The False Memory Syndrome: Science or Misogyny?

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Any American who reads the newspapers or watches television has by now heard of "False Memory Syndrome (FMS)" and "Recovered Memory Therapy (RMT)." Although these terms sound quite official, FMS was made up by a group representing or advocating for family members accused of having abused their children. RMT is a form of "treatment" titled and described by these same FMS advocates. Despite this questionable authority, therapists of all persuasions are routinely told by friends, relatives, and even colleagues that they understand how easy it is for therapists to implant false memories of abuse (referring only to sexual abuse) in the minds of their unstable and disturbed patients (apparently always female), causing serious

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harm to innocent patients who are misled by their greedy or troubled therapists to accuse innocent family members who then suffer irreparable harm. Lawsuits against therapists for practicing "recovered memory therapy" are proliferating. Some therapists are being picked on, their patients harassed, the privacy of their homes invaded. Attempts are being made in several states to introduce legislation that would disallow any therapy that had not been proven "safe and effective" by the standards similar to those used to test new drugs and that would allow a patient's relatives, even against the wishes of the patient, to sue the therapist for malpractice. The "false memory" defense is being utilized routinely in many cases in which a victim is seeking justice through the courts, particularly in cases of sexual offenses. When asked to reimburse patients for therapy, insurers and managed care reviewers are frequently using the presumed existence of "false memory syndrome" as a means of questioning and even refusing claims.

This makes for great press and persuasive propaganda but there are significant omissions from virtually every discussion of this topic. As yet there is no peer-reviewed, published study that supports the view that "false memory syndrome" exists. More troubling is that there is no apparent way to distinguish between "recovered memory therapy" and any other form of therapy that includes taking a good history from a patient. There is no scientifically validated evidence to support the proposition that it is possible to implant entire memories of traumatic events into anyone's mind. There is, however, an abundance of current and historical data that supports the existence of either "false memory" or false reporting on the part of perpetrators. And finally, there has yet to be a balanced presentation about the vast body of theoretical and research data, deriving from several different disciplines and spanning over a hundred years of clinical experience that indicates the significant differences between normal memory, normal forgetting, traumatic memory, and the intrusively experiencing of traumatic events. Amnesia for traumatic events has been described in virtually every survivor group for the last 200 years. The fact that there has not been such a balanced presentation to the public, despite the obvious and overwhelming amount of data that contradicts most of what the false memory advocates offer as evidence, is what has convinced many that this is more of a sociopolitical, than a scientific, debate. Indeed, much of this debate has been conducted in the media, with a one-sided, distorted, and sensationalist bias, rather than in professional journals and in the courtroom as it is used to provide accused perpetrators with a defense.

The "false memory" controversy is distinguished by a linguistic dilemma. The same words—memory and remembering—are used to describe two entirely different brain activities, different neurometabolic and neurophysiological bases, as well as entirely different clinical presentations. When people experience intrusive flashbacks as visual, olfactory, affective, auditory, or kinesthetic sensations, although we term this "traumatic memory," it bears little if any relationship to the normal process of remembering. Remembering in our normal terms is based on language while traumatic recall is nonlinguistic. Gradually, as people begin to process these intrusive images, they begin to form a narrative as a means of explaining their experience. Once such an experience enters the narrative sphere it may be open to many of the distortions and changes related to "normal" memory processing, the distortions so highlighted by the false memory advocates. In their recent book, Traumatic Stress, Van der Kolk, McFarlane, and Weisaeth review the growing body of data indicating that a traumatic memory is relatively indelible even while being inexpressible in words. Much of the confusion in the popular and, sadly, professional literature is related to unintentional or deliberate attempts to perpetuate this confusion.

In an article in a recent issue of the PTSD Research Quarterly, Metcalf and Jacobs summarized the differences between the two important component systems of the memory, what they have termed the "cool" or cognitive system and the "hot" or emotional system. The "cool" hippocampal system records in an emotional way, with autobiographical details and spatio-temporal context, events as they occur. The "hot" amygdala system responds to unorganized, fragmented, fear-provoking features of events. It is direct, quick, highly emotional, inflexible and fragmentary. Hot-system recall of events is driven largely by fear and entails reliving with no attendant spatio-temporal context. In contrast, "cool" system memories are narrative, recollective, and episodic, lacking the sense of reliving in the present. Under normal conditions, these two systems work in parallel and are integrated as a whole. LeDoux has studied the functioning of the amygdala and its role in memory and it is apparent that once fear is conditioned, it is virtually indelible, although parts of the "cool" system can suppress fear responding.
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These two systems respond quite differently to stress. Initially, as stress increases, the “cool” hippocampal system becomes enhanced, but at traumatic levels of stress it becomes dysfunctional, probably due to the effects of cortisol. Meanwhile, the “hot” system becomes increasingly responsive as stress increases and, at traumatic levels of stress, becomes hyper-responsive. As a result, at traumatic levels of stress, the individual will focus exclusively on fear-evoking features of the experience and the memories of this event will be fragmentary, lack a spatio-temporal context, and be associated with high levels of emotional arousal, particularly fear. These fragments of memory will probably be accurate to the extent of the focus on the fear-provoking stimuli but will lack any kind of narrative format or context in time and space.

The October, 1995 issue of the Journal of Traumatic Stress (obtainable through the ISTSS offices 847-480-9028) was devoted to the latest research on traumatic memory, all of which provides support for this description of memory functioning and of clinical presentations. In one study by Van der Kolk and Fisler, all subjects, regardless of age at which the trauma occurred, reported that their initial memory was not in the form of a narrative, but was instead a somatosensory or emotional flashback experience. In their report of a brain imaging study, these authors suggest that the notion of “speechless terror” which is part of the trauma response is not merely a popular metaphor, but an experience that is based on altered brain function at the moment of the trauma. In a general population survey of traumatic experiences by Elliott and Briere, 30% of females and 14% of males reported a history of sexual abuse and 42% of these described some period of time when they were amnestic for the abuse, with 20% of sexual abuse victims describing a period of time when they were completely amnestic for the abuse. Interestingly, only 8% of the entire sample were in psychological treatment and treatment status was not predictive of recall status—individuals recovering abuse memories were no more likely to be in psychotherapy than their cohorts with self-reported continuous memory. Linda Williams reported on her study originating almost 20 years ago in which she followed children who had documented sexual abuse. Of those who remembered the abuse, 16% reported that there was a time when they did not remember that the sexual abuse had happened to them.

The implications of this work for treatment are enormous. Our growing understanding of the mechanics of memory helps us to develop a theoretical framework for why psychotherapy works. Healing apparently necessitates the creation of a verbal and relational narrative as a way of healing from trauma and integrating traumatic memory fragments so that they no longer are as likely to produce the troublesome intrusive symptoms typical of trauma syndromes. But once this narrative process has been engaged, reality is subject to alteration and distortion.

The sociopolitical implications of this “debate” must also be taken seriously by every clinician, particularly given the present socioeconomic climate which is so hostile to the practice of psychotherapy and often so seemingly invested in maintaining an atmosphere of violence towards women and children. The creation of the “False Memory Syndrome” has provided sexual offenders with an excellent defense which puts the victim at a serious disadvantage unless she has witnesses to the events, which is not likely in the case of childhood sexual abuse. The question has yet to be raised why memories of sexual assault should be any less reliable than memories of witnessing a shooting, a bank robbery, or a car accident. In attacking the therapist—not the patient—the tactics adopted by the false memory advocates are similar to anti-abortion strategies which attack the physician—not the woman seeking the abortion. The characterization of Svengalian therapists implanting suggestions of abuse simultaneously elevates the malevolent intent of therapists while perpetuating the stereotype of hysterical, naive, easily led, misguided female patients and successfully masking the very real malicious intent of perpetrators. Violent perpetration against women and children in these “enlightened”

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