Hypnosis and Memory: A Hazardous Interplay[1]

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Abstract

It has been claimed that repressed memories can be recovered by hypnotic suggestion and other interventions. This claim has great relevance to mental health counselors faced with distressed clients who attribute their symptomatology to repressed early life trauma. However, the scientific evidence does not support the claim. This paper evaluates this issue and suggests ways clinicians might productively confront the attendant clinical dilemmas.

Recently, the mental health profession has become polarized by views about the nature of memory in general and of repressed memory in particular (Lynn & Nash, 1994). This polarization is characterized by two disparate, often stridently expressed views: 1) Repressed memory is a myth and no method can reliably uncover forgotten memories. 2)

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Repressed memories can be recovered and the apparently recovered memories are essentially reliable.

I will review the state of knowledge concerning the recovery of memories with the use of hypnotic methods and illustrate the clinical significance of the problem of attempting to recover memories. Finally, I will offer suggestions for the consideration of clinicians who encounter clients who believe that they are troubled by repressed traumatic memories and also believe that their troubles can be relieved by hypnotically uncovering the memories.

Let me begin with my own view of the problem: Without independent verification, no one—not even the most talented clinician—has a reliable means for determining the accuracy of a client's report. Even the use of sodium amytal—the so-called truth serum—does not yield reliable reports (Piper, 1993). Further, if, despite this evidence, we nonetheless believe in the reliability of an otherwise unverified report, we risk harm to our client by facilitating a misguided search for a mythic truth.

The Hypnotic Experience

Hypnosis is a condition in which a person's imagination creates vivid reality from suggestions offered either by someone else, by suggestions inferred from ambient social cues, or by suggestions initiated by the person himself or herself. In this circumstance, the person is unusually able to alter perception, memory and physiological processes not ordinarily susceptible to conscious control (Barber, 1992; Hilgard, 1992).

In this condition, reality fades into the background of awareness, replaced in the foreground by a believed-in blend of fantasy and reality. There is greater receptivity to the clinician's point of view and greater dissociation of the observing ego from the experiencing ego. In general, there is enhanced awareness of unconscious mental processes. Transference is also accelerated and intensified, and becomes what Shor (1962) described as *archaic involvement*. All of these characteristics render the hypnotized client unusually suggestible to his or her own imagination and to that of the clinician.

Three of these characteristics are especially pertinent to the issue of recovering forgotten memory: 1) The capacity to create vivid reality from suggestions, 2) the capacity to alter memory, and 3) the tendency to regress to an archaic relationship.

The capacity to systematically create amnesia through hypnotic methods has led to the investigation of the possibility of recalling material that is not ordinarily available to the memory process (Bowers & Farvolden, 1996a, 1996b; Bowers & Woody, 1996; Davidson & Bowers, 1991). Although there are intriguing anecdotal accounts of hypnotic methods used to retrieve forgotten information (Kroger & Doucé, 1979), such accounts seem exceptional and are hard to interpret in the context of our contemporary understanding of memory processes.

Perhaps the first experimental attempt to examine the potential for hypnotically facilitated recall was made in 1932 by Stalnaker and Riddle. They found that hypnotized subjects' recall of literary selections learned in a prior year could be improved by the use of hypnosis. This finding seems to support the possibility of hypnotically enhanced memory. However, upon further reflection, this improvement in recall was discovered to be confounded by substantial inaccuracies (Laurence & Perry, 1988, p. 322). By reference to Stalnaker and Riddle's original lists, it was possible to determine that the apparent improvement in memory was unreliable; therefore, this report did not actually confirm the lore that hypnotic methods can improve memory.

Dywan and Bowers (1983) also came to the conclusion that hypnotic methods do not reliably improve memory. They found that memory seemed to be credibly enhanced, but that it was actually distorted by the hypnotic experience. Further, Laurence and Perry (1983) also demonstrated that the mere subtle cueing of hypnotized subjects could produce profoundly believed-in but totally false memory. With one modest exception (Geiselman, Fisher, MacKinnon & Holland, 1985), the scientific literature is consistent in its failure to find evidence supporting the claim that hypnotic suggestion can reliably improve recall (Bowers & Farvolden, 1996a; Dasgupta, Juza, White & Maloney, 1995;

Dinges, Whitehouse, E. Orne, Powell, J. W., M. Orne, & Erdelyi, 1992; Geiselman & Machlovitz, 1987; Steblay & Bothwell, 1994; Wagstaff & Mercer, 1993). A particularly telling series of investigations of hypnotic age regression yielded unequivocal evidence of the confounding of subjects' memories and of the resulting unreliability of their reports (Nash, Drake, Wiley & Khalsa, 1986). It may be that hypnotic methods potentially facilitate recall, but they do so at the cost of also potentiating imaginal processes.

Of interest to clinicians is the evidence that the highly malleable nature of memory is not limited to laboratory research. M. Orne, Whitehouse, Dinges and E. Orne (1988) reported a number of forensic cases in which hypnotized witnesses testified to remembering seeing events that they could not have seen, as well as to a variety of other demonstrably false recollections.

It is worth emphasizing that it is not only the distortion of memory which is at issue, but also the utter sincerity with which people believe their distorted memories to be accurate. It is in this context that the other two characteristics of the hypnotic experience are pertinent: Suggestibility and the regressed hypnotic relationship. These features interact to foster the client's sense that the experience is real and not imaginary; more, they support his or her confidence that the apparent memory is an accurate and integral part of his or her life history. Because the hypnotic experience tends to foster a sense of deep safety and trust, the client is ineluctably led to the belief that the thoughts and feelings and images that the treatment evokes are actually remnants of historical memory.

Because such sincerity in the reporting of their memories powerfully enhances the credibility of these completely mistaken witnesses, the application of hypnotic methods in forensic circumstances is a very hazardous undertaking (and, in most circumstances, is now prohibited by law). As we shall see, the clinical application of hypnotic methods for the recovery of memory is similarly hazardous.

The crucial importance of independent verification has become clarified in recent years in the forensic context and the courts have taken these facts into appropriate consideration (Giannelli, 1995). However, although this same capacity for memory distortion operates in the clinical context, clinicians often seem unaware of the problem.

The Clinical Problem

When a hypnotized client reports an experience, it is characteristically a compelling report and the clinician commonly believes the client's report to be *historically true*—as opposed to *psychologically true*—because of the added credibility of the hypnotic experience (Bowers & Farvolden, 1996a; Ewin, 1994; Poole, Lindsay, Memon & Bull, 1995; Ross & Newby, 1996). As the literature amply demonstrates, however, clinicians are highly susceptible to misinterpreting a hypnotized client's reports (Bowers & Farvolden, 1996a; Newman & Baumeister, 1996; Sheehan & Linton, 1993; Stevenson, 1994).

It is not an exaggeration to suggest that any clinical intervention involving the imagination—including, but not confined to hypnotic intervention—increases the likelihood that the client's memory will be distorted. That is, it is likely that the client will have images, feelings, thoughts, perceptions, and other experiences that he or she believes to be memories—but that are at least partly, and perhaps mostly, the result of imagination and not memory (Bowers & Farvolden, 1996a, 1996b; Bowers & Woody, 1996; Ganaway, 1995; Garry, Manning & Loftus, 1996; Loftus & Pickrell, 1995).

Garry et al. (1996) demonstrated that merely imagining an event can lead to subsequent belief that the event actually occurred. So, even if we are exceedingly careful in our attempt to avoid contaminating the client's memory with our own beliefs and expectations, it is inevitable that the experience of discussing events in the context of heightened imagination will alter the client's memory, however subtly. Moreover, it is likely that the client will then honestly believe and confidently report the distorted memory to be accurate. "False memories are constructed by combining actual memories with the

content of suggestions received from others. During the process, individuals may forget the source of the information. This is a classic example of source confusion, in which the content and the source become dissociated." (Loftus, 1997a, p. 75). Consequently, we must be willing to acknowledge that a hypnotized client's report—however compelling—may be completely accurate, partially accurate and partly imagined, or completely imagined.

However, despite the abundance of evidence to the contrary, many clinicians believe they can discern when a client is telling the truth. Our confidence in our ability to discriminate truth from fiction rests largely with our appreciation of sincerity. That is, we tend to believe the client's report if it is plausible, internally consistent, congruent with accompanying affect, or some combination of the above (Herman, 1992). Our tenacious confidence in this belief is understandable: The ambiguity of not knowing if someone is telling the truth is quite uncomfortable. Unfortunately, however, there is no evidence to support our confidence in these criteria (Kihlstrom, 1994). Unless we have independent verification, we cannot know if someone's report is accurate or not. Moreover, the issue is not whether the client believes in the truth of what is said—we assume this is so—but whether the events are accurately reported. However, even though the client is being honest and is conscientiously attempting to be truthful and accurate in reporting, he or she cannot correct for the constant activity of the human imagination, hypnotized or not, which leads to the vagaries of individual perception and, inevitably, to distortion of memory (Bowers & Farvolden, 1996a, 1996b; Ganaway, 1995; Loftus & Pickrell, 1995; Ofshe & Singer, 1994).

In this context, then, let us examine further the third hypnotic experience creation of believed-in reality from imagination. A dream is a universal example of a fully believable yet completely imagined experience. Similarly, the hypnotic experience offers the occasion for an individual to experience imagery, laden with affect, and surely also laden with psychological import. Such imagery, because of its meaning and affect, provides the

opportunity for an important clinical intervention. But psychological meaningfulness does not equate with reality. That is, even if the imagery yields clinically meaningful material, the material may not be factually accurate.

Just as we generally accept a dream as a metaphor—not as a journalistic account of the client's life—so, too, any client's report, hypnotically-induced or otherwise, may be psychologically meaningful, even if it may not be an accurate account of an event (Bowers & Eastwood, 1996; Bowers & Farvolden, 1996a, 1996b; Spence, 1996).

For example, a female client may present with symptoms of depression and interpersonal difficulties, including avoidance of sexual contact. These symptoms are consistent with (though not unique to) a history of sexual abuse. Suppose that the clinical intervention includes either ordinary suggestion or hypnotic suggestion—initially, perhaps, merely to promote a more comfortable, trusting relationship with the counselor. Or perhaps this method is used to facilitate the development of primary process material if she seems unable to generate such material on his or her own. Suppose, further, she now begins to report images that increasingly seem to the counselor to indicate that the client has experienced physical or sexual trauma. As the client reports these images, she is also likely to experience increasingly disturbed affect in response. As the we witness this affect-laden report, we naturally find it quite compelling.

How, though, does the competent counselor interpret this experience? Is there independent reason to believe that these images, thoughts and feelings are an historically accurate reflection of events in the client's life? Symptoms of depression and avoidance of intimacy are often associated with abusive histories. But there are other etiologies for such symptoms, as well, and these reports may or may not represent memories of actual trauma. Faced with a client's emotional drama, however, the counselor may feel confirmed in his or her hypothesis of abuse.

Frankel's (1993) review of reports of childhood events in the multiple personality literature clearly suggests the rarity with which a client's self-reported history, including

claim of abuse, is ever independently documented. While this is usually inevitable given the practical and clinical difficulties in attempting to document an adult's childhood history, the fact should also give us pause, for two reasons:

1. Troubled people are seeking a solution to their unhappiness when they seek counseling. Even if they had no prior memory of childhood abuse, nor reason to suspect abuse, the current widespread cultural emphasis on childhood abuse as a primary etiology of adult unhappiness provokes at least the question in many people's minds about their own childhood histories.

In addition to the ubiquity of childhood abuse stories in the media, a clinical specialty has developed to assess and treat this problem. Certain books in the popular press, despite the absence of supporting evidence, assert that childhood abuse is the *primary source* of most neurotic symptomatology (Bass & Davis, 1988). It is only natural, then, that some naive readers will be encouraged by such assertions to search for memories of such abuse in order to explain their problems.

2. Although anyone is potentially susceptible to suggestion from such an affect-charged cultural environment, some people's suggestibility is unusually high. Clients with a diagnosis of Dissociative Identity Disorder, for example, tend also to be remarkably responsive to suggestion (Frankel, 1993; Ganaway, 1995); but many other clients whose disorders are far less severe are similarly suggestible.

Especially within the current cultural focus on trauma and abuse, it is quite possible for an unhappy person, especially if he or she has boundary confusion, pondering the source of his or her unhappiness, to unconsciously generate images, feelings, and thoughts which he or she then begins to interpret as recall of actual experiences—even though the source for the images, feelings and thoughts is imagination (or the counselor's subtle cueing), not memory. Yet, he or she (nor the counselor) may not consider the possibility that these experiences are primarily the product of the need to make sense of his or her life.

Rather, he or she is supported by a variety of sources in the otherwise groundless interpretation that the experiences are *de-repressed memories* of traumatic events in childhood. If the counselor is also a source for this interpretation, then a fully realized and totally erroneous belief about a traumatic experience is likely to develop. Ganaway (1995) reminds us that part of our clinical responsibility to such a client is to offer psychological understanding and support, while, simultaneously, not actually adopting nor promoting the client's point of view.

When such apparent memory recovery occurs through the use of either hypnotic or other methods, the pressure on the clinician to interpret the experience as historical fact rather than psychological coping can become very compelling. This is especially likely to occur when the clinician already believes that the client was traumatized—but this is also the case when more cautious clinicians are faced with such a dramatic and credible narration of events.

Why Would Anyone Make This Up?

It is sometimes asserted that no one would intentionally create the horrific histories that develop within claims of abuse. Yet, a substantial literature explains why an individual might do so (Baron, Beattie & Hershey, 1988; Bowers & Eastwood, 1996; Bowers & Farvolden, 1996a, 1996b; Frankel, 1993; Ganaway, 1995; Kihlstrom, 1994; Laurence & Perry, 1988; Loftus, 1982, 1993, 1994, 1997a, 1997b; Loftus & Pickrell, 1995; Nash, 1994; Newman & Baumeister, 1996; Orne et al., 1988; Piper, 1988; Ross & Newby, 1996; Stevenson, 1994). The unsettling fact is that all of us—clients and clinicians—make up our memories, in the sense that all of our memories are constructed, all of the time. Sometimes what we construct is a generally accurate representation of events and sometimes it is not. Aside from this, of course, is the more complex issue of any client's motive for confabulation, which may be considerable.

A substantial body of research effectively demonstrates that the so-called videotape recorder model of memory is an inaccurate one. This appealingly simple model has

been replaced by one that may be less appealing, since it does not substantiate our confidence in the reliable recovery of forgotten memories. By contrast, the evidence has led to a contemporary model that portrays memory as a highly complex, constantly evolving interactive process, *always* susceptible to continuing modification by the individual's psychological needs (Bowers & Farvolden, 1996a; Loftus, 1982, 1993, 1994, 1997a). Unlike the videotape recorder model, this empirically-based dynamic model demands the need for caution in the way a clinician interprets a client's reports of memory.

In rare cases, it may be that there is accurate recall of memories that have been forgotten for years; however, the literature yields no evidence to credit the contemporary widespread reports of sudden recovery of long-repressed memories of early trauma. Yet, without factual verification of these reports, what actual evidence do we have to determine their accuracy?

Often, clinicians interpret the processing, the working-through of such so-called recovered memories in the course of counseling—and the subsequent resolution of symptoms—as proof that the reports were accurate (Herman, 1992). While this criterion has appeal and seems to be supported by common sense, closer examination suggests its inadequacy. Nash (1994) describes a client who presented with anxiety symptoms which he attributed to his abduction by extraterrestrials. In the course of treatment, the anxiety symptoms were relieved, but the client still believed that he was once abducted by aliens. Clearly, we cannot interpret this symptomatic relief as evidence for abduction by aliens.

The successful use of imagination is ubiquitous to all psychological interventions, even among the most basic behavioral methods. If the attribution, however imaginary, of the apparent underlying cause of a symptom has personal meaning to the client, would we not predict the therapeutic usefulness of this attribution, accurate or not? Nash's case demonstrates the inherent problem with interpreting such claims as accurate historical reports, even if clinically relevant: The one may be independent of the other.

In another case involving the treatment of dyssomnia, the client reported the recall of bizarre, traumatic incestuous abuse throughout his childhood (Barber, 1986). (Again, it is often the drama of the client's story which is so compelling to us, not necessarily its inherent plausibility.) After several treatments, his presenting symptoms began to abate. However, there was no way to verify the reality of the traumatic events he described. Perhaps they were largely, if not entirely, the product of his imagination. Or perhaps they were largely, even entirely, true. We cannot know.

Fortunately, in this case, it was not necessary to know. The ultimate resolution of the symptoms was sufficiently satisfying. This case occurred in the late 1970s. In the current litigious climate, however, such a client might well seek legal recourse against the apparent perpetrator of these childhood traumas. And what defense could be offered, after so many years? The ensuing conflict becomes simply an issue of the client's word against the accused—powerfully enhanced by the credibility of a counselor's testimony of the reliability of the client's claim.

As a consequence of society's current emphasis on believing victims' claims of abuse and punishing the perpetrators of abuse, there is a growing vulnerability to creating victims of the falsely accused (Loftus & Ketcham, 1991), as well as the resulting development of a backlash against victims (Wright, 1993b). A poignant example is described by Wright (1993a, 1993b), who recounted the dramatic story of two adolescent daughters claiming to be the victims of satanic ritual abuse. Despite the lack of any evidence that a crime had actually occurred, their father was subsequently convicted and imprisoned for abuse.

One of the challenges of a just society is the maintenance of the balance between both prosecuting and defending the criminally accused. A crucial element in that balance is the proper understanding of the fallibility of memory. As counselors whose work affects the lives of our clients and their families, we have a responsibility to remain aware of these issues. We cannot afford the intuitively appealing but scientifically groundless

beliefs many of us have held for so long about the nature of memory. Wright's account is eloquent testimony to the grave consequences of these beliefs for individuals and families.

Moreover, Ofshe's (1992) instructive description of this same case suggests that the failure on the part of clinicians to appreciate the defendant's unusually high suggestibility was a contributing factor in the elaborate, yet apparently wholly fictitious creation of this man as a perpetrator of ritual abuse.

We all know the seemingly limitless human capacity for harming one another. There is ample evidence of the grotesque abuse that is done, usually by men, to women and to children. But the fact that physical and sexual abuse of children is a significant social problem does not indicate that every report of abuse is a valid one. Our regard for women and children and our recognition of abuse need not blunt our awareness of the unreliability of memory. Our misguided reliance on the archaic videotape recorder model of memory and our uninformed belief in hypnosis as a method for discovering the truth create a further permutation of the problem of abuse. A credulous acceptance of any and all claims of abuse has serious and harmful consequences.

Recommendations

How should a clinician respond when a client reports dreams, images or memories that might suggest a history of traumatic abuse?

1. Do no harm: Obtain appropriate consultation. We must all remain aware of the possibility of our counter transference reactions to clients. For a simple example, if a clinician has unresolved feelings about abuse, it is natural that these feelings will exert pressure, perhaps unwittingly, to interpret the client's symptoms or reports in the context of abuse, rather than to remain open to other interpretations.

2. When thinking about your clients' memories or fantasies, keep your hypotheses open to review. We need to remember that the context of counseling itself often inclines us toward searching for a history of trauma as the etiology of contemporary troubles. Is

such a potentially hazardous search necessary for successful treatment? The possibility of confirmatory bias—the inclination to search only for reasons to confirm our personal hypotheses (and not, also, to disconfirm them)—makes us vulnerable to misinterpretations (Baron et al., 1988; Bowers & Farvolden, 1996a).

3. We must recognize the possibility of memory contamination as an inadvertent but likely complication of counseling. This possibility is greater when hypnotic or other suggestive methods are used, but it exists in every case. We must be aware of and contain our own personal beliefs about a client's history and keep those beliefs from influencing the therapeutic environment. For example, leading questions, comments about abuse and the intensity of our response to clients' reports can all contribute to the unwitting creation of a client's apparent memory, including the apparent memory of traumatic abuse (Loftus, 1997a, 1997b).

4. Finally, the pursuit of our own psychological growth is essential to sustaining our awareness of unconscious attitudes or feelings and to finding a means to their successful resolution. Our own counseling or psychotherapy is critical to our competent conduct as clinicians (Barber, in press).

It can be challenging for us to remain intellectually and emotionally open, without resolution, to the question of the veracity of a client's report, for example, of abuse. However, unless we can independently evaluate a client's report, we must be willing to remain open to all possibilities. It may be that the client was abused; it also may be that the client was not abused. It may be that the client's sense of having been abused is an accurate reflection of how the client felt as a child—not physically or sexually abused, necessarily, but not well cared-for, either. It is likely that there is no way to know. We may need to help the client accept this openness to interpretation, as well.

While the evidence clearly and consistently suggests that there are no methods, hypnotic or otherwise, that can reliably be used to recover forgotten memories, there is no evidence that hypnotic methods should be generally abandoned in the therapeutic enter-

prise. The current debate about memory recovery has unfortunately distorted the various appropriate applications of hypnotic methods in the clinical setting.

It can be exceedingly difficult to convey both an empathic alliance with the client and an openness to various interpretations of the client's experiences. Fortunately, it is not necessary for us to develop a credulous attitude about a client's reports in order to offer effective treatment.

As clinicians, we need to be vigilant and cautious in our treatment of clients where there is a possibility of traumatic abuse. I have tried to convey my own anxiety, concern, and empathy about the difficulty of contending with these issues without exaggerating the gravity of the problem. Perhaps a certain amount of wariness about our capacity to deal with these cases supports a salutary degree of good clinical judgment.

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