



ASCA

28 February 2005

Attention: Anne-Maree Polimeni
Project Officer
Office of the Health Services Commissioner
Level 30 / 570 Bourke Street
Melbourne
Victoria 3000

**Submission to the Inquiry into the
Practice of Recovered Memory Therapy**

ASCA: Advocates for Survivors of Child Abuse

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Advocates for Survivors of Child Abuse

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A. INTRODUCTION

ASCA would like to express its concern that the focus of this inquiry is 'Recovered Memory Therapy.' RMT is a process which has been widely discredited as it directs patients to seek 'proof' that they were sexually abused with the use of a set of particular techniques, ie. utilising the treatment to confirm a diagnosis.

RMT techniques include such dubious practices as trance writing, amytal interviews ('truth serum'), misuse of hypnosis, etc. There is no doubt that the use of such techniques has created a 'witch hunt' type of atmosphere in which scepticism thrives concerning the concept that traumatic experiences from childhood can be lost from conscious recall for a varying period of time, and recalled at a later date.

The term 'recovered (repressed) memories,' however, refers to the recall of traumatic events, typically (but not exclusively) of sexual abuse in childhood — by adults who have exhibited little or no previous awareness of such experiences. Over a period of ten years in supporting 'survivors' of all types of child abuse ASCA has seen many members who lost memories as a consequence of childhood trauma, and subsequently recovered those memories of forgotten aspects of their childhood. In our experience this phenomenon occurs not infrequently, and to varying degrees — from partial amnesia to complete traumatic amnesia for a period (or periods) of time.

ASCA believes that recovery of such memories does not only occur in therapy but can occur in tandem with the development of stability, trust and security for a traumatised individual. A substantial body of empirical evidence of amnesia and delayed recall for abuse now exists. It is not our intent to overload this submission with references to the large volume of scientific data available. However we urge you to review the selected references we have included at the conclusion of this submission. As you will see, significant progress has occurred in how such empirical evidence is described and explained. The use of the term 'repression' now includes more descriptive constructs like dissociation, and explanatory constructs from cognitive science and neuroscience.

The recovery of memories is not a function of any specific therapeutic techniques. Therapy is the least-commonly reported cue for the return of traumatic memories. In situations in which a 'survivor' reports delayed recall of memories of abuse it is just as possible to find corroborative evidence as it is with remembered abuse. Indeed it has been demonstrated that recovered memories are no more accurate or inaccurate than are memories (of anything) which were always present. Studies conducted in diverse parts of the world have produced remarkably consistent results regarding the prevalence of disrupted memories of abuse.

Rather recovery of memories depends on the development of a primary relationship between therapist (or other trusted support person) and 'survivor' — a traumatised adult (child) whose trust was severely betrayed as a child. In such an environment, often for the first time, traumatised clients can allow themselves to become vulnerable enough to allow the memory of events (so traumatic as to threaten the very survival of the individual in childhood) to return to consciousness. With the support of non-judgemental empathic listening 'survivors' feels protected and nurtured enough to access the horror of the past, gradually acknowledge the feelings associated with it, and begin to accept the trauma as part of their history.

ASCA has directly or indirectly helped approximately 50,000 'survivors' of abuse since 1995. Many have little or no memory of large sections of their childhood (others have partial memory), and we have supported them as they have gradually pieced together a picture of what happened to them as children. This is an extremely traumatic process and can often only occur safely with the support of a well-trained

professional who understands the impact of trauma and the potential complications of unravelling a childhood of abuse and the feelings which accompany it.

ASCA contends that indeed we do need to question the process — to look at the qualifications and training of counsellors, psychologists and other practitioners who undertake the care of ‘survivors.’ ‘Survivors’ are frequently both needy and vulnerable and are easy prey to ‘charlatans’ and those offering ready cures. Therapists need to be sensitive to signs of trauma, which may not be fully remembered in clients who present with symptoms of dissociative or post-traumatic stress disorders. Yet retrieving and reconstructing memory into a verbal narrative is crucial. The process is slow and difficult as many ‘survivors’ suffer from PTSD and dissociation, and therefore do not have complete access to their memories in a manner which allows the formation of a verbal narrative.

For this reason we feel most strongly that practitioners practising in this area should be well-qualified and informed — aware of the risks and have undergone extensive training in trauma therapy. They should adhere to a strict code of ethics and follow best-practice guidelines established by a well-respected professional body such as the APS, in which members undergo continuing education and supervision.

Processing the effects of childhood abuse, with or without the complications of recovered memories, is a difficult and protracted process. ‘Survivors’ deserve the help of practitioners who understand and will be available in a professional capacity for the long haul. Recovering ‘repressed memories’ is only part of the process of recovery. ‘Survivors’ also need to process their trauma, get in touch with and learn to express their feelings, attend to various developmental anomalies that they have acquired along the way and review behavioural and relationship patterns. ‘Survivors’ need to find therapists who will believe their pain, validate the way they feel and help them to believe their pain enough to be able to experience it without needing to escape from it in one form or another. Therapists should help the ‘adult’ part listen to the traumatised ‘child’ part co-existing within their clients/patients, in order to understand and acknowledge the experience from childhood, and help the child part (or vulnerable part of the self) to understand, acknowledge and move on from the trauma.

Unfortunately the creation of organisations which label this phenomenon routinely as ‘false memory’ and their focus on discredited therapies has invalidated the struggle of many ‘survivors.’ Surely the fact that the processing of memories, which have been ‘recovered,’ ultimately produces improvements in the general health and well-being of ‘survivors,’ the state of their mental health and emotional equilibrium, as well as capacity to function effectively in society, is a strong argument towards accepting the reality of their existence. One can only presume that a false memory would not produce such an outcome.

The concept that an experience, as extreme as one involving abuse, could be ever lost to the conscious mind is hard to believe and accept. Every instance of recall is a *process of reconstruction*, and therefore involves some degree of distortion. This process is never random, and is always influenced by both internal and external factors (to the person attempting accurate recall). On rare occasions people can sincerely believe they have recovered a memory or memories of abuse, but actually be mistaken. ASCA readily acknowledges that this possibility exists. However one readily-preventable cause of this situation is lack of competence or experience on the part of therapists, who can sometimes contribute to the creation of false details in memories by using inadvisable techniques.

B. REVIEW OF THE PROCESS OF MEMORY¹

This is the process by which explicit memories are stored and recalled. Explicit memories are narrative, verbal, autobiographical, and voluntarily retrievable. This sort of memory is reconstructive and can be distorted, influenced, manipulated by suggestion and, in some situations, even implanted. It was explicit memory that was researched by cognitive psychologists in the 1990s in regard to the 'repressed memories' debate. Understandably, their findings led to concerns about the validity and accuracy of 'repressed memories.'

However, newer technology, which enables researchers to examine the workings of the various parts of the brain more closely, has led researchers to conclude that there are other types of memory stored in different ways and in different parts of the brain and body.

When the amygdala assesses the incoming data as intensely arousing the hippocampus records events with *great accuracy*. Traumatic events occurring to older children or adults can be recalled in extremely vivid and comprehensive detail and remain consciously accessible. These memories are stored with far more detail and accuracy than is normal.

When the incoming data is excessively arousing: a terrifying, overwhelming, traumatic event, the neural pathways to the hippocampus are impaired and the information is stored as emotions and physical sensations. These memories are not stored as normal, conscious, verbal data or integrated with other memories, but as raw physical data (image, smell, sound, taste, touch). These memories cannot be consciously recalled but will be triggered by association. This overwhelm mechanism **can** happen with adults but, because of the greater vulnerability of children to being overwhelmed by an event, happens more frequently in children.

Because the hippocampus is not fully functional until children are from three to five years old, all memories before this time are stored non-verbally and unconsciously. Early memories include body memories, traumatic memories, and implicit memories.

Implicit memories are 'the automatic integration of information with little conscious attention to what is happening.' They are the ongoing effects of events in a person's life in the absence of any cognitive memory of their cause. These memories can affect emotions, behaviour, perceptions, body functions and sleep patterns.

Implicit memories are non-verbal, emotional, and/or sensory. These are the memories which cannot be voluntarily recalled, but which are triggered by association. They are not autobiographical, in that those experiencing them not aware of themselves as an entity in a past situation which is being recalled. Instead they re-experience the sensations, which is like re-living the original experience.

Researchers have also discovered that there is memory capacity in virtually every cell of the body. This has become amazingly clear in the experiences of transplant recipients manifesting the attributes of their organ donor. Body memories include the reappearance in the body of physical symptoms of the original abuse, and physical reactions, which occur in response to a trigger, which is in some way associated with the original abuse. Research has shown that body memories are not susceptible to suggestion or distortion. The body does not lie. The way in which we interpret the

¹ Meryl Lee, Trauma Therapist (2004), Extract of article written for inclusion in a recent ASCA newsletter (ASCA: Melbourne).

memories can be subject to distortion, modification, or suggestion but what the body remembers is reliable.

Clearly the mechanisms of memory are far more complex and varied than was originally thought. The newer findings support the reality of 'survivors' of child abuse who have not always remembered the abuse consciously.

C. REVIEW OF PERTINENT STUDIES FROM THE SCIENTIFIC LITERATURE

1. Two studies by University of New Hampshire psychologist Linda Meyer Williams involving research featuring detailed interviews with 129 women who, 17 years earlier, had been evaluated in a hospital emergency room after having been sexually abused.

a) Study 1²

One in three women of the women with previously documented sexual abuse did not report those abuse experiences.

b) Study 2³

Abstract:

"This study provides evidence that some adults who claim to have recovered memories of sexual abuse recall actual events that occurred in childhood. One hundred twenty-nine women with documented histories of sexual victimization in childhood were interviewed and asked about abuse history. Seventeen years following the initial report of the abuse, 80 of the women recalled the victimization. One in ten women (16% of those who recalled the abuse) reported that at some time in the past they had forgotten about the abuse. Those with a prior period of forgetting — the women with 'recovered memories' — were younger at the time of abuse and were less likely to have received support from their mothers than the women who reported that they had always remembered their victimization. The women who had recovered memories and those who had always remembered had the same number of discrepancies when their accounts of the abuse were compared to the reports from the early 1970s."

² L.M. Williams (1994), 'Recall of childhood trauma: A prospective study of women's memories of child sexual abuse' in *Journal of Consulting and Clinical Psychology* (62), 1167-1176.

³ L.M. Williams (1995), 'Recovered memories of abuse in women with documented child sexual victimization histories' in *Journal of Traumatic Stress* (8), 649-673.

Excerpt:

"[T]hese findings are important because they are based on a prospective study of all reported cases of child sexual abuse in a community sample. Because the abuse was documented in hospital records this is the first study to provide evidence that some adults who claim to have recovered memories of child sexual abuse recall actual events which occurred in childhood. These findings are also not limited to a clinical sample of women in treatment for child sexual abuse. The findings document the occurrence of recovered memories. There is no evidence from this study of child sexual abuse experienced by this community sample of women that recovery of memories was fostered by therapy or therapists. For this sample of women memories resurfaced in conjunction with registering events or reminders and an internal process of rumination and clarification."

2. A study of delayed recall of abuse and other traumatic experiences by Diana Elliott, psychologist at the University of California at Los Angeles (UCLA) School of Medicine.⁴

Abstract:

A random sample of 724 individuals from across the United States was mailed a questionnaire containing demographic information, an abridged version of the Traumatic Events Survey (D.M. Elliott, 1992), and questions regarding memory for traumatic events. Of these, 505 (70%) completed the survey. Among respondents who reported some form of trauma (72%), delayed recall of the event was reported by 32%. This phenomenon was most common among individuals who observed the murder or suicide of a family member, sexual abuse survivors, and combat veterans. The severity of the trauma was predictive of memory status, but demographic variables were not. The most commonly reported trigger to recall of the trauma was some form of media presentation (ie. television show, movie), whereas psychotherapy was the least commonly reported trigger.

Excerpts from the literature review:

"Understood from this perspective, dissociative amnesia for previous traumatic events would be best predicted by the severity of the trauma and most apt to be triggered by intrapersonal, interpersonal, or environmental cues that closely match the original trauma. Although certain forms of memory loss (eg. infantile amnesia, normal forgetting, organic impairment) may best be predicted by demographic variables (eg. age at time of trauma, length of time since the event, current age), avoidance-related traumatic memory loss should be less a function of demographic variables and more related to characteristics of the trauma."⁵

⁴ D.M. Elliott (1997), 'Traumatic events: Prevalence and delayed recall in the general population' in *Journal of Consulting and Clinical Psychology* (65), 811-820.

⁵ Ibid, p 812.

Excerpts from the results section:

"Participants were most likely to report continuous memories of adult sexual assault that did not include penetration (94%), major motor vehicle accidents (92%), and natural disasters (89%). A history of partial memory loss was most common when an individual had witnessed murder or suicide of a loved one (38%), had been victim of child sexual abuse (22%), and had been a victim of child physical abuse (22%). A history of complete memory loss was most common among victims of child sexual abuse (20%), witnesses of combat injury (16%), victims of adult rape (13%), and witnesses of domestic violence as a child (13%)."⁶

Excerpts from the discussion section:

"The findings of the present study suggest that a history of trauma is common in the United States. For example, 40% of respondents experienced a major motor vehicle accident or natural disaster, 43% had witnessed violence, and 50% had been victims of interpersonal violence...

"These data also suggest that delayed recall of traumatic experiences may not be uncommon, with some proportion of individuals reporting impaired recollection for virtually every type of trauma. This phenomenon appears to be more common among events considered particularly upsetting or distressing (eg. among childhood sexual abuse survivors, those who witnessed the murder or suicide of a loved one, and veterans who witnessed combat injury) and less common for events that contained no interpersonal violence (eg. major motor vehicle accidents, disasters, and having a child die under the age of 18)."⁷

3. D.M. Elliott and J. Briere⁸

Abstract:

"This study examined delayed recall of childhood sexual abuse in a stratified random sample of the general population (N = 505). Of participants who reported a history of sexual abuse, 42% described some period of time when they had less memory of the abuse than they did at the time of data collection. No demographic differences were found between subjects with continuous recall and those who reported delayed recall. However, delayed recall was associated with the use of threats at the time of the abuse. Subjects who had recently recalled aspects of their abuse reported particularly high levels of posttraumatic symptomatology and self difficulties (as measured by the IES, SCL, and TSI) at the time of data collection compared to other subjects."

⁶ Ibid, p 814.

⁷ Ibid, p 816.

⁸ D.M. Elliott and J. Briere (1995), 'Posttraumatic stress associated with delayed recall of sexual abuse: A general population study' in *Journal of Traumatic Stress* (8), 629-647.

4. Bessel Van der Kolk⁹

a) Study 1¹⁰

Abstract:

"Since trauma arises from an inescapable stressful event that overwhelms people's coping mechanisms, it is uncertain to what degree the results of laboratory studies of ordinary events are relevant to the understanding of traumatic memories. This paper reviews the literature on differences between recollections of stressful and of traumatic events. It then reviews the evidence implicating dissociation as the central pathogenic mechanism that gives rise to posttraumatic stress disorder (PTSD). A systematic exploratory study of 46 subjects with PTSD indicated that traumatic memories were retrieved, at least initially, in the form of dissociated mental imprints of sensory and affective elements of the traumatic experience: as visual, olfactory, affective, auditory, and kinesthetic experiences. Over time, subjects reported the gradual emergence of a personal narrative that can be properly referred to as 'explicit memory.' The implications of these findings for understanding the nature of traumatic memories are discussed."

b) Study 2¹¹

Excerpt:

"[Posttraumatic Stress Disorder], by definition, is accompanied by memory disturbances, consisting of both hypermnesias [inabilities to forget] and amnesias... Research into the nature of traumatic memories. . . indicates that trauma interferes with declarative memory, i.e. conscious recall of experience, but does not inhibit implicit, or non-declarative memory, the memory system that controls conditioned emotional responses, skills and habits, and sensorimotor sensations related to experience. There now is enough information available about the biology of memory storage and retrieval to start building coherent hypotheses regarding the underlying psychobiological processes involved in these memory disturbances..."

⁹ Bessel van der Kolk is a pre-eminent researcher in the field of traumatic memories. Reference to two studies is included below.

¹⁰ B.A. van der Kolk, and R. Fisler (1995), 'Dissociation and the fragmentary nature of traumatic memories: Overview and exploratory study' in *Journal of Traumatic Stress* (8), 505-525.

¹¹ B.A. van der Kolk (1994), 'The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress' in *Harvard Review of Psychiatry* (1), 253-265.

5. **Judith Herman**¹²

Abstract:

"The clinical evaluations of 77 adult outpatients reporting memories of childhood trauma were reviewed. A majority of patients reported some degree of continuous recall. Roughly half (53%) said they had never forgotten the traumatic events. Two smaller groups described a mixture of continuous and delayed recall (17%) or a period of complete amnesia followed by delayed recall (16%). Patients with and without delayed recall did not differ significantly in the proportions reporting corroboration of their memories from other sources. Idiosyncratic, trauma-specific reminders and recent life crises were most commonly cited as precipitants to delayed recall. A previous psychotherapy was cited as a factor in a minority (28%) of cases. By contrast, intrusion of memories after a period of amnesia was frequently cited as a factor leading to the decision to seek psychotherapy. The implications of these findings are discussed with respect to the role of psychotherapy in the process of recovering traumatic memories."

6. **A groundbreaking Australian study by psychologist Leigh Hodder-Fleming of 77 male and female survivors of childhood sexual abuse with varying levels of recollection of their childhood abuse, including those who had 'recovered' previously repressed memories.**¹³

Abstract:

"My research showed that there is corroboration available for most survivors in the form of confirmation by other family members or other survivors, physical injuries and scarring, and medical and psychological histories."

¹² Judith Herman is a Harvard psychiatrist. Her studies address fundamental issues in the memory controversy. Only one is included here: J.L. Herman and M.R. Harvey (1997), 'Adult memories of childhood trauma: A naturalistic clinical study' in *Journal of Traumatic Stress* (10), 557-571.

¹³ L. Hodder-Fleming (2004), *Adult Survivors of Child Sexual Abuse: Forgetting and Remembering*, PhD thesis (Queensland University of Technology).

D. CONCLUSION

In conclusion, ASCA would like to stress that the provision of appropriate care and acceptance for those who have been traumatised in childhood is crucial to the process of recovery. Those espousing the beliefs of the False Memory Syndrome Foundation (FMSF) or supporting widely discredited 'therapeutic' practices need to be sanctioned and their methods exposed, as they are heaping untold further damage onto an already traumatised and severely disadvantaged population. As a society we need to expose those forces while learning better how to support those in need.

Abuse within our society remains a silent and insidious scourge. The level of substantiated cases of abuse and neglect continues to escalate despite the implementation of child protection strategies and mandatory reporting laws. As we struggle to protect our young people from abuse, let us not forget those who are struggling to cope with the effects of their abuse as adults. Many 'survivors' of childhood abuse carry the added burden of experiencing the often debilitating process of recovering 'repressed memories.' They need to be validated, acknowledged, understood and when seeking therapy, be confident in the knowledge that the professional they choose is competent and informed

It is crucial that those in government with the power to legislate keep abreast of scientific developments in the field of 'recovered memories' and act accordingly.

Thank you for giving us the opportunity to make a submission to this inquiry.

ASCA: Advocates for Survivors of Child Abuse

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25 February 2005

Attention: Anne-Maree Polimeni
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Level 30 / 570 Bourke Street
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Victoria 3000

Dear Ms Polimeni,

Submission to the Inquiry into the Practice of Recovered Memory Therapy

As survivors of childhood sexual abuse and members of ASCA (Advocates for Survivors of Child Abuse), we find it appalling that an inquiry into the practice of 'Recovered/False Memory Therapy' has been deemed necessary, for the following reasons:

1. There is very little scientific evidence for a 'False Memory Syndrome' or the associated concept of 'Recovered/False Memory Therapy'. The genesis of the term 'false memory' was primarily political, not scientific, and was first coined by the False Memory Syndrome Foundation (FMSF) in the USA. This organisation was founded by Pamela and Peter Freyd in response to private accusations by their daughter, Professor Jennifer Freyd, of childhood sexual abuse, about which she had 'recovered' previously repressed memories. This is hardly an objective or scientific impetus for the establishment of either an organisation or a diagnostic category. Professor Freyd's uncle Bill Freyd has since corroborated some of her memories as true.

We are alarmed that the term 'false memory' has become part of the vernacular of our society, particularly in media circles, without any empirical basis for even the existence of such a psychological phenomenon.

2. By contrast, much recent empirical research supports the idea that traumatic memory is encoded 'implicitly' and stored differently in the brain from (non-traumatic) 'explicit' or narrative memory. This research highlights the fact that traumatic memory can be dissociated/repressed (cf. extensive work by John Briere, Bessel van der Kolk and Judith Herman, for example). We are also enclosing a news release about Dr Leigh Hodder-Fleming's PhD thesis in Psychology on the topic, *Adult Survivors of Child Sexual Abuse: Forgetting and Remembering*. This thesis is available through the Queensland University of Technology.
3. It is striking that 'recovered memory' is most controversial when the focus of the memories is childhood (sexual) abuse, rather than other types of repressed traumatic memory, such as individuals' experiences of the Holocaust or road trauma. This suggests that it is the emotive content of childhood sexual abuse, rather than the nature of recovered traumatic memory itself, that is difficult for society to accept.

As survivors of childhood sexual abuse we find the extreme and largely scientifically unsubstantiated opinions of groups like the FMSF, distressing and detrimental to our own healing process.

We also find it particularly distressing that these views are often presented in the media as 'fact.'

Over the last fifteen years, we have both seen many therapists working from different therapeutic frameworks. None has tried to 'implant' memories of abuse. In fact, the opposite has sometimes been the case — at times there has not been much focus or credence given to the memories and symptoms we have brought to therapy, and thus our healing process has been hindered. For both of us, the initial recognition of our own childhood abuse occurred outside therapy. In our experience, the greatest benefit has come when our abuse has been acknowledged and accepted as true within a safe and validating therapeutic context.

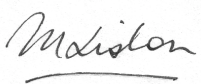
We understand and endorse the need for mental health professionals, therapists and counsellors to have comprehensive training prior to working with survivors of trauma, and to exercise appropriate caution when responding to clients/patients who present with memories or symptoms of childhood abuse.

However, our fear is that the current political climate in relation to this issue will prevent therapists providing that which their clients/patients most need in healing from their past, ie. validation of and belief in our experiences, and an open acknowledgement of the validity of the previously repressed traumatic memories we may 'recover' in a safe and therapeutic context.

We feel that the issue most needing addressing by our society is not that of so-called 'Recovered/False Memory Therapy' but rather the widespread extent of childhood sexual abuse itself, which many wings of society continue to deny.

Instead of an enquiry into the practice of 'Recovered Memory Therapy', we would question why resources are not offered to aid the understanding and prevention of the hidden epidemic of childhood sexual abuse, and into supporting the healing process for adult survivors of abuse through groups such as ASCA.

Yours sincerely,



Monique Lisbon



S. Joy



News Release

Research backs sexual abuse victims

CHILD sexual abuse victims have been given new hope by QUT research which proves that it is possible to bury traumatic memories for long periods of time.

Psychologist Leigh Hodder-Fleming believes her PhD research on forgetting and remembering childhood sexual abuse will lead to greater understanding of the phenomenon by legal professionals, clinical psychologists and others who accuse survivors of having false memories.

“The average person does not believe that a person can recall an abuse memory that has been locked away for a certain amount of time,” Ms Hodder-Fleming said.

“This study aims to educate the public, solicitors, court officials and to help juries better understand a victim’s evidence, improving the scope for criminal compensation.”

For her PhD, Ms Hodder-Fleming interviewed and gathered evidence from 77 male and female survivors, who had varying recollections of their childhood abuse.

She said there was a distinct lack of research in Australia on how people forgot and remembered a sexual attack despite the media’s recent focus on adult survivors of childhood sexual abuse.

She said her findings showed those able to block the attack from their conscious mind were normally younger when the abuse started, and had strong dissociative skills.

“‘I locked it away and lost the key’ or ‘I would pretend I was a bird and fly out the window’ were the kind of responses from survivors who forgot their attack until later in life,” Ms Hodder-Fleming said.

Ms Hodder-Fleming said how victims remembered an attack had significant setbacks when trying to bring the person responsible to justice.

“Memory does not come back in a time line – courts and police expect memory to be sequential when in fact it comes back in dribs and drabs and over a period of time,” she said.

“Survivors do not usually recover all of their abuse memories in one hit and some may never recover all of their memories.

“Because of this and a lack of physical evidence, such as genital bruising, courts have difficulty convicting the perpetrator.

“My research showed that there is corroboration available for most survivors in the form of confirmation by other family members or other survivors, physical injuries and scarring, and medical and psychological histories.”

Ms Hodder-Fleming said forgetting the abuse did not provide any protection against the development of emotional problems.

Problems normally experienced by those who forgot and those who remembered their abuse included suicidal thoughts, depression, psychological disorders, eating disorders and the inability to hold down a relationship.

“Many think they are going mad because they can’t remember and don’t know why they feel the way they do – it is sometimes harder for those who don’t know the reason for their pain.”

Ms Hodder-Fleming said a variety of factors could provoke an incident’s recall and victims would often remember being abused when they had a feeling of safety.

“The triggers for remembering are various, and range from being in a safe relationship, smells, tastes, touch, sights, sounds or medical procedures, such as childbirth,” she said.

Ms. Hodder-Fleming said further research was needed to help formulate and update policies and procedures for legal personnel and to ensure a victim’s claims were not dismissed too easily.

For further information:

Contact: Heath Kelly, QUT media, 07 3864 1841

Date: Friday, July 30, 2004