"Can I Feel Better Even If I Can't Remember?"
Helping Clients With Incomplete Memories

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Abstract

Clients may request therapy for symptoms that resemble those for sexual abuse survivors, although they have sketchy or no memories for abuse. “Recovered memory” therapy has been the subject of considerable controversy and legal debate. There are still many other options for treating the clients distress without using “memory recovery” techniques. Goals, skills, and techniques for working with these clients are presented here.

Recently public awareness has increased regarding childhood sexual abuse. The number of individuals seeking treatment for the effects of abuse has risen dramatically. A major controversy in treatment has focused on treating clients who disclose memories that were absent for a period of time and then were later remembered. Critics of psychotherapy have charged that therapists use techniques that create or implant false memories in suggestible clients. They also claim that some therapists are overzealous in seeking out memories of abuse or accepting fragmentary accounts as historical reality. The False Memory Foundation is currently attempting to pass legislation in many states outlawing “recovered memory” therapy. Many malprac-

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tice suits have been related to recovered memories (Knapp and Van de Creek, 1997; Loftus, 1994). The spiritual consequences of false accusations can be profound for all who are involved.

In support of psychotherapy, however, considerable evidence does exist for the belief that partial or complete amnesia for traumatic events does occur (Bremner et al. 1993; Wagenaar and Groenweg, 1990). Cases of delayed recall of traumatic events are documented and often external validating evidence can be found (Kluff, 1997; Karon and Widener, 1997; American Psychological Association, 1996). The client has often experienced detrimental effects from not being believed or from being coerced into secrecy. Therapy can validate the client and serve as a powerful tool for healing.

LDS counselors who work with LDS clients experience an important spiritual stewardship. Often the reported perpetrator is also a member of the Church. Confronting the reality that “all is not well in Zion” while not reacting with vengeance and judgment requires sensitivity and integrity on the part of the therapist. Recognizing and combatting the evils of abuse while continuing to work towards the healing and progression of all involved is facilitated by informed practice. Being aware of current research on memory as well as knowing the risks and benefits of specific interventions can reduce the risk of harm to the client as well as innocent others, including the therapist.

It may be difficult or impossible to reconstruct a completely accurate picture of past events. The goal of therapy is not archaeology nor detective work but to help the client gain relief from distress and find positive meaning in life’s experiences. When the details of past traumatic events are ambiguous or incomplete, there is still much that can be done to help the client.

**Useful Goals of Therapy**

**Cope Effectively With Life’s Tasks**

It is important to learn how to tolerate, soothe, and appropriately respond to intense emotions and also to work within a “therapeutic window.” Pacing discussion of painful memories and affects while building
safety, trust, and coping skills for managing affects can reduce clinical problems. If the client is flooded with painful affects at a faster rate than coping mechanisms are developed, the client may act out, decompensate, or rely on dissociation (Gil, 1996; Briere, 1992). Flooding the client through intrusive techniques that push rapid disclosure, memory retrieval, or discussion of painful material before safety, trust, and coping mechanisms are built may be risky. A focus on growth and development of skills for emotional management can improve the client's functioning even if memories are unclear or inconsistent.

**Experience a Subjective Sense of Well-Being**

Healing is often a developmental process and the client's symptoms may fluctuate. Therapy can treat depression, anxiety, or other concerns and stabilize the client without solving all of their life's problems and challenges (Garfield, 1989; Budman and Gurman, 1988). Other concerns may arise later in response to life events and developmental challenges, requiring further therapy. These can be addressed as they arise without probing for further memories.

**Achieve a Sense of Wholeness**

Frequently individuals develop a self-image of a flawed or damaged person. One goal of treatment is to help the client develop a positive internalized representation of self that can withstand external challenges. An additional goal is to help the client integrate both pleasant and painful life events as part of one's life story and make useful meaning of both.

**Improve Personal Relationships**

Protecting personal safety while still allowing closeness and intimacy with others is a crucial task. To be able to distinguish between safe and unsafe or abusive relationships, set appropriate boundaries, and still take risks with personal disclosure and emotional openness in safe relationships can improve the quality of relationships. Working with the client to develop and practice these skills can be productive even if the original source of disturbance is unclear.
Safe Practice Skills

The leading causes of ethical complaints against psychologists in the state of Utah include the therapist insisting that the client must remember abuse, pressuring the client to take legal action against the perpetrator, requiring the client to sever family relationships, traveling with the client to the scene of the abuse, diagnosing over the phone without meeting, and evaluating the client and use of hypnosis or other intrusive techniques without therapy time to process information (Utah Psychological Association, 1995). The following practice strategies can reduce ethical and legal problems.

Be Aware of Personal Cognitive Distortions

All therapists have blind spots and personal biases. Making use of scientific research, professional information, and consultation with colleagues can reduce the impact of personal distortions.

Avoid All-or-Nothing Categories

Do not assume that all anorectics, bulimics, vaginismus, or other categories of presenting concerns involve sexual abuse. Flashbacks, sexual concerns, and body image disturbances are not specific to sexual abuse. Other problems often contribute to similar symptoms.

Don’t Use Defensive Questioning That Assumes an Abuse Agenda

Let the client take the lead in setting the direction and concerns that are addressed in treatment. Be careful with leading or suggestive statements as well as questions that assume abuse without evidence.

Be Aware of Unsupported Stereotypes

Many stereotypes are not supported by research. For example, some therapists assume that all schizophrenic clients must have experienced abuse at an early age. Hallucinations may resemble flashbacks and onset of delusions may be experienced as “recovered” memories.

On the other hand, severe trauma symptoms may be similar to psychotic symptoms (Briere 1992). Understanding that the client’s
symptoms from a holistic integration—one which includes biological vulnerabilities, personal history, family dynamics, substance abuse history, and other individual factors—provides a more accurate picture.

Stereotypes about sexual abuse survivors may also be inaccurate. Many individuals who were abused as children show no psychopathology and are similar to non-clinical individuals (Beutler, Williams, and Zetzer 1994, Westerlund 1992).

Seek External Validation and Confirmation of Memories
Encourage clients to talk with appropriate family members or friends, or to consult other sources, such as medical records, that may clarify or validate sketchy information. External evidence may fill in gaps or explain inconsistencies in existing memories. Other witnesses and external evidence can also protect against accusations of false memories.

Don’t Push a “Political” Agenda
It is safer to take a position of supportive neutrality than to push a strong political agenda. Pushing the client into highly confrontive or legal action or coercing the client to sever family relationships may result in legal or ethical problems.

Get Training for Competency
Get specialized training for work with sexual abuse survivors. A personal history of abuse and recovery is not the same as training. Personal history may give important insights but may also create blind spots. Training in disaster or war trauma or work with perpetrators is not sufficient alone as training for work with sexual abuse survivors.

To prepare for competent treatment of sexual abuse clients, the therapist needs a background in multiple areas. These areas include:

1. Development Theory
To understand how a client would experience and interpret childhood events, the therapist should understand child development.
Knowing how children grow in cognitive, verbal, and sensory motor skills puts recollection of events in a developmental perspective. Also, an understanding how children develop can alert the therapist to differences between normal development and problems or unusual responses.

2. Models of Trauma and Dissociation

Research on how people respond to traumatic events informs the therapist about typical reactions (McCann and Pearlman, 1990; Everstine, 1989; Marmar, C. R. and Horowitz, M. J., 1988; Roth and Lebowitz, 1988; Kardiner, 1941). The client experiences less self-condemnation and fear when taught to understand trauma symptoms as a normal reaction to abnormal events.

3. Trance and Suggestibility

Trance and suggestibility are powerful tools with vulnerable clients. Therapists should not attempt to use intrusive techniques such as hypnosis, sodium amytal interviews, EMDR, or guided imagery without adequate training in their use and awareness of the hazards of misuse. Using such methods even for ego strengthening and anxiety reduction can compromise the client’s testimony in court (Colwick, 1995). Some states will not allow testimony from such clients as admissible evidence. To understand the judgment and skill required in making decisions about the use of intrusive techniques, one can use the analogy of a powerful drug. Suppose that a drug were available that could help to cure a verifiable cancer but could create that same form of cancer if given to a person without a verifiable disease. Careful and accurate diagnosis before administering the drug would be critical in protecting the safety of the patient (American Psychological Association, 1996). The decision to use and the administration of the drug should only be done by individuals with adequate training. Clients also have the right to informed consent with regard to the use of these procedures.
4. Treatment Methods

Research based on models of treatment that acknowledge stages of treatment and pacing of interventions can provide some legal protection. If the therapist can show evidence of practice that is accepted by the profession as standard treatment and research evidence of its efficacy, there is less risk of malpractice conviction (Bednar et al., 1991).

5. Models of Pathology, Assessment, and Diagnosis

Be aware of other diagnoses and how they might interact with or mimic abuse symptoms. Psychotic disorders, bipolar mood disorder, obsessive compulsive disorder, and borderline personality disorder may all co-occur or have symptoms that resemble those that may result from childhood sexual abuse (Morrison, 1995; American Psychological Association, 1994; Othmer and Othmer, 1989). Understanding the complexity of models of psychopathology and using careful diagnostic assessment can reduce hasty decisions made with inadequate information.

6. Assessment Tools

Be aware that checklists claiming to differentiate between sex abuse clients and other clients may be poorly constructed and inadequately validated (Pope and Brown, 1996). Standardized and well-researched tests such as the MMPI may be useful in understanding other problems, such as depression, thought disorder, and psychological functioning, but should not be interpreted beyond what research shows to be valid interpretation. Such tests cannot be construed as “proof” of an abuse history. Therapists should understand principles of test construction and use, and should only use and interpret tests for which they have had adequate training.

7. Critical Thinking Skills

Learning to think logically and to recognize logical errors can reduce risks to both the client and the therapist. Be cautious with errors such as overgeneralizing, affirming the consequent, unsupported
assumptions, emotional reasoning, prejudice, and faulty inductive or deductive reasoning (Pope and Brown, 1996; Boostrom, 1992). An example of a logical error would be “Sexual abuse survivors experience flashbacks. This client is experiencing flashbacks. Therefore, this client must have been sexually abused.” This conclusion ignores the facts that many sexual abuse survivors do not have flashbacks and that many individuals who experience flashbacks were never sexually abused.

Strategies and Techniques

There are many strategies and techniques besides recovering memories that can assist clients who present with symptoms of distress which may be a result of sexual abuse. These can be effective in strengthening the client’s functioning and relationships even when a complete and accurate understanding of the past is impossible. A partial list of non-intrusive techniques and strategies includes:

- Reinforce positive autonomous functioning. Empower the client to act in his or her own best interest. Reclaim agency.
- “Dosing” exposure to emotional discomfort and stress. Develop skills for managing effects without flooding.
- Stress inoculation. Anticipate difficult and stressful situations. Practice how to respond before their occurrence.
- Assertiveness skills. Learn how to protect personal rights and safety without resorting to abusive behavior towards others.
- Thought stopping and cognitive strategies. Recognize and change cognitive distortions, irrational beliefs, and intrusive thoughts.
- Expression and catharsis. Be able to express and release emotions through art, drama, music, writing, movement, or verbal language.
- Role play. Try out skills, test, and understand interpersonal relationships in a safe environment.
- Skills training. Work on useful skills such as anger management or communication that have not been developed.
- Education about symptoms. Learn about depression, anxiety or trauma reactions.
• Insight into patterns and reactions. Understand how previously
learned patterns and reactions may not be working in current situa-
tions, and learn new ways of responding.
• Reframe and find meaning. Transform painful, difficult experiences
into growth-promoting ones.
• Find positive meaning and spiritual purpose in life.

Conclusion

For LDS therapists, finding absolute and sure answers concerning
past events may not be as important as trusting that a wise, just, and
merciful God will eventually make the truth known. There is no evi-
dence that clients must accurately remember past events in order to
heal and continue development (American Psychological Association,
1996). Mortal limitations may make clear, immediate understanding
of absolute truth difficult for all of us, but that does not have the
power to stop growth and progression. Humble acceptance of the lim-
its to our power and knowledge can free us to focus our efforts on act-
ing as allies in support of the client’s growth and eternal progression.

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