amnesia and later recall is mysterious enough. We know even less about the process involved in the apparent recall of false memories with the attendant shame and guilt, depression, and frequently suicidal thoughts. These memories carry with them, at first, self-accusations as well as accusations against others. We agree with de Rivera that one way to understand this process is to study retractors. De Rivera cites our work with retractors, and that study furnishes the data with which we comment on his target article.

In addition to the concerns raised by memories recovered from very early childhood and memories of SRA, we find another reason for questioning repressed memory accusations. An increasing number of patients making childhood sexual abuse (CSA) allegations are retracting their accusations, claiming the memories that they had brought forth were illusory. How do we explain this phenomenon?

The report of the American Psychological Association Working Group (Alpert et al., 1996) on recovered memory has not brought consensus; instead it has sharpened the divisions between "memory work" practitioners and memory experts. The memory experts presented data demonstrating the suggestibility of "subjects" to memory distortion and recall. The practitioners countered with the argument that "subjects and experiments" are not "patients and treatment."

Trying to deal with this seemingly unbridgeable chasm and to understand the process of the evolution of pseudomemories led to de Rivera's study and our study of retractors (Lief & Fetkewicz, 1995), a study of former patients who now claim that their memories formed during therapy were false and were the consequence of what took place in treatment.

De Rivera conducted interviews with four retractors. He constructed a typology of two conceptual frameworks: a mind-control model and a narrative model. In the mind-control model, the major vector is from the outside in, an extrinsic force, whereas in the narrative model, the major vector is from the inside out, an intrinsic force. One might quip that there are two types of researchers, one that believes in typology, and another that does not. Still, in the early stages of research, having some organizing perspective, such as a typology, even if it ultimately proves to be incomplete or misleading, is helpful.

In the mind-control model, the emphasis is on the external factors influencing the patient. De Rivera cites information control, behavior control, thought control,

and emotion control. Demonstrating how these factors were carried out and to what extent is useful. In the mind-control model, one has to ask what the personality features of a patient vulnerable to this type of mind control are. For example, the personality aspects that one might find in the mind-control group would be a greater than usual dependency and a tendency to magical thinking in which the patient expects that problems would be solved instantly and effortlessly. The patient might have a tendency to attribute causation to outside forces rather than to blame oneself and to allow others to think for oneself, a belief in the ideas of authority (less than usual skepticism), and a rather rigid right and wrong belief system, avoiding shades of gray.

In the narrative model, the emphasis shifts to the individual; to what is going on in the patient that lends itself to the process of formulating illusory memories. In contrast to the mind-control group, the narrative group might show greater introspection, independence and self-reliance, distrust of authority, and a greater tendency to self-attribution with accompanying guilt and shame. These tendencies would be enhanced by a therapist who is less authoritarian, less committed to a belief system in which CSA is the causative agent of much of adult psychopathology and who allows the patient's story to develop slowly and gradually. (Is this not a more credible method of uncovering true CSA memories? Yet we do not know whether fewer pseudomemories occur in the narrative group than in the mind-control group.)

De Rivera's "conceptual encounter" is certainly a useful tool for both research investigations and clinical work. However, its use raises obvious concerns. There is the danger of bias in the presentation of alternative constructs. For an investigator to eliminate his or her personal bias in one direction or the other by the way the models are presented is difficult. Subtle positive and negative reinforcers are apt to creep into the transaction between investigator and participant. However, in some situations, the advantages outweigh the disadvantages. A skilled researcher, exploring explanatory models with the participant, can illuminate features of the participant's experience that might be otherwise lost. Imagine if this method had been pursued by the various therapists in the cases we are discussing. If a sexual abuse model had been presented alongside a nonsexual abuse model as explanations for the patient's symptoms and dysfunctions, the consequences might have been very different.

Although a dichotomous model may be appropriate in some cases, the basic position we take is that we need a transactional model in which the elements of the therapy situation have to be examined as well as the patient's personality characteristics. The weight may be on one side or the other, but in all likelihood finding "pure culture" cases is difficult.

In terms of the exploration of the process of evolution and devolution of false memories, some cautionary statements are in order. The retractors struggling to understand and reconcile their false memories with reality are subject to social influence and biases of retrospection. In a sense, retractors are engaged in an explanatory narrative, just as they were when they attempted to understand their symptoms in therapy. Moreover, we may possibly find a developmental aspect to the process of devolution; that is, over time the "fit" of one conceptual model or another may shift as the retractor's understanding and integration of her false memory experience coalesces. This does not mean that a retractor's analysis of her experience is not as valid and valuable. Furthermore, we are faced not only with selection bias, but also, as de Rivera points out, with the inability to verify certain aspects of cases, particularly those having to do with therapy itself. In addition to a lack of objective information about their therapy, we certainly have limited knowledge about the kinds of families from which these retractors come and limited knowledge of their characterological strengths and weaknesses.

We thought examining our data with de Rivera's explanatory models in mind would be useful to determine informally whether retractors' responses to survey questions might be interpreted as compatible with either the mind-control or the narrative construct. Forty retractors responded to our survey answering both closed and open-ended questions. Themes of mind control and creation of an explanatory narrative certainly were evident in their responses. Furthermore, although our survey focused primarily on the many descriptive and concrete aspects of the retractors' experience with pseudomemories, responses to open-ended questions revealed endorsements of explanations similar to those de Rivera identified. Additionally, some elements illuminated by the retractors' responses to closed questions seemed to support the notion that one could become vulnerable to either mind control or involved in creating a defensive narrative if exposed to particular techniques and therapeutic relationships.

de Rivera's characterization of "iatrogenic therapy," as he terms it, is for the most part supported by our data. The retractors surveyed enter therapy with a presenting problem other than CSA; most often, the presenting problem included family or marital issues, depression, or, uncommonly, an eating disorder. They come to believe that childhood sexual trauma is the cause for their current distress. The ensuing search for memories requires a psychological commitment on the part of the patient, as does the dependence on the therapist, which

in our sample was typical. Although most retractors in our survey (65%) did not sever relations with family completely, avoiding those who might offer alternative explanations or challenge emerging CSA memories might be one reason for the patient's alienation from family of origin reported in the FMSF family survey (Freyd et al., 1993). A second explanation might involve an attempt by an authoritarian therapist to impose information control.

The retractor's need to explain her current distress is coupled with trust in the judgment and professional opinion of the therapist, which was a significant feature of the narrative group. However, separating trust in professional judgment from dependency is difficult. As Ann related in de Rivera's study, her therapist told her that "she had the symptoms of someone who had been sexually abused," which she later came to believe. More than 80% of the retractors in our survey reported that their therapist made a direct suggestion that they were victims of sexual abuse before memories were recovered, even though a history of sexual abuse was not the presenting problem.

As they recovered memories of sexual abuse, retractors reported an increase in the level of dependence on the therapist. One indicator of the intensity of this dependency relationship is the increase in the frequency of contact with the therapist. Cath, one of de Rivera's participants, described a situation in which she began to see her therapist more frequently and, with his encouragement, telephone him daily, ultimately feeling as though she "gave him all her power." Similarly, in our survey, nearly 50% of the respondents reported an increase in the frequency of therapy sessions after they began to recover memories of sexual abuse. Thirty-six (90%) reported calling their therapist between sessions, some as often as daily.

Many retractors report experiencing suggestive techniques during the course of therapy. In those we studied, almost 68% underwent hypnosis to recover memories. De Rivera's participants spoke about suggestive techniques and group therapy as influential in the development of their false memories. For example, Cath discussed the power of the "realization techniques" she experienced in therapy. Cath also talked about her participation in group therapy (even before she began to recover memories). Of the retractors we surveyed, 70% participated in group therapy for incest survivors, and most reported reading self-help literature. In responses to open-ended questions, these techniques were mentioned frequently as important aspects in the development of pseudomemories.

In light of the mind-control and narrative models, we looked at responses of retractors to two open-ended questions to determine whether they recounted patterns that could be associated with these constructs. We focused on two survey questions involving retractors' descriptions of subjective experiences as memories evolved, as well as descriptions of contributing factors that may have influenced thoughts and feelings, including doubts about those memories. (These questions were not constructed with de Rivera's typologies in mind. We are merely reexamining retractors' responses for parallels to the narrative and mind-control constructs.) Of the 37 responses to the two relevant open-ended questions, several themes emerged, including a search for explanations for current problems and the need to believe that CSA was at the heart of that explanation. These factors were mentioned by 13 of the 37 respondents, which is consistent with the narrative model. Ten retractors mentioned trust in the therapist and extreme dependence and need for the therapist's attention. Seven respondents saw control, pressure by the therapist, and "giving in" to that pressure as a central part of their experience, which is consistent with the mind-control model. Because some overlap occurred between these responses, an equal number of retractors could exhibit features of each of the models.

In many instances, the two-model conceptualization seems to be a stretch. As de Rivera notes, neither the mind-control nor the narrative model is an appropriate conceptualization for all retractors. Nor are the models necessarily completely exclusive. Elements of both models or an alternative conceptualization may produce more suitable descriptions for some retractors. What should we think of the retractors' active participation in the formation of an abuse narrative, while at the same time, they are in the hands of a mind-control therapist? That seems to be the case with many of our respondents. For example, in our open-ended questions, 14 respondents reported that they had read numerous books about sexual abuse. Although some books were suggested by a therapist, several retractors stated that they were motivated to read self-help literature by their search for an explanation, and they were ready to believe the possibility of buried memories of sexual abuse. Similarly, group therapy is a powerful influence, mentioned specifically by 11 respondents, and yet both mind-control and narrative endorsers might be in group therapy. The group is influential not only because of its support, but also because stories told by the group members often form the content of pseudomemories. The similarities among the stories are striking. What runs through the accounts told by the recantors is the development of a new identity, that of survivor. Belonging to a readily identified group can provide great comfort, which was enhanced not only because of the isolation from family and from outside information, but also because of the insulation provided by the group and the therapist.

Eight respondents reported that the suggestions and information provided by the therapist were the most influential of all. A common description in these open responses was the authoritarian nature of therapy. Another common theme was a search for an explanation for the retractors' current stress. Most of the retractors reported that the therapist made a direct suggestion that sexual abuse was at the heart of that explanation. Contributing to the development of these false memories were the memory-enhancing (and -distorting) techniques cited earlier.

As de Rivera suggests, we certainly need to know much more about the nature of therapy. We have suggested that an authoritarian mind-control therapist may have a substantially different approach from a nonauthoritarian therapist. How do these stances on the part of the therapist coincide with the patient's personality characteristics? We need to know much more about the beliefs and practices of therapists, but we also need to know about the complex interaction of patient and therapist as cocreators of a narrative.

Not all patients subjected to mind-control attempts buy into the therapist's seductive (because it is parsimonious and simplistic) belief that CSA accounts for an enormous variety of adult psychopathology. We need to know why some patients can resist this approach and others cannot. What personality characteristics and external factors enable an individual to reject the suggestion of abuse?

We know that one of the significant factors in the devolution of memories is switching to a new therapist. This occurred in two of the four cases de Rivera studied. Another significant factor found in both his cases and ours is the patient being weaned from medication. Many retractors could only cut away from therapy after their minds cleared and they were able to think more appropriately. So the question arises: How much does medication contribute to the vulnerability of patients developing pseudomemories (e.g., some patients in our study were given huge doses of inderol and valium)? We believe that medication is an important factor, but research needs to be carried out comparing medicated versus nonmedicated patients (if the latter can be found).

The notion of attribution is another aspect of this scenario that merits further inspection. Why do some individuals view themselves as active participants in the process, whereas others, more passive, are willing to assign control to therapist, group, or hospital? Does attribution play a role in the resistors, those who reject a suggestion of CSAs as the cause of their current problems? As de Rivera suggests, we need to know much more about the personality and psychological characteristics of people who develop pseudomemories. Do they have common Axis I diagnoses or is the process largely a function of psychodynamic mechanisms generated by characterological features?

Of one thing we can be certain: Patients who develop pseudomemories get worse, usually much worse. Depression deepens, demoralization heightens, suicidal ideation increases, and suicide attempts are common. This is a ubiquitous feature of these patients. As Beth said, "I was on the verge of being mentally ill." Another de Rivera participant, Doris, who was hospitalized 14 times in the year after her search for cult abuse memories was created, said, "They diagnosed me as everything in the book."

For many retractors, only when they "hit bottom" do they realize that something is very wrong and they begin to retract their false beliefs and start the long journey back toward health. The journey is long and, indeed, painful. Retractors have to face the reality that they have wrongly accused a loved one, damaged relationships, and forfeited their own mental health. A paradox awaits them. On the one hand, their distress warrants professional help; on the other, they have lost trust in mental health professionals and are thrown back on their own resources at a time when their coping skills have been undermined by the recovered memory therapy. For these patients, perhaps we should create a new definition of PTSD—"Post Therapy Stress Disorder."

Note

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