



Discerning Truth In Memory (previously under the title: “False” Memories?)

(K.D. Lehman MD, New 8/27/2002, last revised 7/17/26)

My perception is that some who work with “recovered” traumatic memories lose credibility by denying *all* memory error concerns in their reaction against the “false memory” movement. I believe that it is much wiser to non-anxiously acknowledge any legitimate concerns about memory errors, *along with* careful discussion of the evidence showing that repressed and dissociated memories are real phenomena that contain historical truth.

In this essay I discuss legitimate concerns about the possibility of memory errors. I discuss why it is *so* important to not suggest specific details regarding traumatic events and to not use imagination/guided imagery tools to “search” for traumatic memories, and why it *so* important to be cautious about making specific accusations on the basis of remembered traumatic events. In this essay I also discuss the compelling evidence proving that repressed memories and dissociated memories are real phenomena, and the evidence indicating that most “recovered” memories have a core of historical truth. I discuss why it is *so* important to not dismiss all recovered memory because of the possibility of memory errors.

I. Legitimate Concerns About the Possibility of Memory Errors

A. Memory prompts and imagination/guided imagery memory retrieval tools: All of us have had the experience of having our memories prompted. We see a scene in a movie that causes us to remember a similar event in our own lives that we had “forgotten” about for many years. We hear someone else telling a story and are reminded of similar events in our own lives. Or our spouse asks: “Did you remember you have a dentist appointment this afternoon?” To which we respond: “Oh! Thanks for reminding me! I had forgotten all about it.” Doctors are aware of this memory phenomena and routinely use specific questions as simple memory prompts in the course of medical evaluations. For example, if I ask “Have you noticed any side effects from the medication?” the patient will usually forget several of the concerns he had intended to ask me about. However, if I prompt his memory with specific questions such as “Have you noticed any changes in your sleep pattern since starting the Zoloft?” he will be much more likely to remember; and will often respond with something like “Oh, yes, I’ve been having trouble falling asleep since starting the new medication. I wanted to ask you about that – thanks for reminding me.”

An especially thorough memory prompt goes something like this:

Friend: “Karl, have you ever met John and Sara Smith?”

Karl: “No, I don’t think so.”

Charlotte: “Yes you have. We met them that time we were visiting the Johnson’s – remember?”

Karl: “Are you sure? I don’t remember anything.”

Charlotte: “It was two years after we got married. We were driving home from your temporary assignment at the State hospital in Virginia. We stopped overnight in Kansas City to visit the

Johnson's and the Smiths were there. She kept talking about their grandson who is a park ranger in Wyoming and he kept asking you about your time at Philmont. Don't you remember?"

Karl: "Uh,... I'm not sure. I think maybe I remember. What did they look like?"

Charlotte: "She was tall and thin and was wearing this fluorescent pink hat, and he had this dramatic walrus mustache."

Karl: "Oh Yeah! Now I remember! How could I forget that pink hat!...etc."

The psychologist Willem Wagenaar carefully documented the increasing effectiveness of increasingly thorough memory prompts in a simple yet elegant study of his own memories. Each day for four years, he recorded the details of a unique event in his personal life, describing what had happened, the time and location of the event, who had been present, and an additional distinguishing detail of the event. After four years of this recording process, he then went back and tested himself regarding whether he could remember the events described in his diary, carefully probing his memory with different combinations of the memory prompt clues he had recorded. He found that as he used more and more of the memory prompt cues, he remembered more and more of the events. However, even with all of the memory prompt cues he had recorded, there were still events that he could not remember. He then took the process a step further by interviewing people who had been involved in ten of these "forgotten" events. In every one of the ten cases, he eventually remembered the event as the people provided additional details.¹

Many therapists and emotional healing ministers have understood these memory phenomena, and have used a variety of memory prompts to help people access suppressed, repressed, or dissociated traumatic memories. One of the simplest memory prompts is to ask direct questions, such as: "Can you remember being sexually abused at any point in your childhood? Were there any adults or older children who made inappropriate sexual comments? Did anybody ever touch you sexually or force you to do anything you were uncomfortable with?" Some therapists have also used imagination/guided imagery based "recovery tools," such as coaching the person to imagine possible scenarios, in the hopes that memories would be activated if the imaginary scenarios were close enough to real historical events.² These various forms of memory prompts *are* effective for activating suppressed, repressed, and dissociated memories, but unfortunately they can also create memory errors. Memory prompts can be especially problematic if they are combined with suggestive statements such as: "Just look at all the clues. It sure looks like you've been sexually abused by someone in your family. I think the biggest problem is that you just need to let go of denial."

B. Misattribution, suggestion, and suggestibility: We all use memory prompts as helpful tools in everyday life, but they can contribute to misattribution and suggestion memory errors when used in working with repressed and/or dissociated memories. **Misattribution** is what

¹ Wagenaar, W.A. "My memory: A study of autobiographical memory over six years." *Cognitive Psychology*, Vol 18, 1986. Pp 225-52.

² Surveys of psychotherapists conducted in the 1990's found that many used this kind of guided imagery as a tool for stimulating retrieval of "lost"/buried childhood memories. See, for example, Poole, D.A., Lindsay, S.D., Memon, A., and Bull, R. "Psychotherapy and the recovery of memories of childhood sexual abuse: U.S. and British practitioner's opinions, practices, and experiences." *Journal of Consulting and Clinical Psychology*, Vol 63, 1995. Pp 426-87.

psychologists call a “binding error,” an error in which the brain links the content of a memory with an incorrect context. For example, several years ago I was talking with a close friend, discussing a particular question regarding human behavior. At a point of disagreement my friend related a story illustrating that a certain phenomena was indeed possible, and presented this anecdotal evidence as something that had happened to one of his personal acquaintances. After a moment of thought I realized that his story was actually from a fiction novel (well written and very convincing, but fiction). When I responded with “I think I read that in a book – isn’t that from...,” he immediately recognized and acknowledged his misattribution error. He *correctly* remembered the content of the story, but had *incorrectly* linked the content of the story to the context of a conversation with one of his friends. **Suggestion** supplies (*suggests*) a specific possibility, instead of leaving the question, statement, or situation completely open. For example, an open ended question, carefully avoiding any suggestion about the appearance of the cashier, would be “What do you remember about the person at the cash register?” In contrast, “Do you remember whether the person behind the cash register was wearing a white apron?” would be a mildly suggestive question – gently presenting (suggesting) the specific option of the white apron. “What do you remember about the man with the white apron who was running the cash register?” would be much more suggestive – strongly implying (suggesting) that the person was a man, and that he was wearing a white apron. Suggestion can lead to a specific misattribution error in which we generate internal imagery in response to a suggestive comment or question, but then mistakenly perceive that it is coming from memory of personal experience. **Suggestibility** refers to the vulnerability of the human mind to suggestion – the way in which our minds often allow suggestion to lead us into misattribution memory errors.

C. Research regarding misattribution and suggestibility: There is substantial research data supporting the reality and importance of misattribution and suggestibility.³ For example, ten months after an El Al cargo flight crashed into an apartment building outside of Amsterdam, Dutch psychologists questioned colleagues about their memories of television footage of the crash. The researchers asked the simple question: “Did you see the television film of the moment the plane hit the apartment building?” 55% of the respondents said “yes,” and many claimed to have clear memories, including details such as the speed and angle of the plane as it hit the building, whether the plane was on fire before it hit the building, and where the plane fell after impact. We know that these people constructed visual images in their imaginations on the basis of newspaper reports and other information, and then misattributed these images to non-existent video footage, *because there was no television footage of the accident*.⁴ This research provides a good example of how suggestion encourages misattribution. The intentionally suggestive question obviously implying that there had been TV footage of the moment of impact led people to make misattribution source errors – mistaking their internal imagery as memory of film footage instead of imagination imagery associated with other sources of information and/or discussion.

³ Schacter, D.L. *The Seven Sins of Memory* (New York: Houghton Mifflin, 2001), pp 88-137 provides a written-for-lay-people review of this research. Note: Dr. Schacter does not adequately acknowledge the importance of repressed or dissociated memory, and his logic is faulty in his argument dismissing ritual abuse, but excepting these important blind-spots in his presentation, he provides an excellent review of the research regarding misattribution and suggestibility.

⁴ Crombag, H.F.M., Wagenaar, W.A., and Van Koppen, P.J. “Crashing memories and the problem of ‘source monitoring.’ *Applied Cognitive Psychology*, 10, 1996. pp 95-104.

Research studying misattribution, suggestion, and suggestibility indicates that an *imaginary, fictitious* scenario will begin to feel subjectively more and more real and true if a person repeatedly imagines the fictitious scenario, and especially if the person imagines the fictitious scenario in a setting where the scenario is presented as a possible/probable real scenario. For example, if a person is repeatedly asked if he remembers a specific scenario, he will usually imagine the scenario in his mind's eye each time it is described. Even if the scenario is fictitious, the images will become familiar because he has been repeatedly revisiting the mental images. Even *without* any suggestion, if significant amounts of time go by, the person can begin to misattribute the source of the images that feel familiar, and begin to believe that he is remembering an actual event as opposed to remembering imagined images. If the person repeatedly imagines the fictitious scenario in a setting where it is presented as a possible/-probable real scenario, then serious misattribution errors become soberingly common.⁵ It is very significant (somewhere between sobering and alarming) that some of these studies document the implantation of fabricated memories for even very dramatic events, such as spilling punch on the bride's parents at a wedding reception.⁶

Recent PET scan studies demonstrate that the visual images associated with imagined events are generated by some of the same neurological circuits that contribute to the visual perception of actual events.⁷ This neurological data point is certainly consistent with the clinical observation that incidents that people frequently imagine can come to feel like events that actually occurred. Research studies also show that people can distort the *details* of a *true* memory if erroneous information is suggested in certain ways (such as asking leading questions)⁸.

Note that misattribution errors can occur spontaneously, even without any suggestion. Suggestion increases the frequency and severity of misattribution – it presents a specific focus around which misattribution errors can occur, and in more intensely suggestive situations, actively invites and encourages misattribution errors. But suggestion is *not required* for

⁵ See, for example, Bruck, M., Ceci, S.J., and Hembrooke, H. "Children's reports of pleasant and unpleasant events. In D. Read and S. Lindsay (eds.), *Recollections of Trauma: Scientific Research and Clinical Practice*, (New York: Plenum Press) 1997. pp 119-219; Hyman, I.E., Husband, T.H., and Billings, F.J. "False memories of childhood experiences." *Applied Cognitive Psychology*, 1995 9(3), pp 181-97; Porter-S, Yuille-JC, Lehman-DR, "The nature of real, implanted, and fabricated memories for emotional childhood events: implications for the recovered memory debate." *Law-Hum-Behav.* 1999 Oct 23(5): 517-37; Zaragoza, MS and Lane, SM, "Source misattributions and the suggestibility of eyewitness memory." *J-Exp-Psychol-Learn-Mem-Cogn.* 1994 Jul, 20(4): 934-45; and Zaragoza, M.D., & Mitchell, K.J. "Repeated exposure to suggestion and the creation of false memories," *Psychological Science*, 1996, Vol. 7, pages 294-300.

⁶ See, for example, Hyman, I.E., Husband, T.H., and Billings, F.J. "False memories of childhood experiences." *Applied Cognitive Psychology*, 1995 9(3), pp 181-97; and Hyman, I. E., & Billings, F. J. "Individual differences and the creation of false childhood memories." *Memory*, 1998 Jan 6(1), pp 1-20.

⁷ Kosslyn, S.M. (1994). *Image and Brain*. (Cambridge: MIT Press) 1994.

⁸ See, for example, Miller-MB; Gazzaniga-MS, "Creating false memories for visual scenes." *Neuropsychologia*. 1998 Jun; 36(6): 513-20, Bruck-M; Ceci-SJ; Francoeur-E; Barr-R, "I hardly cried when I got my shot!" Influencing children's reports about a visit to their pediatrician. *Child-Dev.* 1995 Feb; 66(1): 193-208, and Weingardt-KR; Loftus-EF; Lindsay-DS, "Misinformation revisited: new evidence on the suggestibility of memory." *Mem-Cognit.* 1995 Jan; 23(1): 72-82.

misattribution to occur. To keep things in perspective, it is also important to note that suggestion does not always produce misattribution memory errors. Suggestion increases the frequency and severity of misattribution, but it does not *always* cause misattribution. In fact, suggestion *often* fails to produce memory errors, even in very suggestive situations. (Most studies on suggestion and suggestibility report a substantial proportion of subjects who do *not* demonstrate misattribution errors in response to the suggestive questions, statements, or situations).

D. “Downgrade” memory errors: In our experience, memory errors such as misattribution usually *downgrade* the painful implications of traumatic memories. It is especially important to understand how this can affect the perceived identity of a perpetrator. For example, a person who was sexually abused by her father might “remember” her first grade teacher as the perpetrator because the implications of this false perpetrator identity would be much less painful than the truth. We are familiar with more than one situation in which there are clear clinical indicators that the person reporting abuse memories was indeed sexually abused, but also clear corroborating evidence indicating that the specific person accused of the abuse was not the true perpetrator.⁹

E. An important and common logical error – “If it causes pain, it must be true”: I used to think “A thought/image that isn’t associated with a true historical event can’t produce negative emotions, so if the person has intense negative emotions, then the thought/image associated with the negative emotions must be a memory of a true historical event.” However, as I have thought more carefully about this, I have realized that there are many real-life-experience data points that show this to be erroneous thinking. For example:

1. Bone cancer scare: A number of years ago, I experienced persistent pain in my right leg, and eventually went in for x-rays to figure out what was the matter. Being a physician, I asked the technician to let me look at the films before she took them to the radiology department. Unfortunately, I was able to read the x-rays just well enough to make myself miserable. I could see that there was a lump towards the top of my right femur. Several days later, the radiologist gave me the good news that the lump indicated a painful but harmless condition – myositis ossificans – as opposed to bone cancer (which is often hard to treat, rapidly progressing, and eventually fatal). However, during the several days between the x-ray and the radiology report, I thought I probably had bone cancer. During these miserable several days, horrible scenarios, and associated thoughts and emotions, flooded into my mind. I imagined painful medical procedures, toxic chemotherapy, tremendous medical bills, and then dying prematurely. “What will happen to Charlotte? Have I provided for her adequately?...etc.” I was sad and frightened, with intense negative emotions and also physical manifestations associated with adrenaline release (sweating, increased heart rate, increased respiration rate). Just *believing* that I had bone cancer caused me to experience intense negative emotions, even though it wasn’t true.

2. Classic hypnosis demonstration: A classic hypnosis demonstration, which has been repeated by a number of different practitioners, provides a dramatic data point. While the demonstration subject is in hypnotic trance, the hypnotist takes a pencil and tells him that the

⁹ In one of these situations, other individuals (that we personally know and trust) were present with the person being accused and the person reporting the abuse at the exact time and place that the abuse supposedly occurred.

eraser is the red hot end of a probe used for some kind of medical procedure. The hypnotist informs the subject that she needs to test something, and therefore needs to touch them with the hot probe for one moment. As the hypnotist touches him/tries to touch him, he will express and demonstrate intense fear, and if she does actually touch him with the pencil eraser, he reports intense, burning pain. The demonstration subject experiences intense negative emotions, and subjective physical pain, even though the traumatic event is entirely illusory.

3. Vicarious “Ouch!”: When I was in Jr. High school, we would play various running games during our lunch break. For reasons I don’t understand, there was a pipe sticking up in the middle of one of the fields we would run in. The pipe was just the right height so that the top would hit an average Jr. High kid squarely in the crotch. One unfortunate day, one of my friends hit the pipe at full running speed. Mike crawled all the way from the playing field to the nurses office, and the rest of us boys were crossing our legs, wincing, and groaning in sympathetic pain just from watching him. Just thinking about this story still makes me cringe, and often when I tell the story, all the guys in the room cringe in the same way. We experience negative emotions from thinking about and visualizing this scenario, even though we are *not* remembering an event that actually happened to us.

4. Simple experiment: There is a simple experiment you can do right now – imagine, vividly, something scary and painful, such as somebody holding you down and chopping off one of your fingers. Most people will experience some negative emotions just by imagining this scenario, even though it has never happened to most of us. (Look at your hands – how many fingers do you have?).

F. Dangerous psychotherapy scenario: In light of the above discussion, consider what could happen in a psychotherapy group where the leader and participants don’t understand these principles and are not careful regarding suggestibility. A new member is brought into the group because her therapist thinks she has thoughts and emotions consistent with sexual abuse. As she listens to others talk about sexual abuse memories week after week, she often has images in her own mind corresponding to the stories others are telling – just like images of imagined scenes come into your mind when you read a story. If the new member’s father was alcoholic, the group leader might say, “Your symptoms sure look like sexual abuse, and your father is alcoholic. Alcoholics often molest their children. I’m guessing that your father probably molested you. I think you just need to let go of your denial.” Eventually, the therapist might suggest, “I want you to imagine your father molesting you. That might help you to connect with your repressed/dissociated memories.”¹⁰

If the person does imagine her father molesting her, she will probably have negative thoughts and emotions associated with the imagined scenario (even if the imagined events never occurred – just as you experienced negative emotions as you imagined somebody cutting off your finger). The therapist and group members could then respond with, “Why are you upset? If it didn’t really happen, it wouldn’t be upsetting! I think you just need to let go of your denial.” If they succeed in convincing the new group member that her father did, indeed, molest her, she could be flooded with negative emotions just from thinking about family systems

¹⁰ Again, research has documented that many psychotherapists have used this kind of guided imagery as a tool for stimulating retrieval of “lost”/buried childhood memories.

consequences: “Oh my Gosh – this is so horrible. I have worked so hard to build a good relationship with my father since he stopped drinking. How could he have betrayed me like this? How can I go home for Christmas? How will I explain to Mom that I don’t want to come home for Christmas? I wonder if he has molested my kids?...etc.” If you come to *believe* that your father molested you, you will predictably have intense negative emotions, even if it didn’t actually happen.

The memory phenomena and psychotherapy practices just discussed are the basis for legitimate concerns about the possibility that memory errors might occur in the context of psychotherapy or emotional healing ministry. This is why it is *so* important to not suggest specific details regarding traumatic events and to not use imagination/guided imagery tools to “search” for traumatic memories, and why it *so* important to be cautious about making specific accusations on the basis of remembered traumatic events.

II. Repressed and Dissociated Memories are Real and True Phenomena

There are some people who have challenged the existence of traumatic memories that are important enough to still be affecting the person, but that are not available to the conscious mind because they are repressed and/or dissociated. These people have proposed that repression and/or dissociation of important traumatic memories are misguided concepts, and that the mind simply does not forget traumatic memories that are important enough to still be affecting a person. Our assessment is that our own healing journeys, our professional experience, information from personal colleagues, well documented case studies in the professional literature, and extensive research specifically addressing the question provide overwhelming evidence supporting the reality of repressed and/or dissociated traumatic memories.

A. Personal experience with “lost” memories that have been recovered: As described in “Avoidance, Neglect, Repression, and Denial: ‘Where Did Kindergarten and First Grade Go?’” on the Case Studies page of our website, my memories of being in kindergarten and first grade classrooms at Oakton School were completely “lost” until I began my personal healing journey. As also described in this case study, the recovered memories that have come forward during my own emotional healing work fit many of the lies I have believed and the corresponding negative emotions I have experienced since grade school, and Charlotte and I have observed lasting changes in my thoughts, emotions, and behaviors as I have been working through these recovered memories. My personal experience is that “lost” memories are a real and true phenomenon.

B. Clients with repressed and/or dissociated memories that have been recovered: Charlotte and I have worked with a number of people who have recovered memories that they had not been able to remember consciously for many years. In each case, the recovered memories have matched certain lies, negative emotions, and behaviors in the person’s life. Some of these people had signs and symptoms that met full DSM IV¹¹ diagnostic criteria for conditions such as phobias, panic disorder, obsessive compulsive disorder, eating disorders, major depression, various addictive disorders, and Post Traumatic Stress Disorder, and had been on corresponding psychiatric medications for years. The corresponding problems in the person’s adult life have resolved as the truth-based pain, lies, sins, and demonic infection associated with the recovered

¹¹ DSM IV is short for the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth edition (American Psychiatric Association: Washington, DC, 1994) – the standard diagnostic listing/tool used by mental health professionals.

memories were resolved, and in several cases I have had the privilege of steadily decreasing and/or stopping the psychiatric medications. I have continued to follow a number of these people, and have verified that their clinical improvement has been maintained for many years now.¹² In some of these situations we have also been able to obtain corroborating evidence supporting the recovered memories. For example, one person has siblings who have corroborated many of the specific details in the previously dissociated memories that have now come back to her. Another person has medical and legal records verifying the childhood events she had repeatedly stated she could not remember, but then suddenly recovered during a session in my office.

Note: As of July 2026, we have four video recordings that are available to the public that present live ministry sessions in which the persons receiving ministry “recover” and resolve traumatic childhood memories that had previously been lost/buried/missing (not available to their conscious minds). The videos also include follow-up interviews where they describe several dramatic positive changes that have unfolded spontaneously since the ministry sessions on the tapes.¹³

C. Colleagues with corroborating evidence: Colleagues that we know and trust have also obtained corroborating evidence supporting the validity of recovered memories. In several situations, careful medical examination revealed scar tissue exactly matching traumatic memories recovered during emotional healing ministry. It is significant to note that “hidden” scar tissue was found in places like the inside of the mouth and the inside of the vagina, where it would only be found by careful medical examination and where the person receiving ministry would not even be aware of it (addressing the concern that people receiving ministry might make up traumatic memories to match their scars).¹⁴ Note: We would like to hear from others who have obtained strong corroborating evidence verifying the historical accuracy of recovered memories.

D. 2004 Research demonstrating an *active forgetting process*, and also identifying corresponding neurological phenomena: Collaborating scientists at Stanford University and the University of Oregon have just published¹⁵ research results that clearly demonstrate the existence of an *active forgetting process* that looks a lot like the avoidance/neglect that I describe in the case study from my own experience mentioned above. This study shows that we can *choose* to “look away” from selected memory content, and that this voluntary “looking away” impairs later attempts to recall the selected material. These research results also identify, with functional magnetic resonance imaging (MRI), neurological phenomena that correspond to this active forgetting process. One fascinating aspect of this research is that it doesn’t even involve emotionally painful memories – this rigorous and careful study shows that we can

¹² As of 2026, the improvement in some of these cases has continued for more than twenty-five years.

¹³ The videos, *Grace: Childhood Abuse Memory*, *Patricia: First Session with Internal Parts*, *Lisa: Childhood Surgery, Panic Attacks, and Abreaction*, and *Kay: Dissociated Sexual Abuse Trauma, Internal Child Part* are available from the Store page of our web site, www.kclehman.com. The explanatory comments discussing the videos are also available (free download) from the Case Studies and Store pages of our web site.

¹⁴ This was described by Dr. Ed Smith during the advanced apprenticeship training July 16-20, 2002.

¹⁵ Remember that this essay was first posted in 2002, with a major update in 2005.

actively increase forgetting for even mundane memory content by deliberately directing our attention away from it.¹⁶

E. Research regarding the existence of repressed and dissociated memories, and/or the historical accuracy of recovered memories: Note: Many of the studies described below also included other components. We are describing only the material in each study that addresses the question of whether repressed and dissociated memories are real phenomena and/or the question of how well recovered memories correspond to historical truth.

Andrews, B., Brewin, C., Ochera, J., Morton, J., Bekerian, D., Davies, G., and Mollon, P. "Characteristics, context and consequences of memory recovery among adults in therapy." *British Journal of Psychiatry*. 1999 August; 175:141-146.

One-hundred and eight therapists provided information on all clients with recovered memories seen in the past three years, and were interviewed in detail on up to three such clients. Of a total of 690 clients, therapists reported that 32% started recovering memories before entering therapy. According to therapists' accounts, very few of the 236 detailed client cases appeared improbable and corroborating evidence supporting the historical truth of recovered memories was reported in 41%. 78% of the clients' initial recovered memories either preceded therapy or preceded the use of memory recovery techniques.

Bagley, C. *The Prevalence and Mental Health Sequels of Child Sexual Abuse in Community Sample of Women Aged 18 to 27. Child Sexual abuse and mental health in adolescents and adults.* (Aldershot: Avebury, 1995).

This book describes a study of women between 18 and 24 years of age who had been removed from the home 10 years previously by social services due to intra familial sexual abuse. Of the 19 women for whom there was evidence of serious sexual abuse, 14 remembered events corresponding to their records. Two remembered that abuse had taken place but could recall no specific details, and three had no memory. Two of the last three described large gaps in their memories of childhood corresponding to the ages when abuse had taken place.¹⁷

Bull, D. "A verified case of recovered memories of sexual abuse." *American Journal of Psychotherapy*. 1999 Spring; 53(2): 221-224.

This case study describes the experience of a 40-year-old woman, with no history of mental illness and ten years of exemplary professional work, who recovers memories of childhood sexual abuse through a call from her youth pastor in whom she had confided as an adolescent. This reminder triggered a severe depression, suicidal action, and the need for hospitalization. The woman reported no memory of the sexual abuse prior to the reminder phone call. Corroborating evidence supporting the historical truth of the recovered memories was obtained (the woman's older sister reports that she witnessed the abuse).

¹⁶ Anderson, M. C., Ochsner, Kevin N., et al. "Neural Systems Underlying the Suppression of Unwanted Memories." *Science*. January 9, 2004, 303:232-235.

¹⁷ Adapted from 7-31-02 e-mail from Lynn Crook, M. Ed., to Ellen Lacter, Ph.D.

Chu JA, Frey LM, Ganzel BL, Matthews JA. "Memories of childhood abuse: Dissociation, amnesia, and corroboration." *American Journal of Psychiatry*. 1999 May; 156(5):749-755.

90 female patients admitted to a unit specializing in the treatment of trauma-related disorders underwent a structured interview that asked about amnesia for traumatic experiences, the circumstances of recovered memory, the role of suggestion in recovered memories, and independent corroboration of the memories. A substantial proportion of participants with all types of abuse reported partial or complete amnesia for abuse memories. For physical and sexual abuse, early age at onset was correlated with greater levels of amnesia. Participants who reported recovering memories of abuse generally recalled these experiences while at home, alone, or with family or friends. Although some participants were in treatment at the time, very few were in therapy sessions during their first memory recovery. Suggestion was generally denied as a factor in memory recovery. A majority of participants were able to find strong corroborating evidence supporting the historical truth of their recovered memories.

Corwin, D. & Olson, E. "Videotaped discovery of a reportedly unrecalable memory of child sexual abuse: Comparison with a childhood interview taped 11 years before." *Child Maltreatment*. 1997; 2(2): 91-112.

This article presents a unique case involving the recovery of traumatic memory by a 17-year-old victim of documented childhood sexual abuse. The authors present the history, verbatim transcripts, and behavioral observations of a child's disclosure of sexual abuse to Dr. David Corwin in 1984 and the spontaneous return of that reportedly unrecalable memory during an interview with Dr. Corwin 11 years later.

The case was originally referred to Corwin for a court-appointed evaluation of allegations of sexual and physical abuse. Corwin had three interviews with the child (Jane Doe) and also met with both parents. Dr. Corwin's evaluation, along with previous documentation, strongly supported the child's allegation of both physical and sexual abuse by her mother. In her first interview, her disclosure was spontaneous and not in response to a question directed to sexual abuse. Jane made consistent statements regarding the identity of her sexual abuser and the nature of the abuse in all three forensic interviews. Her accounts included sensory detail and she reported detailed maternal threats not to disclose. Parental behavior during the interviews and psychological testing of both parents was also consistent with the mother having abused Jane. Based on the weight of the evidence the court gave Jane's father full custody and denied visitation to Jane's mother. In addition to the interviews, the records included protective services reports, court declarations by the parents, pleadings, court decisions, reports by prior evaluators and therapists, letters from Jane's parents, friends, and relatives, and Jane's medical records.

After her father's death, Jane wanted a closer relationship with her mother. Jane no longer had any memory of the abuse but did remember that she had alleged abuse. Her mother denied the abuse allegations and told Jane that her allegations were based on pressure by her father so he could get custody of her. Jane contacted Dr. Corwin and told him that she would like to see the videotapes of herself because she was unable to recall the actual events. Jane said: "I've chosen to believe that my real mom didn't do anything, even though I don't really remember if she did or not."

Before showing her the videotape, Corwin asks Jane to remember everything that she can

about her interviews with him at age 6. Corwin asks her if she remembers “anything about the concerns about sexual abuse.” Jane says: “No. I mean, I remember that was part of the accusation, but I don’t remember anything – wait a minute, yeah, I do.” Corwin asks her what she remembers. Jane responds, “My gosh, that’s really, really weird.” This is followed by tears and Jane’s speech becoming choked up. Jane then reports some of the details described in the interviews when she was 6 years old. Corwin then shows Jane the videotapes of his interviews with her when she was 6 years old. After watching the videotapes, Jane believes that the child on the tapes was telling the truth.

Both the child’s disclosure at age 6 and the young woman’s sudden recall of the abuse at age 17 after several years of reported inability to recall the abuse are recorded on videotape.¹⁸

Duggal S, Stroufe LA. “Recovered memory of childhood sexual trauma: A documented case from a longitudinal study.” *Journal of Traumatic Stress*. 1998 April; 11(2): 301-21.

The authors present the case of a child with documented history of sexual abuse, chronicled evidence of amnesia (no recall of the abuse in extensive interviews and consecutive written assessments as a teenager), and then spontaneous recall of the abuse memories outside of therapy at age 19. This account contains the first available *prospective* report of memory loss in a case in which there is both *documented evidence of trauma* and *evidence of recovery of memory*. The case emerged as part of a broadband, large-scale study of children followed closely from birth to adulthood which was not focused on memory for trauma. Prospective data gathered in a neutral research context, and corroborated and supplemented by retrospective information, circumvent many limitations of previous retrospective accounts of recovered memories.

Feldman-Summers S; Pope KS. “The experience of forgetting childhood abuse: a national survey of psychologists.” *J Consult Clin Psychol*. 1994 Jun; 62(3):636-9

A national sample of 330 psychologists were asked whether they had been abused as children and, if so, whether they had ever forgotten some or all of the abuse. Almost a quarter of the sample (23.9%) reported childhood abuse, and of those, approximately 40% reported a period of forgetting some or all of the abuse. The major findings were that (a) both sexual and nonsexual abuse were subject to periods of forgetting; (b) the most frequently reported factor related to recall was being in therapy; (c) approximately one half of those who reported forgetting also reported corroboration of the abuse; and (d) reported forgetting was not related to gender or age of the respondent but was related to severity of the abuse.

Fish V., Scott C.G. “Childhood abuse recollections in a non-clinical population: forgetting and secrecy.” *Child Abuse Neglect*. 1999 Aug;23(8):791-802

Fifteen hundred people were randomly selected from the membership of the American Counseling Association and sent a questionnaire regarding childhood abuse history. Four hundred and twenty-three usable questionnaires were returned and analyzed. Thirty-two percent of the sample reported childhood abuse. Fifty-two percent of those reporting abuse also noted periods of forgetting some or all of the abuse.

¹⁸ Adapted from 7-31-02 e-mail from Lynn Crook, M. Ed., to Ellen Lacter, Ph.D.

Herman, J. L., & Harvey, M. R. "Adult memories of childhood trauma: A naturalistic clinical study." *Journal of Traumatic Stress*. 1997 October; 10(4), 557-571.

The clinical evaluations of 77 adult psychiatric 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 new memories after a period of amnesia was frequently cited as a factor leading to the decision to seek psychotherapy.

Martinez, Taboas, A. "Repressed memories: Some clinical data contributing toward its elucidation." *American Journal of Psychotherapy*. (1996) Spring; 50(2), 217-30.

This article offers two case reports that include amnesia of traumatic memories, recovery of traumatic memories, and corroborating evidence for the traumatic memories. The author documented that both patients had no conscious memory of their childhood abusive experiences, documented the recovery of childhood traumatic memories in therapy, and then obtained definite and clear-cut independent corroborating evidence supporting the historical truth of the abuse memories in both cases.

Nash, M.R. "Memory distortion and sexual trauma: The problem of false negatives and false positives." *The International Journal of Clinical and Experimental Hypnosis*, 1994; 42, 346-362.

Nash describes a 42 year old man who entered therapy because of bothersome, intrusive images that he thought might allude to a sexual experience. He eventually recovered a traumatic sexual memory, and then obtained corroboration from one of those he recalled as being present – a cousin who acknowledged participating in the event, and who reported retaining clear memory of the episode since it had happened.

Penfield, Wilder. "The Permanent Record of the Stream of Consciousness." *Proceedings of the Fourteenth International Congress of Psychology, Montreal, June 1954*. (Amsterdam: North-Holland Publishing Company), Wednesday, June 9, pages 47-69, and Penfield, Wilder, and Perot, P. "The brain's record of auditory and visual experience. A final summary and discussion." *Brain*, (1963) 86:595-696. In an extensive series of surgical case studies, Penfield and Perot document that direct electrical stimulation of the temporal lobe can elicit vivid, detailed recall of autobiographical memories that is qualitatively more like *re-experiencing* the original events than like the normal subjective experience of remembering. The patients report that the detail they *re-experience* (see, hear, etc.) during stimulation is much more vivid and minute than they can normally recall regarding the events in question (often reported to be true autobiographical events that the person also has "normal" memory for).¹⁹ Patients report that

¹⁹ Drs. Penfield and Perot noted that in some of the cases, the accuracy of the recalled details were verified by family members who could corroborate memory content, or by verifying the accuracy of other details, such as the melody and words of music the patients sang as the "memory songs" were being

they can't retain/recall the same level of details, even moments after the stimulation is stopped. For example, if you are looking at this sentence, and I ask "Did I use 'you are' or 'you're'?" you could answer with little difficulty. However, you would have trouble accurately remembering such detail, even moments after reading the sentence, if you were not looking at the sentence when I asked you the question. The important point for this discussion is that these case studies demonstrate that the mind can carry detailed, accurate autobiographical memory content that is not usually available to the conscious mind.

Sacks, Oliver. *The Man Who Mistook His Wife for a Hat*, (Harper Collins: New York, NY, 1990). Dr. Oliver Sacks, a clinical neurologist, describes several fascinating case studies in which biological changes in a patient's brain resulted in "recovering" memories that had previously been inaccessible to the person's conscious mind.

"Recovered" memories with temporal lobe stroke and associated seizures (pages 132-149): Dr. Sacks describes the case of an 88 year old woman who began remembering vivid details from her early childhood following a temporal lobe stroke and the onset of associated temporal lobe seizures. This woman had been born in Ireland. Her father had died before she was born, and her mother died when she was five years old. Before the temporal lobe seizures started, she had no conscious memory of her mother, her mother's death, or any other details from the first five years of her life. She could not remember this material, even with repeated, intentional, directed effort, trying to bring these memories into her conscious mind. During the temporal lobe seizures, she did not just remember details from the first five years of her life, but *re-experienced* them in vivid, detailed memory hallucinations (flashbacks): "...I feel I'm a child in Ireland again – I feel my mother's arms, I see her, I hear her voice singing." Then, after the seizures stopped with resolution²⁰ of the small stroke, she was again unable to remember anything from the first five years of her life. She could remember that she *had* remembered the "lost" material – she could remember the recent adult experience of remembering the "lost" material – but she could no longer consciously, directly remember the "lost" material.

Note that the observations and neurology in this case study are consistent with the hypothesis that these memories were "blocked" by psychological defenses such as repression and/or

"heard" in their minds. Note that Drs. Penfield and Perot were stimulating the temporal cortex as a part of a neurosurgical procedure, making observations about memory phenomena as a side issue. They were not carefully documenting corroboration as a part of systematic memory research. Their observations therefore do not carry the same scientific evidence "weight" as carefully controlled cognitive psychology experiments. Nevertheless, when I took the time to go through their original material (the articles referenced above, which include verbatim transcripts from their interactions with patients during temporal lobe stimulations), I am left with the clear overall impression that the direct stimulation elicited accurate recall of extraordinary detail not usually accessible to the conscious mind (as described above).

²⁰ Regarding the reference to a stroke "resolving:" With any true stroke, there is a small core of tissue that dies, and a much larger area that is damaged, but that does not die. A stroke never *completely* resolves, because the dead tissue is never recovered, but the injury to the larger damaged area does resolve with time. Seizures in the area of a stroke are mostly caused by the *acute* inflammation and irritation associated with the stroke. The acute inflammation and irritation resolve as the dead tissue consolidates into a small scar and as the temporary injury to the larger area is healed. Sometimes there is a small, lingering irritation associated with the scar tissue, but seizures associated with strokes usually resolve as the acute inflammation and irritation resolve.

dissociation. As Penfield and Perot thoroughly demonstrated and documented, direct stimulation of the temporal lobe, such as would occur with seizures in the temporal lobe, can directly activate memory circuits. And direct activation of the memory circuits would bypass higher brain function psychological defenses moderated by the prefrontal cortex. If this were the case, it would be *expected* that the memories would be “lost” again once the temporal lobe seizures stopped. The psychological defenses had been temporarily bypassed by the direct stimulation of the temporal lobes, but they were still in place, and would be expected to resume their function of blocking the memories as soon as the direct stimulation bypass stopped.

“Recovered” memories with increased L-Dopa dosage (pages 150-152): Dr. Sacks describes the case of a 63 year old woman with Parkinson’s disease who began to report vivid, detailed memories from her youth in the 1920’s after her dose of L-Dopa was increased. “The patient requested a tape-recorder, and in the course of a few days recorded innumerable salacious songs, ‘dirty’ jokes and limericks, all derived from party-gossip, ‘smutty’ comics, night clubs, and music halls of the middle and late 1920’s.” “Nobody was more astonished than the patient herself: ‘It’s amazing,’ she said. ‘I can’t understand it. I haven’t heard or thought of those things for more than 40 years. I never knew I still knew them. But now they keep running through my mind.’” It is also interesting to note that these memories were “lost” again when the L-Dopa dose was decreased: “Increasing excitement necessitated a reduction of the dosage of L-Dopa, and with this the patient, although remaining quite articulate, instantly ‘forgot’ all these early memories and was never again able to recall a single line of the songs she had recorded.”

Note that Dr. Sacks did not obtain independent, corroborating evidence to verify the details of the songs and other details of the first patient’s early childhood, but everything she remembered was consistent with the facts that were documented (that she had grown up in Ireland with her mother, had been orphaned at 5 years old, and had then moved to America). He did not obtain independent, corroborating evidence to verify the details of the 1920’s songs, jokes, etc. recorded by the second patient, but his subjective impression was that they were accurate reproductions, and that they certainly fit the “flapper” era of the patient’s youth. Because of the lack of independent, research grade collaboration, these case studies do not *prove* anything, but they strongly indicate that it is common to carry material in our minds that we cannot consciously remember.

Note also that the details of these case studies *do not* indicate whether the memories were repressed, dissociated, or just “lost” in the filing system, but they *do* indicate that the patients’ minds carried memory content that they could not access consciously. It is interesting to note that the “lost” material in the one patient’s case included her childhood memories up to and including the death of her mother.

“Recovered” memories with frontal lobe injury (pages 161-165): Dr. Sacks describes the case of a young man who murdered his girl friend while under the influence of the powerful hallucinogenic drug PCP, had no conscious memory of the murder, and then experienced spontaneous return of the “lost” memory four years later after traumatic injury to the frontal lobes of his brain. This case study is especially valuable because of the details that are carefully documented and corroborated, both legally and medically. There was enough carefully documented legal evidence to convict the young man of murder, even though thorough legal, neurological, and psychiatric examination (including hypnosis and sodium amytal injection –

“truth serum”) concluded that he had no conscious memory of the crime. An additional important point is that the details of the murder were so macabre that they were not revealed to the public or to the patient – the forensic examiners discussed them only with the judge.

During the fifth year following the murder, the patient was injured in a bicycle accident, sustaining serious damage to both frontal lobes of his brain. As he awoke from the coma resulting from this injury, he began having nightmares, and then vivid, detailed hallucinations of re-experiencing the murder. Dr. Sacks wondered whether the content of his nightmares and hallucinations were psychotic/fabricated/imagination, or whether they were accurate memory. He obtained permission to examine the forensic details documented in the legal records, previously known only to the judge and the forensic examiners, and found that every detail described by the patient matched exactly the details documented by the forensic examiners: “He was questioned in great detail, with the greatest care to avoid any hints or suggestions – and it was very soon clear that....*he now knew the minutest details of the murder: all the details revealed by forensic examination, but never revealed in open court – or to him.*”

Note that the patient accepted his sentence to an asylum for the criminally insane with the feeling that he deserved it (“I’m not fit for society”), and remained there for four years prior to his bicycle accident, still claiming that he had no conscious memory of the murder. Furthermore, he remained in the institution for the criminally insane after the bicycle accident and the return of conscious memory of the murder. Another significant point is that before the bicycle accident he felt some guilt about the murder, but did not seem to be intensely troubled by it. However, following the accident, when he reported spontaneous return of memories of the murder, he became tormented by these memories to the point that he attempted suicide twice, and had to be physically restrained and heavily sedated to prevent further suicide attempts. These observations/facts would argue against the possibility that he was simply lying about not having any memory in hopes of escaping or moderating punishment.

Note also that injury to the patient’s frontal lobes would be consistent with losing higher brain functions that had been blocking the memories of the murder through psychological defense mechanisms. This would be consistent with the observation that, after the injury, the horrific details of the memory came obsessively, constantly, and intrusively into his consciousness – as if he had suddenly lost the ability to “block” them from his conscious mind. This hypothesis that injury to his frontal lobes weakened/disabled the psychological defenses that had previously blocked these memories is also consistent with the observation that the memories continued to be accessible. That is, there was clear neurological evidence of permanent frontal lobe damage, and this fits with the clear psychological evidence of irreversible loss of his ability to “block” the traumatic memories from his conscious mind.²¹

Schooler, J.R. “Seeking the core: The issues and evidence surrounding recovered accounts of sexual trauma.” *Consciousness and Cognition*, 1994; 3, 452-469.

The 32 year old man described in this case study reports that he had forgotten about several

²¹ The memories did not come forward *temporarily* during the crisis stress of the injury and then disappear again, but rather *remained* accessible to his conscious mind. With extensive therapy, the memories lost their obsessive, intrusive, Post Traumatic Stress Disorder (PTSD) quality, but he was still able to recall the details of the murder if he chose to do so.

incidents of molestation that had occurred during early adolescence. The case study records him as stating explicitly “If you had done a survey of people walking into the movie theater when I saw the movie...asking people about child and sexual abuse, ‘Have you ever been, or do you know anybody who has ever been,’ I would have absolutely, flatly, unhesitatingly, said no!” However, at the age of thirty, after watching a movie portraying a person struggling with recollections of childhood sexual abuse, he was suddenly overwhelmed with vivid memories of his own abuse. Strong corroboration was obtained to support the accuracy of his recovered memories, in that the *perpetrator* then *acknowledged* the abuse.

Van der Kolk, BA, & Fisler, R. “Dissociation and the fragmentary nature of traumatic memories: Overview and exploratory study.” *Journal of Traumatic Stress*. 1995 October; 8(4), 505-525.

In depth interviews were obtained from 46 adults with Post Traumatic Stress Disorder (PTSD). Of the 36 with childhood trauma, 42% suffered significant or total amnesia at some time. Corroborating evidence supporting the historical truth of the childhood trauma was available for 75%.

Viederman M. “The reconstruction of a repressed sexual molestation fifty years later.” *Journal of the American Psychoanalytic Association*. 1995; 43(4): 1169-95.

The patient in this case study recovers memories of sexual abuse that had previously been completely repressed, and then also obtains corroboration (six years following termination of therapy the patient wrote a letter describing confirmation of the event from another person who had knowledge of what had happened).

Williams LM. “Recall of Childhood Trauma: A Prospective Study of Women’s Memories of Child Sexual Abuse,” *Journal of Consulting and Clinical Psychology*. 1994, Vol. 62, No. 6, pages 1167-1176; Williams LM. “What Does it Mean to Forget Child Sexual Abuse? A Reply to Loftus, Garry, and Feldman (1994),” *Journal of Consulting and Clinical Psychology*, 1994, Vol. 62, No. 6, pages 1182-1186; and Williams LM. “Recovered memories of abuse in women with documented child sexual victimization histories.” *Journal of Traumatic Stress*. 1995 October; Vol. 8, No. 4, pages 649-73.

129 women with histories of childhood sexual abuse documented at the time of the trauma were interviewed 17 years after the initial report and asked detailed questions about their abuse histories. 80 (62%) of the women recalled the abuse, 49 (38%) did not remember the specific incident that precipitated the documented hospital admission or any other incidents of abuse by the same perpetrator, but did report other abuse, and 16 (12%) of the women did not appear to have any memory of being abused. Thirteen of the women who recalled the abuse at the time of the interview reported that at some time in the past they had forgotten about the abuse. Williams specifically notes that the women with a prior period during which they had no conscious memory of the abuse – the women with “recovered memories” – did *not* recover the memories in therapy, or use special techniques (such as hypnosis) to search for them. Most of these women stated that they did not forget the abuse until years later, but two clearly and explicitly described forgetting each episode of abuse immediately after it occurred. 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.

Yovell, Y. et al. “Amnesia for Traumatic Events Among Recent Survivors: A Pilot Study” *CNS Spectrums*, September 2003 (Vol 8, #9) pp 676-685.

Yoram Yovell, MD, PhD, and his colleagues have recently published a study that is especially significant because the evaluation of memory was carried out *very quickly after the traumatic events occurred*,²² information from other sources regarding details of the events was also gathered shortly after the traumatic events occurred,²³ and the completeness and accuracy of recall was evaluated in long and detailed interviews that systematically probed for memory gaps. Instead of asking more general questions about amnesia, such as “Do you remember the traumatic event?” or “Are there any parts of the traumatic events that you don’t remember?” the interviewers asked the subjects to describe the events in detail, and then systematically probed for memory gaps. This systematic probing was especially effective because the interviewers used the information from other sources to guide their systematic questions. Since the evaluation interviews were conducted so quickly after the incident, psychogenic amnesia for traumatic details did not get mistaken for other “normal” forgetting processes – both the interviewers and the subjects expected that all the important details of the event would be remembered, and were therefore much more likely to recognize psychogenic memory gaps, as opposed to mistaking significant amnesia for “normal” forgetting processes that might be expected in the studies that don’t assess for psychogenic memory gaps until years after the traumatic events.

Dr. Yovell and his colleagues observe several very significant results:

All of the six subjects had some memory of the traumatic events (none of them demonstrated complete amnesia).

For details of moderate, or even severe emotional intensity, the subjects displayed the well documented pattern of *increased memory* detail and accuracy for events that were more emotionally intense.

However, amnesic memory gaps were observed under conditions of *extreme* stress (such as the moment of impact in an automobile accident), or for details that were *extremely* upsetting (such as the moment of seeing the dead body of the person in the other car). *Every one of the four subjects* that participated in the 1 week assessment interview demonstrated clearly delineated, complete amnesia for certain especially emotionally intense details of the traumatic events, and *all of the subjects* displayed this same pattern of clearly delineated, complete amnesia for certain especially intense details at both the 30 day and 120 day interviews.

²² All other research and case studies that I am aware of don’t evaluate amnesia for traumatic events until years after the actual events. However, this study was set up so that subjects could be recruited in the emergency room, only hours after the trauma occurred, and the interviews to assess completeness and detail of memory were then performed 1 week, 30 days, and 120 days after the traumatic events.

²³ Additional information regarding details of the traumatic events was gathered from ambulance reports, emergency room medical reports, emergency room psychological evaluations, and eye witness reports from others present at the scene of the trauma.

Most of the subjects were initially unaware of their memory gaps, and, in fact, specifically denied memory loss for any part of the traumatic events when questioned about this as part of the psychological evaluation at the beginning of the study. Most of the subjects did not perceive their amnesia until the interviewers systematically probed for possible memory gaps. NOTE that studies asking more general questions instead of systematic probing, and/or studies performed after a longer delay, probably would have missed the psychogenic amnesia in these subjects.

The following excerpt provides an example of the clearly defined memory gaps that were observed to cut out the most intense moments of traumatic events (from one subject's description of a fight with his father):

"I wanted to avoid any further violence, so I told him I was leaving. I went to my room to get my bag and he followed me, screaming. I don't remember how I got from the living room to my room. But when I got there I turned around and saw that he was holding a knife. He looked stunned. I raised my hands to protect myself and it was then that I felt a stream of blood coming from under my armpit. He must have stabbed me when I was on my way from the living room to my room, but I can't remember it happening." pg 679.

III. Summary

Suggestion, misattribution, and false memories are real: Careful examination of the whole body of evidence indicates that suggestion and misattribution are real phenomena, and that it is possible to cause serious memory errors if one uses imagination/guided imagery recovery tools, makes suggestive comments, and asks suggestive questions. People also distort memory spontaneously in order to downgrade painful implications. All of this is why it is *so* important to not suggest specific details regarding traumatic events and to not use imagination/guided imagery tools to "search" for traumatic memories. This is also why it is *so* important to be cautious about making specific accusations on the basis of remembered traumatic events. Focus on cooperating with Jesus to resolve the unresolved toxic content, sins, and demonic infections associated with the traumatic memories. When the person receiving healing has reached the perfect peace of Christ with respect to a particular set of traumatic memories, then she should ask Jesus whether or not she should take any action based on what she has remembered. She (or he) should also bear in mind the risks involved in making accusations. The ideal situation would include having clear corroborating evidence verifying the identity of the perpetrators.

Repression, dissociation, losing memories through avoidance and neglect, and "recovered" memories are also real: Careful examination of the whole body of evidence *also* indicates that memories for serious traumatic events can be lost to conscious awareness through avoidance and neglect, repression, and dissociation, and that most "recovered" traumatic memories have a core of historical truth (with common small memory errors regarding details).²⁴ This is why it is *so* important to start with the assumption of validity when a recipient reports traumatic events that they had not previously remembered.

IV. Addendum – Prophetic words of knowledge: The toughest discernment question regarding suggestion, misattribution, and memory errors is what to do with prophetic words of knowledge

²⁴ That is, proving that suggestion and misattribution can create serious memory errors does NOT prove that many/most/all recovered memories are false memories created by misattribution errors.

that include detailed imagery of some kind of abuse situation. For example, consider the following hypothetical scenario of the ministry facilitator getting a possible prophetic word of knowledge:

The facilitator sees an image of the recipient at the age of 8, in pink pajamas, in a small bedroom with bunk beds. She is on the top bunk, it's dark, the lights are out except a small night light to the left of the bottom bunk. There is a green rug on the floor in the shape of a teddy bear, and there is a window across from the bunk bed that is open. It's summer, there is a breeze blowing in the window, and the green curtains are blowing towards her. Her father comes into this scene and walks up to the bunk bed. She experiences fear and dread as this happens, and pretends to be asleep. He begins to fondle her.

If this is truly from the Lord, it can provide very valuable guidance for the facilitator as he makes judgment calls about direction for the session. If he shares this word of knowledge, it could provide an exceptionally powerful memory prompt, helping to clarify the recipient's choices, and helping to overcome psychological defense habits, brain biology ruts, and fallible filing systems.

If this is not from the Lord, and the facilitator shares the details, this could present very real risk of suggestion, misattribution, and memory error that could deeply wound the person receiving ministry and her family.

The thoughts, principles, and practical guidelines below will hopefully provide some tools with which to sort out how to use prophetic guidance and words of knowledge in emotional healing ministry settings.

A. Five phenomena that especially impair discernment: Triggered negative thoughts and emotions, triggered positive thoughts and emotions, resonance triggering, internal parts, and demonic deception are important specific phenomena to be aware of when evaluating the use of prophetic gifts in emotional healing ministry. All of these phenomena can dramatically interfere with discernment; and resonance triggering, internal parts, and demonic deception can produce thoughts and images that can be mistake for words of knowledge.

1 & 2. Triggered negative thoughts and emotions & triggered positive thoughts and emotions (in the facilitator):

a.) Triggered negative thoughts and emotions: Triggered negative thoughts and emotions will be produced by anything in the present that activates, or triggers, the memory content from traumatic experiences that have not yet been healed. When this happens, the distorted negative thoughts anchored in the memories and the painful emotions carried in the memories will come forward and feel true in the present. Furthermore, this content from the traumatic memories will usually come forward as implicit memory, so that the person has no awareness that it is memory content, but rather perceives that it belongs in the present and that it is valid and appropriate in the present.

b. Triggered positive thoughts and emotions: Triggered positive thoughts and emotions will be produced by anything in the present that comforts, covers, or counter-acts the pain in traumatic memories. The triggered positive thoughts will be the opposite of the distorted negative beliefs anchored in the trauma, and the triggered positive emotions will be the

opposite of the emotions usually associated with the erroneous trauma-anchored beliefs.

c. Impaired discernment: First of all, triggered negative thoughts will always carry distorted content that will directly mislead you, and the negative emotions associated with the distorted thoughts will also impair discernment. Secondly, with both triggered negative emotions and triggered positive emotions, the perceived importance of the trigger, the perceived validity of the triggered thoughts and emotions, and the subjective intensity of the triggered thoughts and emotions will all be exaggerated because they will match the importance, intensity, and perceived validity of the underlying trauma (as opposed to being appropriate for the current situation). This inflated perceived importance, perceived validity, and subjective emotional intensity will all impair discernment.

d. Triggering mistaken for guidance from the Holy Spirit: Subtle triggered negative emotions often result in the subjective experience of a vague, intuitive reluctance to do something – “I just get the feeling that I shouldn’t do this.” And this intuitive reluctance – this subjective experience of “I feel like I shouldn’t do this” – is easily mistaken for a “check in the Spirit.” In mirror image, triggered positive emotions often result in the subjective experience of vague, intuitive energy or pressure to do something – “I just get the feeling that I should do this.” And this subjective experience is easily mistaken for a “prompting from the Spirit.” Furthermore, triggered implicit memory thoughts and emotions always come with the intense subjective perception that they are real, and valid, and important in the present. This aspect of implicit memory adds conviction to triggered “guidance” that we mistake for a check or prompting from the Holy Spirit.

Our perception is that many people, including ourselves, have mistaken triggered thoughts and emotions for guidance from the Holy Spirit. The good news is that it is reasonably easy to tell the difference once you learn to recognize both triggered negative emotions and triggered positive emotions. See, “Guidance from Holy Spirit Vs Triggering”²⁵ for additional discussion of how triggering can be mistaken for guidance from the Holy Spirit, and especially for additional discussion of how to tell the difference.

3. Resonance triggering (in the facilitator): The phenomena of physical resonance provides a very helpful analogy for an important-but-often-subtle way in which unresolved traumatic memories in the therapist/facilitator can be stirred up. In physics, resonance occurs when the timing of a power source matches the timing of the receiving physical system. Pushing a child on a swing is an example we are all familiar with. Your push will do the most good if you push them at just the right time (when they have come to a stop right in front of you, and are about to start swinging away from you). If you push them at any other time, your pushing will not be as effective, or will even slow them down. Another way to understand resonance at an experiential level is to do a simple experiment with two tuning forks for the same musical note. If you strike the first fork, the second fork will start to vibrate as well. This is because it is *resonating* with the same note sound energy from the first.

We have observed a similar pattern with respect to unresolved trauma. If one person is describing details from, and expressing emotions associated with, certain unresolved trauma, then anybody else in the room with similar unresolved wounds will start to “resonate” – the

²⁵ Available as a free download from the Special Resources/Advanced Topics section of the Resources page of our Immanuel Approach website: www.immanuelapproach.com/special-subjectsadvanced-topics/.

words and emotions from the first person will stir up similar thoughts and emotions in anybody else who has similar unresolved trauma. We have often seen this in our group training settings, where everyone in the audience with unresolved traumatic memories similar to those being addressed in the demonstration will be crying by the end of the session. People facilitating emotional healing are no exception. If the therapist/facilitator has unresolved trauma similar to those being addressed in the ministry session, they will start to resonate with the person receiving ministry – the words and emotions of the person receiving ministry will stir up the therapist’s similar unresolved trauma.

When a facilitator resonates with the person receiving ministry, she can be unconsciously triggered to her own memories. Thoughts, words, and even images *from the facilitator’s own memories* might then come forward into her mind. If the resonance triggering is occurring in a subtle, quiet way, and the facilitator’s traumatic memories are not yet accessible to her conscious mind, she might mistake this phenomena for prophetic “words of knowledge.” Similar misattribution could also occur with images that are brought forward by resonance triggering, but that are from sources she has forgotten (for example, images from TV/movie content, imagination images associated with reading or stories she has heard, etc). Or it might be even more subtle. For example, if the facilitator was molested by an older cousin, but has not yet fully resolved these wounds, when the person receiving ministry starts talking about an older cousin the facilitator might “just get the feeling” that the older cousin is a creep, and that this older cousin probably molested the person receiving ministry.

If the facilitator doesn’t recognize this resonance triggering, and mis-attributes the material from her own triggered memories to guidance from the Holy Spirit, she might comment “I have a sense from the Holy Spirit that your cousin molested you.” Or she might describe the images from her own triggered memories: “I’m getting an image of a little girl, lying in her bed at night, and then the door opens and her older brother comes in and starts to fondle her,” and then comment “I think this is a word of knowledge – the Lord is showing me that your cousin molested you.”

4. Internal parts (in the facilitator): Internal parts can provide thoughts/words/images that can feel very distinct, “other,” and “from another source.” As discussed at length in the big lion book and in other essays, people can sometimes mistakenly perceive content coming from internal parts to be content coming from Jesus/the Holy Spirit.²⁶ And just as with resonance triggering, a facilitator might mistake thoughts and images from her own internal parts as words of knowledge from the Lord.

5. Demonic deception/counterfeits (affecting the facilitator): I would like to introduce this point with a case-study example of how demonic spirits can produce imagery that is mistaken for traumatic memory:

“Five year old Molly woke up with graphic dreams of sex and human sacrifice. She

²⁶ For additional discussion of content from internal parts being mistaken for content from the Lord, see the “Accidental Counterfeits from Dissociated Internal Parts” and “Dissociated Internal Parts and Deliberate Counterfeits” sections in chapter thirty two and the first eleven pages of chapter thirty-three from *The Immanuel Approach: For Emotional Healing and for Life*. See also “Dissociated Parts Presenting as Jesus,” available as a free download from the “Kleehman.com Website Archive” section of Special Subjects/Advanced Topics page of our Immanuel Approach website, <https://www.immanuelapproach.com/kleehman-com-website-archives/>.

described them in anatomically correct detail that few people but a surgeon would know. She and her parents had moved just before these dreams started terrifying Molly, so her family suspected she had been ritually abused in the town they just left. Soon after, a neighbor mentioned that the people next door were witches and had cursed Molly's new house. Without the girl's knowledge, her parents invited a prayer team to the house to cleanse it. From that point on Molly had no more bad dreams."²⁷

Especially in light of this example, if an emotional healing minister has unresolved trauma with associated demonic infection, it seems possible that these evil spiritual forces that are experts in deception could produce imagery that the minister might perceive as a word of knowledge for the recipient. (I have not personally seen this happen, but it certainly seems possible.)

B. Protections for using prophetic words of knowledge in emotional healing ministry: It is really important for emotional healing ministers who use prophetic words of knowledge to understand why it is *so* important to be *so* careful with words of knowledge that include details that suggest abuse. It is really important for these facilitators to maintain peak performance with respect to discernment. And it is really important for these facilitators to be able to tell the difference between thoughts and images produced by resonance triggering, thoughts and images produced by internal parts, thoughts and images produced by demonic spirits, and genuine prophetic words of knowledge.

1. Understanding these phenomena: Understanding how suggestion and misattribution can cause serious memory errors, and understanding the five specific phenomena just discussed in section "A." above, will help facilitators to *really* hold onto why it is *so* important to be *so* careful. And even just understanding these phenomena will help facilitators discern between true words of knowledge and thoughts and images from these other sources.
2. Deliberate attention and practice regarding these phenomena in their own experience. With deliberate attention and practice, facilitators can become increasingly self-aware regarding all of these phenomena in their own lives. Becoming more self-aware regarding all of these phenomena will increasingly improve their overall discernment. And with deliberate attention and practice regarding this specific discernment task, facilitators can become increasingly skillful at telling the difference between true words of knowledge and thoughts and images from other sources.
3. Immanuel Approach work for themselves: Being misled by positive triggering, negative triggering, resonance triggering, and internal parts can only occur where there is unresolved underlying trauma. Unresolved trauma/issues in the facilitator's own life will also make her more susceptible to demonic deception. Therefore, healing work to resolve their own trauma/issues will provide protection from all five of these problems. Once again, we strongly encourage all facilitators to embrace a lifestyle of regular, ongoing Immanuel Approach work for themselves.
4. Specific prayers and commands to block demonic deception: In light of the sobering risks associated with words of knowledge that include details suggesting abuse, if you are going to

²⁷ Wilder, E. James. *Red Dragon Cast Down*. (Grand Rapids, MI: Chosen Books), 1999, page 40.

include this piece in your Immanuel Approach work it is especially important to include specific prayers and commands to block demonic deception. For example, the “Opening Prayer” we use at the beginning of each ministry session includes commands that demonic spirits must manifesting only as Jesus allows, and this would certainly prohibit counterfeit words of knowledge.

5. Be very humble in presenting words of knowledge: Whenever facilitators perceive guidance from the Lord that they sense should be shared with the recipient during the session, they should always present this content very humbly and gently. For example, “Some thoughts are coming to me that I think may be guidance from the Lord. If you would like to hear them, let me know when there is a pause in your work with Jesus when I could share them without being disruptive.” This is especially important for words of knowledge that include details that suggest abuse.

6. Both facilitator and recipient ask Jesus for guidance and help: With a word of knowledge with details suggesting abuse, both the recipient and the facilitator should engage directly with Jesus regarding whether the apparent word of knowledge is genuine.

C. Risks and benefits: One option with respect to prophetic words of knowledge would be to just forbid facilitators from sharing any details that suggest possible abuse. This approach would certainly be safe. Unfortunately, this safe approach would also throw the baby out with the bath water.

I would like to propose that we approach words of knowledge with the same risk/benefit approach that we bring to many other situations in life. Many good things have risk (getting pregnant, driving a car, doing any kind of prayer ministry, etc). It is untenable to avoid everything that has risk. The way we deal with this reality in all other aspects of life is to weigh the risks and benefits in any given situation. For example, there is benefit with using guided imagery as a memory prompt, since this can be one of the most effective memory access tools in certain situations. But our assessment is that the *risks* of memory error from suggestibility and misattribution are *greater than* the potential *benefits*. In contrast, there is benefit with using words of knowledge as part of Immanuel Approach work, since they can be one of the most powerful resources for helping recipients to find buried traumatic memories. And (as opposed to guided imagery), our assessment is that the potential *benefits* are *greater than* the *risks*.

Another important part of thinking clearly is to include consideration of the risks of *not* doing something. Charlotte’s grandfather’s experience provides especially clear examples. Grandpa Stringham was a doctor on the mission field, and in some situations the *risk of death* from a certain surgical intervention might be thirty, or even *fifty* percent. OF COURSE he shouldn’t do the procedure...right? One simple-but-important fact changes the whole picture: the risk of death if he did *not* perform the procedure was 100%. Sometimes, if an effective ministry tool is not used, the person is unable to minister effectively, or loses his job, or loses his marriage, or hurts his child, or even commits suicide. Words of knowledge are not risk free, but sometimes *not* sharing them is even more costly.

D. Guidelines regarding prophetic words of knowledge (our assessment regarding the risk/benefit analysis):

1. Words of knowledge that include details regarding non-abuse trauma: If the protections

described above are applied, there is minimal risk with words of knowledge that do **not** include details that indicate possible abuse. And again, these words of knowledge can be very valuable in helping recipients find and/or acknowledge trauma. For example, in his book, *Authority to Heal*, Ken Blue reports the following experience:

“I prayed over a woman who suffered from a host of stress-related ailments. She was chronically tired and was in constant pain because of muscle tension. I thought that if we could deal with the source of the stress, we could more effectively pray for healing. When I asked her what the stress was, she said she didn’t know. Then in my mind I saw this woman sitting in the corner of a room, tears streaming down her face, holding a broken doll. I asked her if she had ever had an abortion. She stared back at me, wide-eyed, and whispered, ‘My husband doesn’t even know about it.’ After a time of confession and receiving God’s forgiveness, her pain left and her energy returned. She has been fine ever since.”

So facilitators who receive words of knowledge regarding **non-abuse** trauma should feel free to include them as part of their Immanuel Approach work.

2. Words of knowledge that include details suggesting abuse: Words of knowledge that **do** include details that indicate abuse can be tremendously valuable for helping the recipient remember and/or acknowledge trauma, just as with words of knowledge for non-abuse trauma. But words of knowledge for abuse trauma also carry tremendous risk. Again, *describing detailed scenarios will cause the person to create imagination-based mental images of what is being described, even if it never occurred, and these mental images can be mistaken for actual memory.* And if a counterfeit “word of knowledge” leads the recipient to falsely believe that she has been abused, and then to make allegations against some innocent person, the facilitator will have caused serious harm. Therefore, our recommendation is that only ministers/therapists who are minimally triggered during ministry, who have a setting where they receive regular, ongoing healing ministry for themselves, who are very mature, and who have clear, thorough understanding of suggestion, misattribution, memory errors, resonance triggering, positive and negative triggering, internal parts phenomena, and demonic deception should even consider sharing details from a possible word of knowledge that indicates abuse.

Even if you meet all of the above criteria, you still need to be very careful:

- Be especially thorough in applying the protections described above.
- Assess the risk/benefit balance very carefully.
- Start with the details that do not include abuse, and see whether the recipient will connect with the rest of the memory on her own.
- Include the details that indicate abuse only if nothing else seems to work.
- DO NOT take this last step if you have trouble mistaking your own thoughts/triggering for the Lord’s guidance.

NOTE: It would be very helpful for us to have more case-study information regarding both true and counterfeit words of knowledge that included details indicating abuse. If you have experienced either of these, or know of others who have, please contact me at drkarl@kclehman.com.