

Title	Recovered memories and clinical practice
Authors	Carey, Oisín
Publication date	2025
Original Citation	Carey, O. 2025. Recovered memories and clinical practice. DClinPsych Thesis, University College Cork.
Type of publication	Doctoral thesis
Rights	© 2025, Oisin Carey. - https://creativecommons.org/licenses/by/4.0/
Download date	2026-10-28 09:12:54
Item downloaded from	https://hdl.handle.net/10468/17937

Recovered Memories and Clinical Practice

Thesis presented by

Oisín Carey

for the degree of

Doctor of Clinical Psychology



Supervisors: Dr Gillian Murphy and Dr Maria Dempsey

University College Cork

School of Applied Psychology

April 2025

Declaration

This is to certify that the work I am submitting is my own and has not been submitted for another degree, either at University College Cork or elsewhere. All external references and sources are clearly acknowledged and identified within the contents. I have read and understood the regulations of University College Cork concerning plagiarism.

Signed:

_____ 29/04/2025

Oisín Carey

Acknowledgements

I would like to thank all of the clinical psychologists who volunteered their time and wisdom in support of this research project. I would like to thank my research supervisors, Dr Gillian Murphy and Dr Maria Dempsey, for all of their support throughout this research project, guiding me and working through all the complexities with me. Thank you to all of my classmates for being part of this journey with me, and to the UCC Clinical Psychology Doctoral course team for the help along the way. My earnest thanks to my family for your unwavering belief in me. I am eternally grateful to my fiancée—you have been my rock.

Table of Contents

Declaration	2
Acknowledgements.....	3
Table of Contents	4
Thesis Abstract.....	8
Thesis Overview	9
Chapter 1: When, Where, and How Often do Individuals Recover Memories of Traumatic Experiences? A Systematic Review.	
Title Page	13
Abstract	14
Introduction.....	15
Method	22
Results.....	26
Discussion	48
References	54
Chapter 2: Methodological Challenges and Critical Foundations of the Systematic Review on Recovered Memories.	
Rationale for a Systematic Review	67
Scope of Systematic Review.....	71
Protocol Development	72
Purposive Sample Studies.....	76
Quality Appraisal Considerations	79
Excluded Studies Despite Relevance.....	79

Conclusion	80
References	82

Chapter 3: Strategic Ambiguity: A Reflexive Thematic Analysis of Irish Clinical Psychologist Perspectives on Recovered Memories of Trauma.

Title Page	88
Abstract	89
Introduction.....	90
Transparency and Openness	92
Methodology	93
Analysis.....	98
Discussion	122
Conclusion	127
References.....	128

Chapter 4: Navigating Methodological Reflexivity, Researcher Positioning, and Epistemological Integrity in Reflexive Thematic Analysis.

Introduction.....	134
Epistemological Commitments and Theoretical Framing	134
Researcher Positionality.....	136
Analytic Approach.....	138
Reflections on Analytic Product	140
Conclusion	141
References.....	143

Chapter 5: Towards A Therapeutic Model For Management Of Recovered Memories.

False Memory Theory: Avoiding Iatrogenic Practice	146
Non-Repression Theories of Recovered Memories	147
Self Memory System and Stages of Autobiographical Memory Retrieval.....	148
Mapping Retrieval Stages to Therapeutic Interventions.....	150
Limitations and Future Directions	156
References	158
Conclusions: Caution And Care Need Not Be In Opposition.....	164

Appendices:

A: Journal Guidelines, <i>Memory</i>	170
B: Systematic Review Prevalence Quality Assessment	175
C: Studies Excluded from Systematic Review at Full-Text Screening	180
D: Journal Guidelines, <i>Clinical Psychological Science</i>	185
E: Ethical Approval Application and Confirmation	191
F: Participant Information Sheet.....	197
G: Interview Protocol.....	199
H: Consent Form.....	201
I: Reflexive Thematic Analysis Analytic Stages and Audit Trail.....	202

Tables:

Table 1: Summary of included studies using survey research design	28
Table 2: Therapist-report studies summary	34
Table 3: Purposive samples studying characteristics of people reporting recovered memories.....	40
Table 4: Categorisation of the definitions utilised to conceptualise and operationalise ‘recovered memories’	46
Table 5: Screening guide document.....	76
Table 6: Participant pseudonyms with details of occupation and education	95
Table 7: Stages of Autobiographical Memory Retrieval: Mechanisms, Inhibitory Factors, Memory Distortion Risks and Therapeutic Interventions.....	151
Table 8: Quality assessment of included systematic review studies.....	177
Table 9: Studies Excluded from Systematic Review at Full-Text Screening....	180

Figures:

Figure 1: PRISMA Flow Diagram.....	25
Figure 2: Thematic Map of Themes and Subthemes	99
Figure 3: Knowledge structures in autobiographical memory.....	149

Thesis Abstract

Recovered memories of trauma and abuse remain clinically and theoretically divisive, despite the decline in public controversy since the Memory Wars of the 1990s. This thesis aims to synthesise the contemporary evidence base, explore clinician perspectives, and develop a clinical model for managing recovered memories grounded in cognitive science. A systematic review of 42 empirical studies published since 2000 revealed that recovered memories remain relatively common, but definitional inconsistencies hinder clear prevalence estimates. A qualitative study using reflexive thematic analysis of interviews with seven Irish clinical psychologists found that therapists employ ‘strategic ambiguity’ to navigate the epistemic and ethical challenges posed by recovered memories, often compensating for gaps in professional training. Drawing together insights from memory science and clinical practice, a novel staged-intervention model is proposed to minimise risks of memory distortion while enabling therapeutic engagement with ambiguous memory content. The thesis advocates for improved prevalence research, a practical framework for clinicians, and educational reforms to bridge the persistent scientist-practitioner gap regarding recovered memories.

Word Count of Overall Thesis, Excluding Titles, References, and Appendices:

35,171

Thesis Overview

Background

Recovered memories of trauma and abuse have been a divisive concept in psychology for almost four decades. With a history connecting back to the very foundation of talk therapy—rooted in Freudian repression theory and associated with early hypnotism and mesmerism—recovered memories became a flashpoint in a major moral panic in the United States of America during the 1980s and 1990s. The ‘Satanic Panic’ involved a media frenzy about recovered memories of satanic ritual abuse and a movement of therapists offering to recover repressed trauma memories, with numerous resulting accusations and legal cases. These early trauma theories posited that overwhelming experiences of abuse were repressed and held outside of conscious awareness while causing mental health symptoms, and that their symptoms could be relieved by the successful retrieval of those memories.

In the 1990s, a movement arose in response to the Satanic Panic, dubbed the ‘Memory Wars’. Concerns arose that many of the recovered memories were not accurate, proposed to reflect a pattern of memory distortion dubbed ‘false memory syndrome’ by its proponents. Legal advocacy organisations formed to support the defence of the alleged abusers, such as the False Memory Syndrome Foundation (FMSF) in the USA, the British False Memory Foundation (BFMF) in the UK, and other similar organisations internationally including in Australia and the Netherlands. Among cognitive scientists, emerging laboratory evidence demonstrated that false memories could be implanted in members of the public, and this resulted in criticism of suggestive practices among legal professionals (e.g., leading interview questions) and therapists (e.g., the use of hypnotism to encourage the retrieval of repressed memories) which risked false memory formation. This represented a paradigm shift in memory science, supplanting earlier

models that treated memory as a stable repository of stored representations, with a view of memory as dynamically reconstructive at every retrieval, and thus malleable and susceptible to internal, social and environmental influences. Psychologist accreditation organisations such as the American Psychological Association (APA) and the British Psychological Society (BPS) issued cautionary guidance regarding the risk of false memory formation as a result of the use of memory recovery techniques and suggestion.

By the 2000s, the controversy had largely calmed. Media interest in repressed memories had significantly reduced, the legal system had reformed its use of suggestive interviewing tactics, reliance on eyewitness testimony, and acceptance of memories recovered in therapy as evidence in court. Therapists had begun to disavow repression theories and started to rely on less risky techniques and models of therapy. It seemed that the Memory Wars had ended, and the associated false memory advocacy societies had begun to close, e.g. the FMSF in 2019 and the BFMS in 2023 due to lack of cases and successes in influencing the training of legal and law enforcement professionals, along with therapists. Despite the decline in public and legal controversy, professional guidance on managing such memories in therapy has remained fragmentary, cautious, and largely unchanged since the 1990s.

Current Landscape

At the time of the Memory Wars and subsequently, many professional mental health associations produced guidelines regarding recovered memories, but into modern times ambiguities and incongruencies have emerged. The BPS, as a key institution influencing clinical psychology practice across the UK and more broadly, produced '*Recovered Memories: The Report of the Working Party of The British Psychological Society*' in 1995, drawing attention to the possibility of "*the emergence of memories of trauma which are not immediately available to*

the client's consciousness" (p. 25) and "*the therapist should be alert to a range of possibilities, for example that a recovered memory may be literally true, metaphorically true or may derive from fantasy or dream material*" (p. 25). The BPS magazine *The Psychologist* published a number of relevant articles on the topic subsequently, e.g., updated draft guidelines in 1999 and an updated review of the evidence of the risk of false memories in 2006—however, official guidance did not change, retaining the underlying core message of caution and uncertainty. In contrast, in 2023 the BPS published '*Guidance on responding to disclosures of non-recent (historic) child sexual abuse: Safeguarding and support implications*', which indicated a significant divergence from prior guidance by citing the Crown Protection Service to state "*there is no substantive evidence that therapy will generate 'false memories'*" (p. 35), and that the primary issue for practitioners is to be aware of how such framings of evidence can be detrimental to a client's legal case—an apparently radical rejection of prior guidance over previous decades. This incongruence remains unresolved, with most other similar institutions not having updated their guidance to practitioners, e.g., the APA having similar cautionary guidance to the BPS but not having updated guidance since its statement in 1995, "*A competent psychotherapist will attempt to stick to the facts as you report them. He or she will be careful to let the information evolve as your memory does and not to steer you toward a particular conclusion or interpretation...A competent psychotherapist is likely to acknowledge that current knowledge does not allow the definite conclusion that a memory is real or false without other corroborating evidence.*"

Further, recent literature reviews have argued that the Memory Wars did not end after all. It has been provocatively argued that dissociative amnesia, a DSM-5 condition which refers to significant memory loss associated with a traumatic or stressful event, has been developed as a

mere relabelling of repressed memory theories, allowing for a continuation of problematic theory and practice in mental health fields. People continue to report recovered memories of abuse or trauma in significant numbers well into modern times, and surveys of practicing therapists of all disciplines show that large numbers of practitioners continue to hold controversial beliefs about the possibility of repressed memories coming to the surface in therapy. In the absence of public controversy, many of the core issues appear to remain in the present day, and therapeutic guidance on recovered memories has remained virtually unchanged since the 1990s. This indicates significant risks for clients, and indicates an urgent need for the evidence base to be reviewed in a manner that will facilitate the emergence of clear, uncontroversial clinical guidelines. A new approach is needed: one that not only cautions practitioners, but also offers a theoretically coherent, active, and practical framework to guide clinical practice.

The purpose of this thesis is to draw together the evidence base regarding recovered memories that has developed in the modern era, to synthesise clinically-relevant insights, and to map out a pathway towards closing the scientist-practitioner gap between the cognitive science of memory and modern trauma-informed therapeutic practice. Therefore, the thesis asks the following questions:

1. How often, where, and under what conditions do recovered memories surface?
2. How do clinicians currently conceptualise and manage such cases?
3. How can memory science principles be synthesised into a framework to describe best practice therapy in the specific context of recovered memories?

Chapter 1 starts with a systematic review of the evidence base since the year 2000. It is apparent that recovered memories of trauma and abuse remain a significant clinical phenomenon into the present, with people reporting recovering memories outside of therapy and during

therapeutic engagements, and therapists report robust experience with clients recovering memories internationally. Significant definitional issues regarding recovered memories became apparent due to a lack of consensus among researchers, and participants (both the general public and therapists) frequently report experiences as recovered memories which do not match operational definitions.

Next, in Chapter 2 the methodology of the systematic review is explored in depth, noting challenges in the evidence base that preclude the pooling of prevalence estimates to conduct a meta-analysis. Studies that were excluded at full text screening are also explored briefly to note the consequences of definitional issues in the field preventing full synthesis of the evidence regarding recovered memories.

Chapter 3 transitions to a more explicitly practice-focused aim, exploring the perspectives and meaning making of Irish clinical psychologists regarding recovered memories. Reflexive thematic analysis (RTA) of interview data reveals a core ‘strategic ambiguity’ among participants, where practitioners intentionally avoid epistemic closure as a means of preventing the dual iatrogenic risks of invalidating clients’ recollections and also of distorting memories through suggestion. Using broad definitions of recovered memories, they described providing trauma-informed treatment—not specific to recovered memories—but specifically dealing with the ambiguities and uncertainties that arise in this context. They described managing significant educational gaps on the topic of traumatic memories during professional training, relying on continuing professional development and their own reading to gain knowledge in this area, noting the inadequacy of cautionary guidance and instead relying on trauma theories to guide treatment.

Chapter 4 explores the ontological and epistemic commitments entailed in the RTA approach to qualitative research, aiming to make transparent the reflexivity and decision making that went into completing this research. The dialectical approach taken to the recovered memory topic is explored in more detail, as is how my positionality affected the direction and content of the analysis. It makes the connection between the strategic ambiguity that interviewees described in therapy with recovered memories, and my own disinclination towards epistemic closure regarding the realities of recovered memories.

Finally, Chapter 5 stands as the thesis's third empirical contribution, a novel, preliminary model for best practice in therapy with recovered memories, integrated with modern memory science. Grounded in the prevalence patterns and broad recovered memory definitions found in Chapters 1 and 2, the practice-based knowledge and 'strategic ambiguity' evidenced in Chapter 3, and modern cognitive science models of autobiographical memory, it proposes a model of therapy for recovered memories. The central claim is that the correct timing and staging of therapeutic interventions can minimise the risk of memory distortion—crucially, without therapists needing to avoid addressing ambiguous memories in therapy.

Taken together, Chapters 1 and 2 show a robust clinical phenomenon of recovered memories which defies accurate prevalence estimation due to definitional problems; Chapter 3 explores the practice-based constraints and needs of clinicians; Chapter 4 ensures the epistemic footing of this qualitative research; and Chapter 5 synthesises these threads into the first therapeutic model to guide work with recovered memories. As such, the thesis moves from asking "*how often and in what conditions do recovered memories occur?*" to "*how do clinicians manage recovered memories currently?*" to "*how can cognitive science translate into safer*

practice?’. The goal is to set out a pathway towards closing the scientist-practitioner gap regarding recovered memories.

Glossary

Recovered memories:

Refers broadly to the phenomenon whereby individuals recall traumatic experiences (often childhood sexual abuse) that they had not been able to access or recall for a significant period.

Definitions vary across contexts; some imply repression and later retrieval, while others simply denote delayed recall or later reinterpretation of memories which have not been thought about for lengthy periods of time. This thesis argues that ‘recovered memory’ is a term characterised by definitional ambiguity and different philosophical assumptions across studies. For the duration of the thesis, this term is used as an umbrella term without implying a specific mechanism.

Repressed memories:

A psychoanalytic concept positing that certain traumatic experiences can be excluded from conscious awareness through a defence mechanism, yet influence behaviour and symptoms until recalled, typically through therapeutic intervention.

False memory syndrome:

A term popularised by the False Memory Syndrome Foundation to describe cases in which individuals develop detailed but inaccurate memories, often of traumatic events, through suggestion or therapeutic techniques. The term is not recognised as a formal psychiatric diagnosis and is considered ideologically loaded by many clinicians.

False memory:

A term developed through cognitive science experimentation demonstrating that research participants can be induced to report recalling events which did not occur and that were intentionally implanted by experimental manipulations such as priming and misinformation effects. It has been suggested that suggestive interviewing techniques among law enforcement professionals, along with therapeutic memory recovery techniques such as hypnotic age regression and guided visualisation, can induce false memories.

Dissociative amnesia:

A DSM-5 diagnosis referring to an inability to recall autobiographical information, usually of a traumatic or stressful nature, inconsistent with ordinary forgetting, substance abuse, and physiological causes of amnesia.

Constructive Memory

A theoretical model in cognitive science that emphasises the reconstructive nature of memory, positing that each act of remembering involves active reconstruction influenced by internal and contextual factors. This model underpins critiques of memory accuracy, particularly in research on eyewitness testimony but also including in clinical settings.

Memory Wars

Refers to the 1990s-era intellectual, legal, and clinical controversy over the validity of recovered memories of abuse, especially in the context of therapy. It involved sharp divides between

proponents of trauma theory and false memory theory, and between clinicians and cognitive scientists.

Note:

Chapter 1 is formatted for submission to the journal *Memory*, and Chapter 3 is formatted for submission to the journal *Clinical Psychological Science*. The supplementary materials for these chapters are uploaded to OSF (links provided), but are also included in the Appendices of this thesis for ease of access.

Chapter 1: When, Where, and How Often do Individuals Recover Memories of Traumatic Experiences? A Systematic Review.

Oisín G. Carey¹  <https://orcid.org/0009-0002-3766-5906>, Keith Minihane*¹ 
<https://orcid.org/0000-0001-7064-7457>, Maria Dempsey¹  <https://orcid.org/0000-0002-7001-0568>, Gillian Murphy¹  <https://orcid.org/0000-0001-8898-139X>

¹School of Applied Psychology, University College Cork, Cork, Ireland.

Corresponding author: Oisín G. Carey

Acknowledgements

The lead researcher's Doctorate in Clinical Psychology, during which this study was conducted, was partially funded by the Irish Prison Service.

Disclosure of Interest / Funding Details

No potential conflict of interest was reported by the author(s). This research received no external funding.

Word Count (excl. Title, References, and Appendices)

10,473

Data Availability Statement

Data supporting this review are derived from published studies listed in the References and the quality assessment in Appendix B, available at <https://osf.io/b7c2j/>.

Prepared in accordance with the journal guidelines for *Memory* (Appendix A). Submitted 25th March 2025, under review at time of submission.

*Co-author participated as second reviewer during screening.

**For the purpose of examination, figures and tables have been included in the text rather than separate file.

Abstract

The phenomenon of recovered memories of childhood abuse—memories recalled after a period of not remembering—remains controversial and poorly defined. Here, we report a systematic review of empirical research (since 2000) on the rates at which recovered memories are reported in various populations and contexts, examining definitions, triggers, and methodological approaches. In total, 42 studies were included. Reported rates of recovered memories varied widely, from approximately 3% in legally corroborated cases, to approximately 7% in self-reported general public samples, to as high as 39% in self-reported samples of adults with childhood abuse histories. Definitions of recovered memories differed substantially, ranging from strict criteria (total amnesia followed by sudden recall) to broader interpretations (partial forgetting or reinterpretation). Contextual factors—such as whether samples were drawn from the general population, clinical populations, individuals with documented histories of CSA (childhood sexual abuse), or legally corroborated cases—further influenced the frequency and nature of reported memory recovery. We conclude that recovered memories are commonly encountered in clinical settings, with many therapists internationally encountering this phenomenon at least once. Future research should strive for clearer operational definitions, standardized methodologies, and careful consideration of how clinical practices may shape memory reporting.

Keywords:

Recovered memories, childhood sexual abuse, systematic review, prevalence, trauma therapy, dissociative amnesia, false memories.

Recovered memories (RM), where individuals recall long-forgotten traumatic experiences, remain a contentious topic in psychology and psychotherapy (Patihis et al., 2014; Otgaar et al., 2019). Members of the public across Western countries continue to report recovering memories both inside and outside therapy into the present day. Reports of varying degrees of forgetting appear to be relatively common among adults who experienced traumatic events during childhood, though rates vary depending on the sample, and the specific questions asked.

Early studies reported rates of RM between 15-59% in general public samples and in a sample of clients accessing sexual abuse treatment, respectively (Briere & Conte, 1993; Elliott, 1997), however the degree of amnesia was loosely defined, e.g. allowing for some memory loss vs. full amnesia for the event. Elliott (1997) reported that the most common triggers of recall were television shows and films, with psychotherapy being the least frequent trigger for recall. Recent studies report that 5-11% of therapy clients recall abuse during treatment (Patihis & Pendergrast, 2019; Dodier et al., 2019). Additionally, up to 13.3% of people not in therapy report recovering memories (Dodier & Patihis, 2021). A multitude of narrative reviews have been published on the topic of RM (e.g., Kearney et al., 2023; Loftus & Davis, 2006; McNally, 2001; Otgaar et al., 2019; Piper et al., 2008; van der Kolk, 1998), along with recent bibliometric analyses (Dodier, 2019; Pope et al., 2023), and a case study review of dissociative amnesia cases by Mangiulli et al. (2022). However, to date, no study has systematically synthesised the available empirical data concerning the rates of people reporting RM, or the contextual factors associated with memory recovery.

Despite extensive research, no clear consensus has emerged regarding the validity of RM, leading to a scientist-practitioner divide (Patihis et al., 2014). The concept of ‘repressed memory’ has been strongly criticised as impossible to prove, where more simple explanations are often

readily available. It has been argued that theorists have simply carried forward discredited theories of repressed memories by relabelling these experiences as dissociative amnesia (Otgaar et al., 2019), such that dissociative amnesia has become a synonym for repressed memories (McNally, 2018).

Research highlights individual susceptibility to implanted false memories, raising concerns about similar risks in psychotherapy (Otgaar et al., 2019; Scoboria et al., 2017). In contrast, many mental health practitioners report belief in reports of remembering long-forgotten trauma and abuse (e.g., Zappalà et al., 2024). Emerging evidence suggests that increased education regarding the science of memory significantly impacts beliefs about RM (Otgaar et al., 2022b). However, discourse on RM remains polarized between two primary perspectives: trauma-based theories (based on the diagnostic category of dissociative amnesia) and false memory theories (based on the impact of suggestion).

Trauma theories of recovered memories

The first generation of talk therapists believed that traumatic memories can be pushed out of conscious awareness by the defence mechanism of repression (Freud, 1940; Ross, 2022). Initially, Freud described repression as a process of motivated forgetting, inhibition, and suppression of awareness of the abuse, interchangeably using the terms repression and suppression (Anderson, 2020). It has been claimed that Anna Freud introduced the differentiation between conscious suppression (with awareness of trying not to think of something) and unconscious repression (without awareness of the memories or their meaning) (Erdelyi, 2006). These attempts to clarify Freud's contributions have been critiqued as removing the distinct psychoanalytic character of the concept of repression, highlighting that Freud's central

contention was that patients experiencing mental health symptoms needed to have their symptoms interpreted as derived from repressed memories of childhood abuse so that the memories could be recovered and emotionally processed (McNally, 2006). In a modern update, Van der Kolk's (1998) dissociation theory proposes that traumatic experiences may be stored only at a somatosensory-affective level. Overwhelming emotional content means that the memories are not narrated or integrated into autobiographical memory and instead are fragmented or dissociated. This creates an obstacle to memory retrieval.

Freud situated repression in the context of an internal psychological conflict, where repression defends against incompatible ideas or memories that are distressing to the child's emerging self-concept (Freud, 1953–1974). Reduced awareness of abusive behaviour has been suggested as a mechanism to allow children to maintain attachment behaviours based around approaching rather than withdrawing from primary caregivers, prioritising attachment over safety for evolutionary reasons (Boag, 2012; Sivers et al., 2002). Freyd et al. (2007) named the overall experience “betrayal trauma,” with some evidence that reports of forgetting abuse are more frequent in cases of incest and parental abuse (Sivers et al., 2002). Freyd tentatively linked this experience of forgetting with pressure to be silent and deny experiences of abuse by those with power over the child or adolescent (Freyd, 1997). This is consistent with emerging evidence that disclosure of abuse can have a long-term detrimental impact in cases where disclosure does not lead to the abuse stopping and treatment being accessed (Swingle et al., 2016). Dissociation would serve to prevent abusive memories coming into awareness due to the risk of damaging essential caregiver relationships.

False memory theories of recovered memories

In the USA during the 1980s and 1990s, the ‘Satanic Panic’ spread among the public due to a number of high-profile cases of people recovering repressed memories of Satanic child abuse cults (Hughes, 2017). Many of these cases proved to be false or highly implausible, with 60 exonerations post-conviction recorded between 1984 and 1998 (National Registry of Exonerations, 2023). This period led to the ‘Memory Wars’ in academic psychology during the 1990s, in which serious objections were raised regarding claims of uncovering repressed memories (Lynn et al., 2023). A growing population of ‘retractors’ has been identified, i.e. people who later concluded that their RM of abuse were false (e.g., de Rivera, 2000; Kenny & Felstead, 2024), and a number of high-profile legal cases have provided evidence of instances of therapists implanting false memories of abuse in clients (e.g., Otgaar et al., 2017; Otgaar et al., 2022a). Otgaar et al. (2019) argue that the use of dissociative amnesia diagnoses perpetuates these same iatrogenic therapeutic practices and that the ‘Memory Wars’ never ended.

Under particular scrutiny were practices popular in psychotherapy at the time, dubbed “memory work,” in which therapists interpreted symptoms of depression or somatic presentations as evidence of hidden trauma. A proportion of therapists were making diagnoses of repressed memories of abuse on this basis and were attempting to bring these memories to their clients’ conscious awareness using a variety of techniques (Loftus, 1994). It was claimed that therapists were inadvertently pressuring clients into recalling false memories of abuse through their position of power and authority, along with strong suggestion akin to (and sometimes in the context of) hypnosis (Loftus, 1993). Criticisms of the repressed memory paradigm emerged from research into the cognitive psychology of memory, dovetailing with research into eyewitness testimony in the context of police interviewing and evaluating the reliability of legal evidence.

The core theory is that human memory is fundamentally reconstructive, where post-event information is frequently incorporated into memories of the event during subsequent retrievals (Wells & Loftus, 2003). Memory implantation experimental paradigms often involve accessing a list of the participant's memories from family members, adding an additional but false memory to the list, then presenting the full list as true family-provided memories to the participants (Hyman et al., 1995; Loftus & Pickrell, 1995; Murphy et al., 2023). In some studies, instructions were given to elaborate beyond the suggestion or engage in imagery visualisation of the false memory. Scoboria et al. (2017) completed a 'mega-analysis' of experimental studies, finding that over 30% of participants showed evidence of accepting a suggested false memory. While some criticise this evidence base as lacking ecological validity (e.g., Pezdek & Lam, 2007), there are ethical limitations on the type of evidence experimental research can produce.

In practice, multiple case studies provide evidence of suggestion and social contagion effects in false memory development. Otgaar et al. (2017) offer evidence of a therapist suggesting abuse to a child using dolls, followed by letters home from the school which influenced the entire class, resulting in a swathe of bizarre and falsifiable abuse claims against their teachers. Otgaar et al. (2022a) explored the recorded sessions of an Italian therapist who was prosecuted for causing psychological injuries, inducing false memories of abuse using intensely suggestive interviewing methods, direct suggestions of ongoing amnesia for abuse, and lengthy memory recovery sessions. These and other case studies provide direct evidence of the potential harms that unethical therapeutic practices can cause – when unconscious trauma or abuse is assumed *a priori*. Theorists in this area have taken an additional step of hypothesising that the forgetting of traumatic memories may be a culture-bound syndrome that is specific to modern Western societies, suggesting that these ideas spread from therapeutic circles to popular

media via television and books (Pope et al., 2007). This research has been critiqued as overly general due to the existence of historic narratives of forgetting and remembering trauma dating back to Shakespeare and even to the first century AD (Goldsmith et al., 2009), and recent cross-cultural reviews of dissociative symptoms emphasise that, while there are significant cultural differences, there is a shared symptomatic core which is also seen in non-Western psychiatric populations (Şar, 2022). While further research is needed, it is likely that recovered memory phenomena are culturally mediated.

Ordinary memory mechanism theories of recovered memories

In opposition to a simplistic dichotomy, many researchers have posited mechanisms for RM that are entirely consistent with how ordinary, non-traumatic memory systems function. Theorists of betrayal trauma have walked back the use of terms like “amnesia,” arguing for a mechanism-agnostic stance of “knowledge isolation” which can be explained by ordinary forgetting due to lack of rehearsal opportunities, or by active inhibition of memories and associated affects (Freyd et al., 2007). Survey research on RM (e.g., Dodier & Patihis, 2021) indicates that large swathes of the public often interpret their experiences as RM, when actually they are reporting a process of reinterpreting continuous memories as abusive (i.e., I did not know that this was an abuse memory until I reflected on it later in life). McNally (2018) notes that there are many reasons for people to forget traumatic experiences, which crucially often preclude the possibility of recovering the memories: head injuries, substance abuse, childhood amnesia, lack of encoding during the events, etc. McNally (2018) also notes the crucial difference between non-remembering and non-disclosure – many CSA survivors are embarrassed and ashamed of having been victimised and will be highly reluctant to share their experience

with acquaintances or strangers. McNally and Geraerts (2009) review a number of ordinary memory mechanisms that can explain how people experience RM: non-traumatic forgetting, where the initial abuse experience was not accompanied by terror or pain; the absence of environmental cues to trigger memory of the abuse (e.g., the abuser moving away soon after the abuse); deliberately not thinking about the abuse (conscious, cognitive avoidance); and the forgot-it-all-along effect (i.e., forgetting the previous times that they remembered the traumatic events over the years).

The Current Study

There is a need to draw together the current state of knowledge about RM—an umbrella term which seems to capture several important but possibly distinct ways of forgetting and remembering. The period during the Memory Wars was characterised by a moral panic in the USA, and researchers taking sides in a weighty debate about what constitutes legal evidence of historic abuse. Since the end of this period, much more research has been completed, necessitating an updated review of the evidence. Members of the public still seem to report RM, despite the end of the Memory Wars (e.g., Patihis & Pendergrast, 2019). Furthermore, people still attend therapy and report having RM within therapy, just prior to engaging in therapy, or after their therapy has concluded (Leavitt, 2001), thus the perspectives of mental health clients and also practicing mental health professionals need to be captured. This is the first systematic review of this evidence, applying a descriptive approach which is mechanism-agnostic. It seeks to explore estimates of the how often people report recovering memories across contexts, to establish a clear evidence base for further research and policy. The review synthesises empirical data regarding the rates of people reporting RM of trauma among the general public, in clinical

populations, and reported by a treating mental health professional in modern research published after the ‘Memory Wars’ period (here taken to be from the year 2000 onwards). The systematic review also explores how RM are defined and operationalised across studies, and gaps in the knowledge base. By doing so, we hope to inform future research, clinical practice, and training.

Method

Ethical Considerations

Ethical approval was not required as this study involved secondary analysis of published data.

Review methodology

The systematic review protocol was prospectively registered with PROSPERO (ID: CRD42024544426). The core research question was: ‘*What is the rate at which recovered memories of abuse or trauma are reported?*’, looking specifically at general population studies, clinical samples, and clinicians’ reports of their clients’ experiences. The goal of the study was to systematically review the evidence base to date, assess the quality and generalisability of research findings, and begin to establish what is presently known about the phenomenon of RM.

Literature search strategy

Preliminary searches were completed on 7th February 2024. Key words associated with publications in this area were identified and used to develop the final search term which was searched at title, abstract, and keyword level on 6th April 2024, with a second updated search on 11th March 2025 (which added one included study):

"recover memor*" OR "dissociative amnesia" OR "repress* memor*"*

The following databases were used: APA PsycInfo, Scopus, and Web of Science. Given the high volume of studies retrieved, we did not extend the search further to maintain feasibility and ensure thorough screening and analysis of included studies. This was deemed appropriate given a specific interest in research published in the discipline of psychology. No manual search of reference lists was conducted due to the sufficient volume of studies retrieved from database searches alone.

Eligibility criteria

To be eligible for the current review, the publications had to be primary empirical studies of people reporting RM (self-reported or reported by clinicians). They needed to be published in the English language in peer-reviewed journals from the year 2000 onwards, as the end of the 1990s is commonly seen as the end point in the ‘Memory Wars’ (Patihis et al., 2014). Included studies required a clearly described method of assessing or evaluating the presence or absence of RM of trauma.

Exclusion criteria were non-primary studies utilizing previously published research, narrative reviews, commentary articles, letters, research into organic amnesias (e.g., drug-induced or traumatic brain injury), research into dissociative amnesia without memory recovery or retrieval, animal studies, studies conducted in forensic environments (due to malingering incentives in the contexts of legal cases creating unacceptable risk of bias), case studies (due to a lack of information answering the question regarding rates of occurrence) and publications in languages other than English.

Literature selection

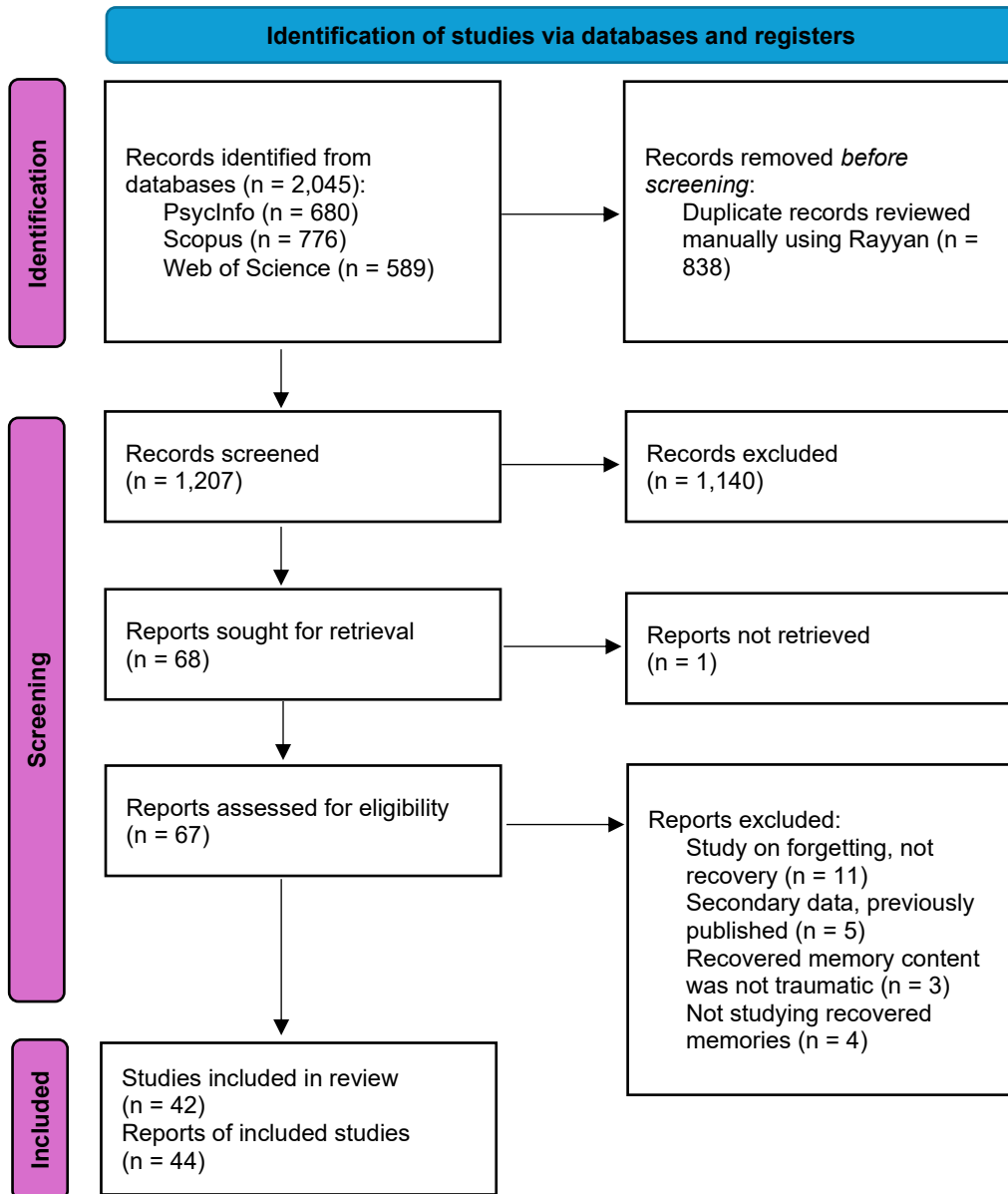
See Figure 1 for a PRISMA flow diagram of the screening and eligibility process. The initial search term identified 2,045 citations. Duplicates (n=838) were removed, leaving 1,207 citations for screening. Of the 68 papers which underwent full text screening, 24 were excluded leaving a total of 44 papers which were identified as meeting the inclusion criteria of the current study. Three papers were combined as the identical participant numbers indicated a shared sample, resulting in a count of 42 included studies (Geraerts et al. 2005, 2006a, 2006b). A second blind reviewer screened 25% of the papers during the title and abstract review, and another 25% at full-text screening, resulting in an inter-rater agreement rate of 99.73% at abstract screening stage, and 76.47% at full text screening stage. The majority of disagreements at full-text stage were due to the first reviewer including studies that report the forgetting of trauma without explicitly confirming that traumatic memories were *recovered* later. This was resolved through discussion with the other co-authors.

Synthesis of results

Publications were grouped based on the population drawn from and sampling method utilized, with a narrative synthesis to describe the diversity of methodologies and research questions being asked. A quality assessment is included in Appendix B (accessible at: <https://osf.io/b7c2j/>), utilising the JBI Checklist for Prevalence Studies (Munn et al., 2015). However—given that many included studies are unsuitable for prevalence estimates (e.g., purposive sampling methods) and no study met all quality criteria for inclusion in a prevalence review—this data was not utilised as part of the narrative synthesis.

Figure 1

PRISMA Flow Diagram



Results

Due to the heterogeneity of the research designs included, the results are divided by the type of research. The large-scale survey research answers the broadest questions about the rate at which RM are reported—within these, sampling methods produce differences, e.g., differences between uncorroborated general population studies, vs. corroborated legal samples. The therapist-report studies answer questions more specific to the clinical populations—how often these types of clients present in therapeutic settings, the styles of practice that are more likely to see these types of clients and the beliefs of therapists associated. Finally, smaller purposive studies shed light on the specific characteristics of people who recover memories, not answering questions regarding the rate at which people have these experiences. Instead, these studies inform the interpretation of larger survey studies by looking at the mental health characteristics, corroboration, triggers and contextual factors in the recovery of memories, and experimental evidence testing theoretical hypotheses about the mechanisms and functions of RM.

Survey research

Answering questions regarding the rate at which people report RM of trauma depends significantly on the characteristics of the sample being examined (see Table 1). Among those with CSA histories, reported rates vary widely, from the 3% observed by O'Donohue et al. (2013) in legally corroborated cases to the 39% reported by Westerhof et al. (2000) in a sample relying on self-reported CSA. Importantly, studies involving corroborated cases (e.g., Ghatti et al., 2006; O'Donohue et al., 2013) often highlight that memory recovery tends to occur during childhood, particularly when caregivers or legal authorities appropriately respond to trauma. In contrast, self-reported CSA samples (e.g., Westerhof et al., 2000; Wager, 2011) include

individuals who report memory recovery in adulthood, sometimes triggered by reflection or external events.

Studies focusing on therapy attendees report lower but still significant rates of RM, ranging from 6% to 11% (Dodier et al., 2019; Patihis & Pendergrast, 2019; Patihis et al., 2022; Murphy et al., 2025). These studies reveal that while memories are sometimes recovered in therapy, many occur outside of therapy, triggered by life events such as flashbacks, exposure to media, or significant personal milestones. Studies including individuals who have never been to therapy suggest that a majority of RM arise from environmental triggers, such as the death of a loved one, revisiting childhood locations, or childbirth (Dodier & Patihis, 2021; Wager, 2011; Wilsnack et al., 2002).

The variability in operational definitions further complicates these findings. Some studies require participants to report total amnesia followed by recovery (e.g., Ghatti et al., 2006), while others include partial amnesia or reinterpretation of past events (e.g., Westerhof et al., 2000). Recent efforts to clarify participants' understanding of RM (e.g., Dodier & Patihis, 2021) highlight how public interpretations often deviate from strict theoretical definitions, with many individuals equating "recovery" to years of not thinking about an event or reframing past experiences as abusive.

Table 1

Summary of included studies using survey research design

Study	Sample	Description	Recovered Memories Operationalisation	Rate of Recovered Memories	Triggers of Memory Recovery
Westerhof et al. (2000)	N= 308 Dutch psychologists (51% f, 62% under 45 y/o); CSA n = 41	Dutch psychologists reporting own experiences	Periods of not remembering childhood abuse (partially or totally)	n = 16 (39%): - Recovered memories: n = 9 - Partially forgotten memories recovered : n = 7	- Therapy-related: n = 11 - Media exposure: n = 4 - Reminded by someone: n = 1 - Other: n = 9 - No specific trigger: n = 1
Wilsnack et al. (2002)	N = 711, all f, 26–54 y/o; CSA n = 106	USA national probability sample	Exps of CSA which they forget then remembered.	Familial CSA: - n = 14 (28.1% of CSA respondents) Extrafamilial CSA: - n = 23 (33.6% of CSA)	Familial CSA: - Remembered alone: n = 13 - With professional: n = 1 Extrafamilial CSA: - Remembered alone: n = 21 - With professional: n = 2
Ghetti et al. (2006)	N = 138 individuals (80% f) with documented CSA	USA longitudinal study of victims in legal prosecutions	Temporarily forgot or had no memory of the sexual exps, which they could not have recalled if someone asked.	15% (n = 21) - Of those, 24% (n = 5) would not have remembered even if asked directly. 2 of these reported recovering their memories.	All memory recovery recorded occurred during childhood: - n = 1 Perpetrator confessed. - n = 1 Memory triggered by the court case.

Study	Sample	Description	Recovered Memories Operationalisation	Rate of Recovered Memories	Triggers of Memory Recovery
Wager (2011)	N = 210, 74% f, 16-65 y/o; CSA n = 88 (37%)	UK opportunistic sample	Periods of being unable to remember CSA, circumstances of remembering.	• 11% (n = 23) of total sample (30% of CSA subgroup), reported psychogenic amnesia for CSA • 18 of these recovered the memories	• Recovered in therapy: n=3 • Not in therapy: n = 15 • External triggers: death of a loved one, nightmares, childbirth, parents' divorce, later assault, medication
O'Donohue et al. (2013)	N = 97, 85% f, 3-17 y/o. USA CSA victims	USA selected sample from forensic clinics	Complete forgetting and remembering years later.	• Repressed memories reported in 3 out of 93 cases (3.1%)	Not specified
Dodier et al. (2019)	N = 551, 65% f, 18-74 y/o. French adults who accessed therapy	French convenience sample	Recovered memories in therapy of which they were previously unaware.	• Raw data: 5.4% (n = 30) • After data cleaning: 6.0% (n = 33)	All recovered during therapy, not otherwise specified.

Study	Sample	Description	Recovered Memories Operationalisation	Rate of Recovered Memories	Triggers of Memory Recovery
Patihis & Pendergrast (2019)	N = 1,082 who accessed therapy	U.S.A. age and geographically representative sample	Came to remember childhood abuse which they had no previous memory of.	11.3% (n = 122)	Context of recovery • Inside therapy: n = 36 • Outside therapy: n = 36 • Both: n = 50 Triggers of recovery: • Therapeutic techniques/contexts (guided imagery, group therapy, hypnosis, dream interpretation): n=31 • Other factors (flashbacks, panic attacks, body memories, reading a book): n=81
Dodier & Patihis (2021)	N = 3,346, 52% f, 18-76 y/o. French adults; CSA n = 905	French convenience sample	Recovered memory of childhood abuse when they had no previous memory of such abuse.	Of 905 with CSA memories: • 23% (n = 211) reported recovered memories • 9% (n = 82) did not know they were abused beforehand	Of 73 with amnesia: • 52.1% (n=38) alone, • 38.4% (n=28) with others, • 9.6% (n=7) in therapy. Triggers varied: • e.g., media, discussion, romance cues, location visits. • Many could not identify a trigger.

Study	Sample	Description	Recovered Memories Operationalisation	Rate of Recovered Memories	Triggers of Memory Recovery
Patihis et al. (2022)	N = 188 who accessed therapy	USA convenience undergraduate sample	Recovered memories in therapy of which they previously had no memory.	7.5% (n = 14) of those who received therapy reported recovering memories	Therapeutic context • Inside therapy: n = 2 • Outside therapy: n = 6 • Both: n = 7 Triggers: • Flashbacks: n = 6 • Guided imagery: n = 2 • Body memories: n = 1 • Triggered by someone else's memory: n = 1
Murphy et al. (2025)	N = 338 who accessed therapy	Irish convenience sample recruited via university email lists and social networks	Recovered memories in therapy of which they previously had no memory, which they could not have recalled if someone asked.	8% (n = 26) of those who received therapy reported recovering memories	All recovered during therapy, not otherwise specified.

Note: m = Male; f = Female; CSA = Childhood sexual abuse; Exps = Experiences; y/o = Years old.

Therapist report studies

Critical examination of therapist-report studies reveals significant variability in the reported rates of RM, influenced by factors such as therapists' professional backgrounds, theoretical orientations, and the therapeutic techniques employed (see Table 2).

A striking aspect across these studies is the variability in the reported rates at which therapists encounter clients with RM. Legault and Laurence (2007) found that 55% of Canadian therapists reported having seen at least one client who had RM of abuse, yet these cases constituted a median of only 0.56% of their total client load. In contrast, Schemmel et al. (2024) reported that 78% of German therapists had clients who had RM, with a median of 20% of their clients experiencing such recoveries. Ost et al. (2013) observed that 28% of British therapists encountered clients with RM but did not provide data on the proportion relative to their caseloads. Murphy et al. (2025) found 29% of Irish therapists reported experiences of RM, but again did not identify the proportion of clients. The broad similarities in how these studies recruited and surveyed participants suggest true heterogeneity in therapist experiences.

Explaining this wide variability is challenging: there may be international differences, there may be differences in how therapists are trained, there may be cultural differences in how clients and practitioners parse the concept of RM. There are clear differences in practitioners' beliefs and practices based on their training and school of therapy. Therapist beliefs and practices vary based on training and therapy school. Social workers and hypnotherapists are more likely to believe in RM and use suggestive practices (Legault & Laurence, 2007). Psychodynamic therapists report a significantly higher proportion of RM than CBT therapists (Schemmel et al., 2024). Belief in RM, use of memory-recovery techniques, and the rate of client memory recovery are linked (Legault & Laurence, 2007). Schemmel et al. (2024) and Murphy et al.

(2025) provide evidence of additional training needs, particularly in relation to false memories and guidelines for working in this area. A potentially key finding is that Legault and Laurence (2007) show that their data on the proportion of clients recovering memory is significantly skewed. It is not yet possible to say whether this finding is generalizable, but it points to the outsized influence of a minority of practitioners. It is also noteworthy that a significant portion of therapists reporting on client RM also report that they themselves recovered memories of trauma, indicating a potential personal stake in this debate (Murphy et al., 2025).

Table 2*Therapist-report studies summary*

Study (Year)	Sample Description	Therapist Experience of RM	Proportion of Clients	Other Findings
Legault & Laurence (2007)	Canada N = 240 56% f, - mean = 46 y/o Professionals: - n = 85 SW - n = 76 Psys - n = 59 Psychiatrists	55% (n = 132)	Mdn: 0.56% of clients w/ RM. Geometric Mean: Skews higher at 4.31% small numbers of higher values. SD: High variability (8.16%).	Belief in RM: - Higher belief associated w/ wider variety of RM techniques and w/ higher RM rate. - Using more techniques was also linked to higher RM rate. Profession differences: - Belief in RM: SW > Psys > Psychiatrists. - RM Techniques: SW = Psys > Psychiatrists. - RM Rates: No significant differences
Ost et al. (2013)	UK N = 302 - n = 183 Chartered Clinical Psychologists (58% f, mean 45 y/o). - n = 119 Hypnotherapists (58% f, mean 52 y/o).	27.8% (n = 66)	No data.	35% reported FM cases. - Hypnotherapists were more likely to see cases of RM (40% vs. 20%) but also cases of FM. They were less likely to see cases of satanic/ritual abuse (25% vs. 38%). - Psys predominantly used CBT, while Hypnotherapists favoured Eclectic and Client-Centred/Humanistic methods. - Beliefs in RM, ritual abuse, and DID correlated, and inversely with belief in FM.

Study (Year)	Sample Description	Therapist Experience of RM	Proportion of Clients	Other Findings
Schemmel et al. (2024)	Germany N = 301 74% female, - mean 50 y/o.	78% (n = 201)	Mdn: 20% of patients recovery/ RM - CBT: Mdn = 15% - PDT: Mdn = 35% - n=200; p < .01 Types of Recovered Events: - Abuse (44-76%) - Accidents (26%) - Positive memories (56%) - events from within the first 3 years of life (36%)	Associated diagnoses and treatments - PTSD (32%), depression (13%) 53% used trauma interventions like EMDR; 22% discussed possible FM. Use of Suggestive Techniques 82% assumed trauma. - Common techniques: Affect bridges, dream interpretation, repeated questioning, exposure, and hypnosis. - Doubts about authenticity were rare (Mdn of 5% for CBT, 10% for PDT). - RM as therapeutic goal strongly correlated with recovery attempts (r = .46, p < .01). Training and Guidance - FM rarely/never covered in training: 72%. - Lack of RM guidelines: 84%.
Murphy et al. (2025)	Ireland N = 37 62% female - Mean 55 y/o	29% (n = 10)	No data.	- High belief in RM accuracy (86%) compared to academic sample (48%). - Use of suggestive techniques: 57% suggested to clients they had RM, 76% prompted discussion of RM with clients. - Majority personally experienced RM (62%). - Reported limited training on memory recovery (57%) and false memories (47%) - Mixed opinions on RM being accurate (48% may or may not be important).

Note: f = Female, RM = Recovered memories; FM = False memories; SW = Social workers; Psys = Psychologists; CBT = Cognitive behavioural therapy; PDT = Psychodynamic therapy; EMDR = Eye Movement Desensitization and Reprocessing; Mdn = Median; SIQR = Semi-interquartile range; y/o = Years old.

Purposive samples

Purposive sampling studies, while unable to answer questions about the rate at which memories of trauma are recovered, shed light on what is known about the psychological characteristics of people who recover memories, the contextual factors of memory recovery, and relevant phenomenological aspects of memory recovery (see Table 3).

People who report RM often exhibit elevated trauma-related symptoms, such as PTSD, anxiety and depression (McNally et al., 2001; Smeets et al., 2007). There is evidence in favour of emotional avoidance as the mechanism underlying suppression or fragmentation of memories, and also of distress associated with recall (Clancy & McNally, 2005; Nijenhuis et al., 2001). This fragmentation is apparent in the form of incoherent autobiographical narratives, suggesting a lack of integration (Fivush & Edwards, 2004). A lack of autobiographical memory specificity is evident across participants who report a history of CSA regardless of memory status (Raymaekers et al., 2010), along with semantic autobiographical memory difficulties specific to those reporting RM.

However, there is a notable lack of evidence that people who recover memories show enhanced trauma memory inhibition or suppression of retrieval in experimental designs (McNally et al., 2004; Geraerts et al., 2006a). Instead, it appears that people who recover memories tend to underestimate how often they recalled their memories, the ‘forgot-it-all-along’ effect (Merckelbach et al., 2006). This poor meta-awareness has been hypothesized to induce a difficulty distinguishing fantasy from reality, but while there is significant evidence of the fantasy-proneness and dissociative qualities of recovered memory participants (McNally et al., 2000b; Geraerts et al., 2006c), this does not appear to translate to difficulties distinguishing experiences they imagined from those that they directly perceived (McNally et al., 2005). That

being said, there is a consistent finding that recovered memory participants tend to be significantly more susceptible to false recognition (Clancy et al., 2000; Geraerts et al., 2005), and potentially to false memory formation. Overall, the evidence suggests that people who recover memories are a highly vulnerable population, at risk of significant distress and confusion in response to inadequate therapeutic approaches. This also creates challenges when interpreting large-scale self-report studies.

Memory recovery triggers and contexts

Exploring the triggers of RM provides key insights into how clients experience and process these experiences. A key controversy centres around the use of therapy to trigger RM, given the vulnerability of this population and the risk of false memory creation. Certain techniques have been found to increase the likelihood of RM occurring in therapy (without evaluating RM veracity; Legault & Laurence, 2007). This is associated with techniques such as intensive recounting of trauma narratives, trauma journalling, and being placed in group therapy with trauma survivors recounting their experiences (Spitzer & Avis, 2006; Ross et al., 2022). Hypnosis has been highlighted as a risky practice, though Leavitt (2001) did not find an increased rate of RM in-session compared to psychotherapy.

Furthermore, many studies have found that memory recovery frequently occurs outside of therapeutic engagements, triggered by environmental cues (e.g., television or media, sensory experiences, locations linked to childhood; Geraerts et al., 2005; Ross et al., 2022), social engagements (e.g., disclosures from friends, family milestones, or observing abuse in others; Alaggia, 2004; Crowley, 2007; Geraerts et al., 2007), and significant life events (e.g., childbirth, sobriety, or moving away from an abuser; MacIntosh et al., 2016; Crowley, 2007). Continuous

memories more often had corroborative evidence compared to therapy-recovered memories, which were less likely to show external confirmation (Geraerts et al., 2007; McNally et al., 2005). This suggests that differentiating the triggers for recovery may provide clinically meaningful information about what the client is experiencing and how it should be interpreted. Research that only explores therapy-related RM risks missing these nuances.

Ambiguity and corroboration

Many large-scale surveys operationalize RM by investigating people who indicate a clear point in their life when memories were absent (amnesia), and then suddenly were retrieved once more (recovered). While spontaneous recall without an obvious trigger has been documented (Clancy & McNally, 2005; Ross et al., 2022), qualitative studies, exploring from the clients' perspective, tend to find clients report a different process of recovery. Crowley (2007) notes a theme of the accumulation of a set of experiences that slowly trigger recall over a prolonged period, rather than a sharp distinction between one moment being amnesic and the next being flooded with memories. Alaggia (2004) emphasizes a core emotional trigger for memory recovery in the form of feelings of safety and security associated with adulthood and mastery. Studies that operationalise RM as a sudden flood of memories at a specific point in time risk excluding participants who experience a more gradual or fragmentary process.

Many participants actively tried to forget, rather than passively repressing memories, and later reconstructed or reinterpreted past events as abusive (Clancy & McNally, 2005; Fivush & Edwards, 2004). Some theorists posit that this reinterpretation and conscious suppression do not constitute the same phenomenon of RM (e.g., McNally, 2006), however the demarcation line is unclear to many survey respondents. Raymaekers et al. (2012) highlighted challenges in reliably

classifying RM, as expert raters disagreed in almost half of the cases. This raises concerns about the categorization of memories into clear "recovered" or "continuous" types, indicating that this type of research may not be representative of all people reporting RM of abuse. How research paradigms define and operationalize becomes of key importance in developing a reliable science of RM.

Table 3

Purposive samples studying characteristics of people reporting recovered memories.

Study	Design	Sample	Findings
McNally et al. (2000a)	Experimental	CM: n = 15 RM: n = 13 RpM: n = 15 C: n = 12	- PTSD symptom severity predicted Stroop interference. - Memory status did not predict interference. - Dissociation and depression were not predictors of interference.
Clancy et al. (2000)	Experimental	CM: n = 12 RM: n = 15 RpM: n = 15 C: n = 15	- RM showed higher false recognition of semantic associates than CM and RpM. - RM and RpM reduced false recognition over time but still had higher rates than other groups.
McNally et al. (2000b)	Experimental	RM: n = 28 CM: n = 15 RpM: n = 25 C: n = 24	- RM scored higher on absorption (fantasy-proneness) than CM and C. - RpM scored highest on dissociation, followed by recovered, then CM and C. - CM showed no difference in mental health symptoms from C. - RpM had the highest levels of mental health symptoms and distress.
Nijenhuis et al. (2001)	Experimental	CM: n = 14 PM: n = 12 RM: n = 21	- RM more strongly tied to peritraumatic dissociation than CM. - Psychological dissociation linked to intermediate CSA severity; somatoform dissociation to total severity, trending with very severe CSA. - Peritraumatic somatoform dissociation specifically tied to physical abuse reports. - About two-thirds sought external corroboration; 75% of them reported finding it. - Corroboration not dependent on recall type.
McNally et al. (2001)	Experimental	RpM n = 13 RM: n = 13 C: n = 15	- No differences in directed forgetting across groups; RM not better at forgetting trauma words. - RpM scored significantly higher on clinical measures than C. - RM scored higher on dissociation than C, but not significantly.

Study	Design	Sample	Findings
Hunter & Andrews (2002)	Experimental	CSA: N = 74; RM: n = 42 C: n = 60	- No difference in specific autobiographical memory between CSA and C. - CSA group had less semantic autobiographical memory than C. - No difference in specific memory between CM and RM. - RM had worse semantic memory than continuous; CM did not differ from C.
McNally et al. (2004)	Experimental	CM: n = 72 RM: n = 25 RpM: n = 33 C: n = 20	- Neither RM nor RpM showed superior forgetting of trauma words vs. positive words. - All groups recalled trauma words better than positive words.
Clancy & McNally (2005)	Experimental	RM: n = 27	93% (n=25) found abuse unpleasant/distressing but not traumatic at the time. - Over half (n=14) actively tried to forget; 30% (n=7) forgot without trying; 11% (n=3) cited unconscious mechanisms. - All reported multiple adverse effects: trust issues, relationship difficulties, sexual problems, self-esteem issues, mental health problems, substance abuse, functional impairment.
Geraerts et al. (2005); Geraerts et al. (2006a); Geraerts et al. (2006b)	Experimental	RM: n = 23 RpM: n = 16 CM: n = 55 C: n = 20	- RM showed higher false recall/recognition of neutral and trauma-related words; no dissociation link; fantasy proneness tied to false memories. - No superior retrieval inhibition of trauma words in RM or RpM. - RM and RpM had higher dissociation than CM; all CSA groups showed elevated fantasy proneness.
McNally et al. (2005)	Experimental	CM: n = 72 RM: n = 28 RpM: n = 38 C: n = 26	- RM outperformed CM and C in sensitivity in distinguishing percepts from images. - No individual differences, including fantasy-proneness, predicted sensitivity scores.
Merckelbach et al. (2006)	Experimental	RM: n = 15 CM: n = 15	- RM more likely to underestimate prior recall of vivid memories. - Demonstrated a "forgot-it-all-along" effect.

Study	Design	Sample	Findings
Spitzer & Avis (2006)	Experimental	RM: n = 59	- Five types of abuse memories decreased pre- to post-therapy; recovered memories more common during therapy. 92% retold abuse details; over 60% had therapists encouraging recall, group sharing, or journaling; 20% guided to recall forgotten abuse. - Women recounting abuse more had lower pre- and during-therapy functioning but reached similar levels post-therapy. - Most time spent on "increasing understanding of abuse," rated most helpful. "Accepting trauma without clear details" deemed most important for healing; re-living abuse least helpful
McNally et al. (2006a)	Experimental	CM: n = 71 RM: n = 29 RpM: n = 39 C: n = 25	- No consistent autobiographical memory retrieval deficits across groups. - RM had more difficulty retrieving specific memories vs. C. - PTSD diagnosis did not predict memory specificity.
McNally et al. (2006b)	Experimental	CM: n = 92 RM: n = 38 RpM: n = 42 C: n = 36	- All CSA groups (CM, RM, RpM) more distressed, dissociative, and fantasy-prone than C, but not different from each other. - No increased difficulty in fantasy-reality discrimination across groups. - No greater closeness to perpetrators in RM vs. CM.
Geraerts et al. (2006c)	Experimental	RM: n = 66 CM: n = 119 C: n = 83	- Both CSA groups had higher symptom exaggeration scores than C; trauma severity correlated with over-reporting, suggesting trauma process, not malingering. - No significant differences in emotional numbing scores between RM and CM.
Smeets et al. (2007)	Experimental	RM: n = 7 RpM: n = 8 CM: n = 6 C: n = 9	- No abnormalities in cortisol secretion across CSA memory groups. - CSA groups reported more trauma-related and dissociative symptoms than C. - Symptoms did not correlate with cortisol levels.
Geraerts et al. (2007)	Experimental	RM: n = 57 CM: n = 71	- CM and RM recalled outside therapy had similar corroboration rates. - RM recovered in therapy less likely to be corroborated. - Degree of surprise at recall strongly predicted corroboration; less surprise linked to lower corroboration.

Study	Design	Sample	Findings
Raymaekers et al. (2010)	Experimental	CM: n = 42 RM: n = 44 C: n = 26	- CSA history groups showed less memory specificity than C. - No difference in memory specificity between RM and CM.
Raymaekers et al. (2012)	Experimental	RM: n = 52	- Expert raters disagreed in 37% of cases when classifying RM. - Only 54% of cases had full agreement among raters, suggesting inconsistent classification guidelines.
Leavitt (2000a)	Clinical	RM: n = 40 C: n = 40	- RM showed higher identification of sexually threatening signs on Rorschach. - No effect of media exposure on processing of threat imagery.
Leavitt (2000b)	Clinical	RM: n = 27 CM: n = 27 PTSD: n = 27 C: n = 27	- High prevalence of texture-less (T-less) responses in CSA survivors (63%) vs. non-abused psychiatric patients (18.5%). - RM had more T-less responses (77.8%) than CM (25.9%).
Leavitt (2000c)	Clinical	RM: n = 114 CM: n = 36 C: n = 115	- Sex-abuse signs correctly classified CM as abused (83.3%), RM as abused (51.8%), non-abused as non-abused (95.7%). - No significant difference in therapy duration between RM cases with or without sex-abuse signs, suggesting other factors influence memory emergence.
Leavitt (2001)	Clinical	Hypnosis n = 37 No Hypnosis n = 123	- Memories equally likely to emerge independent of therapy. - Most patients aware of abuse before therapy; a third recovered memories before therapy; a quarter after therapy ended.
Van der Hart et al. (2005)	Clinical	30 DID patients	- Amnesia for childhood traumatic events common among DID patients. - Initial recall of traumatic events often fragmentary, involving sensorimotor and affective experiences. - Fragmented recall also seen for significant non-traumatic events, suggesting integration issues in DID.
Ross et al. (2022)	Clinical	118 inpatients	94 participants met dissociative disorder criteria (42 DID, 52 OSDD). - Only 14.6% reported RM during therapy. - Primary triggers were flashbacks/nightmares, media exposure, people acting as reminders, visual cues, sexual situations, and someone informing of trauma. - Sexual abuse most frequent RM. - Findings challenge idea that RM in DID are mainly therapy artifacts.

Study	Design	Sample	Findings
Fivush & Edwards (2004)	Qualitative	RM: n = 6 CM: n = 6	- Remembering and forgetting abuse occurred on a continuum, not a dichotomy. - Participants showed inconsistent memory awareness. - Many actively tried to forget or block memories while retaining some awareness. - Those claiming to have forgotten gave less coherent narratives and felt uncertain. - Subjective memory experience closely tied to narrative coherence.
Alaggia (2004)	Qualitative	RM: n = 7 CM: n = 17	- Perpetrators used psychological tactics to suppress disclosure. - Children delayed disclosure until feeling safe. - Disclosure processes similar across groups. - RM occurring as flood of memories over time, after initial triggering by environmental cue.
Crowley (2007)	Qualitative	CM: n = 6 RM: n = 14 Both RM and CM: n = 10	- Participants labelled memories in varied ways, indicating need for new linguistic frames. - CSA memory recovery was gradual, involving interpretation of accumulated experiences, not sudden recall.
MacIntosh et al. (2016)	Qualitative	RM: n = 7 PM: n = 14 CM: n = 6	21 of 27 participants reported amnesia for CSA. - RM themes included flashbacks and triggers. - PM themes involved dreams, triggers, and active forgetting.

Note. CSA = Childhood sexual abuse; n = Number of participants; RM = Recovered memory group; CM = Continuous memory group; RpM = Repressed memory group; C = control group; PM = Partial memory group; DM = Delayed memory group; DID = Dissociative Identity Disorder; OSDD = Other Specified Dissociative Disorder; PTSD = Post-Traumatic Stress Disorder.

Definitions of ‘Recovered Memories’

How the phenomenon of RM is operationalised will determine what questions a piece of research can and cannot answer. By being more specific, there is more confidence that the phenomenon of interest is being studied, and future studies can clearly operationalise the same phenomenon. In essence, this prevents the problem of comparing apples to oranges. However, a clear finding across all study designs investigating RM is that members of the public, clients receiving care, and therapists themselves hold broad views regarding what constitutes a recovered memory (see Table 4).

The experience of amnesia is assumed both by the historic repressed memory perspective, and by the trauma-informed dissociative amnesia perspective, whereas such clear delineation is not apparent in the data. Asking questions requiring people to endorse statements like “If someone had asked me about it, I would not have been able to remember” provides clear boundaries to categorise study participants. However, given that such classification appears significantly challenging even in expert ratings of interview transcripts (Raymaekers et al., 2012), the lack of consensus across studies raises questions about how best to delineate definitional boundaries. With the mixed evidence from purposive studies on the clinical markers of RM and how this group is distinguishable from those with continuous memories, along with qualitative evidence that many people’s experiences do not fit with a dichotomy of remembering/forgetting – operational definition of this phenomenon will be paramount for future research and resulting clinical guidelines.

Table 4

Categorisation of the definitions utilised to conceptualise and operationalise ‘recovered memories’.

Categories	Description of Theme	Example Definitions	Studies
1: Total Amnesia Followed by Memory Recovery	Studies that specify that the memories must have been completely forgotten, often specifying that the person would have denied trauma/abuse if asked, but then remembered the abuse at a specific point in their life.	<i>“There was a time when you were completely unaware that you had ever been a victim of abuse, and that you later came to remember that you were abused” – (Geraerts et al., 2007)</i> <i>“Report of repressed memories in the allegation—defined as the child reporting that he or she completely forgot the abuse for a period of years and then remembered it.” – (O'Donohue et al., 2013)</i>	McNally et al. (2000b), Leavitt (2000a), Leavitt (2000b), Leavitt (2000c), Nijenhuis et al. (2001), Leavitt (2001), Alaggia (2004), van der Hart et al. (2005), Geraerts et al. (2006a), Geraerts et al. (2006b), Merckelbach et al. (2006), Geraerts et al. (2006c), Ghetti et al. (2006), Geraerts et al. (2007), Smeets et al. (2007), Raymaekers et al. (2010), Raymaekers et al. (2012), O'Donohue et al. (2013), MacIntosh et al. (2016), Dodier and Patihis (2021), Ross et al. (2022), Schemmel et al. (2024).
2: Partial Amnesia or Vague Memories	Studies whose definition of recovered memories was inclusive of people who reported periods of partial amnesia, missing key details or portions of the trauma/abuse before recovery.	<i>“a significant period of time when the participant could not remember the abuse, either partially or totally...[and] events, experiences, or circumstances that triggered recovery of the memories of abuse” – (Westerhof et al., 2000)</i> <i>“The partially discontinuous recovered memory group comprised participants who indicated that at times they felt they ‘knew’ about their abuse but that it receded from their waking consciousness to emerge later.” – (MacIntosh et al., 2016)</i>	Westerhof et al. (2000), Hunter and Andrews (2002), Fivush and Edwards (2004), Crowley (2007), Wager (2011), MacIntosh et al. (2016).

Categories	Description of Theme	Example Definitions	Studies
3: Memories Recovered in Therapy Exclusively	Studies whose only definition of recovered memories was specific to memories that were recovered during the therapeutic engagement.	<i>“therapists indicated how many clients they had seen since 2001 who had remembered abuse from a state of prior amnesia (i.e. no prior conscious knowledge of the occurrence of the abuse prior to treatment)” – (Ost et al., 2013)</i> <i>“Recovered memories of abuse in therapy that they did not know about before therapy” – (Dodier et al., 2019)</i>	Legault and Laurence (2007), Spitzer and Avis (2006), Ost et al. (2013), Dodier et al. (2019), Patihis and Pendergrast (2019), Patihis et al. (2022).
4: Descriptive Definitions Without Emphasis on Amnesia	Studies whose definition of recovered memories was broad enough to encompass a variety of ways of understanding recovered memories.	<i>“self-reported experience of having remembered instances of childhood sexual abuse (CSA) after a period of not recalling them” – (Clancy et al., 2000)</i> <i>“Define a recovered memory of sexual abuse purely in descriptive terms as one that has not entered awareness for years” – (McNally et al., 2004)</i>	Clancy et al. (2000), McNally et al. (2000a), McNally et al. (2001), Wilsnack et al. (2002), McNally et al. (2004), Clancy and McNally (2005), Geraerts et al. (2005), McNally et al. (2005), McNally et al. (2006a), and McNally et al. (2006b).

Discussion

We report what we believe to be the first systematic review of 42 empirical studies of RM published since 2000. The central finding of this review is that a lack of definitional and epistemic coherence creates problems in developing a reliable evidence base, posing not only a methodological challenge but also a clinical risk, as therapists lack a stable evidence base on which to form guidance. Differences in participant selection, question framing, and interpretation of RM across samples mean that synthesising the data is not clear-cut. We see ranges of 3% in corroborated samples, 5-11% among people who accessed therapy in the past, 39% among CSA victim samples, and anywhere between 27.8% to 78% of therapists reporting having seen clients like this. These estimates suggest a higher level of prevalence than is typically estimated for the phenomenon of dissociative amnesia (e.g. ranging between 0.2 to 7.3%; Staniloiu & Markowitsch, 2014). Our findings suggest a post-Memory Wars robust clinical phenomenon of reported loss and recovery of traumatic memories. Reports of RM are common enough to warrant routine consideration in clinical practice. Large minorities of people reporting CSA histories report periods of forgetting or being unaware of their abuse, and a not-insignificant minority of the general population report the same. In some studies, a majority of therapists have experienced at least one client reporting RM, and even the lower estimates appear to be in the double digits. This underscores the need for further research and training in this area, as our findings support the argument that “the Memory Wars are not over” (Otgaar et al., 2019).

There is still substantial disagreement amongst researchers and practitioners as to what may be occurring when an individual reports a RM – whether that might be dissociative memory fragmentation in response to overwhelming trauma (van der Kolk, 1998); false memories arising from suggestion (Loftus & Davis 2006); or ordinary memory mechanisms (McNally, 2018). These theoretical framings not only generate divergent hypotheses but

often preclude integration, creating a fractured literature where similar clinical reports are interpreted through fundamentally incompatible lenses. However, it is important to note that this review could not simply categorise studies into opposing theoretical camps, as such ideological affiliations are not explicitly declared—such categorisations would be unacceptably subjective.

The most consequential such difference found in the current review was in studies which excluded participants who have not been to therapy before asking questions about RM. By over-focusing on the question of whether therapists might be practicing in a suggestive manner, studies fail to provide any evidence about the broader contexts in which RM emerge. The Dodier and Patihis (2021) study provides convincing evidence that these designs have excluded large proportions of people who report RM outside of therapy. Further, an epistemological issue is also present here: what proportion of those attending therapy for RM recovered the memories first in therapy, vs. those who recovered memories first and sought therapy as a result of RM? The research to date does not allow for this question to be conclusively answered, though one purposive sample provided evidence that most RM occurred before beginning therapy or after therapy had concluded (Leavitt, 2001). On the other side of the debate, the high disagreement regarding studies for inclusion in the current review stemmed in part from a trend among trauma-informed and dissociative amnesia approaches to RM, where the recovery of memories was not asked or addressed, just the forgetting. This may have been an adaptation to avoid controversy, but unfortunately it precluded those studies from informing the current review. Alignment with particular research and clinical traditions here appears to have hindered the development of a neutral and descriptive knowledge base.

Perhaps the most substantial finding of this review is that the term “recovered memory” is a large umbrella term that is being used by different authors to mean different

things. Several self-report studies reveal that participants struggle to interpret complex questions regarding their memory status—such as whether they would have recalled an experience if prompted—often requiring researchers to apply post hoc data cleaning to align responses with operational definitions. This is justified through reference to the foundations of RM research, however this research was based on the debunking of repressed memory theories. This debunking approach forecloses the possibility of describing the experiences that people intuitively label as RM by relabelling them as continuous memories and thus as not the phenomenon of interest. This narrowing not only distorts prevalence estimates but also severs empirical research from the lived experience of clients, undermining its utility for frontline clinicians. Accurate guidance for therapists to manage RM presentations in therapeutic contexts cannot be provided if most of the experiences people call RM are redefined as irrelevant by researchers. For example, if a large portion of those reporting RM are describing the reinterpretation of continuous or rarely-recalled memories, therapists completing ‘memory work’ in these cases will be on far less risky grounding than if clients have no memories and therapists are utilising suggestive techniques to draw out hidden memories.

Strengths & limitations

There are a number of strengths in the current study. Given challenges in pooling estimates, including a set of purposive samples provides added depth to the analysis. With problems defining recovered memory phenomena, characterising the psychological characteristics of people reporting RM along with including qualitative reports from these samples allows for greater critical engagement with and interrogation of larger studies. Taking a descriptive approach that does not assume a mechanism for RM allows for understanding to be grounded in the experiences of this client group and the therapists who

work with them, rather than an *a priori* theoretical commitment. Comparison of international samples, and inclusion of diverse data sources from self-report, clinical samples, and the experiences of treating therapists provides a big-picture view of the state of knowledge in the area. By starting to delineate the triggers of memory recovery, there is an emerging differentiation of subgroups under the umbrella of RM, particularly identifying that the larger portion of this group appear to be recovering memories without being engaged in therapy.

The present study also has relevant limitations. The studies in the current review were not appropriate for prevalence estimation, given open questions about how to operationalise the phenomenon of interest, as well as heterogeneity of methods and sampling procedures. The absence of an agreed-upon typology of RM also constrained our ability to categorise studies meaningfully or compare the results found for different types of RM. The samples included were exclusively from WEIRD (Western, Educated, Industrialized, Rich, Democratic) countries (Henrich et al., 2010), and so the hypothesis that RM represent a culture-bound syndrome remains untested (Pope et al., 2007). Though historical and cross-cultural evidence suggests a shared symptomatic core (Goldsmith et al., 2009; Şar, 2022), further research is needed. This restricts our ability to assess cultural influences on memory recovery. These studies rely heavily on self-report, due to the nature of the phenomenon at hand, and so there is little to no corroboration of reported CSA and of the loss and recovery of memories. This review did not engage in a full quality assessment of the included studies, primarily as studies did not meet the full criteria for prevalence estimation, and so interpretation may be skewed due to all studies being given equal weight despite differences in quality. There was no assessment of publication bias, and the focus on peer-reviewed studies excludes representation of grey literature or unpublished studies which may have neutral or negative findings.

Future directions

If the ranges suggested in the current review are representative, recovered memory is a phenomenon, indicating that this phenomenon may merit greater prioritisation in research and therapeutic education. Current evidence suggests that many practitioners receive little to no training on memory science and managing the risks of false memory formation (e.g. Schemmel et al., 2024; Murphy et al., 2025). Given how often people report RM, it is clear that best-practice training in working with this client group should be prioritised as part of the educational programmes. This would be relevant for all therapists who will work with adults that may disclose a history of CSA or other childhood traumas. The current review highlights evidence that therapist training history significantly influences the utilisation of ‘memory work’ techniques (e.g. Legault & Laurence, 2007; Ost et al., 2013; Schemmel et al., 2024), suggesting the potential benefits to increasing and improving training in this area. McNally (2018) offers guidelines for forensic evaluation of claims of RM (noting that not all cases are false), and limited guidelines for therapists aside from discouraging techniques for direct retrieval and estimating that asking people if they have a history of abuse is “most likely harmless” (p. 397). The evidence suggests a range of triggers for the recovery of memories, some of which may include therapy-induced false memories, but equally are likely to include a variety of environmentally triggered flashbacks, or memories recovered in therapy which was practiced entirely ethically and competently. Therefore, educational initiatives will be needed to develop a generation of practitioners who are aware of the problems of suggestive therapeutic practices, cognizant of how ordinary memory mechanisms can relate to reports of RM, and also have the competency to work with traumatic dissociation, inclusive of sudden or gradual recall of traumatic events later in life. Guidelines specific to therapeutic practice would support such initiatives.

Further research in the area of RM is needed to facilitate the development of prevalence estimates. Large-scale studies with randomised sampling methods would allow for true prevalence estimation, but to take a descriptive approach it is essential that the variations of RM discussed across the included studies in this review can be represented. Therapist-recovered memories should of course be included, but surveys should also be capable of including participants who reported that they experienced RM either prior to therapy or having never accessed therapy. Survey designs which differentiate between those who are reinterpreting continuous memories vs. those who forgotten and later recalled memories may be fruitfully utilised. A descriptive and exploratory approach to this data is needed, as theory has not definitively established whether these differences are best understood as categorically different phenomena or merely differences in degree of prior amnesia. It may also be beneficial to have questions regarding partial forgetting and partial recall, along with gradual memory recovery as reported in qualitative research (e.g., Crowley, 2007). These conceptual differentiations are necessary for developing best-practice guidelines. In addition, it would be beneficial for these studies to characterise the nature and severity of the abuse experiences, as McNally and Geraerts (2009) note that low severity abuse may simply not register in one's awareness as abusive, rather than being forgotten due to overwhelming trauma. This should also include the nature of the person's relationship to the abuser, allowing for testing of the hypotheses of betrayal trauma theory (Freyd et al., 2007).

General population studies should be conducted in non-WEIRD populations, to test claims regarding dissociative amnesia as a culture-bound syndrome, e.g., countries in the Middle East, Africa, East Asia, South-East Asia, etc., perhaps taking into account levels of economic development and the degree to which English-language media is part of the culture. Therapist-report studies in future will need to include clients who had RM as part of the

therapeutic engagement, but also crucially differentiating from clients who started recovering the memories prior to therapy, indicating spontaneous-recovery. There is also a dearth of studies of clinical populations, e.g. specialist CSA treatment clinics, looking specifically at forgetting and recovery of memories—it may be more ethically feasible to engage in deeper studies of RM in clinical treatment settings as participants will be actively supported should they have a negative reaction to the research content.

Conclusion

RM, as a broad phenomenon, should no longer be considered a rare or fringe phenomenon. The evidence suggests that a significant minority of the general population have these experiences, and they are far more frequent among traumatised populations. Large numbers of therapists report seeing clients having these experiences, though the rates vary hugely. More detailed research on people reporting RM suggests that they experience poor mental health and general memory difficulties, but there is heterogeneity in experiences of how the memories are recovered and under what conditions. These differences appear to be clinically meaningful and so require clear delineation in future research, as this review demonstrates that a lack of definitional clarity has obstructed the field's ability to produce clinically actionable knowledge. By refocusing future research within a broad, descriptive approach to data collection and analysis, the groundwork will be laid for education on RM in therapeutic training programmes and for clear guidelines for how to handle this in practice.

Disclosure statement

No potential conflict of interest was reported by the author(s).

References

- Anderson, (2020). Motivated Forgetting. In A. Baddeley, M. W. Eysenck, & M. C. Anderson (eds.). *Memory* (3rd ed.). Routledge. <https://doi.org/10.4324/9780429449642>
- Alaggia, R. (2004). Many ways of telling: Expanding conceptualizations of child sexual abuse disclosure. *Child abuse & neglect*, 28(11), 1213-1227.
<https://doi.org/10.1016/j.chiabu.2004.03.016>
- Briere, J., & Conte, J. R. (1993). Self-reported amnesia for abuse in adults molested as children. *Journal of Traumatic Stress*, 6(1), 21–31.
<https://doi.org/10.1002/jts.2490060104>
- Boag, S. (2012). *Freudian Repression, the Unconscious, and the Dynamics of Inhibition*. Karnac.
- Clancy, S. A., Schacter, D. L., McNally, R. J., & Pitman, R. K. (2000). False recognition in women reporting recovered memories of sexual abuse. *Psychological Science*, 11(1), 26-31. <https://doi.org/10.1111/1467-9280.00210>
- Clancy, S. A., & McNally, R. J. (2005). Who needs repression? Normal memory processes can explain "forgetting" of childhood sexual abuse. *The Scientific Review of Mental Health Practice: Objective Investigations of Controversial and Unorthodox Claims in Clinical Psychology, Psychiatry, and Social Work*, 4(2), 66–73.
- Crowley, M. S. (2007). Memories of childhood sexual abuse: Narrative analyses of types, experiences, and processes of remembering. *Journal of interpersonal violence*, 22(9), 1095-1113. <https://doi.org/10.1177/0886260507302879>
- de Rivera, J. (2000). Understanding persons who repudiate memories recovered in therapy. *Professional Psychology: Research and Practice*, 31(4), 378–386.
<https://doi.org/10.1037/0735-7028.31.4.378>

- Dodier, O. (2019). A bibliometric analysis of the recovered memory controversy in the 21st century. *Applied Cognitive Psychology*, 33(4), 571-584.
<https://doi.org/10.1002/acp.3498>
- Dodier, O., Patihis, L., & Payoux, M. (2019). Reports of recovered memories of childhood abuse in therapy in France. *Memory*, 27(9), 1283-1298.
<https://doi.org/10.1080/09658211.2019.1652654>
- Dodier, O., & Patihis, L. (2021). Recovered memories of child abuse outside of therapy. *Applied Cognitive Psychology*, 35(2), 538-547. <https://doi.org/10.1002/acp.3783>
- Elliott, D. M. (1997). Traumatic events: Prevalence and delayed recall in the general population. *Journal of Consulting and Clinical Psychology*, 65(5), 811–820.
<https://doi.org/10.1037/0022-006X.65.5.811>
- Erdelyi, M. H. (2006). The unified theory of repression. *Behavioral and Brain Sciences*, 29(5), 499–511. doi:10.1017/S0140525X06009113
- Fivush, R., & Edwards, V. J. (2004). Remembering and forgetting childhood sexual abuse. *Journal of Child Sexual Abuse*, 13(2), 1-19. https://doi.org/10.1300/J070v13n02_01
- Freud, S. (1940). An outline of psycho-analysis. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 23, pp. 141–207). Hogarth Press.
- Freud, S. (1953–1974). The etiology of hysteria. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 3, pp. 189–221). Hogarth Press and the Institute of Psycho-analysis.
- Freyd, J. J. (1997). Violations of power, adaptive blindness and betrayal trauma theory. *Feminism & Psychology*, 7(1), 22–32. <https://doi.org/10.1177/0959353597071004>

- Freyd, J. J., DePrince, A. P., & Gleaves, D. H. (2007). The state of betrayal trauma theory: Reply to McNally—Conceptual issues, and future directions. *Memory*, 15(3), 295-311. <https://doi.org/10.1080/09658210701256514>
- Geraerts, E., Smeets, E., Jelicic, M., van Heerden, J., & Merckelbach, H. (2005). Fantasy proneness, but not self-reported trauma is related to DRM performance of women reporting recovered memories of childhood sexual abuse. *Consciousness and cognition*, 14(3), 602-612. <https://doi.org/10.1016/j.concog.2005.01.006>
- Geraerts, E. G. (2006). Remembrance of things past: the cognitive psychology of remembering and forgetting trauma. [Doctoral Thesis, Maastricht University]. Datawyse / Universitaire Pers Maastricht. <https://doi.org/10.26481/dis.20060616eg>
- Geraerts, E., Merckelbach, H., Jelicic, M., Smeets, E., & van Heerden, J. (2006a). Dissociative symptoms and how they relate to fantasy proneness in women reporting repressed or recovered memories. *Personality and Individual Differences*, 40(6), 1143-1151. <https://doi.org/10.1016/j.paid.2005.11.003>
- Geraerts, E., Smeets, E., Jelicic, M., Merckelbach, H., & Van Heerden, J. (2006b). Retrieval inhibition of trauma-related words in women reporting repressed or recovered memories of childhood sexual abuse. *Behaviour research and therapy*, 44(8), 1129-1136. <https://doi.org/10.1016/j.brat.2005.09.001>
- Geraerts, E., Jelicic, M., & Merckelbach, H. (2006c). Symptom overreporting and recovered memories of childhood sexual abuse. *Law and human behavior*, 30, 621-630. <https://doi.org/10.1007/s10979-006-9043-y>
- Geraerts, E., Schooler, J. W., Merckelbach, H., Jelicic, M., JA Hauer, B., & Ambadar, Z. (2007). The reality of recovered memories: Corroborating continuous and discontinuous memories of childhood sexual abuse. *Psychological Science*, 18(7), 564-568. <https://doi.org/10.1111/j.1467-9280.2007.01940.x>

- Ghetti, S., Edelstein, R. S., Goodman, G. S., Cordón, I. M., Quas, J. A., Alexander, K. W., ... & Jones, D. P. (2006). What can subjective forgetting tell us about memory for childhood trauma?. *Memory & Cognition*, 34, 1011-1025.
<https://doi.org/10.3758/BF03193248>
- Goldsmith, R. E., Cheit, R. E., & Wood, M. E. (2009). Evidence of Dissociative Amnesia in Science and Literature: Culture-Bound Approaches to Trauma in. *Journal of trauma & dissociation*, 10(3), 237-253. <https://doi.org/10.1080/15299730902956572>
- Henrich, J., Heine, S. J., & Norenzayan, A. (2010). The weirdest people in the world? *Behavioral and Brain Sciences*, 33(2–3), 61–83. doi:10.1017/S0140525X0999152X
- Hughes, S. (2017). American Monsters: Tabloid Media and the Satanic Panic, 1970–2000. *Journal of American Studies*, 51(3), 691–719.
<https://doi.org/10.1017/S0021875816001298>
- Hunter, E. C. M., & Andrews, B. (2002). Memory for autobiographical facts and events: A comparison of women reporting childhood sexual abuse and non-abused controls. *Applied Cognitive Psychology*, 16(5), 575–588. <https://doi.org/10.1002/acp.815>
- Hyman Jr, I. E., Husband, T. H., & Billings, F. J. (1995). False memories of childhood experiences. *Applied cognitive psychology*, 9(3), 181-197.
<https://doi.org/10.1002/acp.2350090302>
- Kearney, B. E., Terpou, B. A., Densmore, M., Shaw, S. B., Théberge, J., Jetly, R., ... & Lanius, R. A. (2023). How the body remembers: examining the default mode and sensorimotor networks during moral injury autobiographical memory retrieval in PTSD. *Neuroimage: clinical*, 38, 103426. <https://doi.org/10.1016/j.nicl.2023.103426>
- Kenny, M., & Felstead, K. (2024). Making Memories: A Qualitative Exploration of the Impact of False Allegations of Satanic Ritual Abuse. *Journal of Forensic Psychology Research and Practice*, 1-19. <https://doi.org/10.1080/24732850.2024.2397000>

- Legault, E., & Laurence, J. R. (2007). Recovered memories of childhood sexual abuse: Social worker, psychologist, and psychiatrist reports of beliefs, practices, and cases. *Australian Journal of Clinical and Experimental Hypnosis*, 35(2), 111-133.
- Leavitt, F. (2000a). Media Impact on Biased Perceptual Processing of Threat-Relevant Imagery Among Patients Who Recovered Memory of Childhood Sexual Abuse Prior to the Onset of Treatment. *Journal of Child Sexual Abuse*, 8(4), 91-102.
https://doi.org/10.1300/J070v08n04_06
- Leavitt, F. (2000b). Texture response patterns associated with sexual trauma of childhood and adult onset: Developmental and recovered memory implications. *Child abuse & neglect*, 24(2), 251-257. [https://doi.org/10.1016/S0145-2134\(99\)00131-3](https://doi.org/10.1016/S0145-2134(99)00131-3)
- Leavitt, F. (2000c). Surviving roots of trauma: Prevalence of silent signs of sex abuse in patients who recover memories of childhood sex abuse as adults. *Journal of Personality Assessment*, 74(2), 311-323. □
https://doi.org/10.1207/S15327752JPA7402_10
- Leavitt, F. (2001). Iatrogenic Recovered Memories: Examining the Empirical Evidence. *American Journal of Forensic Psychology*, 19(2), 21-32.
- Legault, E., & Laurence, J. R. (2007). Recovered memories of childhood sexual abuse: Social worker, psychologist, and psychiatrist reports of beliefs, practices, and cases. *Australian Journal of Clinical and Experimental Hypnosis*, 35(2), 111-133.
- Loftus, E. F. (1993). The reality of repressed memories. *The American Psychologist*, 48(5), 518-537. <https://doi.org/10.1037/0003-066X.48.5.518>
- Loftus, E. F. (1994). The repressed memory controversy. *American Psychologist*, 49(5), 443–445. <https://doi.org/10.1037/0003-066X.49.5.443.b>
- Loftus, E. F., & Davis, D. (2006). Recovered memories. *Annu. Rev. Clin. Psychol.*, 2, 469-498. <https://doi.org/10.1146/annurev.clinpsy.2.022305.095315>

- Loftus, E. F., & Pickrell, J. E. (1995). The formation of false memories. *Psychiatric annals*, 25(12), 720-725. <https://doi.org/10.3928/0048-5713-19951201-07>
- Lynn, S. J., McNally, R. J., & Loftus, E. F. (2023). The memory wars then and now: The contributions of Scott O. Lilienfeld. *Clinical Psychological Science*, 11(4), 725-743. <https://doi.org/10.1177/21677026221133034>
- MacIntosh, H. B., Fletcher, K., & Collin-Vézina, D. (2016). “As time went on, I just forgot about it”: thematic analysis of spontaneous disclosures of recovered memories of childhood sexual abuse. *Journal of child sexual abuse*, 25(1), 56-72. <https://doi.org/10.1080/10538712.2015.1042564>
- Mangiulli, I., Otgaar, H., Jelicic, M., & Merckelbach, H. (2022). A critical review of case studies on dissociative amnesia. *Clinical Psychological Science*, 10(2), 191-211. <https://doi.org/10.1177/21677026211018194>
- McNally, R. J., Clancy, S. A., Schacter, D. L., & Pitman, R. K. (2000a). Cognitive processing of trauma cues in adults reporting repressed, recovered, or continuous memories of childhood sexual abuse. *Journal of Abnormal Psychology*, 109(3), 355–359. <https://doi.org/10.1037/0021-843X.109.3.355>
- McNally, R. J., Clancy, S. A., Schacter, D. L., & Pitman, R. K. (2000b). Personality profiles, dissociations, and absorption in women reporting repressed, recovered, or continuous memories of childhood sexual abuse. *Journal of Consulting and Clinical Psychology*, 68(6), 1033–1037. <https://doi.org/10.1037/0022-006X.68.6.1033>
- McNally, R. J. (2001). The cognitive psychology of repressed and recovered memories of childhood sexual abuse: Clinical implications. *Psychiatric Annals*, 31(8), 509–514. <https://doi.org/10.3928/0048-5713-20010801-09>
- McNally, R. J., Clancy, S. A., & Schacter, D. L. (2001). Directed forgetting of trauma cues in adults reporting repressed or recovered memories of childhood sexual abuse. *Journal*

of Abnormal Psychology, 110(1), 151–156. <https://doi.org/10.1037/0021-843X.110.1.151>

McNally, R., Clancy, S., Barrett, H., & Parker, H. (2004). Inhibiting retrieval of trauma cues in adults reporting histories of childhood sexual abuse. *Cognition and Emotion*, 18(4), 479–493. <https://doi.org/10.1080/02699930341000400>

McNally, R. J., Clancy, S. A., Barrett, H. M., & Parker, H. A. (2005). Reality Monitoring in Adults Reporting Repressed, Recovered, or Continuous Memories of Childhood Sexual Abuse. *Journal of Abnormal Psychology*, 114(1), 147–152. <https://doi.org/10.1037/0021-843X.114.1.147>

McNally, R. J. (2006). Let Freud rest in peace. *Behavioral and Brain Sciences*, 29(5), 526–527. doi:10.1017/S0140525X06379113

McNally, R. J., Clancy, S. A., Barrett, H. M., Parker, H. A., Ristuccia, C. S., & Perlman, C. A. (2006a). Autobiographical memory specificity in adults reporting repressed, recovered, or continuous memories of childhood sexual abuse. *Cognition and Emotion*, 20(3-4), 527–535. <https://doi.org/10.1080/02699930500342779>

McNally, R. J., Perlman, C. A., Ristuccia, C. S., & Clancy, S. A. (2006b). Clinical characteristics of adults reporting repressed, recovered, or continuous memories of childhood sexual abuse. *Journal of Consulting and Clinical Psychology*, 74(2), 237–242. <https://doi.org/10.1037/0022-006X.74.2.237>

McNally, R. J., & Geraerts, E. (2009). A new solution to the recovered memory debate. *Perspectives on Psychological Science*, 4(2), 126–134. <https://doi.org/10.1111/j.1745-6924.2009.01112.x>

McNally, R. J. (2018). Recovered memories of childhood sexual abuse. In R. Rogers & S. D. Bender (Eds.), *Clinical assessment of malingering and deception* (4th ed., pp. 387–400). The Guilford Press.

- Merckelbach, H., Smeets, T., Geraerts, E., Jelicic, M., Bouwen, A., & Smeets, E. (2006). I haven't thought about this for years! Dating recent recalls of vivid memories. *Applied Cognitive Psychology: The Official Journal of the Society for Applied Research in Memory and Cognition*, 20(1), 33-42. <https://doi.org/10.1002/acp.1153>
- Munn, Z., Moola, S., Lisy, K., Riitano, D., & Tufanaru, C. (2015). Methodological guidance for systematic reviews of observational epidemiological studies reporting prevalence and incidence data. *International Journal of Evidence-Based Healthcare*, 13(3), 147–153.
- Murphy, G., Dawson, C. A., Huston, C., Ballantyne, L., Barrett, E., Cowman, C. S., ... & Greene, C. M. (2023). Lost in the mall again: a preregistered replication and extension of Loftus & Pickrell (1995). *Memory*, 31(6), 818-830.
<https://doi.org/10.1080/09658211.2023.2198327>
- Murphy, G., Coyle, O., Kerin, M., Ryan, C., & Dempsey, M. (2025). Recovered memory practices in Ireland: public & professional perspectives. *Memory*, 1-12.
<https://doi.org/10.1080/09658211.2025.2462645>
- National Registry of Exonerations. (2023, May). 'Satanic panic' exonerations [Newsletter].
<https://www.law.umich.edu/special/exoneration/Documents/MAY%20NEWSLETTER.pdf>
- Nijenhuis, E., Van Engen, A., Kusters, I., & Van Der Hart, O. (2001). Peritraumatic somatoform and psychological dissociation in relation to recall of childhood sexual abuse. *Journal of Trauma & Dissociation*, 2(3), 47-66.
https://doi.org/10.1300/J229v02n03_04
- O'Donohue, W., Benuto, L. T., Fondren, R. N., Tolle, L., Vijay, A., & Fanetti, M. (2013). Dimensions of child sexual abuse allegations: What is unusual and what is not?.

Journal of forensic psychology practice, 13(5), 456-475.

<https://doi.org/10.1080/15228932.2013.838103>

Ost, J., Wright, D. B., Easton, S., Hope, L., & French, C. C. (2013). Recovered memories, satanic abuse, dissociative identity disorder and false memories in the UK: A survey of clinical psychologists and hypnotherapists. *Psychology, Crime & Law*, 19(1), 1-19.

<https://doi.org/10.1080/1068316X.2011.598157>

Otgaar, H., Curci, A., Mangiulli, I., Battista, F., Rizzotti, E., & Sartori, G. (2022a). A court ruled case on therapy-induced false memories. *Journal of Forensic Sciences*, 67(5), 2122-2129.

<https://doi.org/10.1111/1556-4029.15073>

Otgaar, H., De Ruiter, C., Howe, M. L., Hoetmer, L., & van Reekum, P. (2017). A case concerning children's false memories of abuse: Recommendations regarding expert witness work. *Psychiatry, Psychology and Law*, 24(3), 365-378.

<https://doi.org/10.1080/13218719.2016.1230924>

Otgaar, H., Howe, M. L., Patihis, L., Merckelbach, H., Lynn, S. J., Lilienfeld, S. O., & Loftus, E. F. (2019). The return of the repressed: The persistent and problematic claims of long-forgotten trauma. *Perspectives on Psychological Science*, 14(6), 1072-1095.

<https://doi.org/10.1177/1745691619862306>

Otgaar, H., Mangiulli, I., Riesthuis, P., Dodier, O., & Patihis, L. (2022b). Changing beliefs in repressed memory and dissociative amnesia. *Applied Cognitive Psychology*, 36(6), 1234-1250.

<https://doi.org/10.1002/acp.4005>

Patihis, L., Ho, L. Y., Tingen, I. W., Lilienfeld, S. O., & Loftus, E. F. (2014). Are the “memory wars” over? A scientist-practitioner gap in beliefs about repressed memory.

Psychological science, 25(2), 519-530. <https://doi.org/10.1177/0956797613510718>

Patihis, L., & Pendergrast, M. H. (2019). Reports of recovered memories of abuse in therapy in a large age-representative US national sample: Therapy type and decade

- comparisons. *Clinical Psychological Science*, 7(1), 3-21.
<https://doi.org/10.1177/2167702618773315>
- Patihis, L., Wood, R. S., Pendergrast, M. H., & Herrera, M. E. (2022). Reports of recovered memories in therapy in undergraduate students. *Psychological Reports*, 125(1), 129-147. <https://doi.org/10.1177/0033294120971756>
- Pezdek, K., & Lam, S. (2007). What research paradigms have cognitive psychologists used to study “false memory,” and what are the implications of these choices?. *Consciousness and cognition*, 16(1), 2-17. <https://doi.org/10.1016/j.concog.2005.06.006>
- Piper, A., Lillevik, L., & Kritzer, R. (2008). What’s wrong with believing in repression?: A review for legal professionals. *Psychology, Public Policy, and Law*, 14(3), 223–242. <https://doi.org/10.1037/a0014090>
- Pope, H. G., Poliakoff, M. B., Parker, M. P., Boynes, M., & Hudson, J. I. (2007). Is dissociative amnesia a culture-bound syndrome? Findings from a survey of historical literature. *Psychological medicine*, 37(2), 225-233. doi:10.1017/S0033291706009500
- Pope Jr, H. G., Schnabel, J., & Hudson, J. I. (2023). Current scientific interest in dissociative amnesia: A bibliometric analysis. *Applied Cognitive Psychology*, 37(1), 42-51. <https://doi.org/10.1002/acp.4021>
- Raymaekers, L., Smeets, T., Peters, M. J., & Merckelbach, H. (2010). Autobiographical memory specificity among people with recovered memories of childhood sexual abuse. *Journal of behavior therapy and experimental psychiatry*, 41(4), 338-344. <https://doi.org/10.1016/j.jbtep.2010.03.004>
- Raymaekers, L., Smeets, T., Peters, M. J., Otgaar, H., & Merckelbach, H. (2012). The classification of recovered memories: A cautionary note. *Consciousness and cognition*, 21(4), 1640-1643. <https://doi.org/10.1016/j.concog.2012.09.002>

- Ross, C. (2022). False memory researchers misunderstand repression, dissociation, and Freud. *Journal of Child Sexual Abuse*.
<https://doi.org/10.1080/10538712.2022.2067095>
- Ross, C. A., Ridgway, J., Neighbors, Q., & Myron, T. (2022). Reversal of amnesia for trauma in a sample of psychiatric inpatients with dissociative identity disorder and dissociative disorder not otherwise specified. *Journal of Child Sexual Abuse*, 31(5), 550-561. <https://doi.org/10.1080/10538712.2022.2067096>
- Şar V. (2022). Dissociation Across Cultures: A Transdiagnostic Guide for Clinical Assessment and Management. *Alpha psychiatry*, 23(3), 95–103.
<https://doi.org/10.5152/alphapsychiatry.2022.21556>
- Schemmel, J., Datschewski-Verch, L., & Volbert, R. (2024). Recovered memories in psychotherapy: a survey of practicing psychotherapists in Germany. *Memory*, 32(2), 176-196. <https://doi.org/10.1080/09658211.2024.2305870>
- Scoboria, A., Wade, K. A., Lindsay, D. S., Azad, T., Strange, D., Ost, J., & Hyman, I. E. (2017). A mega-analysis of memory reports from eight peer-reviewed false memory implantation studies. *Memory*, 25(2), 146-163.
<https://doi.org/10.1080/09658211.2016.1260747>
- Sivers, H., Schooler, J., Freyd, J. J. (2002) Recovered memories. In V.S. Ramachandran (Ed.) *Encyclopedia of the Human Brain*, Volume 4. (pp 169-184). San Diego, California and London: Academic Press.
- Smeets, T., Geraerts, E., Jelicic, M., & Merckelbach, H. (2007). Delayed recall of childhood sexual abuse memories and the awakening rise and diurnal pattern of cortisol. *Psychiatry research*, 152(2-3), 197-204.
<https://doi.org/10.1016/j.psychres.2006.07.008>

- Spitzer, B., & Avis, J. M. (2006). Recounting graphic sexual abuse memories in therapy: The impact on women's healing. *Journal of Family Violence*, 21(3), 173-184.
<https://doi.org/10.1007/s10896-006-9015-5>
- Staniloiu, A., & Markowitsch, H. J. (2014). Dissociative amnesia. *The lancet. Psychiatry*, 1(3), 226–241. [https://doi.org/10.1016/S2215-0366\(14\)70279-2](https://doi.org/10.1016/S2215-0366(14)70279-2)
- Swingle, J. M., Tursich, M., Cleveland, J. M., Gold, S. N., Tolliver, S. F., Michaels, L., ... & Sciarrino, N. A. (2016). Childhood disclosure of sexual abuse: Necessary but not necessarily sufficient. *Child Abuse & Neglect*, 62, 10-18.
- Van der Hart, O., Bolt, H., & van der Kolk, B. A. (2005). Memory fragmentation in dissociative identity disorder. *Journal of Trauma & Dissociation*, 6(1), 55-70.
https://doi.org/10.1300/J229v06n01_04
- Van Der Kolk, B. A. (1998). Trauma and memory. *Psychiatry and Clinical Neurosciences*, 52(S1), S52-S64. <https://doi.org/10.1046/j.1440-1819.1998.0520s5S97.x>
- Wager, N. (2011). Psychogenic amnesia for childhood sexual abuse and risk for sexual revictimisation in both adolescence and adulthood. *Sex Education*, 12(3), 331–349.
<https://doi.org/10.1080/14681811.2011.615619>
- Wells, G. L., & Loftus, E. F. (2003). *Eyewitness memory for people and events*. In A. M. Goldstein (Ed.), *Handbook of psychology: Forensic psychology* (Vol. 11, pp. 149–160). John Wiley & Sons, Inc.
- Westerhof, Y., Woertman, L., Van der Hart, O., & Nijenhuis, E. (2000). Forgetting child abuse: Feldman-Summers and Pope's (1994) study replicated among Dutch psychologists. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice*, 7(3), 220-229. [https://doi.org/10.1002/1099-0879\(200007\)7:3<220::AID-CPP243>3.0.CO;2-F](https://doi.org/10.1002/1099-0879(200007)7:3<220::AID-CPP243>3.0.CO;2-F)

- Wilsnack, S. C., Wonderlich, S. A., Kristjanson, A. F., Vogeltanz-Holm, N. D., & Wilsnack, R. W. (2002). Self-reports of forgetting and remembering childhood sexual abuse in a nationally representative sample of US women. *Child abuse & neglect*, 26(2), 139-147. [https://doi.org/10.1016/S0145-2134\(01\)00313-1](https://doi.org/10.1016/S0145-2134(01)00313-1)
- Zappalà, A., Mangiulli, I., Santtila, P., Loftus, E. F., & Otgaar, H. (2024). Beliefs and therapeutic practices related to traumatic memories among Italian cognitive behavioral therapists and trainees. *Journal of Criminal Psychology*, 14(1), 24-37. <https://doi.org/10.1108/JCP-05-2023-0035>

Chapter 2: Methodological Challenges and Critical Foundations of the Systematic Review on Recovered Memories

This chapter outlines the methodological design and interpretive logic of the preceding systematic review on recovered memories (RM). Its purpose is to ensure transparency in methodological decisions, articulate trade-offs inherent to the chosen approach, and support the quality assurance aims of the broader thesis.

Rationale for a Systematic Review

In developing the current study, a number of approaches to aggregating the evidence were considered: narrative review, meta-analysis, scoping review, and systematic review. These are discussed in turn below.

Narrative Review Considerations

Purely narrative reviews have an important role in the scientific process, offering scholarly interpretation and criticism of the research base, utilising intuitively selected papers to build an “authoritative argument” (Greenhalgh et al., 2018, p. 3). However, the selection of articles is prone to bias due to a lack of transparency, risking the production of a one-sided argument which would only add to an already saturated literature of narrative reviews regarding RM (e.g., Brewin, 2007; Dodier et al., 2024; Loftus & Davis, 2006; Otgaar et al., 2019). Additionally, a purely narrative review would not be replicable in principle, and could lack methodological rigour.

Meta-analysis Considerations

A meta-analysis was initially considered. Establishing an evidence-based prevalence estimate of the occurrence of RM, by pooling the rates identified across the included studies, would be a significant contribution to the field. Boyle (1998) outlines three key considerations in designing high quality prevalence studies. The first is sampling, which involves selecting a clearly-defined population, using a probability sampling method such as random or stratified methods to reduce selection bias, and including an evaluation of response rate. The second is measurement, utilising standardised, reliable, and valid measurement instruments with pre-established evidence bases. The third involves the analytic strategy, which ideally would involve establishing confidence intervals, and should account for—or control for—complex sampling methods.

Unfortunately, the data available to date was determined to be unsuitable for pooling. The largest survey research designs relied predominantly on convenience and snowball sampling methods via online surveys, though this alone would not be prohibitive in producing at least preliminary prevalence estimates. Only one included study assessed RM among a selected population of childhood sexual abuse (CSA) survivors (Ghetti et al., 2006). There are also key measurement issues in the RM research. Operational definitions of the phenomenon of RM show significant differences across studies, as discussed in Chapter 1, and this risked obscuring such heterogeneity by “mixing apples and oranges” (Yuan & Hunt, 2009, p. 1088). The required degree of amnesia prior to recovery has not been fully agreed across studies, from acceptance of partial recall (e.g., Westerhof et al., 2000), to simple definitions of forgetting then remembering years later (e.g., Wilsnack et al., 2002) to strict definitions requiring complete amnesia to the point that participants would have denied a trauma history if asked (Ghetti et al., 2006; Murphy et al., 2025). While in theory a structured interview to assess for the presence of RM might be considered to improve measurement

quality, evidence suggests that expert review of interview transcripts produces unacceptably low rates of agreement regarding the presence or absence of RM (54% full agreement and 37% disagreement; Raymaekers et al., 2012).

Furthermore, the survey designs of many recent studies significantly reduced their participant pool, risking selection effects and underestimation of true prevalence. These studies drew on large national convenience samples, but, after gathering demographic information, the question of whether participants had previously accessed therapy was used to screen out those who had never been to therapy. Crucially, this occurred prior to asking questions regarding RM (Dodier et al., 2019; Murphy et al., 2025; Patihis & Pendergrast, 2019; Patihis et al., 2022). Even within the therapy-selected cases, the data suggests that the majority of therapy clients who reported RM did so prior to entering into therapy (e.g., Patihis & Pendergrast, 2019; Patihis et al., 2022). Given that the study which explicitly included participants who had not accessed therapy found that the majority of RM occurred without having accessed or prior to accessing therapy (Dodier & Patihis, 2021), these designs prevented estimates of true prevalence at population level. Many studies reported descriptive statistics and lacked confidence intervals or controls for demographic characteristics which could introduce other types of selection bias (e.g., many of the studies were conducted online, selecting for high literacy and competence with technology). As such, pooling was deemed inappropriate for included self-report studies. Once this was decided, included therapist-report studies also appeared to lack face validity for pooling due to drastically different rates of therapists with experience of RM cases despite a small set of four studies—ranging from 25% (Murphy et al., 2025) to 78% (Schemmel et al., 2024). In addition to the above methodological challenges, there is a conceptual challenge in determining the degree to which RM rates are driven by false memory cases, and the degree to which differences in rates of RM between different samples might be explainable by increased false memory rates.

Scoping Review Considerations

Scoping review methodology is intended to systematically collate the broader evidence base to explore how research has developed on a given topic, and this was considered as a potential approach to the current research. Colquhoun et al. (2014) proposed a definition of scoping reviews: “*A scoping review or scoping study is a form of knowledge synthesis that addresses an exploratory research question aimed at mapping key concepts, types of evidence, and gaps in research related to a defined area or field by systematically searching, selecting, and synthesizing existing knowledge*” (p. 1294). Scoping review procedures were developed to answer broad research questions unsuitable for systematic reviews or meta-analyses, acting as a type of “reconnaissance” (Peters et al., 2015) in summarising the type of evidence being collected and the operational definitions within a given subject area. Notably, scoping reviews do not aim to address the quality of the evidence on a given subject—they act as a means of identifying gaps in the literature and potential tensions in the conceptual underpinnings of the variety of research methods being employed (Peters et al., 2015).

Given the broad base of evidence explored in scoping reviews and the focus on gaps in the research and operational definitions, scoping review methodology was considered for the current study, using the research question ‘*What is currently known about recovered memories?*’. The heterogeneity of the evidence base here further added to the case for a scoping review. However, the goal of the current review was not merely to map the field (scoping reviews are typically inclusive of theoretical and review papers), but to synthesise current empirical evidence regarding RM within pre-defined inclusion and exclusion boundaries using a transparent, reproducible method. The specificity of the final research question—‘*What is the rate at which recovered memories of abuse or trauma are*

reported?’—favours the structure of a systematic review over the exploratory breadth of a scoping review. While the systematic review appears to explore similar topics to those in scoping reviews, this review adheres to systematic review norms: preregistration of the review protocol, a database-defined search strategy, and attempts at quality appraisal (Page et al., 2021)—though the nature of the evidence in this area limited the application of some systematic review steps.

Scope of Systematic Review

Although prevalence could not be estimated, the review focused on the frequency with which RM are reported in modern studies. Given the methodological and conceptual issues in the research, there remains significant clinical value in examining how often the public and clinicians report RM—establishing whether this phenomenon occurs frequently provides critical justification for further research and for educational provision on the topic among mental health professionals.

During the era of the Memory Wars, many studies explored the evidence on this topic, but frequently the analysis was designed to bolster a particular side of the debate—some illustrative examples are explored below. One of the most famous of these studies, Williams (1994), found that 38% of corroborated CSA victims reported full amnesia, but it was criticised by Loftus et al. (1994) as conflating childhood amnesia and ordinary forgetting with repression. Similarly, Elliott and Briere (1995) produced a stratified random sample with a rate of 42% of CSA cases reporting RM, but again this study was critiqued by Lindsay and Read (1995) for a lack of corroboration, lack of context of recovery, and risks of bias toward repression theories rather than well-established memory mechanisms. Research during this era was heavily publicised and produced heightened public interest, and debates in the literature fell clearly into partisan camps of researchers.

Given the challenges of assessing study quality during this period of heated debate, the current systematic review aimed to explore the evidence that has accumulated in the contemporary era. While a number of recent reviews have posited that the Memory Wars continue into the present (e.g., Otgaar et al., 2019), it has also been argued that the controversy had effectively concluded by the early 2000s. Patihis and Felstead (2025) reviewed the history of the British False Memory Society suspected false memory cases between 1993 and 2023, showing a significant drop in annual cases in the 2000s, plateauing between approx. 2004 and 2023. McHugh et al. (2004) found a similar large decline in cases of suspected false memory recorded by the USA-based False Memory Syndrome Foundation, identifying an inflection point between 1999 and 2000. Given challenges in assessing the evidence gathered during the era of debate and controversy, the current study aimed to explore research published after the controversy had abated, and so a heuristic cutoff date of the year 2000 was utilised. The value in utilising this cutoff was to establish the findings in the contemporary era, particularly with reduced media coverage and declining public participation in the debate.

Protocol Development

Search strategy considerations

This review utilised an intentionally broad search term intended to capture the heterogeneity in terminology and research design in RM literature, relying on a focused set of databases (APA PsycInfo, Scopus, and Web of Science) with broad disciplinary coverage but a focus on psychological research.

This search strategy was developed iteratively due to limitations found in more complex search strings and relying on a larger set of databases. Initially, search terms included more specifiers aligned with the CoCoPop mnemonic (condition, context, and

population) recommended for prevalence reviews (Munn et al., 2015) using a broad range of cross-disciplinary databases (Academic Search Complete, CINAHL, MEDLINE, PsycInfo, SocIndex, ScienceDirect, Proquest (Criminal justice database, Health and medical collection, Nursing and allied health database, Psychology database, Public health database, Social science database, UK & Ireland Database). These were the CoCoPop search terms:

"recover memor*" OR "dissociative amnesia" OR "repress* memor"*

AND

Prevalence OR Estimate OR Frequenc or Incidence OR Rate OR rates OR percent**

AND

"Clinical population" OR Outpatient OR "Secondary care" OR "Community mental health" OR "Secondary service" OR "Tertiary care" OR "Tertiary service*" OR "patient*" or "psych*" OR Survey or Population or epidemiolog* OR communit* OR "general population" OR population OR student* OR "healthy sample" OR "normal population" OR "representative sample*"*

However, concerns were raised within the supervisory team regarding the above-mentioned issues of attempting a prevalence study, and with the inclusion of research outside of the psychological discipline as moving beyond the intended scope of the current review. As such, it was decided that the broad search term should be used without population or context specifiers, focusing on screening to ensure population and context selection ("recover* memor*" OR "dissociative amnesia" OR "repress* memor*"). When this was utilised for the above databases, there were over 6,000 results retrieved, pushing against the practical scope of the review due to its over-inclusiveness.

As such, in reviewing similar past research, particularly systematic reviews published in *Memory* (the target journal), along with their high overlap with psychological and mental health literature at the core of the review's focus, the selected set of three databases were chosen: APA PsycInfo, Scopus, and Web of Science. As such, a manageable number of results were returned (2,045 after deduplication) which were specifically within the domain of the psychology discipline, broadly-construed. With deduplication resulting in 1,207 unique papers to screen, it was determined that there was a sufficient volume of papers to maintain feasibility, and so reference searching and manual searching were not utilised. While a search of grey literature was considered due to its potential to reduce publication bias, the lack of peer review risked inclusion of studies with lower quality and inconsistent reporting standards—particularly given the polarised nature of RM discourse creating incentives for questionable research practices (QRPs)—so the risks were considered to outweigh the benefits.

Inclusion/Exclusion Criteria

The selected inclusion and exclusion criteria were chosen to ensure the inclusion of a broad base of knowledge on RM, while focusing the results on the most clinically relevant literature—therapists frequently play the role of gatekeepers of RM reports, given therapy's important role in the 1990s literature on RM, and a key aim of the review was to produce an evidence based guide to inform therapist education and practice. The only included papers were those written in English, a feasibility constraint that creates a language bias. Case studies were excluded as they cannot inform the review's central question on RM rates. Their findings are idiosyncratic and often non-generalisable. Forensic settings were excluded, as there is an evidence base suggesting problems of malingered amnesia in forensic research—the legal incentives specific to that population risk inflation of RM rate estimates (e.g.,

Merckelbach & Christianson, 2007). Organic amnesias were excluded as significant evidence suggests that they are frequently mistaken for psychogenic or dissociative amnesia (e.g., Jellic, 2024).

These limitations narrowed down the criteria for studies being selected for this review, however there remained some conceptual ambiguity at the heart of the RM debates. Otgaar et al. (2019) emphasise the importance of dissociative amnesia (DA) in the field of RM, arguing that this is frequently and practically a synonym for repressed memory. Diagnosis of DA presents an epistemological challenge at its core: the loss of memory can only be diagnosed in the context of the clinician or researcher being aware that the person has experienced this traumatic event and should be expected to remember it (Staniloiu & Markowitsch, 2014). While there are a multitude of papers on DA, there is a lack of clarity on whether the condition had remitted and the memories had returned—particularly problematic in studies where DA relies on self-report, e.g., using dissociation psychometrics.

During full-text screening in the current study, inter-rater agreement (76.47%) reflected a tendency by first author to favour inclusion of DA studies. However, discussion revealed that the papers were not clearly and emphatically stating that the memories had been recovered. It was a core aspect of the inclusion criteria that the review was examining memories which were now accessible, a key definition of RM (see Table 5 for the screening guide used for the current study to support the second rater). It was determined that DA cases which lack memory recovery could not be included in the review, resolving all remaining disagreements.

Table 5*Screening guide document*

Exclusion	Y/N
Review/commentary/letter/case study	☐
Amnesia caused by drugs or traumatic brain injury (TBI)	☐
Animal study	☐
Neuroscience study	☐
Forensic participants	☐
Inclusion	Y/N
English language	☐
Published after the year 2000	☐
Peer-reviewed journal publication	☐
Focused on people reporting they recovered forgotten memories of trauma	☐
Primary study involving general population, clinical population, or therapists/clinicians reporting the experiences of clients	☐

Purposive Sample Studies

A key part of the current review was the narrative synthesis of studies with purposive samples of people reporting RM. Despite the fact that the review was not intended to be a prevalence study, purposive samples cannot truly answer questions about the rate of RM, within that sample or any sample. Yet, these studies often provided key information about the psychological characteristics of people reporting RM, from experimental studies to qualitative studies, and this information has the potential to inform how large-scale RM survey samples are understood and reported on through illumination of the potential

mechanisms and phenomenological experience of people reporting RM. This type of narrative synthesis of low-n sample studies is seen commonly in the cognitive science literature. Smith et al. (2018) emphasise that a significant body of evidence demonstrates the replicability of findings originating in low-n studies, crucially in the context of strong measurement, strong quantitative models, and effective control of error variance (e.g., Weber's Law, Ebbinghaus's Law of Forgetting, and many areas of vision science).

It is not clear that the RM literature of purposive samples has these replicability indicators, particularly as the field lacks quantitative models and, due to conceptual and epistemological issues already noted, error variance may be challenging to control. The problems of low statistical power in psychological research has been known for over half a century (Cohen, 1962), yet the problem persists well into modern times and often is an indicator of low reproducibility of theory and findings (though lack of replication can also often be explained by the publication bias of randomly inflated effect sizes; Open Science Collaboration, 2015). The majority of included purposive studies have low numbers of participants, e.g., 28 RM participants being compared to other groups (McNally, Clancy, et al., 2005). As Smith et al (2018) note, this is not necessarily a problem, but low participant numbers can act as a preliminary indicator of lower quality findings and risk producing inconsistencies in the literature due to both Type I and Type II errors (Maxwell, 2004). As such, the narrative synthesis of purposive samples in the current review is weakened by a lack of quality assessment or controlling for bias.

Furthermore, there is an indicator of a potential deeper problem in this literature. Elke Geraerts, a key collaborator in nine of the included studies, had a 2008 paper retracted in 2013 due to concerns raised by collaborators regarding unprincipled removal and addition of participants to experimental groups which was not noted in the method section of the paper (Retraction Watch, 2013). This is an example of a questionable research practice (QRP), data

manipulation, with other examples of QRPs including selective reporting of hypotheses, hypothesising after the results are known (HARKing), and selective reporting of outcomes (Banks et al., 2016). It is well-known that there are significant QRP and statistical power problems in psychological research, leading to what has been deemed the ‘replication crisis’ (Open Science Collaboration, 2015). An additional issue with included papers with Geraerts as the lead author was that three included studies, published separately, had identical participant numbers (Geraerts et al., 2005; Geraerts et al., 2006a; Geraerts et al., 2006b). For the current review, it was assumed that these three studies constituted a single sample and so their results were merged into a single cell. These issues raise broader questions about the quality of experimental research on RM, given the regular collaboration of the different authors on the included papers. However, it is somewhat mitigating to note that it was the coauthors who blew the whistle with the university and requested retraction of the journal article (McNally, Jelicic, Merckelbach, & Raymaekers), and three articles from one of these authors were excluded from the current study as a secondary study due to explicitly noting that this was a reuse of participants from a previous study (McNally & Clancy, 2005a,b; McNally, Ristuccia, et al., 2005).

While these limitations are worth noting, this issue was discussed in detail with research supervisors, and it was agreed that it remains valuable to utilise a narrative synthesis of this evidence base to sketch an outline of the psychological qualities and characteristics of RM samples, providing a comparison for future research in the area to expand on. While statistical comparisons based on null hypothesis testing may risk not replicating, much of the extracted information was based on participant count information, such as reported triggers of memory recall, providing preliminary but necessary evidence to guide larger scale research projects going forward.

Quality Appraisal Considerations

While still determining whether a systematic review of the prevalence of RM was feasible, the JBI Critical Appraisal Checklist for Studies Reporting Prevalence Data (Munn et al., 2015) was introduced to assess the quality of the research for prevalence estimation. The items on the checklist were adapted to the RM topic, reducing the threshold required for items such as Q3 Sample Size, as the precision estimate was the maximum possible given an assumed prevalence of 1% (DSM-5 estimates the prevalence of dissociative amnesia as 1.8%; American Psychiatric Association, 2013). As no studies met all checklist criteria, it was determined that a prevalence review would not be appropriate, so the quality appraisal was placed in an appendix. Key issues with the research to date included reliance on convenience sampling methods which creates challenges in generalising to population-level, variable definitions of RM across studies, utilisation of different populations to draw samples from, different recruitment and evaluation methods, and small but consequential differences in survey designs. Therefore, using a prevalence quality assessment tool to weigh the quality of studies would have been misaligned with the intent of most of the studies, and risked communicating a false precision masking underlying biases. This is a limitation of the study, as the research is not weighted based on quality—this risks giving studies equal weight, irrespective of methodological rigour. The aim of the study was to mitigate this through critical appraisal of the evidence to date, developing a narrative with perhaps a lower level of certainty and claim to generalisability where appropriate.

Excluded Studies Despite Relevance

A number of studies were excluded at full-text screening despite thematic relevance. These exclusions are detailed below to support transparency and highlight gaps in the

existing operationalisation of RM (see Appendix C). There is an apparent trend among the studies, where forgetting is reported but recovery is unspecified, the content of RM is not specified as being traumatic, or the study does not sufficiently specify that memories were specifically forgetting or lost. This reflects an inter-rater disagreement, resolved through discussion with supervisory team, to ensure that included studies specified a rate at which forgotten or lost memories were recovered, excluding studies in which this process may have been implied but was unstated or unmeasurable. Notably, although excluded, several of these studies involved clinical populations with substantial CSA histories and documented memory disruptions, including dissociation and fragmented recall. While they did not meet inclusion criteria due to insufficient specificity regarding the recovery of forgotten memories, they frequently identified triggers and phenomenological features relevant to the broader literature. None explicitly invoked repression-based mechanisms, instead favouring descriptive or cognitive-affective accounts of memory disturbance, perhaps as a post-Memory Wars adaptation.

The exclusion criteria were designed prior to search, and were aligned with recent survey designs which exclude partial forgetting or the absence of full forgetting without awareness of the trauma (see Chapter 1). It is possible that many modern clinical researchers have attempted to avoid the utilisation of controversial concepts associated with the Memory Wars, such as the concept of RM and exploration of that recovery—unfortunately, in the context of this review the result has been that many clinical samples with direct relevance could not be included in the study. This indicates the need for future research to broaden conceptions of RM to ensure the inclusion of partial forgetting or memory fragmentation, memory loss with *implied recovery* due to participants reporting the memory in the study, and the triggers of recall of traumatic memories.

Conclusion

In summary, this chapter has presented a detailed justification for the methodological decisions underpinning the systematic review, situating them within epistemological, conceptual, and practical constraints unique to the topic of RM. The final review product reflects a synthesis of the available empirical literature since the end of the 'Memory Wars', with attention to prevalence, operational definitions, and contextual triggers of recovered memory reporting. While methodological heterogeneity precluded formal meta-analysis, this review offers a critical appraisal of the field's current empirical landscape. The findings now provide a foundational context for the subsequent qualitative study, which explores how Irish clinical psychologists interpret and respond to recovered memory phenomena in practice. This next chapter shifts from evidence synthesis to interpretive analysis, using reflexive thematic analysis to illuminate their meaning-making of clinical judgement under conditions of uncertainty.

References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.)*. American Psychiatric Publishing.
- Banks, G. C., Rogelberg, S. G., Woznyj, H. M., Landis, R. S., & Rupp, D. E. (2016). Evidence on questionable research practices: The good, the bad, and the ugly. *Journal of Business and Psychology*, 31, 323-338. <https://doi.org/10.1007/s10869-016-9456-7>
- Boyle, M. H. (1998). Guidelines for evaluating prevalence studies. *Evidence-Based Mental Health*, 1(2), 37-39. <https://doi.org/10.1136/ebmh.1.2.37>
- Brewin, C. R. (2007). Autobiographical memory for trauma: Update on four controversies. *Memory*, 15(3), 227-248. <https://doi.org/10.1080/09658210701256423>
- Elliott, D. M., & Briere, J. (1995). Posttraumatic stress associated with delayed recall of sexual abuse: A general population study. *Journal of Traumatic Stress*, 8(4), 629-647. <https://doi.org/10.1002/jts.2490080407>
- Cohen, J. (1962). The statistical power of abnormal-social psychological research: A review. *The Journal of Abnormal and Social Psychology*, 65(3), 145-153. <https://doi.org/10.1037/h0045186>
- Colquhoun, H. L., Levac, D., O'Brien, K. K., Straus, S., Tricco, A. C., Perrier, L., Kastner, M., & Moher, D. (2014). Scoping reviews: time for clarity in definition, methods, and reporting. *Journal of Clinical Epidemiology*, 67(12), 1291-1294. <https://doi.org/10.1016/j.jclinepi.2014.03.013>
- Dodier, O., Otgaar, H., & Mangiulli, I. (2024). Beyond Repressed Memory: Current Alternative Solutions to the Controversy. *Topics in Cognitive Science*. <https://doi.org/10.1111/tops.12754>
- Dodier, O., & Patihis, L. (2021). Recovered memories of child abuse outside of therapy. *Applied Cognitive Psychology*, 35(2), 538-547. <https://doi.org/10.1002/acp.3783>

- Dodier, O., Patihis, L., & Payoux, M. (2019). Reports of recovered memories of childhood abuse in therapy in France. *Memory*, 27(9), 1283-1298.
<https://doi.org/10.1080/09658211.2019.1652654>
- Geraerts, E., Smeets, E., Jelicic, M., van Heerden, J., & Merckelbach, H. (2005). Fantasy proneness, but not self-reported trauma is related to DRM performance of women reporting recovered memories of childhood sexual abuse. *Consciousness and cognition*, 14(3), 602-612. <https://doi.org/10.1016/j.concog.2005.01.006>
- Geraerts, E., Merckelbach, H., Jelicic, M., Smeets, E., & van Heerden, J. (2006a). Dissociative symptoms and how they relate to fantasy proneness in women reporting repressed or recovered memories. *Personality and Individual Differences*, 40(6), 1143-1151. <https://doi.org/10.1016/j.paid.2005.11.003>
- Geraerts, E., Smeets, E., Jelicic, M., Merckelbach, H., & Van Heerden, J. (2006b). Retrieval inhibition of trauma-related words in women reporting repressed or recovered memories of childhood sexual abuse. *Behaviour research and therapy*, 44(8), 1129-1136. <https://doi.org/10.1016/j.brat.2005.09.001>
- Ghetti, S., Edelstein, R. S., Goodman, G. S., Cordón, I. M., Quas, J. A., Alexander, K. W., ... & Jones, D. P. (2006). What can subjective forgetting tell us about memory for childhood trauma?. *Memory & Cognition*, 34, 1011-1025.
<https://doi.org/10.3758/BF03193248>
- Greenhalgh, T., Thorne, S., & Malterud, K. (2018). Time to challenge the spurious hierarchy of systematic over narrative reviews?. *European journal of clinical investigation*, 48(6), e12931. <https://doi.org/10.1111/eci.12931>
- Jelicic, M. (2024). Dissociative amnesia? It might be organic memory loss!. *Topics in Cognitive Science*, 16(4), 770-776. <https://doi.org/10.1111/tops.12640>

- Lindsay, D. S., & Read, J. D. (1995). "Memory work" and recovered memories of childhood sexual abuse: Scientific evidence and public, professional, and personal issues. *Psychology, Public Policy, and Law*, 1(4), 846–908. <https://doi.org/10.1037/1076-8971.1.4.846>
- Loftus, E. F., & Davis, D. (2006). Recovered Memories. *Annual Review of Clinical Psychology*, 2(1), 469–498. <https://doi.org/10.1146/annurev.clinpsy.2.022305.095315>
- Loftus, E. F., Garry, M., & Feldman, J. (1994). Forgetting sexual trauma: What does it mean when 38% forget? *Journal of Consulting and Clinical Psychology*, 62(6), 1177–1181. <https://doi.org/10.1037/0022-006X.62.6.1177>
- Maxwell, S. E. (2004). The persistence of underpowered studies in psychological research: causes, consequences, and remedies. *Psychological methods*, 9(2), 147. doi:10.1037/1082-989X.9.2.147
- McHugh, P. R., Lief, H. I., Freyd, P. P., & Fetkewicz, J. M. (2004). From refusal to reconciliation: Family relationships after an accusation based on recovered memories. *The Journal of nervous and mental disease*, 192(8), 525-531. <https://doi.org/10.1097/01.nmd.0000136301.18598.52>
- McNally, R. J., & Clancy, S. A. (2005a). Sleep paralysis in adults reporting repressed, recovered, or continuous memories of childhood sexual abuse. *Journal of Anxiety Disorders*, 19(5), 595–602. <https://doi.org/10.1016/j.janxdis.2004.05.003>
- McNally, R. J., & Clancy, S. A. (2005b). Sleep Paralysis, Sexual Abuse, and Space Alien Abduction. *Transcultural Psychiatry*, 42(1), 113–122. <https://doi.org/10.1177/1363461505050715>
- McNally, R. J., Clancy, S. A., Barrett, H. M., & Parker, H. A. (2005). Reality Monitoring in Adults Reporting Repressed, Recovered, or Continuous Memories of Childhood

- Sexual Abuse. *Journal of Abnormal Psychology*, 114(1), 147–152.
<https://doi.org/10.1037/0021-843X.114.1.147>
- McNally, R. J., Ristuccia, C. S., & Perlman, C. A. (2005). Forgetting of Trauma Cues in Adults Reporting Continuous or Recovered Memories of Childhood Sexual Abuse. *Psychological Science*, 16(4), 336–340. <https://doi.org/10.1111/j.0956-7976.2005.01536.x>
- Merckelbach, H., & Christianson, S. Å. (2007). Amnesia for homicide as a form of malingering. In S. Å. Christianson (Ed.), *Offenders' memories of violent crimes* (pp. 165–190). Wiley. <https://doi.org/10.1002/9780470713082.ch7>
- Munn, Z., Moola, S., Lisy, K., Riitano, D., & Tufanaru, C. (2015). Methodological guidance for systematic reviews of observational epidemiological studies reporting prevalence and cumulative incidence data. *JBIM Evidence Implementation*, 13(3), 147-153.
<https://doi.org/10.1097/xeb.0000000000000054>
- Murphy, G., Coyle, O., Kerin, M., Ryan, C., & Dempsey, M. (2025). Recovered memory practices in Ireland: public & professional perspectives. *Memory*, 1-12.
<https://doi.org/10.1080/09658211.2025.2462645>
- Open Science Collaboration. (2015). Estimating the reproducibility of psychological science. *Science*, 349(6251), aac4716. <https://doi.org/10.1126/science.aac4716>
- Otgaar, H., Howe, M. L., Patihis, L., Merckelbach, H., Lynn, S. J., Lilienfeld, S. O., & Loftus, E. F. (2019). The Return of the Repressed: The Persistent and Problematic Claims of Long-Forgotten Trauma. *Perspectives on Psychological Science*, 14(6), 1072–1095. <https://doi.org/10.1177/1745691619862306>
- Page, M. J., Moher, D., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson,

- E., McDonald, S., & McGuinness, L. A. (2021). PRISMA 2020 Explanation and elaboration: Updated Guidance and Exemplars for Reporting Systematic Reviews. *British Medical Journal*, 372(160). NCBI. <https://doi.org/10.1136/bmj.n160>
- Patihis, L., & Felstead, K. (2025). British False Memory Society: Caseload and details by year (1993 onwards). *Legal and Criminological Psychology*.
<https://doi.org/10.1111/lcrp.12274>
- Patihis, L., & Pendergrast, M. H. (2019). Reports of recovered memories of abuse in therapy in a large age-representative US national sample: Therapy type and decade comparisons. *Clinical Psychological Science*, 7(1), 3-21.
<https://doi.org/10.1177/2167702618773315>
- Patihis, L., Wood, R. S., Pendergrast, M. H., & Herrera, M. E. (2022). Reports of recovered memories in therapy in undergraduate students. *Psychological Reports*, 125(1), 129-147. <https://doi.org/10.1177/0033294120971756>
- Peters, M. D., Godfrey, C. M., Khalil, H., McInerney, P., Parker, D., & Soares, C. B. (2015). Guidance for conducting systematic scoping reviews. *JBIM Evidence Implementation*, 13(3), 141-146. <https://doi.org/10.1097/XEB.0000000000000050>
- Raymaekers, L., Smeets, T., Peters, M. J., Otgaar, H., & Merckelbach, H. (2012). The classification of recovered memories: A cautionary note. *Consciousness and cognition*, 21(4), 1640-1643. <https://doi.org/10.1016/j.concog.2012.09.002>
- Retraction Watch. (2013, July 24). *Bad Memory? Repressed sexual abuse memory paper retracted for data inconsistencies*. <https://retractionwatch.com/2013/07/24/bad-memory-repressed-sexual-abuse-memory-paper-retracted-for-data-inconsistencies/#more-15023>

- Schemmel, J., Datschewski-Verch, L., & Volbert, R. (2024). Recovered memories in psychotherapy: a survey of practicing psychotherapists in Germany. *Memory*, 32(2), 176-196. <https://doi.org/10.1080/09658211.2024.2305870>
- Smith, P. L., & Little, D. R. (2018). Small is beautiful: In defense of the small-N design. *Psychonomic bulletin & review*, 25, 2083-2101. <https://doi.org/10.3758/s13423-018-1451-8>
- Staniloiu, A., & Markowitsch, H. J. (2014). Dissociative amnesia. *The Lancet Psychiatry*, 1(3), 226-241. [https://doi.org/10.1016/S2215-0366\(14\)70279-2](https://doi.org/10.1016/S2215-0366(14)70279-2)
- Westerhof, Y., Woertman, L., Van der Hart, O., & Nijenhuis, E. (2000). Forgetting child abuse: Feldman-Summers and Pope's (1994) study replicated among Dutch psychologists. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice*, 7(3), 220-229. [https://doi.org/10.1002/1099-0879\(200007\)7:3<220::AID-CPP243>3.0.CO;2-F](https://doi.org/10.1002/1099-0879(200007)7:3<220::AID-CPP243>3.0.CO;2-F)
- Williams, L. M. (1994). Recall of childhood trauma: A prospective study of women's memories of child sexual abuse. *Journal of Consulting and Clinical Psychology*, 62(6), 1167–1176. <https://doi.org/10.1037/0022-006X.62.6.1167>
- Wilsnack, S. C., Wonderlich, S. A., Kristjanson, A. F., Vogeltanz-Holm, N. D., & Wilsnack, R. W. (2002). Self-reports of forgetting and remembering childhood sexual abuse in a nationally representative sample of US women. *Child abuse & neglect*, 26(2), 139-147. [https://doi.org/10.1016/S0145-2134\(01\)00313-1](https://doi.org/10.1016/S0145-2134(01)00313-1)
- Yuan, Y., & Hunt, R. H. (2009). Systematic Reviews: The Good, the Bad and the Ugly. *The American Journal of Gastroenterology*, 104(5), 1086–1092. <https://doi.org/10.1038/ajg.2009.118>

Chapter 3: Strategic Ambiguity: A Reflexive Thematic Analysis of Irish Clinical Psychologist Perspectives on Recovered Memories of Trauma

Authors

Oisín G. Carey¹  <https://orcid.org/0009-0002-3766-5906>, Maria Dempsey¹ 
<https://orcid.org/0000-0002-7001-0568>, Gillian Murphy¹  <https://orcid.org/0000-0001-8898-139X>

¹School of Applied Psychology, University College Cork, Cork, Ireland.

Corresponding author: Oisín G. Carey

Acknowledgements

The lead researcher's Doctorate in Clinical Psychology, during which this study was conducted, was partially funded by the Irish Prison Service.

Funding

This research received no external funding.

Word Count (incl. Title, Abstract, References, and excl. Appendices)

12,459

*Prepared in accordance with the journal guidelines for Clinical Psychological Science (Appendix D).

**For the purpose of examination, figures and tables have been included in the text rather than separate file.

Abstract

Recovered memories remain a source of controversy and clinical risk, decades after the peak of the Memory Wars. This study is a qualitative exploration of how clinical psychologists in Ireland interpret and respond to RM phenomena in therapeutic contexts. Guided by a Big Q epistemology and using reflexive thematic analysis (RTA), interviews were conducted with seven experienced clinicians. Three themes were developed: conceptual distancing from the term ‘recovered memory’, integration of recovered memories into a general trauma-informed framework, and managing risk without guidance. Participants described a pragmatic therapeutic approach marked by epistemic caution, strategic ambiguity, and a focus on emotional regulation and meaning-making rather than memory accuracy. These findings call for a shift in memory-related clinical guidelines: away from cautionary restrictions and toward guidance on therapeutic engagement with ambiguous memory material. Implications are outlined for clinical training, research, and cognitive memory theory to better reflect the realities of psychological practice.

Introduction

During the 1990s, the ‘Memory Wars’ emerged as a debate within psychological science and therapeutic practice over the validity of ‘recovered memories’ (RM)—accounts of trauma recalled after a period of forgetting, often surfacing in therapy and popularised during the era of the Satanic Panic in the United States (Loftus & Davis, 2006). ‘Memory work’ has been defined as therapeutic practices in which practitioners suggest that mental health symptoms imply hidden memories of trauma, and that recovery depends on accessing those memories. Such practices were criticised as therapeutically harmful and scientifically unfounded, due to concerns that they foster the emergence of false memories (Lindsay & Read, 1995).

Some considered the debate settled in the early 2000s. However, recent research has suggested that the Memory Wars have not ended, and instead the concept of repression has been reframed as dissociative amnesia (Otgaar et al., 2019). A recent case review by the British False Memory Society noted a decline in suspected false memory legal cases and a near absence of convictions, but persisting incidence of legal cases based on RM of abuse (Patihi & Felstead, 2025). A growing body of research shows that mental health professionals continue to endorse disputed ideas about repressed memories (Otgaar et al., 2019).

In many of these survey designs, there has been a significant association between endorsement of beliefs in repressed memories and endorsement of potentially suggestive therapy practices (e.g., Schemmel et al., 2024). However, endorsement of survey items leaves significant room for interpretation. Some have suggested that participants in these studies are frequently taking questions about unconscious or repressed memories as synonymous with conscious but suppressed memories, and that with added contextual explanations endorsement of repressed memory beliefs dropped significantly (Brewin et al., 2019). While quantitative surveys excel at identifying patterns and enabling comparisons across groups,

they offer limited insight into the nuanced meanings and contextual factors shaping participants' responses. A therapist may 'Slightly Agree' with repression theories on a Likert scale, but decline to try to recover memories when requested by clients. Similarly, endorsement of potentially suggestive practices may reflect a willingness to accept and support clients with fragmented or incoherent trauma narratives, rather than active attempts to unearth hidden traumas.

In the Irish context, therapeutic practice has been deeply shaped by mandatory reporting laws. The traditionally conservative culture of Ireland was wracked by a series of controversies in the 1990s and 2000s, centred around heavily publicised retrospective reports of abuse perpetrated by senior religious figures and state institutions. A new culture was developing in which significant trust was given to people reporting abuse many years after the events occurred (Wright, 2017). That culture was enshrined in law with the implementation of 'Children First' legislation, in which the reporting of retrospective abuse became legally required for a wide set of 'mandated people' (Pellegrini et al., 2023). As a result, all retrospective abuse reports of events during childhood must be reported by all Irish mental health professionals. This creates an additional layer of complexity in the RM context, given previous research into the risks of therapeutic suggestion, and so further research into practicing in these contexts is warranted.

A recent study found that 8% of the general Irish sample who had accessed therapy reported RM, and a small set of therapists displayed mixed beliefs about the validity of RM, but crucially also mixed beliefs about the importance of the accuracy of RM in therapy (Murphy et al., 2025). These ambiguous findings indicate significant value in exploring the subjective interpretations, personal experiences, and situational influences that inform therapists' beliefs about repressed memories, complementing the broader trends identified

through survey methods. These findings support further exploration of therapeutic practice in the Irish context.

Clinical psychologists represent a particularly consequential group in this context. As mandated reporters, they are legally required to report retrospective disclosures of abuse. At the same time, they operate under the scientist-practitioner model (Melchert, 2011), and so are ethically obligated to remain informed about the risks of false memory formation due to suggestive therapeutic practices. These dual responsibilities create a dialectic between the legal requirement to accept reports of trauma and abuse by referring clients for investigation, and an epistemic caution regarding the contents of uncertain and ambiguous RM. This ethical tension offers a unique lens to explore how therapists make sense of RM in the modern context. Clinical psychologists are therefore a key group for examining contemporary therapeutic reasoning in the context of RM.

Given the ambiguities in professional attitudes regarding RM, and the limitations of survey methods in capturing contextualised practitioner meaning making, a qualitative approach is warranted. Reflexive Thematic Analysis (RTA; Braun & Clarke, 2022, 2024) was selected as a method aligned with these aims, enabling an exploration of how shared patterns of meaning are constructed around the phenomenon of RM in therapeutic practice. Drawing on Braun and Clarke's (2025) Big Q framework, this study foregrounds the interpretive work of both participants and researcher, treating themes as situated sense-making within professional discourse in a contested field.

This study addresses the need to understand how clinicians make sense of recovered memories in therapeutic practice, a topic that has remained underexplored despite continued controversy. It uses Reflexive Thematic Analysis to examine how Irish clinical psychologists navigate epistemic and ethical tensions around RM in context. In doing so, it contributes

novel insight into how contemporary therapeutic reasoning unfolds in a domain shaped by both trauma-informed care and caution about memory reliability.

Transparency and Openness

Preregistration: This study was not preregistered.

Data, materials, code, and online resources: Supplemental Material was posted to the Open Science Foundation: <https://osf.io/eh3wb/>. Due to lack of consent for public data sharing, de-identified transcripts are available from the corresponding author upon request for research purposes.

Reporting: We report how we determined our sample size, all data exclusions, all manipulations, and all measures in the study. No data were excluded. There were no manipulations. The only measure was a semi-structured interview, guided by a flexible protocol (see Supplemental Material).

Ethical approval: This research received ethical approval from the UCC Clinical Psychology Research Ethics Committee (CPREC; see Appendix E). The study adhered to the ethical principles outlined in the World Medical Association Declaration of Helsinki, except for preregistration in a public database prior to participant recruitment. All participants provided e-signed consent forms (see Appendix H), stored securely on the research team's UCC OneDrive account, retained for at least 10 years in line with UCC policy.

Methodology

Design

RTA was employed within an inductive, interpretivist framework to explore how participants make sense of their experiences in therapeutic practice. The aim was to examine the *tacit knowledge* clinical psychologists draw on—how they integrate research-based and practice-

based knowledge when focusing on a client under conditions of uncertainty (O'Hara, 2012). The analysis adopts a subjectivist epistemology, foregrounding researcher–participant interaction to capture meaning-making, and treating findings as co-constructed through dialogue and interpretation (Ponterotto, 2005). This study aligns with the Big Q tradition, rejecting positivism in favour of “a view of knowledge as partial and situated, and researcher subjectivity as a resource for research” (Braun & Clarke, 2025, p. 405).

Participants

To explore how Irish clinical psychologists interpret and respond to RM in therapy, seven participants (see Table 6 for pseudonyms, occupational information, and background training orientations noted in interviews) were recruited via invitation emails through the Psychological Society of Ireland and Heads of Psychology Services Ireland (see Appendix F for information sheet). Snowball and convenience sampling were employed but did not result in additional participants. Inclusion criteria targeted practicing clinical psychologists with at least two years' post-qualification experience in adult mental health to ensure diverse clinical experience. Direct experience with RM was not required, as the interview design supported exploratory discussion of hypothetical or indirect cases.

Sample size adequacy was assessed using information power (Malterud et al., 2016), which prioritizes a sample's capacity to address the research question. The study's narrow aim of examining subjective RM interpretations required in-depth insights from a specific group. Rich dialogue from one-hour individual semi-structured interviews (see Data Collection) and RTA (see Data Analysis) leveraging trauma and memory science literature ensured robust theme development with seven participants. Findings may be transferable to similar trauma-informed settings under legal obligations regarding mandatory reporting. No demographic data (e.g., race/ethnicity) were collected to protect anonymity.

It is noteworthy that two of the seven participants recruited had completed their clinical psychology training in another country and had practiced in that context prior to their current work in Ireland (Mary and Thomas). In interviews, it was noted that their training context emphasised a psychodynamic orientation. This added diversity to a participant group otherwise drawn from the Irish training context, which is predominantly influenced by cognitive-behavioural frameworks. Given struggles recruiting, it is worth speculating regarding possible selection effects. The high levels of expertise in the sample (forensic training, expert witness experience, RM-related courtroom experience, senior roles) suggests that the more confident practitioners opted in—potentially indicating avoidance by those with less direct experience with RM cases.

Table 6

Participant pseudonyms with details of occupation and education

Pseudonym	Occupation	Background
John	Senior Clinical Psychologist	Clinical psychology, counselling psychology
Mary	Senior Clinical Psychologist	Clinical psychology, psychoanalysis
Theresa	Principal Psychotherapist	Clinical psychology, integrative psychotherapy
Seamus	Principal Clinical Psychologist	Clinical psychology
Rory	Clinical Director (private practice)	Clinical psychology, forensic psychology
Beatrice	Principal Clinical Psychologist	Clinical psychology, structured attachment interviews

Thomas	Clinical Psychologist	Clinical psychology, forensic psychology
--------	-----------------------	--

Reflexivity

My own positioning as a researcher was an important consideration throughout data collection and interpretation. This was regularly reflected upon in a reflexive diary, and in regular meetings with the supervisory team. It was agreed with the supervisory team that I maintain a dialectical perspective to the debates regarding RM. Ethical considerations were paramount, driven by the value of non-maleficence in considering the potential iatrogenic effects of therapeutic practice. These effects could come from false-positives, where clients are harmed by incorrectly believing that they were abused, or equally from false-negatives, where clients' true experiences of trauma are denied or invalidated.

It is also important to consider the social dynamics at play during data collection. As a trainee interviewing senior clinicians, a hierarchical dynamic was present. There is a strong tradition in clinical psychology of respect for the clinical judgement of experienced practitioners, dubbed a "romantic" tradition (Garb, 2005), furthering this hierarchical dynamic. I reflected on a deferential stance I frequently took during interviews, discussing this with the supervisory team, and I employed non-directive and open questioning to mitigate this stance as much as possible. At the same time, there was a real sense of mentorship, in which I was asking experts in the field to educate me on how they deliver therapy and how best to help clients, informing my own practice. This introduced a very satisfying aspect for me in completing the interviews. As Seamus reflected at the end of the interview, "*it was like a podcast.*"

My reflexive journaling showed instances of tacit agreement with participants' perspectives, particularly regarding trauma-focused interpretations of memory experiences.

This positioning informed theme construction and interpretative emphases, and were critically examined with the supervisory team to ensure balanced adherence to the dialectical framing. For example, this resulted in the transformation of one of the themes, which initially comprised simply of trauma-informed practice unrelated to the specifics of RM, but then developed into the final theme of ‘*Folding RM into general trauma-informed practice*’ where the lack of specificity became an important analytic finding (see Appendix I).

Data collection

Interviews were completed (approx. one hour in length) via recorded online video calls with auto-transcription (Microsoft Teams). Auto-transcripts were manually corrected afterwards by the researcher to ensure accuracy. The videos were deleted after transcripts were corrected. The transcripts were anonymised by removing mentions of names and geographically identifiable information, and minor speech disfluencies were removed (e.g., repetitions of words).

A semi-structured interview protocol was utilised, with three main areas to explore: experience and perceptions of RM in practice, best practice and case management of RM, and educational experience and needs regarding RM. These topics were used as ‘anchor points’, where suggested questions were flexibly employed as prompts while maintaining an open interview structure. Notably, after completion of the first interview (with John), I raised concerns with the supervisory team that the topic of ‘false memories’ had not naturally arisen based on the existing prompts. This led to the addition of ‘false memories’ as an anchor point, with its own suggested questions and prompts (see Appendix G for full interview protocol).

Data analysis procedures

The analysis followed Braun and Clarke's (2006) six-phase approach to RTA. In addition, Reflexive Thematic Analysis Reporting Guidelines (RTARG; Braun & Clarke, 2024) and Big Q Qualitative Reporting Guidelines (BQQRG; Braun & Clarke, 2025) were used to structure and coordinate the analysis (See Appendix I for stages of detailed data analysis and analytic audit trail). In phase one, data familiarisation was achieved through transcription and re-reading. In phase two, codes were generated manually in a line-by-line fashion to capture both semantic and latent meaning units. In phase three, initial themes were developed by clustering codes semantically. In phase four, themes and subthemes were revised to address overlap and incorporate previously unassigned codes. In phase five, final theme names and definitions were assigned. Phase six involved writing the analysis narrative, revised iteratively with supervisory feedback.

Analysis

Overview

Reflexive thematic analysis yielded three interrelated themes describing how clinicians encounter, interpret, and respond to RM in routine trauma practice (see Figure 2).

Theme 1 – *“The term is not very helpful”*: *Conceptual distancing from RM.*

Clinicians rejected academic/forensic definitions, preferring pragmatic, trauma-informed framings. Subthemes: terminological rejection; reframing RM as fragmented, emergent memories; and a validating, not-knowing stance.

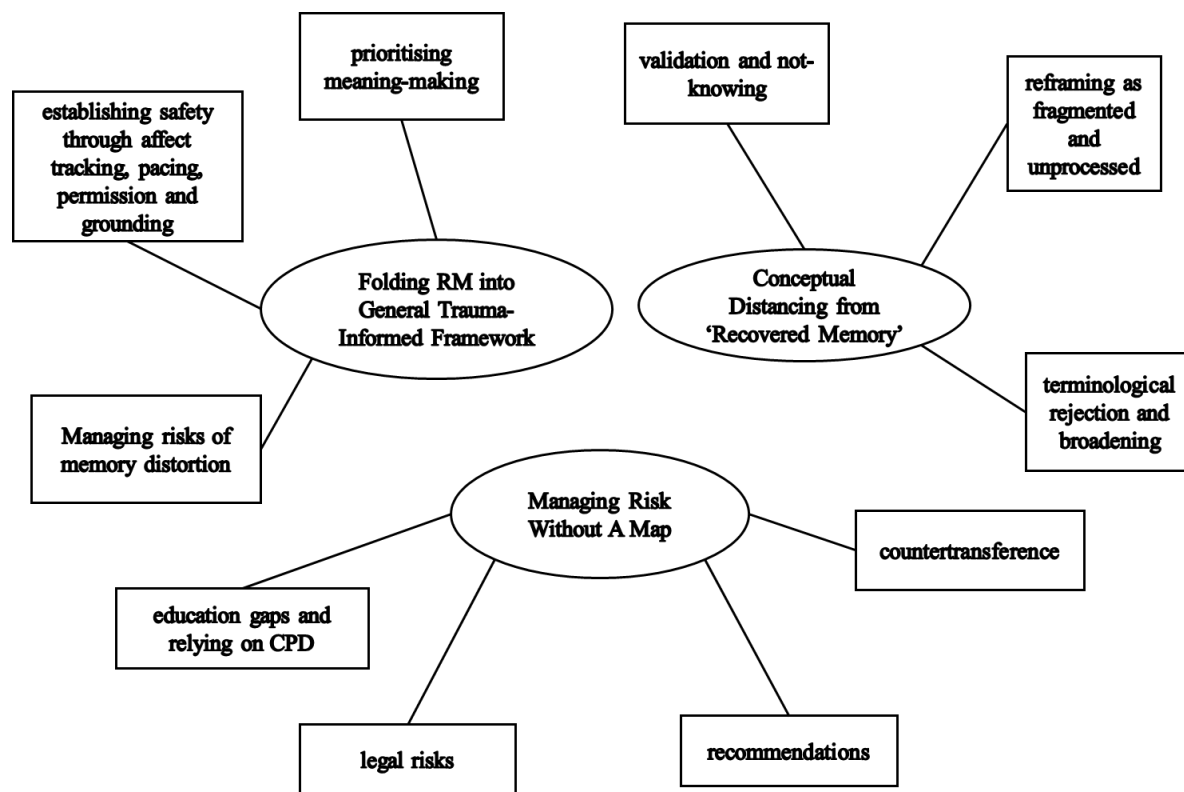
Theme 2 – *Folding RM into general trauma-informed practice.* Participants approached RM similarly to continuous trauma memories. Subthemes: affect tracking; safety via permission, pacing, and grounding; meaning-making; and suggestion management.

Theme 3 – *“My experience of that is mostly from the therapy room”*: *Managing risk without a map.* Clinicians highlighted training gaps and risk management challenges.

Subthemes: reliance on CPD; countertransference (denial, perfectionism); legal concerns; and participant recommendations.

Figure 2

Thematic Map of Themes and Subthemes



“The term is not very helpful”: conceptual distancing from ‘recovered memory’

For most participants in the current study, RM were not treated as a distinct or exceptional phenomenon in clinical practice. Instead, participants seemed to be absorbing the concept into broader trauma frameworks—sometimes rejecting the label entirely, sometimes interpreting it in a very broad way, or reinterpreting it in line with trauma-informed concepts that are consistent with continuous but unprocessed memories. Some participants were quick to mention the legal connotations of the term, indicating some defensiveness or

protectiveness, and used a not-knowing stance to avoid factual adjudication, in line with their ethical positioning and therapeutic aims.

Terminological rejection and broadening definitions

The concept of ‘recovered memories’ has a clear operational definition in the memory science literature, but participants indicated that their conceptual approach differed. John noted a discomfort with the terminology, indicating that it was not how he would formulate clients in routine practice: *“when I see terms such as dissociative amnesia...or...clients who recover forgotten memories...I just wouldn't use that language.”* Instead, John preferred a broad terminology that did not necessitate prior forgetting or trauma, *“recovered memories are past events...that come into conscious awareness...usually...associated with...a challenging experience or a difficult event.”* Similarly, Theresa indicated a lack of interest in applying the term to clients due to its conceptual baggage regarding forgetting and repression: *“for me, recovered memory...I think the term is not very helpful...it wasn't important to me whether it was a recovered memory or just something they hadn't thought about in 20 years.”* This pushback against the terminology may reflect awareness of the problematic history of RM. Many participants noted this lack of personal experience of clients with complete amnesia, along with a lack of experience of false memories in practice. Given clinicians' unease with terminology rooted in memory science—particularly concepts implying repression or inaccessibility—it may be helpful to explicitly differentiate implausible memory recovery mechanisms (e.g., unconscious repression retrieved through therapy; see Otgaar et al., 2021) from memory phenomena with stronger empirical support, such as the reinterpretation of continuous but previously unappraised experiences as abusive (McNally & Geraerts, 2009).

Reframing recovered memories as fragmented and unprocessed 'emergent memories'

The terminology that was preferred by many participants tended to utilise trauma-informed concepts, particularly fragmented memories, sensory memories, and unprocessed memories (e.g., Mary, Seamus, Rory). Rory described that “*fragmented memories are so different...sensory memories, if you like, be they sound, textures,*” and Mary expanded on this idea by suggesting fragments of memories along with specific sensory impressions which have no narrative, “*they might not remember the person's name, just how part of that person's body looked, or their shoes.*” Seamus took similar terminology and added more mechanistic language, e.g., “*non-consolidated memory, or the disintegration between different parts of...somatic feel, emotions, cognition...and...episodic memory.*” While some participants acknowledged the difference between this and standard definitions of RM, e.g., “*we're making a distinction between recovered memories as I understand them as not having been present before, and now being present because of some piece of work. As opposed to the fragments of memory that we have for all sorts of things*” (Rory), what participants tended to describe throughout the interviews was more often a kind of ‘emergent memory’. Rather than true RM, which are forgotten (and often synonymous with repressed memories), these appeared more akin to what Dodier et al. (2023) term ‘involuntary autobiographical memories’ (IAMs). IAMs are long-term memories retrieved in response to a specific internal or external cue. The validity of IAMs varies, depending on the degree of suggestion distorting them from repeated retrievals or reconstructions. In this case, these cues may arise inside or outside of therapy sessions, and the memories which are being retrieved are abusive or traumatic in nature.

These kinds of ‘emergent memories’ were not necessarily inaccessible, but perhaps were being avoided, e.g., “*he suppressed that completely...motivational forgetting*” (Thomas) or “*they haven't been able to make sense of it, and it's like that they compartmentalize that*

experience. Only for [them] to resurface at a later date” (John). What these descriptions capture is not the traditional Freudian sense of memories that are repressed in the unconscious with complete amnesia, *“it's not even a sort of a repressed or forgotten memory...they very much remember it, they just sort of emotionally segment it or segregate it and come back to it at a much later date*” (John). Several participants used the word *“repression,”* but in context this seemed synonymous with ‘suppression’, e.g., *“the experience is not just squashed and repressed, by either some form of medication or with some coping strategy or tool”* (Thomas), or similarly, *“you'll often see little slips that may be clues to more repressed or unprocessed, kind of, memories of trauma. So, for example...everything is described in idealized terms, and then there's a little slip, "But he had a temper"”* (Beatrice).

Seamus expanded on this, describing clients as *“phobically avoidant of any memory,”* denying the presence of memories (e.g., *“I have no memories before 12”*), but that by discussing normative childhood events like a religious communion or confirmation, memories emerge. In the same vein, Theresa noted that *“people go to such lengths to avoid thinking about something.”* As a result, many participants described their experiences of RM through examples of clients who had continuous memories, which were not truly inaccessible, but that these memories had emerged during therapy sessions as a surprise to clients, *“in...a stream of consciousness that the person is surprised that they've nearly....said...It wasn't what they set out to talk about when they came into the session”* (Beatrice). John offered a cogent description of how these memories emerge, again not quite talking about memories that were forgotten and previously inaccessible:

“As a therapeutic relationship strengthens...they begin to mention these memories...it might start at just a mention or a comment...And then a comment might come in at a later date again and that comment might become

a sentence, or maybe a brief paragraph. And then...it almost becomes like an intrusive thought. Then the memories just start to come up and they can't turn them off."

Adopting a validating not-knowing stance

Several participants described how this client group often presented with significant uncertainty about the veracity of their memories. John relayed the questions these clients ask themselves: *"What are these images that I am seeing? What are these emotions that I'm having? Did they really happen?...Did I have these actual experiences?"* Relatedly, Mary described how corroboration from other victims was the only thing that helped one client to overcome this uncertainty: *"it was so vague...that these aren't just fantasies...They weren't just nightmares...it's incredibly hard...[to] trust their own minds because of that vague sense."* Some offered explanations for this uncertainty, from not being believed when disclosing as a youth (Mary), to overwhelming stress reactions that disrupted associations between memories (Seamus), to declining to disclose and simply not being able to *"appreciate the impact that their childhood experiences had on them"* (Theresa).

Participants positioned themselves in a not-knowing stance of epistemic humility, where it is not possible or necessary for a therapist to identify whether the client's memories are objectively true (e.g., John, Mary, Theresa, Thomas). This was seen as part of the role of the therapist to exhibit therapeutic neutrality, e.g., *"I don't think really my job as a therapist is to pass judgment or believe or not believe. I take a position of very much not-knowing"* (Theresa), and similarly for Thomas, *"We work with the subjective experience of the client...If that experience is, for that person, true and real, then that is that person's experience."* Mary described delivering psychoeducation to clients about this, *"look, if you're wanting me to judge or play referee on what happened in your life, I can't do that."* This

conception of the role of the therapist allows practitioners to side-step debates about the veracity of RM, freed from the responsibility of interrogating the experiences of clients. This notion of ‘therapeutic truth’ has been described as “*concerningly postmodern*” (Felstead & Patihis, 2025, p. 11). At the same time, it is important to keep in mind that the not-knowing stance, often termed therapeutic neutrality, is a core component of therapy, described in mentalization-based therapy (MBT) as the sense that “*mental states are opaque, and that the clinician can have no more idea of what is in the patient’s mind than the patient himself*” (Bateman & Fonagy, 2016, p. 186).

Many participants described how validation was usually a higher priority, e.g., “*I think it's therapeutically maybe more beneficial to just validate that experience... Rather than delve into: let's find out exactly what happened*” (Beatrice). Rory described this process as stepping back from the facts and focusing on the meaning being made by the client, “*To be able to put a congruent account together for them of what it is that's distressing about the memory. What that memory does in terms of how it defines them, and how they would prefer to feel or think about themselves,*” so the client’s experience is validated without broader claims about the facts. Thomas put this in the frame of trust in the client and being willing to follow their lead, “*work with that experience and see where that is leading us...It's not necessarily some deeper trauma around every corner with every story, but if there is, then the individual will be able to take you there.*” What connects these framings is rejection of the need for therapists to assess the veracity of RM, or even to determine the presence of RM. Instead, they are advocating for supporting clients emotionally, and non-directively following their lead in making sense of their experiences, without needing to know the truth. It is possible that this preference for validating and not critically analysing clients’ trauma narratives leaves open the door for implicit suggestion to manifest in session, though participants later also acknowledged these risks. At the same time, the technical definition of

‘validation’ must be recalled here in contrast to ‘agreement’ or ‘belief’: “*the therapist communicates to the client that her responses make sense and are understandable within her current life context or situation*” (Linehan, 1997, p. 356).

To make sense of why participants may have avoided debates about RM, it is instructive to see how they linked this with the legal aspects of adult clients retrospectively reporting abuse, such as Rory’s opening answer “*The term immediately brings to mind their inadmissibility in courts of law.*” The not-knowing stance seemed to be protecting against forensic and legal risks. Given mandatory reporting laws, there was a sense that fact-finding was the responsibility of other agencies, taking away the need for therapists to critique or question the client’s experience. As such, abuse disclosures tended to be believed, e.g., “*I have met people who have told me stories that are very convincing...I have no reason to believe that they fabricated it in any way, intentionally or not*” (Theresa), or relatedly, “*for me, a lot of the time, it appears that they’re right, these experiences did happen. That they need to be...handed over to other services for investigation*” (John). In the context of uncertainty about RM, mandatory reporting laws place therapists under ethical pressure to believe and to report. Mary also described the dynamic of the client not needing to prove themselves to the therapist as therapeutically beneficial, with “*the relief that they didn’t have to convince me,*” later in the interview stating how “*I’ve never wanted to do forensic work. I’ve always avoided it like the plague.*” Similarly, Thomas stated “*I’m often very happy that I’m a psychologist and not a lawyer.*” Theresa gave a clear reason for therapists to be very cautious about the language of RM:

“*I have been involved in court processes where people were accused of having recovered memories when there was never any suggestion that they were recovered memories...as a defence strategy.*”

In sum, participants interpreted RM broadly, reframed the concept to be inclusive of more defensible trauma-informed memory concepts. They avoided adjudicating the truth value of RM by sometimes adopting a not-knowing stance and sometimes believing clients to support the therapeutic relationship and as part of mandatory reporting laws. This appears to reflect an adaptation to practicing in the aftermath of the Memory Wars, protecting themselves and clients against the legal complications associated with the added scrutiny of RM of trauma and abuse.

Folding recovered memories into a general trauma-informed framework

Participants described treating RM as continuous with other trauma narratives, using general trauma frameworks rather than distinct memory-recovery techniques. This style was focused on developing clients' emotional regulation and sense of safety so that they would become ready to begin narrating their traumatic experiences, with therapists facilitating them to unpack and process their memories to arrive at a place of meaning-making. In contrast, concerns about suggestive practice usually came from clients who were requesting interpretations of unclear or absent memories, or who needed support after another practitioner had suggested narratives for which they had no memory. Memories recounted in therapy were usually treated the same as continuous memories of trauma and so were absorbed into their existing therapeutic intervention style. However, it is important to attend to how this is done: rather than the research-defined concept of 'memory work', where the therapist actively tries to help clients to retrieve trauma memories, participants painted a picture of a very different therapeutic process.

Slowing the narrative: affect tracking, safety, and grounding

A key priority in this work was in the observational skill of tracking the affective intensity that clients were bringing to sessions, and thus narrated traumatic content was deprioritised. This affective tracking was described by some as beginning from the initial assessment stage, e.g., *“when somebody comes in from to me for therapy and they start mentioning a very traumatic event—initially I don't go near it as part of the ‘do no harm’”* (John). Pushing for immediate trauma recounting challenges *“protective strategies that have worked and been built up for so many years and that are needed for survival”* (Beatrice). The risk can be that clients might experience “decompensation”, where *“they go into a complete shutdown, or, and when we try and manage shutdown, they go into panic...often they're aware of what's happened...but it's just a “is it safe to open that door?””* (Seamus). The risk of retraumatising clients by *“exposing these patients too directly to their trauma history in the absence of their ability to maintain safety in their lives”* is well-known in the literature on complex trauma treatment (Courtois, 2004, p. 415).

The capacity to watch for and understand shifts in clients' emotional reactions was noted by multiple participants (John, Theresa, Seamus, Rory, Beatrice). It was described as developing over time through experience with clients, as a specific observational skill, e.g., *“you developed a sense of the kind of emotions that would be evoked and a kind of sense of someone that would come up as they were speaking”* (Mary). This could be a visual observation, or from attending to client narratives, e.g., *“we're often paying attention to the pauses, the disfluency...paying attention obviously to the non-verbals...crying or sighing...there's a real somatic response”* (Beatrice). This affective tracking was presented as essential for therapists working with RM clients, and trauma clients more broadly, as *“People can say they've never met somebody who dissociated, and it's just that they don't recognize it...if you're not aware of it...you're not going to recognise it when you see it”* (Theresa).

Many participants described stopping their clients in the middle of trauma disclosures, asking them to pause and check in with their affective intensity before considering any more trauma recounting (John, Seamus, Beatrice), e.g., “*Okay. Let's pause this for a moment...What you're saying is really important and I really want us to hear more, but I want to make sure it's safe for you to talk about this right now*” (Beatrice). The function of this slowed pacing is readiness to change the therapeutic task. Rather than centering trauma recounting, which is especially risky in the context of recovered or uncertain memories, participants described directing clients away from trauma narratives to focus on safety and grounding as the priority.

The importance of the client’s experience of safety in the therapy room was a frequent emphasis for participants, e.g., “*create an environment where someone feels safe in talking to you about it, at the pace they feel comfortable talking about it*” (Mary) or “*just create a space for the client to explore in their own way whatever's coming up for them*” (Theresa). Some noted that clients can feel implicitly pressured to disclose trauma memories, “*often they'll be in that fawning place... "to keep safe, I'll do whatever you want"*” (Seamus), or that the client might “*want to tell a big version of their story*” but that therapists must watch out for “*where you're feeling that this might be unsafe for the person to keep going*” (Beatrice).

This required attention to consent and permission throughout the therapy process. One participant described “*inviting permission for every minutia,*” from the position of chairs in the room, to willingness to continue an ongoing conversation, or even for the therapist to ask a question or offer an observation (Seamus). John described saying to clients “*We're going to maybe talk about a part about memory, or that led up to that memory [sic]. We might talk around it,*” and offering that “*we can stop at any stage,*” aiming to give clients as much of a sense of control over the therapeutic process as possible. For RM specifically, Theresa noted

that there is a central importance to “*lift the pressure and...give permission for uncertainty...to try and...manage expectations around it.*”

Another essential component of safety was grounding and somatic awareness. It did not appear to have a special connection to RM but appeared to be the norm for working on challenging memories. There was some importance given to grounding participants again before continuing, e.g., “*do a lot of grounding work, which is breathing, literally getting them to walk around the room*” (Seamus), to manage dissociation or panic resulting from memory disclosure. Similarly, some participants talked about directing clients to get up and move if they appeared to be dissociating, “*something that just brings them back to their bodies, brings them back out of that dissociated thing*” (Rory).

Somatic awareness was framed by reference to the work of Bessel van der Kolk (2014) explicitly by almost every participant, e.g., “*the body is the suitcase...There's no split between the body and the mind because the mind is part of the body*” (Thomas). This indicated the need for increasing somatic awareness through dialogue, also, e.g., “*I would encourage people to focus on how they are feeling in their bodies when they talk about it*” (Theresa). Beatrice described this directly in helping parents improve attachment relationships with children, where they “*build up a greater sense of their awareness of their body through repeated, very regular nurturing experiences with a caregiver,*” with Seamus using a similar parenting metaphor to describe this element of bringing clients’ somatic sensations to their awareness. This “*body memories*” (Beatrice) perspective differs from a repression perspective, instead taking somatic cues to signal dysregulation to be supported and contained. However, it is important to recognise that this term is, at best, contentious among memory science researchers (Davis & Loftus, 2020).

Prioritising meaning-making

These features of pacing and emotion regulation shaped how participants approached later trauma recounting and sense-making. Several participants stated that this piece of the work is not necessary, and was sometimes declined by clients who did not want to recount their memories, e.g., *“I don't need to know the details of a traumatic or abusive event that has happened to someone”* (John), or *“once it gets safe, then they can start to maybe look a little bit and approach, but...I've done lots of work where you don't have to do the memory bit of that and you get them to a place of...safety”* (Seamus). Some participants also clarified that they do not believe in their own ability to recover inaccessible memories, e.g., *“I don't agree with the idea of therapy being a way to remember things...they may end up with the same fuzzy memories that they started with”* (Theresa), or *“people would come in with this hope that...if you just uncover the memory, everything will be OK. And actually, the tragedy then of “No”—then the real mourning starts”* (Mary). However, for all participants, working with clients reporting RM would usually involve discussion of the contents of those memories.

Psychoeducation was often described as being used to support clients' meaning-making process. Some psychoeducation veered towards controversial areas regarding somatic memories, e.g., *“explaining to them the difference between flashbacks and trauma memories, versus how a narrative memory or traditional memory would work”* (Mary), or similarly *“a period of education...around the impact of trauma where we might be...explaining to somebody the links between...what happens before you get language in terms of your body and your sensory experiences”* (Beatrice). Others described negotiating a complex distinction between traumatic episodes and long-term neglect, ‘big T’ versus ‘small t’ trauma, as the latter typically lacks specific problematic memories, *“I'll explain to them that it can actually be worse than the big T. The big T is remembered or non-remembered or broken up in memory, but really often the context of those kids who get abused is that they weren't protected”* (Seamus). While these examples are diverse, it shows that participants valued

teaching their clients scientific and therapeutic concepts to scaffold and provide structure for meaning making. The timing of this psychoeducation is essential to consider, however—an issue that is not generally explored in the literature, and differences were apparent between participants depending on the type of service they worked in (e.g., services where CSA was established prior to the beginning of treatment). If psychoeducation on trauma is offered prior to the client narrating their memories or identifying an abuse history, it risks implicitly regulating the kinds of narratives that should be discussed, i.e. suggestion.

The meaning-making process was described by several participants as facilitation, rather than interpretation, resulting in a collaborative process, *“it is making sense of the bodily experience and the fuzziness and the question...you're trying to help them put names, put words on their feelings...you put out different possibilities and they're so clear when you're wrong. And then when you get it right, they're just, "Yeah. That really fits."”* (Theresa). Open and active questioning was a tool to encourage client reflection, e.g., *“we start to work with, "OK, where did this this come from?"...facilitating a process...allowing the individual's experiences to come forth”* (Thomas). Many participants described client accounts in which they made sense of maladaptive coping strategies in relation to trauma, e.g., *“here's some things that we're curious about that happened when you were a child...And we wondered, did it lead you to kind of protect yourself in this way?”* (Beatrice). What is shared across these examples is centering of a non-directive approach, but with working on memories clearly being a part of the therapy, e.g., *“How to get people to narrate traumatic experiences in a safe and compassionate way”* (John). In contrast to narrative construction, some participants employed structured techniques that intentionally bypass interpretive meaning-making. Rory described using eye movement desensitization and reprocessing (EMDR), as an evidence-based approach, *“processing the stuff that they could recall, however fragmented it was...I*

will not create a narrative out of those sensory memories...I can still process those memories without creating a story around them.”

Navigating the risk of inadvertent suggestion and memory distortion

Therapists were acutely aware of the dangers of suggestion and inappropriate interpretation. Several participants noted that clients had approached them in the past to seek help in recovering forgotten memories of abuse, e.g., from dreams (Seamus), from fuzzy or vague memories (Theresa), and from times prior to infantile amnesia (Rory). Therefore, the risk of suggestive practice can come from the therapist, *“it can be very dangerous...if you want to start to make a suggestion about all sorts of trauma without the client ever raising that, or the client bringing that to the fore,”* but also from clients guessing about their own repressed memories, *“making sure that the individual themselves is not making any suggestions for themselves”* (Thomas). Rory delved into a specific exploration defining the boundaries between RM, *“as I understand them as not having been present before, and now being present because of some piece of work,”* and fragmented trauma memories, *“fragments of memory that we have for all sorts of things, that can form a story...[which] will relate back to...the meaning we attach to things.”* This comparison was used to distinguish *“a memory that didn't exist in any shape or form”* (Rory).

Multiple participants used this as psychoeducation to feed back to clients. Some delivered psychoeducation supporting a not-knowing perspective on memories, e.g., *“look, this is an alleged abuse. But let's treat it as a thought – an unprocessed thought – and you just need to be able to manage this thought if it comes up”* (John). Some participants delivered psychoeducation about RM and memory science, e.g., *“We can have experiences that...make us feel in some way invaded...But it doesn't mean that there was sexual abuse”* (Theresa). Two participants noted examples of clients coming to them after recovering

memories with another practitioner (citing hypnotists and psychics), where “*a very vulnerable person is given fragments of a story that are typical or common, and then imagines the rest*” (Rory). Seamus described overcoming this using psychoeducation about night terrors and sleep paralysis, noting that it was possible to do this early, but that this had come up on a number of occasions. In contrast, Rory described a lengthy therapy guiding the client towards inconsistencies in their timeline, “[*they*] had gone to somebody who recovered memories...[*they were*] now remembering things that probably didn't happen...I...said to [*them*], “but you weren't in [*residential setting*] at that age.” [*they were*] like, “I wasn't”,” describing false memory clients as “*torturous hard work.*” However, the not-knowing stance was important even in these cases, as Mary noted, “*false memories, even if they are false, can represent a fantasy. And that to you might be important to work on, for that person's psychological functioning, is: what is the purpose of that fantasy or false memory?*”. What is apparent here is that participants were highly vigilant to the difference between clients reporting their memories, and clients who were interpreting partial, vague, or absent memories as signs of abuse for which they were seeking confirmation from their therapist, a distinction that has limited coverage in memory science research, aside from Dodier et al. (2023) hypothesising about IAMs.

So, in describing how they practice and what they see as best practice in working with RM, participants seemed to draw on quite a generalist trauma therapy style, or set of styles, without specific recommendations regarding RM. They suggested how important it was to monitor the intensity of their client’s feelings and manage the pace of their trauma recounting accordingly, they suggested that the use of permission and grounding helped to create a sense of safety, and they talked about how they support clients to find meaning in memories with a non-directive approach bolstered by psychoeducation. In terms of suggestion and RM,

participants described a careful distinction between someone having a memory, and someone with an absent or unclear memory for which they were requesting an interpretation—the latter of which participants reported gently questioning. What united participant descriptions was a focus on heightened caution, particularly due to risks of retraumatising vulnerable clients—this caution fed into practices that also tended to reduce suggestion, as participants sought to avoid premature disclosure and inappropriate meaning-making. Despite this caution, it appeared to be routine for clients to experience memories that surprised them, and psychoeducation was being used to educate clients about trauma memories. Therefore, it is important to consider how clinical psychologists and other therapists are educated about the concept of RM.

“My experience of that is mostly from the therapy room”: managing risk without a map

Participants described minimal formal training on RM, memory science, trauma, and dissociation. This education gap pushes responsibility for ethical, epistemic, and emotional management onto individual therapists, who rely on sourcing their own education and personal supports post-qualification, while carrying clinical caseloads. Participants also described distinctive countertransference reactions, involving a perfectionistic and results-oriented mindset driving clinicians to interpret for the client, or alternatively an overwhelmed mindset in which reported traumas are too painful to consider, both of which shape their capacity to tolerate memory uncertainty and trauma intensity. Along with this, participants reported negotiating complicated legal and ethical issues downstream of mandatory reporting rules. All participants gave their own recommendations for the education of clinical psychologists on RM. This theme suggests that institutions may have retreated from providing much needed supports to clinicians for engaging in work which involves trauma

disclosures and the uncertainty of RM, a potential avoidance of the reputational and legal risks associated with RM work.

Reliance on continuing professional development (CPD) due to limited formal coverage of recovered memories and trauma

Working with clients who have experienced trauma is widely considered to be a highly complex and delicate process, requiring careful cultivation of clinical knowledge, skills, and intuitions (Cook et al., 2017). With the addition of RM of trauma or abuse, the complexities and sensitivities are only heightened. However, a key theme in the current study has been that participants reported that their training in clinical psychology rarely prepared them to engage in this type of work, leaving them to seek out additional trainings or rely on their own reading of theory and research. All participants felt that improvements were needed to adequately train new clinicians to prevent the risks of retraumatising clients, causing memory distortion, or overlooking dissociation occurring during therapy sessions.

Many clinicians describing their education noted that the topic of RM was usually only covered at undergraduate level, e.g., *“I'd have to go back to undergrad days about memory...I wouldn't have had specific training about recovered memories...and how to manage recovered memories within a clinical population”* (John). This focus on practice, and what clinicians should be actively doing in sessions, was echoed by many, e.g., *“it was almost just a cautionary side of it to say, you know, “be careful of something like false memory syndrome”...but in terms of dealing with that therapeutically? There's very little training courses that focuses and help psychologists to deal with that”* (Thomas). Guidelines advise therapists to avoid memory-recovery techniques lacking empirical support (e.g., McNally, 2018). There is little in the way of suggesting what treatment *should* look like, particularly in the context of clients reporting RM of trauma.

The gap was not limited to RM specifically, but also to trauma presentations generally, e.g., *“there’s a huge lack of knowledge in our professions generally about trauma, the sequelae of trauma, and the sort of thing that you need to ask yourself”* (Rory). This focus on trauma more broadly than just RM was apparent with every participant, that trauma education more generally ought to be the priority in supporting the development of clinicians. One participant offered an explanation for perceiving a trauma training gap: *“possibly people feeling deskilled, or, ‘because there are specialist services, and I don’t work in a special service, that therefore I can’t do this work’,”* connecting this to a workplace experience of a senior clinical psychologist declining to work with a trauma client because *“they told me they didn’t have any training in working with trauma”* (Theresa). There is significant evidence highlighting inadequate trauma training in clinical psychology, with only approximately 5% of APA-accredited clinical psychology programs requiring a dedicated course on trauma-informed care, defined as coursework focused on understanding the impact of traumatic experiences, assessing trauma-related symptoms, and applying evidence-based interventions to address trauma’s psychological, physical, and social effects (Foltz et al., 2023). Theresa suggested that this is a broad gap connecting multiple phenomena, that clinical psychologists lack a *“good awareness of dissociation and, you know, how memory, particularly in terms of trauma, how memory works, how it doesn’t work...People can say they’ve never met somebody who dissociated, and it’s just that they don’t recognize it.”* This aligns with recent research indicating that dissociation is also frequently not covered in clinical psychology education, resulting in poor symptom recognition (e.g., Bestel et al., 2024).

Many participants stated that their knowledge of RM and trauma derived mainly from their post-qualification reading, work experience, continuing professional development (CPD) trainings, and supervision experiences (e.g., *“there’s supervision... and then my own research and reading around just what’s kind of the best approach,”* John). Several

participants mentioned the importance of Bessel van der Kolk and somatic approaches to trauma, Gabor Maté was mentioned by Rory, Úna McCluskey was mentioned by Seamus, Marylene Cloitre and Stephen Porges were mentioned by Theresa. This indicated that Theresa's experience, "*I was looking to other places and other researchers and other writers who were not memory experts, but more trauma experts,*" may have been shared by other participants. Several participants reported limited exposure to the literature on false memories, often stating that the examples they were aware of were historical and USA-based, e.g., "*the research I was exposed to was more occurring in the 60s...the famous case was of the Baptist pastor's daughter who accused him*" (Mary). Theresa similarly identified "*the Cleveland inquiry...the big McMartin case in the US,*" but also mentioned the British Psychological Society (BPS) guidance documents. Similarly, Rory stated "*I take most of my guidelines from the BPS, from the APA.*" Other specific trainings mentioned included eye-movement desensitisation and reprocessing (EMDR), narrative exposure therapy (NET) and spontaneous healing intra-systemic process (SHIP). What is clear is that there was a perception among the participants that clinical psychologists have been put in the position of being responsible for their own training and development in trauma and RM, and as Rory said, "*Once you have the chartered clinical psychologist label nobody will stand in the way of you...we have to account for ourselves, to ourselves*" (in the context of giving expert witness evidence in forensic cases).

Countertransference: the temptation to make suggestions and to deny client experiences

A key recommendation from the majority of participants was that practitioners need to be supported in managing countertransference, the complex feelings that arise in response to their clients. They recommended that clinical psychologists who work with people reporting RM of trauma should complete their own personal therapy and access high quality

supervision to support their work. It was noted as personally impactful, e.g., *“it took very rigorous, constant therapy of my own...I still saw my own therapist and supervisor once a week and would participate as well in peer supervision in order to deal with some of these more complex cases”* (Mary). Thomas compared personal therapy to practical experience, as the experience informs one’s intuitions about therapeutic practice, *“that is exactly where you learn: What is suggestive behaviour?...How you experience it when something is suggested to you? What is it that you experience when something is really true and really rings a bell with you?”*

In discussing what therapists need to know about RM, participants noted that countertransference reactions may increase the risk of suggestive practice. Seamus identified a problematic level of perfectionism that is common among trainee clinical psychologists, an insecure *“narcissism where the person gets a sense of self through helping others,”* which Theresa attributed to suggestive practices more directly, due to *“not having a space where you reflect on your own biases and your own assumptions and your own...countertransference...where...you don't pay enough attention to yourself in that [therapeutic] relationship.”* Beatrice described how wanting to quickly understand and help could become more important than identifying the best therapeutic approach, *“the temptation, as someone who's curious about that, might be to find out more. But is that actually what the person needs?”* (Beatrice). These are common countertransference reactions to clients that routinely occur in therapy, but they appear similar to what Betan et al. (2005) describe as special/overinvolved countertransference, where the client is experienced as someone in particular need of the therapist’s caregiving—often resulting in boundary issues. Thomas noted that there are significant systemic pressures to increase the pace of trauma work, expressing *“a concern that the training of clinical psychologists and psychotherapists are more and more taking the form of short-term, quick-fix approaches to appease the medical*

model and the pharmaceutical model, and also the financial models.” As a result, clinicians who are experiencing strong countertransference without supervisory support for it, or are under pressure to achieve rapid outcomes, may be tempted to offer premature interpretations that risk being suggestive and inducing memory distortion, *“answering their questions for them”* due to *“stuff that's going on in your own life that you don't want to look at”* (Rory).

Mary noted that *“not all psychologists would want to work with this kind of case”* due to the emotional intensity involved. However, she also highlighted a mirror-image type of countertransference, which is essential for considering improving teaching on the risks of memory distortion and false memories. Mary described her own early reactions during training, where the stories she heard were so bizarre and distressing that she was tempted to deny that anyone could have such terrible experiences: *“I wanted to shut it down and I didn't want to believe her and I think that was part of my human reaction in going, “This can't be true”...a magical belief that the world's a safe place and good things happen to good people...my own sense of needing to protect myself from something I found so painful to hear or witness.”* This is reminiscent of the ‘belief in a just world (BJW)’, a social psychology finding where people tend to disbelieve victims of injustice to avoid cognitive dissonance and maintain a belief that the world is fundamentally a just and fair place (Furnham, 2003). It is apparent that such a reaction could be additionally problematic in the uncertain context of RM—either in the form of being tempted to engage in denial of the client’s experience without due consideration, or in the form of disengaging from this highly at-risk client group.

Legal complications

In the Irish context of child protection laws, therapists are mandatory reporters with a legal obligation to report present or past abuse of children, under Children First legislation introduced in 2015. Unfortunately, for adult clients reporting retrospectively, participants

noted that mandatory reporting risks silencing or discouraging clients from attending therapy (John, Mary, Theresa, Thomas), creating a conflict between legal obligations and therapeutic goals that has been reflected in previous research with Irish clinicians (Pellegrini et al., 2023). Participants described a resistance to the policies despite adhering to their legal responsibilities, e.g., *“I feel like I'm telling on them”* (John). The context of RM brings with it a host of additional considerations and complexities when engaging with the legal system, because there is a certainty assumed by the system that the clinician may lack due to awareness of reconstructive memory, e.g., *“we know human memory doesn't work like a video recording...it's so unclear because it's all that cognitive distortion over time, as well as then the intense emotions”* (Mary).

This creates a particular risk for people whose memories are unclear or fragmented, as *“such a process in itself can be very traumatic”* (Thomas), with an often-insensitive approach taken to extremely sensitive topics, *“Garda interviews in particular can be really hard...it's a nontherapeutic process, obviously”* (Beatrice). Theresa highlighted the risk of retraumatisation from engaging in the adversarial legal process, where a client who had *“a kind of a feeling...a belief”* but with no memories of abuse presented ethical dilemma: *“I actually think it would be really damaging for them...because they would be challenged in ways that...they wouldn't be able to stand over what it is they're saying.”* It is important to recognise that all clinical psychologists have an ethical responsibility to manage these complexities, but that sometimes they exist in an uncomfortable grey area: *“everything that is legal is not necessarily ethical. And the other way around”* (Thomas). It is also interesting to note that no participants identified the risk to the practitioner of inducing false memories and experiencing legal consequences themselves, instead focusing exclusively on the consequences for the client, e.g., *“it is really, really harmful for someone to believe they've been abused if they haven't”* (Theresa).

Recommendations for safe memory work

In terms of training, some participants mentioned that postgraduate training in memory science and RM would be appropriate, e.g., *“a crash course in memory and what it means and how it works and how it's integrated...that educational bit of: what's the up to date science on memory and what we know?”* (Seamus). Beatrice expressed a preference for experiential learning, *“integrating theory and practice...working with actual case material...in formulating,”* and Seamus recommended *“videotape or audio tape and in the moment, with a senior clinician helping them look at it...I think...maybe it's almost like lab work,”* comparing this to army recruits running drills in combat to be prepared for war.

Theresa suggested that best practice would look like going *“back to the basics in terms of the therapeutic relationship...you allow the client to take the lead and you your role really is as a facilitator...those Rogerian principles”* to protect against suggestive styles of practicing. This was echoed by John, suggesting a way to *“package a training for the future psychologists...something along the lines of: ‘How to get people to narrate traumatic experiences in a safe and compassionate way.’”* NET and EMDR training were noted as evidence-based and beneficial by several participants, as were somatic or affect-focused approaches to therapy. Mary added *“every psychologist needs trauma training. Unfortunately...you run the risk every time someone walks in your door. They could be bringing a whole history with them.”*

So, it is apparent that participants perceived an urgent need for robust trauma-memory education in clinical psychology training, to support new clinicians to avoid suggestive practices, manage countertransference, and deliver safe therapy. Crucial aspects of learning to be competent in this area, according to participants, would also include ongoing personal

therapy, effective supervision, and continuous learning in the area throughout one's career. Such an approach would safeguard ethical practice when working with clients reporting RM.

Taken together, participants reported a neglect of trauma and RM in the training of Irish clinical psychologists. Due to insufficient formal education, practitioners are perceived to be responsible for upskilling themselves post-qualification, relying on accessing their own CPD and seeking specialised supervisors with experience in the area. The risks of retraumatising or distorting the memories of clients are increased by the typical countertransference reactions to these clients, where perfectionistic clinicians seeking to quickly target trauma might jump into a 'fix-it' mindset where they suggest trauma interpretations based on ambiguous evidence, or clinicians overwhelmed by the content of trauma narratives might end up in denial about their client's traumatic experiences or withdrawing from such clients. These complexities are compounded by tricky ethical responsibilities in the legal context of mandatory reporting, which may disproportionately impact clients whose memories are fragmented, unclear, or narratively undeveloped—precisely the clients most vulnerable to retraumatisation or epistemic invalidation. Taken together, this illustrates how participants were often left to manage high-stakes ethical and epistemic dilemmas without clear educational guidance. Such education will need to be highly practical and relevant to practice—participants emphasised the need for this learning to be experiential and directly applicable to how to manage RM within therapy sessions, rather than purely theoretical learning about memory science.

Discussion

To the authors' knowledge, this is the first qualitative study to explore how clinical psychologists interpret and work with RM. The three themes developed—conceptual

distancing from the term ‘recovered memory’, folding such experiences into a general trauma-informed framework, and managing risk without a map—suggest that clinicians have developed a distinct set of practices and interpretive strategies in the aftermath of the Memory Wars. Rather than adopting the terminology or conceptual models of memory science, participants described alternative framings of clients’ surprising or emergent memories. Their approaches were marked by epistemic caution, pragmatic therapeutic neutrality, and a focus on addressing underlying trauma. Participants also reported developing their post-qualification understanding of memory and trauma through self-directed learning, often drawing on frameworks that diverge from dominant cognitive memory paradigms due to a lack of coverage in their formative training. This research takes a significant step towards answering questions about how clinicians make sense of RM therapeutically in a way that survey responses cannot. It addresses a core clinical dilemma: how to offer ethically sound, psychologically attuned care when working with ambiguous trauma narratives in the absence of definitive guidance. The findings illustrate how participants negotiated this challenge through trauma-informed containment, flexible meaning-making, and a principled suspension of judgement.

Analytic conclusions and contributions

A coherent interpretative logic connects the three themes, particularly in how participants navigated uncertainty regarding the veracity of RM. They manage multiple intersecting risks: invalidation, retraumatisation, and memory distortion. Participants deployed what might be termed *strategic ambiguity*—an intentional avoidance of epistemic closure—prioritising therapeutic care rather than forensic scrutiny. Even when directly dealing with potential false memories or client requests to interpret hidden traumas, participants’ responses indicated drawing these issues into a trauma informed care approach rather than diverting into forensic

fact-finding. The ambiguity and uncertainty here does not refer to a lack of knowledge or understanding, but a deliberate therapeutic strategy which respects client autonomy and validates their experience without prematurely labelling or interpreting their experiences for them. This is a subtle but deeply significant shift in considering education for therapists about RM: rather than aiming to resolve uncertainty through education, clinicians may need to be explicitly supported in sustaining therapeutic ambiguity as a core feature of ethical practice.

Further, this highlights a critical tension: the false memory paradigm, in focusing on avoidance of suggestion to preserve memory accuracy, can be perceived to come at the expense of addressing clients' clinical needs. Where existing guidelines focus on what not to do (e.g., McNally, 2018), participants emphasised pragmatic strategies for what can and should be done when navigating clinical uncertainty. This ambiguity also appeared at the institutional level, where participants suggested that training programmes underemphasised both trauma theory and memory distortion, leaving clinicians to negotiate these tensions with minimal formal support. Instead, participants described a relatively structured approach to working on memories with traumatic content—grounding, non-directive questioning, reinterpretation of the emotional meaning of the memories—which aligns with treatments for complex trauma (e.g., Courtois, 2004), and fits with the popular trauma treatment framework of Herman (1992): stabilisation, remembrance and mourning, and reconnection and integration.

A key element of this tension lies in defining the phenomenon of RM. Participants mirrored the findings of survey research in the area by suggesting a broad range of memory phenomena as RM, which would typically escape the definition offered by memory scientists, e.g., the person had “*come to remember being abused as a child, when you had no previous memory of such abuse*” (Patihis & Pendergrast, 2019). The typical practice in the memory science field involves exclusion of these memories through the continuous memory label

(e.g., McNally, 2005; Dodier et al., 2024). While the IAM framework for interpreting RM in a broader light is promising and may capture some of the phenomena described by participants (Dodier et al., 2023), participants demonstrated that practice contexts demand moving beyond a dichotomy of continuous and discontinuous memories to respond to clinical needs in the present. Clinical practice, by necessity, proceeds without awaiting resolution of theoretical debates. Participants' accounts highlight that therapists must make sense of ambiguous memory material in immediate clinical work, often under conditions of legal and ethical pressure that exceed the scope of current empirical classifications. These findings raise pressing questions for clinical education and professional regulation, particularly around how institutions prepare clinicians to work ethically and effectively with ambiguous memory material in contexts of legal obligation and psychological risk. A shift toward trauma-informed memory education, grounded in clinical realities rather than theoretical certainty, may be essential.

The core findings regarding ambiguity may also reflect the particular composition of the participant group. Many participants held senior or principal psychologist roles, and some further experience in forensic psychology work, acting as an expert witness in legal cases, and working within specialist trauma services. This likely contributed to a comfort with and high tolerance for uncertainty and complex client presentations, shaping the resulting analysis through pragmatic clinical perspectives developed over years of working at the interface of psychological care and legal scrutiny. This flexible and ambiguous approach may also have been shaped by the contributions of the more specifically psychodynamically-trained participants.

Study evaluation

The Big Q approach of RTA was highly appropriate in drawing out the nuanced meanings and interpretations of RM that practicing Irish clinical psychologists draw on. A rich dataset was developed from a specialised participant group, and this may offer transferable insights for many trauma-informed settings across disciplines. The quality of the analysis was enhanced through reflexive journalling and supervisory dialogue, allowing for a co-construction of meaning which respected participants' lived experiences through reflexive humility.

This study also carries certain limitations. Demographic data beyond sex and professional background was not gathered, limiting explorations of diversity. The research was conducted by a junior clinician interviewing expert clinicians about best practices, with a previously-mentioned respect for participants' clinical judgement. Furthermore, having a shared identity with participants as clinical psychologists, there is an incentive to focus on core therapeutic concerns regarding how best to help clients, rather than solely empirical considerations. This positioning supported exploration of contextual dynamics, such as the tension between mandatory reporting and validation of RM. It also likely created a limitation in the degree of critical interrogation of participants during interviews, in comparison to the possible approach of a researcher whose predominant identification was with memory science or cognitive psychology more broadly.

Implications

Reframing recovered memories in memory science: The false memory paradigm defines RM narrowly—as repressed, unconscious, and retrieved via suggestion—then dismisses them as a “myth” (e.g., Lilienfeld et al., 2013, p. 889). The term “*continuous memory*”, defined simply as “*available to recall*” (Read, 1999, p. 3), encompasses an unhelpfully wide range of memory experiences: incompletely encoded memories, memories not thought about for years, and memories reinterpreted later (McNally, 2005). This

overlooks advances in autobiographical memory, cue-based retrieval, and non-verbal forms of memory (e.g., Dodier et al., 2023), missing an opportunity to reflect what clinicians typically encounter. Many RM cases discussed by participants in this study are perhaps better labelled as delayed recall of memories (e.g., Elliott, 1997): surprising, emotionally intense, but not truly inaccessible. The continuous-repressed dichotomy leaves clinicians without conceptual tools to describe memory presentations which are routine in therapy. Grounding RM in long-term autobiographical memory research, clearly distinguished from repression, could help close the scientist-practitioner gap.

Practice-oriented training: Professional and continuing professional education on RM should incorporate practice-based guidance on how to work therapeutically with ambiguous or emerging memory content. Participants in this study described the use of non-directive approaches, trauma memory exposure work (e.g., NET, EMDR), and integrative depth models (e.g., schema therapy, psychodynamic therapy) in treatments focused on the memories of clients, lacking more specific guidance. From the themes developed in the current study, it may be useful to emphasise staged approaches utilising a treatment hierarchy, aiming to limit suggestive effects by correctly timing trauma narrative recounting, and giving specific guidance on when and how to deploy psychoeducation about memory.

Experiential learning and formulation practice: Memory science education for mental health practitioners should emphasise clinical utility through experiential learning methods. Role-plays, video-taped sessions, and case formulation practice using anonymised real-world cases can bridge the gap between theoretical models and ethical, therapeutic practice (Kaluzeviciute, 2021; Neidhart & Löffler-Stastka, 2020).

Conclusion

This study highlights how clinicians are already engaging in ethically attuned, pragmatically cautious work with RM, despite limited institutional guidance and ongoing scientific uncertainty. Rather than adjudicating memory accuracy, their focus on therapeutic containment and client meaning-making offers a vital counterpoint to dominant risk-avoidant narratives. Future research and training should take seriously this grounded, context-sensitive expertise.

Contributions

Conceptualization: O. Carey, G. Murphy, and M. Dempsey; Methodology: O. Carey, G. Murphy, M. Dempsey; Formal Analysis: O. Carey; Investigation: O. Carey; Writing – Original Draft Preparation: O. Carey; Writing – Review & Editing: O. Carey, G. Murphy, and M. Dempsey; Supervision: G. Murphy, and M. Dempsey; Project Administration: G. Murphy and M. Dempsey.

Conflicts of Interest

No potential conflict of interest was reported by the author(s).

References

- Bateman, A., & Fonagy, P. (2016). *Mentalization-based treatment for personality disorders: A practical guide*. Oxford University Press.
- Bestel, N. S. A., Williamson, D. C., Tirlea, L., & Mackelprang, J. L. (2024). Dissociation training and symptom identification accuracy among Australian psychologists. *Psychological Trauma: Theory, Research, Practice, and Policy*. Advance online publication. <https://doi.org/10.1037/tra0001717>
- Betan, E., Heim, A. K., Zittel Conklin, C., & Westen, D. (2005). Countertransference Phenomena and Personality Pathology in Clinical Practice: An Empirical Investigation. *American Journal of Psychiatry*, 162(5), 890–898. <https://doi.org/10.1176/appi.ajp.162.5.890>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101. <https://doi.org/10.1191/1478088706qp063oa>
- Braun, V., & Clarke, V. (2022). Conceptual and design thinking for thematic analysis. *Qualitative Psychology*, 9(1), 3–26. <https://doi.org/10.1037/qup0000196>
- Braun, V., & Clarke, V. (2024). Supporting best practice in reflexive thematic analysis reporting in Palliative Medicine: A review of published research and introduction to the Reflexive Thematic Analysis Reporting Guidelines (RTARG). *Palliative medicine*, 38(6), 608-616. <https://doi.org/10.1177/02692163241234800>
- Braun, V., & Clarke, V. (2025). Reporting guidelines for qualitative research: A values-based approach. *Qualitative Research in Psychology*, 22(2), 399-438. <https://doi.org/10.1080/14780887.2024.2382244>
- Brewin, C. R., Li, H., Ntarantana, V., Unsworth, C., & McNeilis, J. (2019). Is the public understanding of memory prone to widespread “myths”? *Journal of Experimental Psychology: General*, 148(12), 2245–2257. <https://doi.org/10.1037/xge0000610>

- Cook, J. M., Simiola, V., Ellis, A. E., & Thompson, R. (2017). Training in trauma psychology: A national survey of doctoral graduate programs. *Training and Education in Professional Psychology, 11*(2), 108–114.
<https://doi.org/10.1037/tep0000150>
- Courtois, C. A. (2004). Complex trauma, complex reactions: Assessment and treatment. *Psychotherapy: Theory, Research, Practice, Training, 41*(4), 412–425.
<https://doi.org/10.1037/0033-3204.41.4.412>
- Davis, D., & Loftus, E. F. (2020). Recovered memories and false memories. In J. R. Geddes, N. C. Andreasen, & G. M. Goodwin (Eds.), *New Oxford textbook of psychiatry* (3rd ed.). Oxford University Press.
- Dodier, O., Barzykowski, K., & Souchay, C. (2023). Recovered memories of trauma as a special (or not so special) form of involuntary autobiographical memories. *Frontiers in Psychology, 14*, 1268757. <https://doi.org/10.3389/fpsyg.2023.1268757>
- Dodier, O., Otgaar, H., & Mangiulli, I. (2024). Beyond repressed memory: Current alternative solutions to the controversy. *Topics in cognitive science, 16*(4), 574–589.
<https://doi.org/10.1111/tops.12754>
- Elliott, D. M. (1997). Traumatic events: Prevalence and delayed recall in the general population. *Journal of Consulting and Clinical Psychology, 65*(5), 811–820.
<https://doi.org/10.1037/0022-006X.65.5.811>
- Felstead, K., & Patihis, L. (2025). There is only one truth, the objective truth, in recovered memory cases. *Legal and Criminological Psychology*.
https://doi.org/10.1111/lcrp.2_12275
- Foltz, R., Kaeley, A., Kupchan, J., Mills, A., Murray, K., Pope, A., Rahman, H., & Rubright, C. (2023). Trauma-informed care? Identifying training deficits in accredited doctoral

- programs. *Psychological trauma : theory, research, practice and policy*, 15(7), 1188–1193. <https://doi.org/10.1037/tra0001461>
- Furnham, A. (2003). "Belief in a Just World: Research Progress Over the Past Decade." *Personality and Individual Differences*, 34(5), 795–817.
[https://doi.org/10.1016/S0191-8869\(02\)00072-7](https://doi.org/10.1016/S0191-8869(02)00072-7)
- Garb H. N. (2005). Clinical judgment and decision making. *Annual review of clinical psychology*, 1, 67–89. <https://doi.org/10.1146/annurev.clinpsy.1.102803.143810>
- Herman, J. L. (1992). *Trauma and recovery*. Basic Books/Hachette Book Group.
- Kaluzeviciute, G. (2021). Appraising psychotherapy case studies in practice-based evidence: introducing Case Study Evaluation-tool (CaSE). *Psicologia: Reflexão e Crítica*, 34, 9.
<https://doi.org/10.1186/s41155-021-00175-y>
- Lilienfeld, S. O., Ritschel, L. A., Lynn, S. J., Cautin, R. L., & Latzman, R. D. (2013). Why many clinical psychologists are resistant to evidence-based practice: Root causes and constructive remedies. *Clinical psychology review*, 33(7), 883-900.
<https://doi.org/10.1016/j.cpr.2012.09.008>
- Lindsay, D. S., & Read, J. D. (1995). "Memory work" and recovered memories of childhood sexual abuse: Scientific evidence and public, professional, and personal issues. *Psychology, Public Policy, and Law*, 1(4), 846–908. <https://doi.org/10.1037/1076-8971.1.4.846>
- Linehan, M. M. (1997). Validation and psychotherapy. In A. C. Bohart & L. S. Greenberg (Eds.), *Empathy reconsidered: New directions in psychotherapy* (pp. 353–392). American Psychological Association. <https://doi.org/10.1037/10226-016>
- Loftus, E. F., & Davis, D. (2006). Recovered memories. *Annual Review of Clinical Psychology*, 2, 469–498. <https://doi.org/10.1146/annurev.clinpsy.2.022305.095315>

- Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample Size in Qualitative Interview studies: Guided by Information Power. *Qualitative Health Research*, 26(13), 1753–1760. <https://doi.org/10.1177/1049732315617444>
- McNally, R. J. (2005). Debunking myths about trauma and memory. *The Canadian Journal of Psychiatry*, 50(13), 817–822. <https://doi.org/10.1177/070674370505001302>
- McNally, R. J. (2018). Recovered memories of childhood sexual abuse. In R. Rogers & S. D. Bender (Eds.), *Clinical assessment of malingering and deception* (4th ed., pp. 387–400). The Guilford Press.
- McNally, R. J., & Geraerts, E. (2009). A new solution to the recovered memory debate. *Perspectives on Psychological Science*, 4(2), 126–134. <https://doi.org/10.1111/j.1745-6924.2009.01112.x>
- Melchert, T. P. (2011). *Foundations of professional psychology: The end of theoretical orientations and the emergence of the biopsychosocial approach*. Elsevier.
- Murphy, G., Coyle, O., Kerin, M., Ryan, C., & Dempsey, M. (2025). Recovered memory practices in Ireland: public & professional perspectives. *Memory*, 1–12. <https://doi.org/10.1080/09658211.2025.2462645>
- Neidhart, E., & Löffler-Stastka, H. (2020). Case studies in psychotherapy training using Austria as an example. *World journal of clinical cases*, 8(13), 2787–2801. <https://doi.org/10.12998/wjcc.v8.i13.2787>
- O'Hara, D. (2012). Reconciling technical and practical knowledge in psychotherapy through Polanyi's tacit knowing. *Counselling Psychology Review*, 27(1), 64–72. <https://doi.org/10.53841/bpscpr.2011.27.1.64>
- Otgaar, H., Howe, M. L., & Patihis, L. (2021). What science tells us about false and repressed memories. *Memory*, 30(1), 16–21. <https://doi.org/10.1080/09658211.2020.1870699>

- Otgaar, H., Howe, M. L., Patihis, L., Merckelbach, H., Lynn, S. J., Lilienfeld, S. O., & Loftus, E. F. (2019). The Return of the Repressed: The Persistent and Problematic Claims of Long-Forgotten Trauma. *Perspectives on Psychological Science*, 14(6), 1072–1095. <https://doi.org/10.1177/1745691619862306>
- Patihis, L., & Felstead, K. (2025). British False Memory Society: Caseload and details by year (1993 onwards). *Legal and Criminological Psychology*.
<https://doi.org/10.1111/lcrp.12274>
- Patihis, L., & Pendergrast, M. H. (2019). Reports of recovered memories of abuse in therapy in a large age-representative U.S. National sample: Therapy type and decade comparisons. *Clinical Psychological Science*, 7(1), 3–21.
<https://doi.org/10.1177/2167702618773315>
- Pellegrini, S., Moore, P., Murphy, M., & Flynn, D. (2023). Experiences of psychologists in applying mandatory reporting in Ireland (Children First). *Journal of Public Child Welfare*, 17(5), 1086-1109. <https://doi.org/10.1080/15548732.2022.2137272>
- Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of counseling psychology*, 52(2), 126.
DOI: 10.1037/0022-0167.52.2.126
- Read, J. D. (1999). The recovered/false memory debate: Three steps forward, two steps back?. *Expert Evidence*, 7(1), 1-24. <https://doi.org/10.1023/A:1008944412980>
- Schemmel, J., Datschewski-Verch, L., & Volbert, R. (2024). Recovered memories in psychotherapy: a survey of practicing psychotherapists in Germany. *Memory*, 32(2), 176-196. <https://doi.org/10.1080/09658211.2024.2305870>
- Van der Kolk, B. A. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. Viking.

Wright, K. (2017). Remaking collective knowledge: An analysis of the complex and multiple effects of inquiries into historical institutional child abuse. *Child Abuse & Neglect*, 74, 10–22. <https://doi.org/10.1016/j.chiabu.2017.08.028>

Chapter 4: Navigating Methodological Reflexivity, Researcher Positioning, and Epistemological Integrity in Reflexive Thematic Analysis

Introduction

Reflexive thematic analysis (RTA), situated in the Big Q qualitative tradition, emphasizes interpretative practice over procedural method, foregrounding researcher subjectivity and contextual meaning-making (Braun & Clarke, 2025). This chapter critically audits the methodological choices and epistemological coherence of this RTA study. Integral to this audit is an exploration of the underlying philosophy and positioning of the research and of the researcher, where the internal coherence between the aims, epistemological paradigm, and methods is key to evaluating the piece of work (Levitt et al., 2017). For excerpts of process of RTA stage development, see Appendix I.

Epistemological Commitments and Theoretical Framing

In completing a RTA, it is integral to the framework that particular epistemic assumptions are built into the methodology and logic of the work, and critically are made transparent. Assumptions are also built into quantitative research practices, which themselves have their value and role in the broader scientific endeavour. The positivist and postpositivist paradigms typically guide quantitative designs (and also some qualitative research), in which the goal is to verify or falsify a priori hypotheses derived from theory (Ponterotto, 2005). The perspectives tend to be nomothetic, seeking to identify generalisable predictions about human psychology, and tend to be etic in the aim to find patterns that are universal and apply across humanity. In contrast, much qualitative research tends to operate within the constructivist-interpretivist paradigm, which assumes an epistemic relativism in which multiple truths are possible, and the approach to evidence tends to be idiographic in emphasising individual

complexity and uniqueness, along with an emic approach which situates truths within their specific personal and social context (Ponterotto, 2005).

RTA is situated directly in the constructivist-interpretivist epistemological paradigm. Reflexivity here does not aim for neutrality or unbiased analysis, but instead places the researcher's subjective experience at the centre of the analysis—developing an analysis that is rich, immersed in the data, and with themes that emerge from the researcher's creative engagement with the data (Braun & Clarke, 2022). Methodological quality with this approach is more so associated with the congruence and integrity of the research, where the theoretical assumptions, research questions, methods employed, approach to generating data, and analytic choices are conceptually matched (Levitt et al., 2017). There can be a risk of inappropriate conceptual mixing, such as integrating quantitative or positivist methods like theme counts or the idea of data saturation (Braun & Clarke, 2025)—as such, it is essential to correctly frame the constructivist-interpretivist paradigm inherent to RTA and ensure the methodology reflects this epistemology.

The current study utilised a semi-structured interview that was based around anchor points and suggested questions, rather than rigid structure. This allowed for a messy, flowing quality to conversations that maximised the opportunity for authentic engagement and the co-construction of meaning within the interview itself—I often found myself repeating ideas back to participants, or offering summaries of what I was hearing, and this expanded and deepened the conversation without need for a question to guide us in that moment. This allowed for an atmosphere of mutual exploration: I was exploring the participant's thoughts and experiences, but they were also exploring their thoughts and experiences, noticing what was arising for them in the moment. In analysing the data, my goal was not just to faithfully or accurately describe what was said, but to capture the atmosphere and emotional meaning of what was being communicated, and the way that I had received it both in the moment and

on reflecting and immersing myself in the transcripts. Given the epistemological commitments of RTA, the focus was on making my role in constructing this research transparent, rather than attempting to remove myself or mitigate my influence as in a positivist/postpositivist approach.

Researcher Positionality

My position within this research project had several layers worth exploring, both to meet qualitative quality standards and to illuminate how my positioning shaped the analytic process. I am a male trainee clinical psychologist, supervised by a cognitive scientist with expertise in memory research and a counselling psychologist with expertise in qualitative methods. I had no prior relationships with participants, but in a small country like Ireland it is likely that I will later interact with at least some of the participants again in a professional setting. My communications with them focused on my intent to explore ethical practice in therapy regarding recovered memories (RM). Following calls to “write the researcher in” (Gaddefors & Cunningham, 2024), I articulate here the dialectical stance I brought to the study.

To ensure sensitivity to the risks of both false positives (false memory formation) and false negatives (denial or erasure of traumatic experiences), I engaged critically with case material from both sides of the memory debate. Regarding false memory, I focused particularly on a documented case involving an Italian therapist whose highly suggestive techniques led a teenage client to form demonstrably false abuse allegations (Otgaar et al., 2022). I also examined the case of Barbara Snow, a prominent figure during the Satanic Panic, whose research and therapeutic practices were later discredited. Snow published claims about widespread satanic ritual abuse (e.g., Snow & Sorensen, 1990) and was centrally involved in multiple child sex abuse cases, where courts subsequently found

evidence of improper coaching and coercive interview practices in therapy with children (Schouten, 1994).

To balance this perspective, I examined how trauma survivors can be invalidated or disbelieved. Salter and Blizard (2022) argue that the false memory movement, partly driven by financially incentivised defence experts, demonstrated “*elasticity of the logic of false memories*,” (p. 142) in legal cases. I found this critique persuasive in indicating the existence of overcorrections resulting from the Memory Wars. The Goodman et al. (1994) report, commissioned in response to the Satanic Panic, found no evidence supporting the literal existence of satanic cults, but did document significant levels of intrafamilial and religiously-themed abuse. Bottoms et al. (1996) expanded on the data gathered in the 1994 study, reporting that 44% of ritual abuse cases reviewed by social services were substantiated—but specifically for child abuse, rather than ritualistic elements. This reinforced my view that nuance is essential when evaluating delayed or incoherent trauma narratives.

While my broader intellectual orientation is shaped by postpositivist scepticism and Popperian falsificationism (Popper, 1968), I recognised that this project required an interpretivist stance. In RTA, researcher subjectivity is not a threat to rigour but a resource to be acknowledged and cultivated (Braun & Clarke, 2022). Although the false memory paradigm is often cast as the sceptical position, I found the dichotomy between continuous and RM to be excessively limiting (see Chapter 2). Human memory is reconstructive and fallible, but it also enables long-term recall of autobiographical memories, including trauma. McNally’s (2005) claim that traumatic events are usually vividly remembered struck me as a considerable overstatement. Suggestion works in both directions: just as a therapist can use suggestion to drive false memory formation, an abusive caregiver can use fear, violence and denial to disrupt a child’s ability to reconstruct memories and narrate their experiences. A child chronically subjected to sexual abuse and then accused of lying and attention-seeking

when disclosing may, as an adult, struggle to retrieve those memories with clarity or confidence.

These epistemic tensions between the risk of suggestion and the risk of invalidation were mirrored in participants' own accounts, and they informed my analytic stance. The concept of strategic ambiguity, which emerged as a central theme in this study, resonates deeply with my own posture as a researcher: cautious, reflexive, and committed to navigating complexity without premature closure.

Analytic Approach

The current study selected RTA as the analytic approach, however other approaches were also considered: coding reliability TA, codebook TA, and interpretative phenomenological analysis (IPA). Each approach had its own philosophical underpinnings and methodological consequences.

Coding reliability TA is most aligned with 'small q' qualitative research, placed within the postpositivist paradigm. It prioritises generalisability by developing a coding guide which facilitates calculation of inter-rater reliability to reduce bias—a postpositivist assumption (Ponterotto, 2005). The coding guide is developed by creating topic summaries early in the analysis, structuring data coding based on the guide. This increases perceived transparency and accuracy in what O'Connor & Joffe (2020) call "external quality signalling," but using topics which are descriptive and categorical limits analytic depth (Braun & Clarke, 2022).

Codebook TA pragmatically straddles the divide between small q and Big Q qualitative research, combining a structured approach of coding using a predefined guide to coding the data but allowing a measure of subjectivity and interpretation. The codebook themes are refined as research progresses, aiming to support collaboration between multiple

researchers (Braun & Clarke, 2022). Template Analysis (Brooks et al., 2015) is one codebook approach that uses a priori themes, hierarchical coding, and an iterative theme development process designed for efficiency in team-based analysis, but can reduce attention to holistic understanding of individual accounts (Brooks et al., 2015).

With other approaches to TA available, choosing RTA involved accepting that the analysis produced may not be generalisable in the positivist or postpositivist sense. However, the analysis has the capacity to produce transferable insights, or what Smith (2018) terms “*analytical generalisability*”. In addition, the transparency of the approach can offer an alternative way to conceive of the reliability of the analysis (Tuval-Mashiach, 2017), which was supported in the current analysis by structuring the report based on the Big Q Qualitative Reporting Guidelines (BQQRG; Braun & Clarke, 2025).

The Big Q values underlying the current research meant that IPA was also under strong consideration for the analytic approach. Similarly to RTA, IPA is aligned with the constructivist-interpretivist paradigm (Ponteretto, 2005), with idiographic focus and suitability for an individual researcher. IPA presupposes a specific phenomenological commitment to first-person *lived experience* rather than meaning making as such, focusing on the particulars of the person’s lifeworld and the different layers and parts of what matters to them (Eatough & Smith, 2017). IPA’s employment of a double hermeneutic requires a deep, iterative process of interpreting the participant’s interpretation of their own experience across multiple layers ranging from empathetic to suspicious and identification of ‘gems’ which illuminate the meaning of the experiences (Eatough & Smith, 2017).

While IPA could have been used to explore the subjective experience of uncertainty clinicians had regarding RM, the study had broader aims of synthesising practice-relevant insights across participants. Meaning making was of central interest in addressing these questions, so IPA’s focus on lived experience subtly but importantly shifts the analytic lens to

more idiographic concerns and exploration of participants' internal experiences. The goal was to produce thematically organised, practice-relevant insights about clinicians' perspectives, best-practice approaches, and educational needs regarding RM across the dataset—therefore, RTA was the best fit for this research.

A key methodological decision involved determining an appropriate number of participants. Data saturation, a frequently used concept in qualitative research, assumes themes exist in the data awaiting discovery, whereas RTA assumes themes are generated through researcher interpretation, and thus 'saturation' becomes epistemologically incoherent in this framework (Braun & Clarke, 2022, 2025). Instead, relying on Malterud et al.'s (2016) concept of information power, we aimed for a narrow study aim that was theory driven (memory work and suggestion risking memory distortion) based on a highly specific participant base engaged in deep, complex interviews that valued individual contributions as much as cross-case comparisons. Even with seven participants, there was a richness and nuance to the dataset that facilitated multiple ways to interpret and analyse, and so it was decided that there was sufficient information power to proceed with the analysis with a focus on our theoretical aims.

Reflections on Analytic Product

By situating this research within the Big Q qualitative tradition, in a meaningful sense this analysis is itself socially constructed—a situated interpretation of meaning, rather than a direct or objective representation of reality. With the Memory Wars continuing in a divisive debate (Otgaar et al., 2019), there is a methodological pressure to resolve ambiguity, either by equating RM with false memories developed through suggestion, or by claiming that RM are an accurate representation of the events in people's lives. In such a polarised context, there can be a tension in utilising a subjectivist approach with participants. Had I aligned myself

with a postpositivist paradigm to evaluate the hypotheses of false memory theory, I might have centred distinctions between continuous memories and RM, or introduced interviews with a research-driven definition of RM connected to repression theory. RTA does encourage the researcher's values and perspectives to be a central part of the interpretation process, co-constructing meaning with participants.

However, embedding a postpositivist stance into this research would have created an incoherence with the values of Big Q qualitative research, compromising its epistemological integrity (Braun & Clarke, 2025). The *method* of RTA means that the aim is not to arrive at prediction or “truth”—the aim is to co-construct knowledge of situated meaning. I was not attempting to make empirical truth claims about the veracity of RM or adjudicate that debate. I was creating a space in which clinicians were reflecting and making sense of their experiences of RM. As such, the analytic product—interpreting the perspectives of clinical psychologists on RM through the lens of strategic ambiguity—is a mirror of my own process in completing this research. I engaged reflexively in how meaning was being constructed, deferred, or negotiated by participants, an approach that is epistemologically consistent with constructivist inquiry (Braun & Clarke, 2022; Ponterotto, 2005). This not-knowing stance is not an evasion of the recovered memory debate, but an intentional methodological ethic—one that I interpreted as reflected in the clinical humility and epistemic caution displayed by participants.

Conclusion

The study's reliance on RTA, situated within the Big Q qualitative tradition, resulted in an alignment with the constructivist-interpretivist paradigm (Ponterotto, 2005), which enabled an in-depth exploration of the latent meanings that were co-constructed throughout the interview process. In exploring a contested topic like RM, this subjectivist approach

allowed for movement away from factual adjudication and towards participants' situated meaning-making when working therapeutically under conditions of epistemic uncertainty. Strategic ambiguity emerged as both an organising concept to describe how participants made sense of working with RM, and also as a way to understand the methodology of using RTA to study a controversial field, indicating a coherence and design fit aligned with Big Q values (Braun & Clarke, 2022). Future research on contested topics may benefit from the use of RTA and Big Q qualitative research to offer deeper insight into how meaning is constructed in contexts of emotional and epistemic complexity, thereby enriching ongoing professional and theoretical debates. Future research could employ IPA analysis to deepen understanding of the lived experiences of clinicians working under the pressure and uncertainty of recovered memory cases.

References

- Bottoms, B. L., Shaver, P. R., & Goodman, G. S. (1996). An analysis of ritualistic and religion-related child abuse allegations. *Law and Human Behavior*, 20(1), 1–34.
doi:10.1007/bf01499130
- Braun, V., & Clarke, V. (2022). Conceptual and design thinking for thematic analysis. *Qualitative Psychology*, 9(1), 3–26. <https://doi.org/10.1037/qup0000196>
- Braun, V., & Clarke, V. (2025). Reporting guidelines for qualitative research: A values-based approach. *Qualitative Research in Psychology*, 22(2), 399-438.
<https://doi.org/10.1080/14780887.2024.2382244>
- Brooks, J., McCluskey, S., Turley, E., & King, N. (2015). The utility of template analysis in qualitative psychology research. *Qualitative research in psychology*, 12(2), 202-222.
doi:10.1080/14780887.2014.955224
- Eatough, V., & Smith, J. A. (2017). Interpretative phenomenological analysis. *The SAGE handbook of qualitative research in psychology* (pp. 193-209). SAGE Publications Ltd. <https://doi.org/10.4135/9781526405555.n12>
- Gaddefors, J., and J. Cunningham. 2024. Anatomy of a qualitative methods section: Embracing the researcher as an engaged author. *Entrepreneurship & Regional Development* 36 (5–6):561–76. doi:10.1080/08985626.2024.2315156.
- Goodman, G. S., Qin, J., Bottoms, B. L., & Shaver, P. R. (1994). *Characteristics and sources of allegations of ritualistic child abuse* (Final report to the National Center on Child Abuse and Neglect, Grant No. 90CA1405). University of California, Davis.
<https://www.ojp.gov/ncjrs/virtual-library/abstracts/characteristics-and-sources-allegations-ritualistic-child-abuse>
- Levitt, H. M., S. L. Motulsky, F. J. Wertz, S. L. Morrow, and J. G. Ponterotto. 2017. Recommendations for designing and reviewing qualitative research in psychology:

- Promoting methodological integrity. *Qualitative Psychology* 4(1), pp. 2–22.
doi:10.1037/qup0000082.
- Malterud, K., V. K. Siersma, and A. D. Guassora. 2016. Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research* 26 (13):1753–60.
doi:10.1177/1049732315617444.
- McNally R. J. (2005). Debunking myths about trauma and memory. *Canadian journal of psychiatry. Revue canadienne de psychiatrie*, 50(13), 817–822.
<https://doi.org/10.1177/070674370505001302>
- O'Connor, C., & Joffe, H. (2020). Intercoder reliability in qualitative research: debates and practical guidelines. *International journal of qualitative methods*, 19, 1609406919899220. doi:10.1177/1609406919899220.
- Otgaar, H., Curci, A., Mangiulli, I., Battista, F., Rizzotti, E., & Sartori, G. (2022). A court ruled case on therapy-induced false memories. *Journal of Forensic Sciences*, 67(5), 2122-2129. <https://doi.org/10.1111/1556-4029.15073>
- Otgaar, H., Howe, M. L., Patihis, L., Merckelbach, H., Lynn, S. J., Lilienfeld, S. O., & Loftus, E. F. (2019). The Return of the Repressed: The Persistent and Problematic Claims of Long-Forgotten Trauma. *Perspectives on psychological science : a journal of the Association for Psychological Science*, 14(6), 1072–1095.
<https://doi.org/10.1177/1745691619862306>
- Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of counseling psychology*, 52(2), 126.
DOI: 10.1037/0022-0167.52.2.126
- Popper, K. R. (1968). *The logic of scientific discovery*. Hutchinson.

- Salter, M., & Blizard, R. (2022). False memories and the science of credibility: Who gets to be heard?. *Journal of Trauma & Dissociation*, 23(2), 141-147.
<https://doi.org/10.1080/15299732.2022.2028219>
- Schouten, R. (1994). Allegations of Sexual Abuse: A New Area of Liability Risk. *Harvard Review of Psychiatry*, 1(6), 350–352. <https://doi.org/10.3109/10673229409017102>
- Smith, B. 2018. Generalizability in qualitative research: Misunderstandings, opportunities and recommendations for the sport and exercise sciences. *Qualitative Research in Sport, Exercise & Health* 10 (1), 137–49. doi:10.1080/2159676X.2017.1393221.
- Snow, B., & Sorensen, T. (1990). Ritualistic Child Abuse in a Neighborhood Setting. *Journal of Interpersonal Violence*, 5(4), 474–487.
<https://doi.org/10.1177/088626090005004004>
- Tuval-Mashiach, R. (2017). Raising the curtain: The importance of transparency in qualitative research. *Qualitative Psychology* 4(2), 126–38. doi:10.1037/qup0000062.

Chapter 5: Towards A Therapeutic Model For Management Of Recovered Memories

This chapter draws together knowledge about diverse memory presentations under the umbrella of ‘recovered memories’ (RM; Chapters 1 and 2) and the embodied practice-based knowledge of modern clinicians (Chapter 3) to sketch a preliminary model for how cognitive science can provide guidance on therapeutic management of memories in talk therapy. The Dodier et al. (2023) model of involuntary autobiographical memories maps RM experiences to existing staged models of memory retrieval from cognitive science, and this provides affordances to recommend correctly-timed therapeutic practices which can support recall and minimise memory distortion at each stage.

False Memory Theory: Avoiding Iatrogenic Practice

The core of the Memory Wars centred on evidence of false memory formation (Murphy et al., 2023; Scoboria et al., 2017). Suggestive practices—such as age regression, guided imagery, and interpreting dreams or bodily sensations as trauma—were shown to risk inducing false memories via demand characteristics (Loftus & Pickrell, 1995; Perry, 2002). 60,000–70,000 cases of false memory syndrome were estimated in the USA in the 1990s based on hotline data from the False Memory Syndrome Foundation (de Rivera, 1997a), which were theorised to contribute to reinforced negative beliefs, symptom intensification (Perry, 2002), and family breakdown (Li et al., 2023; McHugh et al., 2004). In response, the field has emphasised avoidance. For example, McNally (2018), a leading critic of repression-based models and a prominent memory researcher (though himself a clinical psychologist), provided the following guideline for clinicians: “*they should refrain from using methods designed to unlock presumably buried memories of abuse...Instead, they should treat the symptoms directly*” (p. 397). Patihis and Pendergrast (2019), other leading cognitive science

researchers in the field of recovered memories, go further in asserting that “*therapists should not be encouraging the reconstruction of memories of anything that the client did not know happened prior to therapy*” (p. 34). Much of the literature prioritises the forensic goal of distortion avoidance (e.g., Dodier et al., 2023; McNally, 2018)—this approach can fruitfully be compared to other forms of forensic evidence, e.g., DNA samples and fingerprints, which need to be protected from contamination.

However, given that all memory is reconstructive and subject to distortion, this excessively forensic approach risks undermining the efficacy of therapy by implying that *retrieval* of unrecalled memories is inappropriate. Arguably the central aim of therapy involves appropriate and adaptive forms of memory distortion: reframing and reinterpreting past experiences (e.g., Brewin, 2011; Fonagy & Target, 1997). In the knowledge that there is a far greater prevalence of trauma than of verified false memories (Goodman et al., 2019), and evidence that significant numbers of clients continue to report recovering memories under a variety of definitions which do not match repression theories (see Chapters 1 and 2), it is imperative that guidance for therapists not only highlights iatrogenic risks, but also provides guidance on empirically verified forms of memories that emerge in therapy.

Non-Repression Theories of RM

Alternative models suggest that RM need not involve repression—experiences usually labelled as ‘continuous memories’ (McNally, 2005). Erdelyi (2006) reframes repression as a combination of inhibitory processes (e.g., thought avoidance) and elaboratively distorting processes (e.g., denial and projection) which reduce memory accessibility to achieve goals like distress reduction and managing cognitive load. Schooler (2001) proposed that framing the memories as truly forgotten or amnesic is a category error, and that instead the phenomenon is best understood as ‘discovered memories’ which the person previously lacked

meta-awareness of—due to lack of understanding, lack of reflection, or disrupted awareness at the time of the event. The Think/No-Think paradigm has provided significant evidence for retrieval suppression, both through thought substitution and direct suppression, with repetition further enhancing forgetting (Anderson & Huddleston, 2012).

Conway (1997) emphasised the overlaps between outdated repression theories and modern memory science, advocated for integration by extending cognitive models to explain RM and trauma memories. These theories take steps towards integration, often connecting therapeutic practice to dissociation treatments involving a two- or three-stage treatment process of stabilisation, then exploration of traumatic memories and unconscious defence mechanisms (Gentile et al., 2014; Staniloiu & Markowitsch, 2014), followed by a stage involving integration and change (Herman, 1992). However, these approaches rarely address differences and considerations with regard to RM, except again to avoid suggestion (Staniloiu & Markowitsch, 2014) or to defend repression theories (Herman, 1992; van der Kolk, 2014).

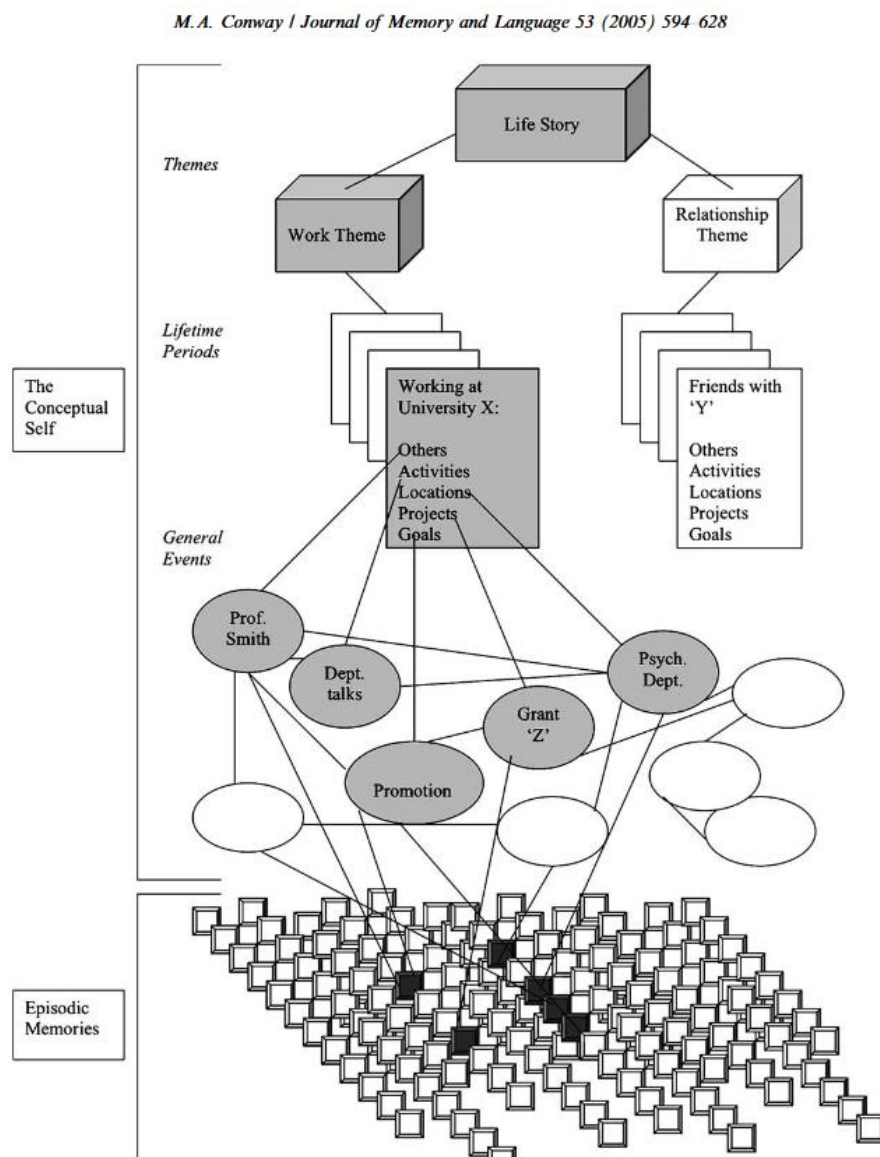
The Self Memory System and Stages of Autobiographical Memory Retrieval

Dodier et al. (2023) introduced a theoretical integration of RM with memory science models of the self-memory system (Conway & Pleydell-Pearce, 2000) and autobiographical memory retrieval stages (Barzykowski & Mazzoni, 2022). The self-memory system is a popular model of autobiographical memory (Conway & Pleydell-Pearce, 2000; Conway, 2005), positing a ‘working self’ which hierarchically modulates access to autobiographical memories based on the individual’s goals, self-image and self beliefs. Conway (2005; see Figure 3) suggests distinguishing the conceptual self (consisting of a life story organised hierarchically by themes, lifetime periods, and general event memories) and episodic memories (containing event-specific knowledge comprised of “*summary records of sensory-perceptual–conceptual-affective processing derived from working memory*,” p. 612).

Barzykowski and Mazzoni (2022) explored these episodic memories, further differentiating between voluntary autobiographical memories, retrieved through conscious and effortful search, and involuntary autobiographical memories (IAMs), which are spontaneously and vividly retrieved through environmental cues.

Figure 3

Knowledge structures in autobiographical memory.



Note. Figure used from Conway (2005).

Dodier et al. (2023) propose that RM are a special case of IAMs, in which the traumatic content of episodic memories is not integrated into the life narrative and may contradict self-beliefs, self-image, or disrupt goals (e.g., emotional stability, relational stability, etc.). Developmentally, episodic memories were not elaborated and processed, perhaps due to age at time of encoding, emotional constraints, or environmental constraints. Due to the incongruence between the self-memory system and the episodic memory, voluntary search is highly unlikely to succeed, so retrieval relies on highly discriminable cues, or spreading activation from associated memories and more generic cues.

Dodier et al. apply Barzykowski and Mazzoni's (2022) four-stage memory retrieval model—pre-retrieval, retrieval, post-retrieval, and outcome—to articulate the moment-to-moment phenomenology of RM emergence. While false memories may arise through suggestive methods, even true memories can be distorted through narrative elaboration or social rehearsal, depending on the degree of misinformation introduced during retrieval or reconstruction. Crucially, they posit that IAMs retrieved without prior recall—especially those triggered by specific environmental cues—can retain greater fidelity to the original encoding than more frequently retrieved or interpreted memories. While Dodier et al. (2023) focus on forensic evaluations of RM to provide specific recommendations of evaluating memory validity, this clear modelling of IAMs creates new affordances for guiding therapeutic timing and mitigating risk.

Mapping Retrieval Stages to Therapeutic Interventions

The following section outlines a preliminary integration of cognitive science with therapeutic practice, incorporating but going further than existing cautionary guidance to contribute toward the development of a best-practice model for working with RM. In Table 7, Dodier et al.'s (2023) stages of retrieval are connected to likely inhibitors of memory

retrieval, the risks of memory distortion at each stage, and suggested staged therapeutic interventions inspired by experiences and practices described by participants in Chapter 3.

Table 7

Stages of Autobiographical Memory Retrieval: Mechanisms, Inhibitory Factors, Memory Distortion Risks and Therapeutic Interventions

Retrieval Stage	Process of Retrieval	Inhibitions on Retrieval	Memory Distortion Risks	Recommended Intervention
<i>Pre-retrieval</i>	Facilitating processes: • Priming and cue exposure. • Entering retrieval mode for intentional search.	• High arousal: panic, fear, anxiety, anger. • Low arousal: drowsiness, inattention, dissociation.	• Psychoeducation about abuse despite no reported abuse. • Joining survivor group with no reported abuse. • Deep relaxation states that increase suggestibility.	• Clinical interview. • Establish safety using permission and validation. • Grounding techniques. • Psychoeducation on fight/flight/freeze.
<i>Retrieval</i>	Threshold reached to activate episodic memory: • Intentional search process completion. • Activated by highly discriminable and unique cue. • Spreading activation from other associated memories and less discriminable/unique cues.	• Negative sensory-perceptual–conceptual-affective components activated. • Defensive avoidance and distraction. • Dissociative episode.	• Guided imagery of hypothetical abuse. • Hypnotic recall and age regression. • Repetitive questioning about abuse. • Recommending memory recovery by recalling more sensory details.	• Free association. • Non-directive approach. • Drawing attention to somatic sensations. • Pause if dissociating.

Retrieval Stage	Process of Retrieval	Inhibitions on Retrieval	Memory Distortion Risks	Recommended Intervention
<i>Post-retrieval</i>	Meta-awareness of a memory having arisen: - Noticing that an autobiographical memory was activated. - Surprisal or curiosity.	- Decline to narrate. - Decline to disclose.	- Premature interpretation of abuse. - Directive questioning suggestive of abuse narrative.	- Validation and naming emotions. - Seek permission to explore. - Readiness to switch therapeutic task. - Consider NET/EMDR.
<i>Elaboration</i>	Narrating and interpreting meaning of memory: - Verbal recounting of memory contents. - Applying abstract descriptors to memory, e.g., abusive. - Applying attributions to event—moral and relational significance.	- Defensive denial, rationalisation, projection. - Overgeneralising or overinterpreting memory content. - Grief or anger response.	- Guided imagery to elaborate on ambiguous memories. - Labelling ambiguous memories as indicating abuse. - Labelling dreams or somatic sensations as indicating abuse.	- Psychoeducation on memory. - Collaborative interpretation. - Explore corroborative details. - Consideration of mandatory reporting thresholds. - Support reality-testing when client is rationalising clear abuse memories.

At the pre-retrieval stage, conditions are being set for recall. Dodier et al. (2023) state that priming and cue exposure can enhance likelihood of memory retrieval at this stage, noting that certain processes can inhibit retrieval at this stage but not specifying. Based on the results of Chapter 3, it is plausible that emotion dysregulation will be an obstacle to memory retrieval here, both from high arousal (panic) and low arousal (dissociation). Trauma psychoeducation without disclosure risks misinformation effects (Jobson et al., 2023), and exposure to survivor groups without prior abuse reports increases false memory risks (Lindsay & Read, 1994). Retractors report that false memories were suggested while dissociating or during deep relaxation exercises (de Rivera, 1997b), indicating the risk of hypnagogic states (sleep-like wakeful dreaming) when paired with hypnotic techniques (Ghibellini & Meier, 2023). As such, therapeutic practice at this stage involves supporting the client to develop emotion regulation skills, to create a safe atmosphere by seeking the client's permission to structure sessions and the environment, psychoeducation on the fight or flight system as needed, as in the stabilisation stage often recommended for trauma and for dissociation (Gentile et al., 2014; Herman, 1992; Staniloiu & Markowitsch, 2014). A clinical interview encourages intentional search of memories, priming clients for ongoing retrieval through spreading activation of mental health-related episodic memories, e.g., with the Clinical Diagnostic Interview (CDI; Drill et al., 2015).

During the retrieval stage, episodic memories have been activated, however they may not have entered conscious awareness or explicit self-reflection (Dodier et al., 2023). Lengthy, leading, and repetitive questions create risks of demand effects, and hypnotic age regression and imaginal exercises visualising abusive scenes risk strong suggestion effects (Lindsay & Read, 1994; Otgaar et al., 2022). Therefore, at this stage non-directive exploration is the safest focus, as most participants in Chapter 3 noted, allowing the client to attend to internal cues while giving gentle guidance to attend to somatic sensations (i.e.

internal cues). If the client is emotionally regulated, they will be in a position to begin to reflect on thoughts and memories coming to mind. Unprocessed trauma memories may present with high emotional salience, resembling flashback-like phenomena in post-traumatic stress disorder (PTSD), and clients can be highly ambivalent about their willingness to have this experience (Shearing et al., 2011). Participants in Chapter 3 noted the importance of constant monitoring for dissociation, which can act as a defence to protect against overwhelming emotion and prevent awareness of internal somatic and cognitive states (Craig, 2023). Crucially, the focus then is not on pushing through to retrieval, but returning to emotion regulation and re-establishing safety in-session, so the therapist will remain agnostic as to the cause of the dissociative episode and thus must be willing to tolerate continued uncertainty.

The client may arrive at the post-retrieval stage as a result of the therapeutic process, as above, but they also may *begin* their therapeutic engagement at the post-retrieval stage. The majority of RM experiences occur outside of therapy and are associated with discriminable and unique cues for recovery (Dodier & Patihis, 2021), aligning with the IAM model. At this point misinformation effects are most at risk of distorting the reconstructed memory, as it has not been narrated or elaborated—premature questions and interpretations risk memory distortion through source-monitoring errors and misinformation effects (Lindsay & Johnson, 2000). Once aware of the memory, clients may be unwilling or unready to narrate it in-session—deferred disclosure, recantation, and consistent denial have constituted the majority of responses in longitudinal studies of corroborated CSA (Hartman et al., 2023). In Chapter 3, participants noted that trauma recounting is not an essential component of successful treatment. However, if the client has become aware of a memory, and has communicated that awareness to their therapist, it is likely that a part of them wishes to discuss it in some manner. Permission-seeking regarding exploring the memory is essential

here, to support the therapeutic relationship and prevent retraumatisation (Chapter 3). Non-directively encouraging narration is appropriate, with gentle exploration contingent on client consent and readiness, and a validating stance that affirms experience without confirming narrative interpretation (Linehan, 1997). Interventions such as Narrative Exposure Therapy (NET) or EMDR may be considered, depending on client preference and clinical judgment, once the client is aware of traumatic memories.

In the elaboration stage, the memory is being communicated, described, and labelled—exposure is reducing its emotional intensity, and new connections are being formed between the episodic memory and the self-memory system’s conceptual self and working self. Introducing narrative construction naturally reduces memory veracity (Dodier et al., 2023), but interpretations can still distort the memory, depending on the quality of detail. Clients can attribute labels inappropriately to the memory (de Rivera, 1997b), but so too can therapists—e.g., interpreting uncomfortable feelings and vague memories as abusive without clear indicators. Intentionally trying to ‘flesh out’ the details of the memory, e.g., by exploring the sensory details to try to activate the memory further, risks memory distortion (Lindsay & Read, 1994). If the memory is highly incongruent with the working self, clients can have defensive reactions triggered such as denial, rationalisation, or projection (Erdelyi, 2006). Gentile et al. (2014) suggest that this can be understood as resistance, providing a useful basis to start exploring the client’s defence mechanisms and relationship patterns. Herman (1992) notes an element of mourning at this stage, when the memories are traumatic. Many clients harbour unrealistic expectations that simply recalling memories will alleviate their mental health difficulties, and realising this is not the case can cause grief or anger (Chapter 3). Once the memory has been narrated there is lower risk of psychoeducation about trauma or memory science creating demand characteristics, so it may support the client in

contextualising their experiences. Mandatory reporting obligations may also need to be considered, whether the memory content meets the threshold for reporting.

Limitations and Future Directions

This preliminary framework suggests an approach that supports spontaneous memory emergence while minimising suggestion and memory distortion across diverse diagnoses and schools of therapy. It builds on existing trauma-informed models like Herman's (1992) three stages of recovery from trauma, but shows how this can be integrated with established cognitive science without reference to repression theory. The contribution of this approach is in emphasising *when* interventions are appropriate, rather than *what* interventions—timing is crucial in preventing suggestion effects inducing memory distortions, while still allowing for memories to be addressed once they do arise.

That said, it is a speculative and untested framework—its conclusions cannot be assumed without evidence. It is assumed that these recommendations apply transdiagnostically—however, there may be diagnosis-specific treatment factors to consider, e.g., differences in how best to approach RM for people experiencing PTSD compared to those experiencing borderline personality disorder (BPD). In addition, there is more depth to therapeutic management of dissociation than this chapter had scope to consider. The model heavily relies on the conceptualization of RM as a special case of IAMs, but not all RM may fit the IAM framework, particularly those influenced by intentional search, suggestion, or narrative reconstruction outside of therapy, which could limit the model's explanatory power. Dalenburg et al. (2020) note that there is an ongoing lack of consensus about RM, with false memory theorists criticising attempts to draw the concept of RM away from repression theories towards less contentious theories (see recent criticism of dissociative amnesia; Otgaar et al., 2019). It has been contended that therapists frequently lack sufficient education

on memory science, and that this education should prioritise reducing beliefs in the myth of repressed memories to be recovered using therapy (e.g., Sauerland & Otgaar, 2022).

Future research could fruitfully explore Dodier et al.'s (2023) integration of RM with cognitive theories of IAMs, e.g., conducting field studies of purposive samples of people reporting RM to evaluate predictions regarding IAMs. Rather than test the preliminary model suggested here as a distinct therapeutic approach, alternatives may be considered. A Delphi study comprised of expert therapists and memory scientists could be used to develop a consensus model of appropriate therapeutic work with RM (Barrett & Heale, 2020)—in the Irish context, such a study could include expertise from key professional bodies such as the Psychological Society of Ireland and the National Counselling Service, among others. Such a model could then be utilised to evaluate therapeutic outcomes across schools of therapy in working with RM, which would be appropriate given the importance of common factors in psychotherapy outcomes (Wampold, 2015)—this could involve new studies on RM, or retrospective qualitative exploration of therapy transcripts. Additionally, Goodman et al. (2017) found preliminary evidence that psychological counselling for victims during CSA prosecution was associated with improved recall longitudinally—there may be value in assessing the impact on memory validity of therapy in adults.

References

- Barrett, D., & Heale, R. (2020). What are Delphi studies?. *Evidence-based nursing*, 23(3), 68-69. <https://doi.org/10.1136/ebnurs-2020-103303>
- Barzykowski, K., & Mazzoni, G. (2022). Do intuitive ideas of the qualities that should characterize involuntary and voluntary memories affect their classification?. *Psychological Research*, 86(1), 170-195. <https://doi.org/10.1007/s00426-020-01465-3>
- Brewin C. R. (2011). The nature and significance of memory disturbance in posttraumatic stress disorder. *Annual review of clinical psychology*, 7, 203–227. <https://doi.org/10.1146/annurev-clinpsy-032210-104544>
- Conway, M. A. (1997). Past and present: Recovered memories and false memories. In M. A. Conway (Ed.), *Recovered memories and false memories* (pp. 150–191). Oxford University Press. <https://doi.org/10.1093/med:psych/9780198523864.003.0007>
- Conway, M. A., & Pleydell-Pearce, C. W. (2000). The construction of autobiographical memories in the self-memory system. *Psychological review*, 107(2), 261–288. <https://doi.org/10.1037/0033-295x.107.2.261>
- Conway, M. A. (2005). Memory and the self. *Journal of memory and language*, 53(4), 594-628. <https://doi.org/10.1016/j.jml.2005.08.005>
- Craige, H. (2023). At Home in Oneself: Self-States and the Treatment of Trauma. *Psychoanalytic Inquiry*, 43(6), 468-481. <https://doi.org/10.1080/07351690.2023.2235305>
- Dalenberg, C. J., Brand, B. L., Loewenstein, R. J., Frewen, P. A., & Spiegel, D. (2020). Inviting scientific discourse on traumatic dissociation: Progress made and obstacles to further resolution. *Psychological Injury and Law*, 13(2), 135–154. <https://doi.org/10.1007/s12207-020-09376-9>

- De Rivera, J. (1997a). Estimating the number of false memory syndrome cases. *American Psychologist*, 52(9), 996–997. <https://doi.org/10.1037/0003-066X.52.9.996>
- De Rivera, J. (1997b). The construction of false memory syndrome: The experience of retractors. *Psychological inquiry*, 8(4), 271-292.
https://doi.org/10.1207/s15327965pli0804_1
- Dodier, O., Barzykowski, K., & Souchay, C. (2023). Recovered memories of trauma as a special (or not so special) form of involuntary autobiographical memories. *Frontiers in Psychology*, 14, 1268757. <https://doi.org/10.3389/fpsyg.2023.1268757>
- Dodier, O., & Patihis, L. (2021). Recovered memories of child abuse outside of therapy. *Applied Cognitive Psychology*, 35(2), 538-547. <https://doi.org/10.1002/acp.3783>
- Drill, R., Nakash, O., DeFife, J. A., & Westen, D. (2015). Assessment of clinical information: comparison of the validity of a structured clinical interview (the SCID) and the clinical diagnostic interview. *The Journal of nervous and mental disease*, 203(6), 459-462. doi:10.1097/NMD.0000000000000300
- Fonagy, P., & Target, M. (1997). Attachment and reflective function: Their role in self-organization. *Development and Psychopathology*, 9(4), 679–700.
<https://doi.org/10.1017/S0954579497001399>
- Gentile, J. P., Snyder, M., & Gillig, P. M. (2014). Stress and trauma: Psychotherapy and pharmacotherapy for depersonalization/derealization disorder. *Innovations in Clinical Neuroscience*, 11(7-8), 37-41.
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4204471/>
- Ghibellini, R., & Meier, B. (2023). Hypnagogic states are quite common: Self-reported prevalence, modalities, and gender differences. *Consciousness and cognition*, 115, 103582. <https://doi.org/10.1016/j.concog.2023.103582>

- Goodman, G. S., Goldfarb, D., Quas, J. A., & Lyon, A. (2017). Psychological counseling and accuracy of memory for child sexual abuse. *American Psychologist*, 72(9), 920–931.
<https://doi.org/10.1037/amp0000282>
- Goodman, G. S., Gonzalves, L., & Wolpe, S. (2019). False Memories and True Memories of Childhood Trauma: Balancing the Risks. *Clinical Psychological Science*, 7(1), 29-31.
<https://doi.org/10.1177/2167702618797106>
- Hartman, D. T., Wang, Y., Wu, Y., Goldfarb, D., Vidales, D., Qin, J., Eisen, M. L., & Goodman, G. S. (2023). Childhood Sexual Abuse: A Longitudinal Study of Disclosures and Denials. *Child Maltreatment*, 28(3), 462-475.
<https://doi.org/10.1177/10775595231165335>
- Herman, J. L. (1992). *Trauma and recovery*. Basic Books/Hachette Book Group.
- Jobson, L., Wade, K. A., Rasor, S., Spearing, E., McEwen, C., & Fahmi, D. (2023). Associations between the misinformation effect, trauma exposure and symptoms of posttraumatic stress disorder and depression. *Memory*, 31(2), 179-191.
<https://doi.org/10.1080/09658211.2022.2134422>
- Li, C., Otgaar, H., van Daele, T., Muris, P., Houben, S. T. L., & Bull, R. (2023). Investigating the memory reports of retractors regarding abuse. *The European Journal of Psychology Applied to Legal Context*, 15(2), 63–71.
<https://doi.org/10.5093/ejpalc2023a7>
- Lindsay, D. S., & Johnson, M. K. (2000). False memories and the source monitoring framework: Reply to Reyna and Lloyd (1997). *Learning and Individual Differences*, 12(2), 145-161. [https://doi.org/10.1016/S1041-6080\(01\)00035-8](https://doi.org/10.1016/S1041-6080(01)00035-8)
- Lindsay, D. S., & Read, J. D. (1994). Psychotherapy and memories of childhood sexual abuse: A cognitive perspective. *Applied cognitive psychology*, 8(4), 281-338.
doi:10.1002/acp.2350080403

- Lindsay, D. S., & Read, J. D. (1995). "Memory work" and recovered memories of childhood sexual abuse: Scientific evidence and public, professional, and personal issues. *Psychology, Public Policy, and Law*, 1(4), 846–908. <https://doi.org/10.1037/1076-8971.1.4.846>
- Linehan, M. M. (1997). Validation and psychotherapy. In A. C. Bohart & L. S. Greenberg (Eds.), *Empathy reconsidered: New directions in psychotherapy* (pp. 353–392). American Psychological Association. <https://doi.org/10.1037/10226-016>
- Loftus, E. F., & Pickrell, J. E. (1995). The formation of false memories. *Psychiatric annals*, 25(12), 720-725. <https://doi.org/10.3928/0048-5713-19951201-07>
- McHugh, P. R., Lief, H. I., Freyd, P. P., & Fetkewicz, J. M. (2004). From refusal to reconciliation: Family relationships after an accusation based on recovered memories. *The Journal of nervous and mental disease*, 192(8), 525-531.
doi:10.1097/01.nmd.0000136301.18598.52
- McNally, R. J. (2005). Debunking myths about trauma and memory. *The Canadian Journal of Psychiatry*, 50(13), 817-822. <https://doi.org/10.1177/070674370505001302>
- McNally, R. J. (2018). Recovered memories of childhood sexual abuse. In R. Rogers & S. D. Bender (Eds.), *Clinical assessment of malingering and deception* (4th ed., pp. 387–400). The Guilford Press.
- Murphy, G., Dawson, C. A., Huston, C., Ballantyne, L., Barrett, E., Cowman, C. S., ... & Greene, C. M. (2023). Lost in the mall again: a preregistered replication and extension of Loftus & Pickrell (1995). *Memory*, 31(6), 818-830.
<https://doi.org/10.1080/09658211.2023.2198327>
- Otgaar, H., Curci, A., Mangiulli, I., Battista, F., Rizzotti, E., & Sartori, G. (2022). A court ruled case on therapy-induced false memories. *Journal of Forensic Sciences*, 67(5), 2122-2129. <https://doi.org/10.1111/1556-4029.15073>

- Otgaar, H., Howe, M. L., Patihis, L., Merckelbach, H., Lynn, S. J., Lilienfeld, S. O., & Loftus, E. F. (2019). The return of the repressed: The persistent and problematic claims of long-forgotten trauma. *Perspectives on Psychological Science*, 14(6), 1072-1095. <https://doi.org/10.1177/1745691619862306>
- Perry, C. (2002). Hypnosis, demand characteristics, and “recovered memory” therapy. *Prevention & Treatment*, 5(1). <https://doi.org/10.1037/1522-3736.5.1.540c>
- Sauerland, M., & Otgaar, H. (2022). Teaching psychology students to change (or correct) controversial beliefs about memory works. *Memory*, 30(6), 753-762. <https://doi.org/10.1080/09658211.2021.1874994>
- Schooler, J. W. (2001). Discovering memories of abuse in the light of meta-awareness. *Journal of Aggression, Maltreatment & Trauma*, 4(2), 105-136. https://doi.org/10.1300/J146v04n02_06
- Scoboria, A., Wade, K. A., Lindsay, D. S., Azad, T., Strange, D., Ost, J., & Hyman, I. E. (2017). A mega-analysis of memory reports from eight peer-reviewed false memory implantation studies. *Memory*, 25(2), 146-163. <https://doi.org/10.1080/09658211.2016.1260747>
- Shearing, V., Lee, D., & Clohessy, S. (2011). How do clients experience reliving as part of trauma-focused cognitive behavioural therapy for posttraumatic stress disorder?. *Psychology and Psychotherapy: Theory, Research and Practice*, 84(4), 458-475. <https://doi.org/10.1111/j.2044-8341.2010.02012.x>
- Staniloiu, A., & Markowitsch, H. J. (2014). Dissociative amnesia. *The Lancet Psychiatry*, 1(3), 226–241. doi:10.1016/s2215-0366(14)70279-2
- Van der Kolk, B. A. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. Viking.

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World psychiatry*, 14(3), 270-277. <https://doi.org/10.1002/wps.20238>

Conclusions: Caution And Care Need Not Be In Opposition

The purpose of this thesis has been to advance conceptual clarity and practical guidance for recovered memories (RM) in therapeutic contexts. Given the wealth of research highlighting the scientist-practitioner gap regarding RM, the approach outlined here has sought to address and narrow this gap by updating and clarifying the evidence, and to build greater connections with best therapeutic practice. An essential part of this process has been to hold the dialectical tension between the empirical scepticism of cognitive science and the compassionate care of psychological practice.

Summarising the narrative arc

What this thesis shows is that RM are common across diverse populations, but these rates vary widely due to inconsistent operational definitions and research designs. Their prevalence cannot be conclusively estimated at present due to these methodological issues. However, the question of definition cuts to the core of the scientist-practitioner gap. The experiences reported by therapists and the public frequently do not match the narrow repression-based definitions relied upon by many memory science researchers. This significantly muddies the waters, perpetuating an impasse rather than prompting broader operational definitions. Many studies utilising broader definitions are simply excluded from reviews and from the academic discourse. The complexities of forgetting and remembering cannot be captured by *a priori* reductionism.

Clinical psychologists in this study employed ‘strategic ambiguity’ to manage the uncertainties of RM in therapy, relying on an ethical pragmatism that balanced epistemic caution with trauma-informed care. Where a memory science perspective could take this as an avoidance of the debate or a lack of conceptual clarity, it was apparent that participants

were rejecting a forensically-oriented focus on adjudicating the facts of clients' memories. Instead, strategic ambiguity represented a thoughtful, client-centred approach to the uncertainties of working with RM. However, this should not become a euphemism for abdication of responsibility or therapeutic passivity. Reflexive thematic analysis facilitated an in-depth exploration of participants' perspectives, demonstrating how a constructivist-interpretivist framework can enrich and contextualize findings from more positivist research approaches.

The development of a preliminary model for therapeutic management of RM represents a step toward moving the field away from impasse, prioritising quality care rather than simply risk avoidance. The cognitive science of autobiographical memory can deepen and sharpen therapeutic practice—not by dictating what skills to use, but by developing clinical precision in the selection and timing of therapeutic skills that are commonly used by all practitioners across different schools of therapy. Rather than another new school of therapy, a transtheoretical approach would allow both for training that is relevant to all practitioners and also for evaluating therapeutic practice without presupposing a specific model or approach to therapy. The hope is that this would help to bridge the scientist-practitioner gap by showing that balance is possible: neither unduly dismissing client memories nor inadvertently distorting them.

The broader context of RM debates

There seems to be a philosophical difference at the core of this debate, mirrored by the distinctions between different philosophical approaches to qualitative research. Memory science as a field is largely rooted in positivist and postpositivist philosophical frameworks, aiming for objective truth through verification and falsification of hypotheses that aim to generalise across populations. The therapeutic approach is inherently idiographic, as the

therapeutic encounter involves developing an in-depth and complex understanding of the person sitting in the other seat—implicitly placing therapists into constructivist epistemic framework in which the relative truths of the client are what will be sought after and prized. This philosophical difference frequently seems to contribute to mutual misunderstandings and ongoing disputes, especially within RM debates.

Dichotomised thinking in these debates creates a polarised deadlock preventing progression in the ‘Memory Wars’. There is value in simplification and reduction of a complex concept to its component parts, but this thesis suggests that debates about the reality or falsehood of repressed memories simply miss the mark when it comes to evaluating RM. There is a significant need for accurate, descriptive approaches to capture the nature of this phenomenon and allow for guidance that represents reality rather than the current emphasis on myth-busting.

The focus on risks regarding RM appears to have led to an institutional avoidance of RM. This risk-aversion has resulted in a lack of training, research, and supportive guidelines that produces systemic barriers to understanding and progress. The resulting paradox is that the avoidance of risky topics increases risks for clients, where clinicians might avoid RM entirely or be pressured to try to engage in work that they were not prepared for by their training. Institutions will be an essential stakeholder in advancing the field, embracing the need to push for clarity in the research and quality training of clinicians to address the needs of this diverse and vulnerable population.

Looking to the future

Training needs

There is a clear need to augment professional training in clinical psychology (along with other mental health disciplines, likely) to ensure that programmes offer specific

guidance on the management of RM with the goal of minimising both retraumatisation of clients and also of memory distortion and false memory formation.

RM dynamics of vague and uncertain memories need sensitive management. Given evidence from this thesis that both trauma and false memory presentations are inadequately covered, focusing exclusively on either would be insufficient. Clinicians must be trained to sensitively engage adults with histories of childhood trauma, particularly those uncertain about their memories, actively avoiding them, or not disclosing memories despite ongoing distress. With this understanding, clinicians can more effectively navigate situations involving potential memory distortions, where clients request interpretations of vague memories or dreams despite possibly lacking factual trauma histories. It will also be important to consider clients who have developed false memories through harmful engagements with other practitioners, and how best to support retractors to undo the harms of incorrect interpretations of memories.

The clinical skill here is in carefully exploring memory content to determine whether there is memory present, and what exactly is remembered rather than what is the client's current interpretation. From here, risky therapeutic techniques can be highlighted as important to avoid—but many techniques that might be risky are common in routine practice and unproblematic outside of the RM context. Therefore, careful timing and staging of interventions is needed to facilitate clients to explore the contents of their mind in a contained and safe manner. This might be best framed as training in trauma memories—incorporating memory science and the risks of suggestion, while also addressing trauma presentations and how this should be managed. Such training should be offered as a module within clinical doctorate curricula, and also in structured continuing professional development workshops for active practitioners.

Research directions

Given the problems of prevalence estimation regarding RM, theoretical progress is required to accurately and descriptively define this phenomenon. Rather than excluding continuous memories, it will be of greater clinical utility to characterise forgetting of trauma and abuse, describing the types and degrees of forgetting along with the conditions under which memories are later retrieved and interpreted. It is more likely that a structured typology of this nature will overcome measurement issues in RM research, facilitating high quality prevalence studies which can lead to pooled meta-analytic estimates of prevalence.

When considering the research participants in the current study, it appeared that a highly experienced and confident group of participants were recruited, potentially indicating some avoidance of this topic from less experienced clinicians. Future research could fruitfully explore this issue more directly, surveying clinicians regarding their interest in accessing trainings on RM and their reasons for being willing or unwilling to engage. It may also be useful, if possible, to attempt further qualitative research exploring the perspectives of clinicians who do not typically see or work with these types of clients, balancing out the potential selection effects seen in the current study.

Given the rich dataset produced here, future qualitative analysis could fruitfully employ interpretative phenomenological analysis to investigate clinicians' lived experiences of working under the uncertainty of clients with RM—looking directly at how they make sense of their clients and how they make sense of their own role within the therapeutic relationship as it evolves over time. This lived experience of uncertainty has the potential to enrich our understanding of RM from the therapeutic perspective in a way that positivist and postpositivist approaches lack the conceptual and methodological tools to do.

The preliminary model for therapeutic best practice regarding RM here relies on a new cognitive science model of involuntary autobiographical memories, a framework which

needs further research and validation to support its relevance to RM debates. However, modelling best practice in this context may not require this particular theory to be effective, and so a Delphi study is strongly recommended to arrive at a consensus view between memory scientists and experienced therapists of what safe and effective therapy in the context of RM would look like. Further work can then be fruitfully done by applying the resulting model to new or existing datasets. Designing randomised control trials is typically seen as the gold standard in therapy, however the proposal here is not for a new type of therapy but simply a guidance framework that should be useful to all therapists regardless of their orientation. Therefore, it may be more fruitful to apply such a framework to transcripts or recordings of therapeutic engagements that would allow for granular exploration of the timing and impact of therapeutic interventions to validate or falsify the predictions of this guidance.

In sum, the Memory Wars persist, but the terms of the debate are changing in response to accumulating empirical evidence and advances in therapeutic practice. Increased interdisciplinary dialogue and collaboration can shift entrenched positions towards more integrative and practical models of RM. The central argument put forward in this thesis is that caution and care are not in opposition, but are instead complementary ethical and professional obligations for psychologists. An interdisciplinary atmosphere of humility, mutual curiosity, and ongoing dialogue will be essential to progress in managing RM therapeutically and to close the scientist-practitioner gap.

Appendix A: Memory Publication Guidelines

Instructions for authors

This title utilises format-free submission. Authors may submit their paper in any scholarly format or layout. References can be in any style or format, so long as a consistent scholarly citation format is applied. For more detail see [the format-free submission section below](#).

About the Journal

Memory is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's [Aims & Scope](#) for information about its focus and peer-review policy. Please note that this journal only publishes manuscripts in English.

Memory accepts the following types of article: Original research articles - both single and multi-experiment articles that advance memory theory are welcomed;

Registered Reports – are a form of empirical article in which the methods and proposed analyses are pre-registered and reviewed prior to the research being conducted. High quality protocols are then provisionally accepted for publication before data collection commences. Acceptance in principle indicates that the article will be published pending successful completion of the study according to the pre-registered methods and analytic procedures, as well as inclusion of a defensible and evidence-based interpretation of the results. Full details on the registered reports workflow and policies can be found [here](#).

The journal also welcomes integrative reviews, commentaries and short reports.

Memory publishes high quality research in all areas of memory research. This includes experimental studies of memory (including laboratory based research, everyday memory studies and applied memory research), developmental, educational, neuropsychological, clinical and social research on memory. By representing all significant areas of memory research, the journal cuts across the traditional distinctions of psychological research.

Memory therefore provides a unique venue for memory researchers to communicate their findings and ideas both to peers within their own research tradition in the study of memory, and also to the wider range of research communities with direct interest in human memory.

Open Access

You have the option to publish open access in this journal via our Open Select publishing program. Publishing open access means that your article will be free to access online immediately on publication, increasing the visibility, readership and impact of your research. Articles published Open Select with Taylor & Francis typically receive 45% more citations* and over 6 times as many downloads** compared to those that are not published Open Select. Your research funder or your institution may require you to publish your article open access. Visit our [Author Services](#) website to find out more about open access policies and how you can comply with these.

You will be asked to pay an article publishing charge (APC) to make your article open access and this cost can often be covered by your institution or funder. Use our [APC finder](#) to view the APC for this journal.

Please visit our [Author Services website](#) if you would like more information about our Open Select Program.

*Citations for articles published online 2018-2022. Data obtained on 23rd August 2023, from Digital Science's Dimensions platform, available at <https://app.dimensions.ai> **Usage in 2020-2022 for articles published online 2018-2022

Peer Review and Ethics

Taylor & Francis is committed to peer-review integrity and upholding the highest standards of review. Once your paper has been assessed for suitability by the editor, it will then be single blind peer reviewed by independent, anonymous expert referees. If you have shared an earlier version of your Author's Original Manuscript on a preprint server, please be aware that anonymity cannot be guaranteed. Further information on our preprints policy and citation requirements can be found on our [Preprints Author Services page](#). Find out more about [what to expect during peer review](#) and read our guidance on [publishing ethics](#).

Preparing Your Paper

All authors submitting to medicine, biomedicine, health sciences, allied and public health journals should conform to the [Uniform Requirements for Manuscripts Submitted to Biomedical Journals](#), prepared by the International Committee of Medical Journal Editors (ICMJE).

Structure

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

Word Limits

Please include a word count for your paper. There are no word limits for papers in this journal.

Format-Free Submission

Authors may submit their paper in any scholarly format or layout. Manuscripts may be supplied as single or multiple files. These can be Word, rich text format (rtf), open document format (odt), PDF, or LaTeX files. Figures and tables can be placed within the text or submitted as separate documents. Figures should be of sufficient resolution to enable refereeing.

- There are no strict formatting requirements, but all manuscripts must contain the essential elements needed to evaluate a manuscript: abstract, author affiliation, figures, tables, funder information, references. Further details may be requested upon acceptance.
- References can be in any style or format, so long as a consistent scholarly citation format is applied. For manuscripts submitted in LaTeX format a .bib reference file must be included. Author name(s), journal or book title, article or chapter title, year of publication, volume and issue (where appropriate) and page numbers are essential. All bibliographic entries must contain a corresponding in-text citation. The addition of DOI (Digital Object Identifier) numbers is recommended but not essential.
- The journal reference style will be applied to the paper post-acceptance by Taylor & Francis.
- Spelling can be US or UK English so long as usage is consistent.

Note that, regardless of the file format of the original submission, an editable version of the article must be supplied at the revision stage.

Checklist: What to Include

1. **Author details.** Please ensure all listed authors meet the [Taylor & Francis authorship criteria](#). Please ensure everyone meeting the International Committee of Medical Journal Editors (ICMJE) [requirements for authorship](#) is included as an author of your paper. All authors of a manuscript should include their full name and affiliation on the cover page of the manuscript. Where available, please also include ORCiDs and social media handles (Facebook, Twitter or LinkedIn). One author will need to be identified as the corresponding author, with their email address normally displayed in the article PDF (depending on the journal) and the online article. Authors' affiliations

are the affiliations where the research was conducted. If any of the named co-authors moves affiliation during the peer-review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after your paper is accepted. [Read more on authorship](#).

2. You can opt to include a **video abstract** with your article. [Find out how these can help your work reach a wider audience, and what to think about when filming](#).
3. Read [making your article more discoverable](#), including information on choosing a title and search engine optimization.
4. **Funding details.** Please supply all details required by your funding and grant-awarding bodies as follows:
For single agency grants
This work was supported by the [Funding Agency] under Grant [number xxxx].
For multiple agency grants
This work was supported by the [Funding Agency #1] under Grant [number xxxx]; [Funding Agency #2] under Grant [number xxxx]; and [Funding Agency #3] under Grant [number xxxx].
5. **Disclosure statement.** This is to acknowledge any financial or non-financial interest that has arisen from the direct applications of your research. If there are no relevant competing interests to declare please state this within the article, for example: *The authors report there are no competing interests to declare*. [Further guidance on what is a conflict of interest and how to disclose it](#).
6. **Data availability statement.** Authors are required to provide a data availability statement, detailing where data associated with a paper can be found and how it can be accessed. If data cannot be made open, authors should state why in the data availability statement. The DAS should include the hyperlink, DOI or other persistent identifier associated with the data set(s), or information on how the data can be requested from the authors. [Templates](#) are also available to support authors.
7. **Data deposition.** If you choose to share or make the data underlying the study open, please deposit your data in a [recognized data repository](#) prior to or at the time of submission. You will be asked to provide the DOI, pre-reserved DOI, or other persistent identifier for the data set.
8. **Data deposition.** If you choose to share or make the data underlying the study open, please deposit your data in a [recognized data repository](#) prior to or at the time of submission. You will be asked to provide the DOI, pre-reserved DOI, or other persistent identifier for the data set.
9. **Supplemental online material.** Supplemental material can be a video, dataset, fileset, sound file or anything which supports (and is pertinent to) your paper. We publish supplemental material online via Figshare. Find out more about [supplemental material and how to submit it with your article](#).
10. **Figures.** Figures should be high quality (1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour, at the correct size). Figures should be supplied in one of our preferred file formats: EPS, PS, JPEG, TIFF, or Microsoft Word (DOC or DOCX) files are acceptable for figures that have been drawn in Word. For information relating to other file types, please consult our [Submission of electronic artwork](#) document.
11. **Tables.** Tables should present new information rather than duplicating what is in the text. Readers should be able to interpret the table without reference to the text. Please supply editable files.
12. **Equations.** If you are submitting your manuscript as a Word document, please ensure that equations are editable. More information about [mathematical symbols and equations](#).

13. **Units.** Please use [SI units](#) (non-italicized).

Disclosure Statement

Please include a disclosure statement, using the subheading “Disclosure of interest.” If you have no interests to declare, please state this (suggested wording: *The authors report no conflict of interest*). For all NIH/Wellcome-funded papers, the grant number(s) must be included in the declaration of interest statement. [Read more on declaring conflicts of interest.](#)

Clinical Trials Registry

In order to be published in a Taylor & Francis journal, all clinical trials must have been registered in a public repository, ideally at the beginning of the research process (prior to participant recruitment). Trial registration numbers should be included in the abstract, with full details in the methods section. Clinical trials should be registered prospectively – i.e. before participant recruitment. However, for clinical trials that have not been registered prospectively, Taylor & Francis journals requires retrospective registration to ensure the transparent and complete dissemination of all clinical trial results which ultimately impact human health. Authors of retrospectively registered trials must be prepared to provide further information to the journal editorial office if requested. The clinical trial registry should be publicly accessible (at no charge), open to all prospective registrants, and managed by a not-for-profit organization. For a list of registries that meet these requirements, please visit the [WHO International Clinical Trials Registry Platform](#) (ICTRP). The registration of all clinical trials facilitates the sharing of information among clinicians, researchers, and patients, enhances public confidence in research, and is in accordance with the [ICMJE guidelines](#).

Complying With Ethics of Experimentation

Please ensure that all research reported in submitted papers has been conducted in an ethical and responsible manner, and is in full compliance with all relevant codes of experimentation and legislation. All original research papers involving humans, animals, plants, biological material, protected or non-public datasets, collections or sites, must include a written statement in the Methods section, confirming ethical approval has been obtained from the appropriate local ethics committee or Institutional Review Board and that where relevant, informed consent has been obtained. For animal studies, approval must have been obtained from the local or institutional animal use and care committee. All research studies on humans (individuals, samples, or data) must have been performed in accordance with the principles stated in the [Declaration of Helsinki](#). In settings where ethics approval for non-interventional studies (e.g. surveys) is not required, authors must include a statement to explain this. In settings where there are no ethics committees in place to provide ethical approval, authors are advised to contact the Editor to discuss further. Detailed guidance on ethics considerations and mandatory declarations can be found in our Editorial Policies section on [Research Ethics](#).

Consent

All authors are required to follow the [ICMJE requirements](#) and [Taylor & Francis Editorial Policies](#) on privacy and informed consent from patients and study participants. Authors must include a statement to confirm that any patient, service user, or participant (or that person’s parent or legal guardian) in any type of qualitative or quantitative research, has given informed consent to participate in the research. For submissions where patients or participants can be potentially identified (e.g. a clinical case report detailing their medical history, identifiable images or media content, etc), authors must include a statement to confirm that they have obtained written informed consent to publish the details from the affected individual (or their parents/guardians if the participant is not an adult or unable to give informed consent; or next of kin if the participant is deceased). The process of obtaining consent to publish should include sharing the article with the individual (or whoever is consenting on their behalf), so that they are fully aware of the content of the article before it is published. Authors should familiarise themselves with our [policy on participant/patient](#)

[privacy and informed consent](#). They may also use the Consent to Publish Form, which can be downloaded from the [same Author Services page](#).

Submitting Your Paper

This journal uses Routledge's [Submission Portal](#) to manage the submission process. The Submission Portal allows you to see your submissions across Taylor & Francis' journal portfolio in one place. To submit your manuscript please click [here](#).

Data Sharing Policy

This journal applies the Taylor & Francis [share upon reasonable request data sharing policy](#). Authors agree to make data and materials supporting the results or analyses presented in their paper available upon reasonable request. It is up to the author to determine whether a request is reasonable. Authors are required to [cite any data sets referenced](#) in the article and provide a [Data Availability Statement](#). Please note that data should only be shared if it is ethically correct to do so, where this does not violate the protection of human subjects, or other valid ethical, privacy, or security concerns.

At the point of submission, you will be asked if there is a data set associated with the paper. If you reply yes, you will be required to provide the DOI, pre-registered DOI, hyperlink, or other persistent identifier associated with the data set(s). If you have selected to provide a pre-registered DOI, please be prepared to share the reviewer URL associated with your data deposit, upon request by reviewers.

Where one or multiple data sets are associated with a manuscript, these are not formally peer reviewed as a part of the journal submission process. It is the author's responsibility to ensure the soundness of data. Any errors in the data rest solely with the producers of the data set(s).

Updated 08-09-2023

Appendix B: Systematic Review Prevalence Quality Assessment

The current study relied on the JBI Critical Appraisal Checklist for Studies Reporting Prevalence Data (Munn et al., 2015). The interpretation of the tool was adapted to the purposes of the current study, which was to be inclusive of a broad range of study designs to paint as complete a picture as possible of the rate of reporting of recovered memories, given known challenges in defining and assessing the phenomenon.

Method

The Q1 sample frame was interpreted as studies which specifically asked about the presence of recovered memories, i.e. prompting the exclusion of a set of studies which asked only about the forgetting of traumatic memories. All included samples met this condition.

The Q2 recruitment question was taken as a typical prevalence study question, requiring random and population-based sampling to be able to estimate the rate of recovered memories.

The Q3 sample size question here utilised the JBI-recommended formula for sample size calculation: $n = d^2 Z^2 \cdot P \cdot (1 - P)$. For the current study the following figures were used: $Z = 1.96$ for 95% confidence, $P =$ Expected prevalence of 1% prevalence (as a ballpark figure), $d =$ Precision of 1% precision (to match the prevalence estimate so that confidence intervals cannot be below zero). This results in a required sample size of 380 participants.

The Q4 sample description question was used to categorise whether a study included data on the context in which memories were recovered, given the potential importance of differentiating between therapeutically-recovered vs. spontaneously-recovered memories.

The Q5 coverage question was taken to assess whether the inclusion criteria allowed for participants who recovered memories in multiple contexts and identified those contexts in

the study using numbers of participants reporting each context (e.g. therapeutically-recovered, spontaneously recovered).

The Q6 validity question was taken as simply whether the study explicitly stated that the phenomenon under question was of recovered memories, as multiple competing definitions impacting defining the phenomenon are live in the literature. As a result, all included studies met this condition.

The Q7 reliability question was used to differentiate between specific and vague definitions of recovered memories, as some studies were inclusive of broad criteria such as partial amnesia for abuse, whereas many studies with rigorous assessment interviews intentionally excluded participants reporting experiences of this nature.

The Q8 statistical analysis question was used to indicate the presence of appropriate statistical analysis to estimate prevalence, e.g. offering specific percentages and confidence intervals, or applying weights to variables in a principled manner.

The Q9 response rate question was based on whether a study reported the response rate, indicating an estimate of the risk of bias in the sampling procedure.

Result

No study met all quality criteria for inclusion in a prevalence systematic review, and so critical narrative synthesis was determined to be the most appropriate methodology for the current review (see Table 8). A large number of studies are of significantly low quality in this regard—many purposive samples only met criteria in terms of specifically recruiting people who reported recovered memories and offering an operational definition of recovered memories, but no other criteria such as sample size, recruitment methods, description of the sample, etc.

Table 8

Quality assessment of included studies using the JBI Critical Appraisal Checklist for Studies Reporting Prevalence Data (Munn et al., 2015).

Study	Q1 - sample frame	Q2 - recruitment	Q3 - size of sample	Q4 - description of sample	Q5 - coverage of sample	Q6 - validity	Q7 - measurement	Q8 - statistics	Q9 - response rate
McNally et al., 2000a	Y					Y	Y		
Clancy et al., 2000	Y					Y	Y		
McNally et al., 2000b	Y			Y		Y	Y		
Leavitt, 2000a	Y	Y				Y	Y		
Leavitt, 2000b	Y	Y				Y	Y		
Leavitt, 2000c	Y	Y		Y		Y	Y		
Westerhof et al., 2000	Y	Y		Y	Y	Y		Y	Y
Nijenhuis et al., 2001	Y	Y				Y	Y		
McNally et al., 2001	Y					Y	Y		
Leavitt, 2001	Y	Y		Y		Y	Y		
Hunter & Andrews, 2002	Y	Y		Y		Y	Y		
Wilsnack et al., 2002	Y	Y	Y	Y	Y	Y		Y	Y
Fivush & Edwards, 2004	Y					Y	Y		
Alaggia, 2004	Y					Y	Y		

Study	Q1 - sample frame	Q2 - recruitment	Q3 - size of sample	Q4 - description of sample	Q5 - coverage of sample	Q6 - validity	Q7 - measurement	Q8 - statistics	Q9 - response rate
McNally et al., 2004	Y			Y		Y	Y		
van der Hart et al., 2005	Y	Y		Y		Y	Y		
Geraerts et al., 2005	Y			Y		Y	Y		
Clancy & McNally, 2005	Y			Y		Y	Y		
McNally et al., 2005	Y			Y		Y	Y		
Merckelbach et al., 2006	Y			Y		Y	Y		
Spitzer & Avis, 2006	Y					Y			
Geraerts et al., 2006a	Y			Y		Y	Y		
Geraerts et al., 2006b	Y			Y		Y	Y		
Ghetti et al., 2006	Y	Y		Y		Y	Y	Y	
McNally et al., 2006a	Y					Y	Y		
McNally et al., 2006b	Y					Y	Y		
Geraerts et al., 2006c	Y			Y		Y	Y		
Smeets et al., 2007	Y					Y	Y		
Crowley, 2007	Y					Y	Y		
Geraerts et al., 2007	Y			Y		Y	Y		
Legault & Laurence, 2007	Y	Y			Y	Y		Y	Y

Study	Q1 - sample frame	Q2 - recruitment	Q3 - size of sample	Q4 - description of sample	Q5 - coverage of sample	Q6 - validity	Q7 - measurement	Q8 - statistics	Q9 - response rate
Raymaeckers et al., 2010	Y			Y		Y	Y		
Raymaeckers et al., 2012	Y					Y	Y		
Wager, 2012	Y			Y		Y			
O'Donohue et al., 2013	Y					Y			
Ost et al., 2013	Y	Y				Y		Y	Y
MacIntosh et al., 2016	Y			Y		Y	Y		
Dodier et al., 2019	Y		Y	Y	Y	Y	Y	Y	Y
Patihis & Pendergrast, 2019	Y		Y	Y	Y	Y	Y	Y	Y
Dodier & Patihis, 2021	Y		Y	Y	Y	Y	Y	Y	Y
Ross et al., 2022	Y	Y				Y			
Patihis et al., 2022	Y		Y	Y	Y	Y	Y	Y	Y
Schemmel et al., 2024	Y	Y			Y	Y		Y	Y
Murphy et al., 2025	Y		Y	Y		Y		Y	

Note: Y=Yes, met criteria listed.

Appendix C: Studies Excluded from Systematic Review at Full-Text Screening

Table 9

Excluded Papers Summary

Study	Exclusion reason	Key Finding
Clancy et al. (2000)	Erratum	n/a
Freyd et al. (2001)	Forgetting only	202 undergraduate students participated in survey. - Memory impairment was greater when abuse was perpetrated by a caregiver (vs. non-caregivers), particularly for sexual and physical abuse.
Epstein & Bottoms (2002)	Forgetting only	- Retrospective survey of over 1,400 college women (aged 18-60 yrs). - The vast majority of forgetting experiences represented relabelling of continuous memories, active avoidance of recall, and normal retrieval failure, with partial forgetting (i.e. fragmented memories) being the norm.
Sjöberg & Lindblad (2002)	Forgetting only	- Examined forensic interviews of victims of child sexual abuse material producer. 3 of 10 children interviewed reported memory difficulties for the videotaped abuse, with 2 of these reporting trying to forget.
Goodman et al. (2003)	Non-disclosure only	- In a sample of 175 participants with documented CSA cases, 19% failed to disclose during interviews as adults. - Non-disclosure was associated with younger age during abuse, lack of maternal support following original disclosure, and less severe abuse.
Sano et al. (2003)	Forgetting only	3 of 12 patients reported prior histories of forgetting abuse, implying recovery but not explicitly stating. 1 other patient reported intentionally forgetting. 3 of the 4 reported a period after disclosing in therapy where their mental health worsened temporarily (e.g., anxiety).
Schultz et al. (2002)	Forgetting only	240 female college students surveyed, 82 reported CSA and 30 reported memory disruption. 20 avoided the memory, 18 always remembered but never thought about it, 8 reported prior amnesia. - Memory disruption associated with more perpetrators, drug abuse in the home, closer relationships with perpetrators, higher dissociation, and higher suggestibility.

Study	Exclusion reason	Key Finding
Merckelbach et al. (2003)	Forgetting only	29 Dutch survivors of Japanese/Indonesian concentration camps interviewed. 1 reported prior amnesia. 11 reported periods of avoiding thinking about memories. 19 survivors reported clinically-significant traumatic memory intrusion and avoidance. 7 reported clinically significant dissociative symptoms. Notably, dissociative symptoms did not correlate with PTSD symptoms.
McNally & Clancy (2005a)	Secondary study	18 repressed memory, 14 RM, 36 continuous memory, 16 control, newspaper advertisement recruitment. - All who reported CSA regardless of memory status showed increased rates of sleep paralysis (44-47% vs. 13% in control). 1 of 6 RM group who had sleep paralysis believed the sleep paralysis was related to their CSA, no-one in any other group did.
McNally & Clancy (2005b)	Review article	- Study 1 involved 10 participants experiencing alien abduction. Higher rates of sleep paralysis among alien abductees and CSA groups compared to controls. No relevance to RM. - Study 2 is a poorly signposted reprint of McNally et al. (2005b).
McNally, Ristuccia, et al. (2005)	Secondary study	21 continuous memory (4 CSA, 2 corroborated), 11 RM (all CSA, none corroborated), 16 control - All CSA groups exhibited increased recall of trauma words presented under divided attention.
Gallo-Silver & Weiner (2006)	No indication of forgetting	15 of 18 patients did not disclose CSA but had memories triggered by medical environment, necessitating safety, grounding, and permission interventions. - Triggers: invasive medical procedures, confined spaces, anaesthesia, disrobing, isolation, intense physical sensations, illness side effects, smells, perceived coercion from staff.
Woodwiss (2009)	No access	Library unable to find copy.
Chiu et al. (2012)	Memory not specifically traumatic	- Nonclinical sample of 687 college students - Correlation between dissociative symptoms and recovered memory, independent of childhood trauma, fantasy proneness, or absorption. - Recovered memories included negative, neutral, and positive events, with no bias toward negative valence.

Study	Exclusion reason	Key Finding
Wager (2013)	No rate of RM	183 of 481 convenience sample reported CSA, 23% reported history of amnesia for abuse - Negative disclosure responses were strongly linked to amnesia (50% of negative response cases vs. 0% for positive responses). - Double betrayal was associated with a 66.7% amnesia rate (vs. 12.5% for low-betrayal negative responses).
Chiu (2018)	Memory not specifically traumatic	68 undergraduates with RM (unspecified content). - RM associated with reduced detail, lower emotional intensity, and lower confidence in veracity. Dissociation proneness associated with increased detail, increased emotional intensity, and fantasy proneness.
Mangiulli et al. (2021)	Memory not specifically traumatic	1,017 convenience sample, 415 reported amnesia (287 recovery), 102 attributed amnesia to emotional distress (65 recovery). 69.2% of those with amnesia reported memory recovery, primarily through talking with family/friends (52.6%) or spontaneously (26.1%); psychotherapy aided 10.8%.
Wolf & Nochajski (2021)	Forgetting only	297 adult CSA survivors, 31% dissociative amnesia (15% complete amnesia, 56% partial amnesia), 59% childhood autobiographical memory loss. - Betrayal, dissociation, duration of abuse, and dissociative amnesia predicted memory loss, lower age of abuse increased dissociation and thus memory loss.
Tsur & Katz (2021)	Forgetting only	42 children alleging intrafamilial child sexual abuse interviewed forensically. - All reported memory disruption and fragmentation, 28 reported fantasy depersonalisation and derealisation (dissociation), 38 appeared to dissociate during interview.
Langeslag & Posey (2023)	Forgetting only	115 undergraduates, 62 report inability to remember aspect of trauma event. - No association with forgetting and trauma intensity. Forgetting associated with dissociation during trauma, sleep problems after event, and repeated traumas.
Cavicchiolo et al. (2023)	Memory loss/recovery not specified	281 general population. - Psychometric dissociation symptoms mediate relationship between emotion dysregulation symptoms and borderline personality symptoms.

Appendix C: References

- Cavicchioli, M., Ogliari, A., Maffei, C., Mucci, C., & Scalabrini, A. (2023). Dissociative Dimensions and Their Implications for Emotional Dysregulation Underlying Borderline Personality Disorder Features. *The Journal of Nervous and Mental Disease*, 211(10), 742–751. <https://doi.org/10.1097/nmd.0000000000001707>
- Chiu, C.-D. (2018). Phenomenological characteristics of recovered memory in nonclinical individuals. *Psychiatry Research*, 259, 135–141. <https://doi.org/10.1016/j.psychres.2017.10.021>
- Chiu, C.-D., Yeh, Y.-Y., Ross, C. A., Lin, S.-F., Huang, W.-T., & Hwu, H.-G. (2012). Recovered memory experience in a nonclinical sample is associated with dissociation rather than with aversive experiences. *Psychiatry Research*, 197(3), 265–269. <https://doi.org/10.1016/j.psychres.2011.10.002>
- Clancy, S. A., Schacter, D. L., McNally, R. J., & Pitman, R. K. (2000). 'False recognition in women reporting recovered memories of sexual abuse': Erratum. *Psychological Science*, 11(1), 26-31. <https://doi.org/10.1111/1467-9280.00253>
- Epstein, M. A., & Bottoms, B. L. (2002). Explaining the Forgetting and Recovery of Abuse and Trauma Memories: Possible Mechanisms. *Child Maltreatment*, 7(3), 210–225. <https://doi.org/10.1177/1077559502007003004>
- Freyd, J. J., Deprince, A. P., & Zurbriggen, E. L. (2001). Self-Reported Memory for Abuse Depends Upon Victim-Perpetrator Relationship. *Journal of Trauma & Dissociation*, 2(3), 5–15. https://doi.org/10.1300/j229v02n03_02
- Gallo-Silver, L., & Weiner, M. O. (2006). Survivors of Childhood Sexual Abuse Diagnosed with Cancer. *Journal of Psychosocial Oncology*, 24(1), 107–134. https://doi.org/10.1300/j077v24n01_08
- Goodman, G. S., Ghatti, S., Quas, J. A., Edelstein, R. S., Alexander, K. W., Redlich, A. D., Cordon, I. M., & Jones, D. P. H. (2003). A Prospective Study of Memory for Child Sexual Abuse. *Psychological Science*, 14(2), 113–118. <https://doi.org/10.1111/1467-9280.01428>
- Langeslag, S. J. E., & Posey, Z. W. (2023). Factors that contribute to an inability to remember an important aspect of a traumatic event. *Memory*, 31(10), 1402–1411. <https://doi.org/10.1080/09658211.2023.2268304>

- Mangiulli, I., Jelicic, M., Patihis, L., & Otgaar, H. (2021). Believing in dissociative amnesia relates to claiming it: a survey of people's experiences and beliefs about dissociative amnesia. *Memory*, 29(10), 1–13. <https://doi.org/10.1080/09658211.2021.1987475>
- Merckelbach, H., Dekkers, T., Wessel, I., & Roefs, A. (2003). Amnesia, flashbacks, nightmares, and dissociation in aging concentration camp survivors. *Behaviour Research and Therapy*, 41(3), 351–360. [https://doi.org/10.1016/s0005-7967\(02\)00019-0](https://doi.org/10.1016/s0005-7967(02)00019-0)
- Sano, S., Kobayashi, N., & Nomura, S. (2003). Impact on Psychotherapeutic Process of Disclosure of Traumatic Sexual Abuse. *International Medical Journal*, 13(1), 13-21.
- Schultz, T., Passmore, J. L., & Yoder, C. Y. (2002). Emotional Closeness with Perpetrators and Amnesia for Child Sexual Abuse. *Journal of Child Sexual Abuse*, 12(1), 67–88. https://doi.org/10.1300/j070v12n01_04
- Sjöberg, R. L., & Lindblad, F. (2002). Limited Disclosure of Sexual Abuse in Children Whose Experiences Were Documented by Videotape. *American Journal of Psychiatry*, 159(2), 312–314. <https://doi.org/10.1176/appi.ajp.159.2.312>
- Tsur, N., & Katz, C. (2021). “And Then Cinderella Was Lying in My Bed”: Dissociation Displays in Forensic Interviews With Children Following Intrafamilial Child Sexual Abuse. *Journal of Interpersonal Violence*, 37(17-18), 088626052110163. <https://doi.org/10.1177/08862605211016347>
- Wager, N. M. (2013). Sexual Revictimization: Double Betrayal and the Risk Associated with Dissociative Amnesia. *Journal of Child Sexual Abuse*, 22(7), 878–899. <https://doi.org/10.1080/10538712.2013.830666>
- Wolf, M. R., & Nochajski, T. H. (2021). “Black Holes” in Memory: Childhood Autobiographical Memory Loss in Adult Survivors of Child Sexual Abuse. *European Journal of Trauma & Dissociation*, 6(1), 100234. <https://doi.org/10.1016/j.ejtd.2021.100234>
- Woodiwiss, J. (2009). Constructing stories of childhood sexual abuse. *The International Journal of Interdisciplinary Social Sciences*, 4(5), 91-100. <https://doi.org/10.18848/1833-1882/CGP/v04i05/52924>

Appendix D: Clinical Psychological Science Submission Guidelines

Before submitting a manuscript to *Clinical Psychological Science*, please read the journal's [Aims and Scope](#), Editor-in-Chief Jennifer Tackett's [interview in the Observer](#), as well as the guidelines below. Please also read the latest [editorial policies](#) from the APS Publications Committee.

Manuscripts must be submitted through *Clinical Psychological Science*'s submission website at <http://mc.manuscriptcentral.com/cpx>.

General Journal Information

Manuscript Review and Journal Emphases

The journal does not require masked review, i.e., that the authors names be omitted from the submitted manuscript. Thus, authors' names and affiliations should be listed on the manuscript title page.

The manuscript will be evaluated in relation to the advancement of and contribution to an empirically robust, representative, and inclusive clinical psychological science. To facilitate this evaluation, authors are asked to answer the following questions during the "Details & Comments" stage of the online submission process:

- Is this contribution the product of scientific interdisciplinarity or collaboration, across the field (e.g., clinical science intersection with other areas within psychology) or beyond (e.g., clinical science intersection with fields other than psychology)?
- Does this work contribute to the journal's commitment to promote diversity, inclusion, and representativeness?
- Does this contribution reflect current best practices and forward thinking in research practices and products that are open, transparent, replicable, and methodologically rigorous?

It is not expected that each contribution reflects all these goals (although such contributions are certainly welcome, as well), but authors are encouraged to clearly state any aspects of the contribution that reflect these priority areas, both in the cover letter as well as throughout the manuscript itself. This will help editorial staff and reviewers attend to the issues the authors see as the salient contribution.

Clinical Psychological Science places a particular priority on manuscripts that are interdisciplinary and bring the best available basic science from within psychology (e.g., social psychology, cross-cultural psychology, personality psychology, cognitive psychology, affective psychology, comparative psychology, neuroscience) and outside of psychology (e.g., sociology, anthropology, genetics, microbiology) to bear on our understanding of psychopathology. Hence, our journal prioritizes manuscripts that cut across multiple levels of analysis in the explanatory hierarchy ranging from "neurons to neighborhoods." Examples might be a manuscript that examines social-cognitive processes and their relevance to the etiology of depression, a manuscript that examines how the interaction between two brain regions places people at risk for anxiety disorders, or a manuscript that examines how cultural variables shape the experience or expression of schizophrenia (of course, these are only three potential examples among hundreds). *CPS* requires that manuscripts bear direct implications for clinical problems; manuscripts that do not contain measures of constructs pertinent to psychopathology are unlikely to be accepted unless authors can make an especially strong case for their relevance to clinical science.

Preparing Your Manuscript

Types of Articles

The primary focus of the journal is on empirical investigations that advance theory, methodology, or application related to topics within clinical psychological science. Empirical contributions from all areas of clinical psychological science are welcome. Interdisciplinary

and cross-disciplinary contributions that connect with clinical psychology, novel methods that reveal phenomena in a different light, and integration of conceptual models in new ways are all well within the scope of the journal. In addition, we welcome articles that provide broad philosophical and historical perspectives on clinical science, as well as those that offer novel methodological or meta-scientific approaches to the field. Replications (both positive and negative) of previous findings in the literature are also welcome, provided that these replications are accompanied by sufficient justification of the importance of the original findings. Replications will be accepted as regular empirical articles, but authors are also encouraged to propose replications as registered reports.

Empirical Articles. Empirical Articles should aim for a 12,000-word maximum, inclusive of front (title page) and back matter (references, footnotes, appendices). Articles are limited to a total combination of 6 tables and figures (e.g., 4 tables and 2 figures) that are not part of the word limit. Each table or figure should occupy no more than one printed page. Reporting of multiple investigations within a single manuscript is encouraged, and length adjustments can be discussed if and as needed. An abstract (maximum of 150 words) is included in the word limit.

In addition, *Clinical Psychological Science* generally does not accept manuscripts focusing on psychotherapy outcome studies given that these manuscripts can generally be accommodated within existing journals (e.g., *Journal of Consulting and Clinical Psychology*). Nevertheless, we will happily consider manuscripts that incorporate rigorous tests of mechanisms of change within psychotherapy outcome studies or address other priority areas (e.g., diversity and inclusion or open and transparent scientific practices) in the context of psychotherapy outcome.

Content Requirements

All articles must include the following two sections immediately after the main text, before the reference section:

- **Author Contributions:** See details below.
- **Conflicts of Interest:** Authors should identify any conflicts of interest in this section (and should also report them during the submission process). If authors have no conflicts of interest, they should state, “The author(s) declare that there were no conflicts of interest with respect to the authorship or the publication of this article.”

All articles may also include the following sections after the main text and before the reference list, as appropriate:

- **Acknowledgments:** Authors should use this section to identify any people who should be credited for their assistance with the reported research.
- **Funding:** This section should be used to acknowledge funding sources, in complete sentences and with the full names of funders spelled out.
- **Supplemental Material:** If Supplemental Material will be posted on the journal’s Web site, include this heading and the appropriate link will be added during editing.
- **Prior versions:** If part or all of a submitted manuscript was previously posted to a blog or to a preprint archive, the authors should provide a link to that source and briefly indicate what aspects of the submitted manuscript are shared with that prior version.

All Empirical Articles, as well as any other article that is eligible for the Open Data, Open Materials, Open Code, or Preregistration badge, must also include the following content in a separate “Transparency and Openness” section immediately prior to the Method section:

- **Preregistration:** This subsection of the Disclosures section provides one or more links to any preregistration documentation, whether for study designs, analysis plans, or both. If only some of the reported studies were preregistered, this subsection should

indicate which ones were and which ones were not. If no studies were preregistered, state as much.

- **Data, materials, code, and online resources:** This subsection provides one or more permanent, persisting links to a public archive (e.g., osf.io, perma.cc, clinicaltrials.gov) where readers can access any code, materials, de-identified data, or other resources. It should also refer to any Supplemental Material that will be posted on the journal's Web site. If any materials, code, or data are not publicly available, this subsection should explain why and should note how researchers can access them for research purposes. Data, materials, and code sharing (or citation to secondary sources) are required to the extent legally and ethically permissible.
- **Reporting:** For all manuscripts reporting new empirical work, the text in this subsection must state, "We report how we determined our sample size, all data exclusions, all manipulations, and all measures in the study" (see [Simmons, Nelson, & Simonsohn, 2011](#)). If any aspect of this statement is untrue or not applicable, the authors should instead explain why (e.g., "This study involved an analysis of existing data rather than new data collection"). For studies not involving new empirical work, authors should verify that they have reported any and all simulations or other analyses they conducted as part of the work.
- **Ethical approval:** Authors reporting research involving human subjects should indicate whether the protocol was approved by an institutional review board or similar committee and whether it was carried out in accordance with the provisions of the World Medical Association [Declaration of Helsinki](#) (note that the latest version of the Declaration of Helsinki requires preregistration before data collection begins). Authors reporting research involving nonhuman animal subjects should indicate whether institutional and national guidelines for the care and use of laboratory animals were followed. If ethical approval was not required, the reason should be given. Information that could identify subjects will not be published unless the information is necessary and written, informed consent is obtained.

Author Contributions

Authorship implies significant participation in the research reported or in writing the manuscript, including participation in the design and/or interpretation of reported experiments or results, participation in the acquisition and/or analysis of data, and participation in the drafting and/or revising of the manuscript. All authors must agree to the order in which the authors are listed and must have read the final manuscript and approved its submission. They must also agree to take responsibility for the work in the event that its integrity or veracity is questioned.

Furthermore, as part of our commitment to ensuring an ethical, transparent, and fair peer review and publication process, APS journals have adopted the use of [CRedit](#) (Contributor Roles Taxonomy). CRedit is a high-level taxonomy, including 14 roles that can be used to represent the roles typically played by contributors to scientific scholarly output.

These roles describe the possible contributions to the published work:

Conceptualization: Ideas; formulation or evolution of overarching research goals and aims

Methodology: Development or design of methodology; creation of models

Software: Programming, software development; designing computer programs; implementation of the computer code and supporting algorithms; testing of existing code components

Validation Verification, whether as a part of the activity or separate, of the overall replication/ reproducibility of results/experiments and other research outputs

Formal Analysis Application of statistical, mathematical, computational, or other formal techniques to analyze or synthesize study data

Investigation: Conducting a research and investigation process, specifically performing the experiments, or data/evidence collection

Resources: Provision of study materials, reagents, materials, patients, laboratory samples, animals, instrumentation, computing resources, or other analysis tools

Data Curation: Management activities to annotate (produce metadata), scrub data and maintain research data (including software code, where it is necessary for interpreting the data itself) for initial use and later reuse

Writing – Original Draft: Preparation, creation and/or presentation of the published work, specifically writing the initial draft (including substantive translation)

Writing – Review & Editing: Preparation, creation and/or presentation of the published work by those from the original research group, specifically critical review, commentary or revision—including pre- or postpublication stages

Visualization: Preparation, creation and/or presentation of the published work, specifically visualization/ data presentation

Supervision: Oversight and leadership responsibility for the research activity planning and execution, including mentorship external to the core team

Project Administration: Management and coordination responsibility for the research activity planning and execution

Funding Acquisition: Acquisition of the financial support for the project leading to this publication.

The submitting author is responsible for listing the contributions of all authors at submission. All authors should agree to their individual contributions prior to submission.

In order to adhere to SAGE’s authorship criteria authors must have been responsible for **at least one** of the following [CRediT](#) roles:

- **Conceptualization**
- **Methodology**
- **Formal Analysis**
- **Investigation**

AND at least one of the following:

- **Writing – Original Draft Preparation**
- **Writing – Review & Editing**

Authors should indicate their contributions by role. For example:

“Conceptualization: D. Wu, A. Brown, and M. Augilera; Methodology: T. Sossou; Formal Analysis: D. Wu and H. Andreas; Investigation: M. Augilera, T. Sossou, and D. Wu; Writing – Original Draft Preparation: D. Wu and A. Brown; Writing – Review & Editing: D. Wu, A. Brown, M. Augilera, and T. Sossou; Supervision: D. Wu; Project Administration: M. Augilera and A. Brown.

SAGE is a supporting member of [ORCID](#), the Open Researcher and Contributor ID. We strongly encourage all authors and co-authors to use ORCID iDs during the peer-review process. If you already have an ORCID iD, please login to your account on SAGE Track and edit the account information to link to your ORCID iD. If you do not already have an ORCID iD, please login to your SAGE Track account to create your unique identifier and automatically add it to your profile. PLEASE NOTE: ORCID iDs must be linked to author accounts prior to manuscript acceptance or they will not be displayed upon publication. ORCID iDs cannot be linked during the copyediting phase.

Manuscript Format and Structure

Submissions should follow the guidelines of the *Publication Manual of the American Psychological Association* (7th ed.) for references, abbreviations, and symbols. After acceptance, authors will need to provide a high-quality version of each figure for production purposes.

The main document file, which is used to create the PDF proof that is the primary document made available to editors and reviewers, must be in Word, RTF, or PDF format in order to render properly. However, authors who wish to submit an already-formatted article (generated using LaTeX, R Markdown, or other methods) in addition to the primary manuscript can submit both the formatted (“knit”) document and the file used to generate it as supplementary files. Such formatted documents (e.g., R Notebooks) allow for a completely reproducible process that incorporates both the manuscript text and analyses within a single file.

Supplemental Online Material

Authors are free to submit certain types of supplemental material for online-only publication. If the manuscript is accepted for publication, such material will be published online on the publisher’s web site, linked to the article.

The editorial team takes the adjective *supplemental* seriously. SOM should include the sort of material that enhances the reader’s understanding of an article but is not essential for understanding the article. SOM files should be uploaded or linked during initial submission.

Statistics

When evaluation of the data involves statistical significance testing, effect sizes and confidence intervals should also accompany the major results wherever possible. When relevant, bar and line graphs should include distributional information, usually confidence intervals or standard errors of the mean.

All statistics reported in *CPS* should be fully reproducible from the data. Authors should provide all statistical scripts and data necessary to reproduce the reported analyses. Authors are strongly encouraged to use open-access tools for their data analysis to allow for maximal reproducibility by other researchers. Authors are also strongly encouraged to verify the accuracy of any reported statistical analyses (e.g., by using online tools such as the R package [statcheck](#) or the [statcheck Web tool](#)).

When using inferential statistics, authors should clearly specify both the proximal population from which they sampled (e.g., the subject pool at their university, Amazon Mechanical Turk) and the assumed target population for their inferences (e.g., students at American universities, typically developing primary-school children). They should also specify and justify their assumptions about the generality of the materials and testing context used in the study (see [Simons, Shoda, & Lindsay, 2017](#), for guidance).

All statistics should be reported to an appropriate number of decimal places given the precision of the measures involved. Reported p values should be exact (e.g., $p = .007$ rather than $p < .01$). All statistical tests should be accompanied by an appropriate effect-size estimate, either in the original units or standardized. Repeated measures analyses should be accompanied by an indication of the correlation between the measures, a reliability estimate, and an effect-size estimate. Effect sizes should be accompanied by confidence intervals.

Demographic Data

Please include data on participants’ racial/ethnic identification, culture/geographic background, sex/gender, and a measure of income, education, or socioeconomic status; if such data were not collected, this point should be noted explicitly as a limitation.

Preparation of Graphics

The journal requires that for accepted manuscripts, figures be embedded within the main document near to where they are discussed in the text. A figure’s caption should be placed in the text just below the figure. For initial submissions, tables and figures may be placed at the end of the manuscript.

Authors who are submitting revisions should also upload separate figure files that adhere to the [APS Figure Format and Style Guidelines](#). Submitting separate, production-quality files helps to facilitate timely publication should the manuscript ultimately be accepted.

Citation Standards

Articles in *CPS* sometimes make use of pre-existing data, code, or other research products. Any use of such materials must be appropriately cited both in the text and in the list of cited sources. For example, a manuscript relying on pre-existing data for secondary analyses should cite the data set(s) by providing a unique identifier. In order of preference, that citation should refer to: (a) the recommended citation for that data set, (b) the DOI or other persistent identifier, (c) an accession number, (d) a persistent URL. When data or other resources are available only in the Supplemental Materials for a published article, the manuscript should cite the Supplemental Materials. When in doubt, cite the most durable, persistent, and unique identifier that is specific to that particular research product.

Data set citation example:

Campbell, A., & Kahn, R. L. (2015). American National Election Study, 1948. ICPSR07218-v4. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor]. <http://doi.org/10.3886/ICPSR07218.v4>

Appendix E: Ethical Approval Application and Confirmation



University College Cork, Ireland
Coláiste na hOllscoile Corcaigh

Coláiste na nEalaíon, an Léinn Cheiltigí
agus na nEolaíochtaí Sóisialta
College of Arts, Celtic Studies
and Social Sciences

Scoil an Síceolaíochta Feidhmi
School of Applied Psychology

University College Cork,
Cork, Ireland.

T +353 (0)21 490 4551 / 4552
E infoapsych@ucc.ie
<http://www.ucc.ie/en/apsych/>

16th October 2023

Dear Oisín,

Clinical Psychology Research and Ethics Meeting 13.10.2023

Thank you for presenting the above research proposal to the Research and Ethics panel.

Based on your written proposal and further clarification and discussion during the meeting, the decision of the panel was:

- **Changes** required (see feedback below).

Proposal

1. The review question, “what is presently known about people recovering forgotten memories of trauma inside or outside of therapy?”, is broad and unfocused, which is a problem when selecting a systematic review (SR) format. Closed-framed questions are more suitable for being addressed using a SR methodology. Here, the apparently open-ended review question would suggest that a more appropriate format is the scoping review, which seeks to map all available research and identify the gaps in our knowledge/understanding might be more appropriate (Munn et al., 2018). The abstract would suggest that the SR is looking at incidence and content but the inclusion/exclusion criteria and search strategy do not support this focus.

- Consider if the research question suits a systematic or scoping review. If systematic, please review the question and revise so it is closed-framed.

2. In the SR methodology section, the quality assessment section refers to “...the use of the JBI Critical Appraisal Checklist for Studies Reporting Prevalence Data (Munn et al., 2020), to explore the appropriateness of inclusion of overall data on prevalence and reporting of

Dr Chris McCusker
Head of School of Applied Psychology

Coláiste na hOllscoile Corcaigh
University College Cork

recovery of previously-forgotten memories.”. This appraisal tool and the statement that follows seems to suggest the review question is focused on the prevalence and content of “previously-forgotten memories”. That is not clearly indicated elsewhere and is not clear from the proposed search strategy.

- To be clarified in the revised document.

3. The description of Braun & Clarke’s TA is a little generic, how will each of the (six) steps be implemented in this instance?

- Consider specifying the detail of implementation.

4. There is ambiguity about the naming of memories/experiences in the proposal. We counted the following potentially overlapping constructs (that each have potentially differing connotations):

- False memories
- Recovered memories
- Recovering previously-forgotten memories
- Repressed memories
- dissociative amnesia
- disorientating and fragmented somatosensory memories

- It would be useful for the reader to clarify early in the proposal what is meant by these terms and be clear and consistent in your own usage in the subsequent text.

Ethics Application

1. Section 30(c): “(c) Data will be stored on student UCC OneDrive account. Physical audio recordings will be deleted immediately after upload.”. Does this mean that the audio recordings will be deleted after the transcript has been saved and uploaded? Do you mean the digital audio recordings will be deleted from the recording device after uploading? Why do you need to store both the audio recording and the transcript? This is also mentioned in the information sheet without explanation.

○

Please clarify the storage of the audio and the rationale.

2. Section 30(f): “The anonymised transcript dataset may be utilised for future research”. If this application is approved, this approval only extends to the current project, it does not provide open-ended permission to use the data in any/all future research.

- For noting.

3. Information Sheet: "The audio recordings will be stored on UCC-owned secure servers for a period of 10 years". How does this match the statement in Section 30(c)?
 - o Please correct so that sections are in accord.
4. The interview schedule contains a number of closed questions and wondered why interviews were to be limited to 50 minutes. Neither of these are ethical issues per se, but do speak to research integrity.
 - o For consideration.

For your reference

Munn, Z., Peters, M.D.J., Stern, C. et al. Systematic review or scoping review? Guidance for authors when choosing between a systematic or scoping review approach. BMC Med Res Methodol 18, 143 (2018). <https://doi.org/10.1186/s12874-018-0611-x>

In your resubmission, please include a data sharing agreement and research contract if you are collaborating with an external research partner or service.

You may re-submit your updated application to ethics@ucc.ie at any time but no later than **Friday 1st December 2023**. Please submit this as a word document and include a cover letter indicating how and where you have responded to these revisions. The cover letter should discuss and address point-by-point the change made, with reference to the page number where any revision was made.

Every best wish with making these revisions.

Every best wish with making these revisions.

Yours sincerely,

Dr Samantha Dockray
Chair Clinical Psychology Research and Ethics Panel

Research Proposal Edits Cover Letter

Thank you to the Research and Ethics panel for your helpful feedback and suggestions from our meeting on 13/10/23. I have endeavoured to incorporate the changes required and the feedback to reflect on, both in the proposal and the ethics form.

Proposal Feedback

1. *Consider if the research question suits a systematic or scoping review. If systematic, please review the question and revise so it is closed-framed.*
 - The content and references have been updated to reflect the nature of the project as being best described as a scoping review, rather than a systematic review as had previously been suggested.
 - pp. 1, 7-10
2. *The quality appraisal tool and the statement that follows seems to suggest the review question is focused on the prevalence and content of “previously-forgotten memories”. That is not clearly indicated elsewhere and is not clear from the proposed search strategy.*
 - As this is a scoping review, quality appraisal is no longer a core aspect of the analysis and there is not a requirement to narrowly define the type of data being extracted
 - Mentions of quality assessment have been removed.
 - Descriptions of the scoping extraction process have been inserted.
 - p. 10
3. *Specify the details of how Braun & Clarke’s TA method will be implemented in the current study.*
 - Outlined the steps of Braun & Clarke’s method of TA in the context of the current study. pp. 13-14
 - Described the epistemic assumptions of the study. p. 14
4. *There is ambiguity about the naming of memories/experiences in the proposal.*
 - Inserted a paragraph explaining the rationale for different phrases being used in the study of recalling previously-forgotten memories, suggesting that “recovered memories” will be the umbrella term utilised for the current study. pp. 4-5

Ethics Feedback

1. Please clarify the storage of the audio and the rationale.
 - On p. 5, section 30(c), clarified that “The audio recordings will be deleted after the anonymised transcript has been saved and uploaded.”
2. Note that any ethical approval of the current study would not provide open-ended permission to use the data in any/all future research.

- On p. 5, section 30(e), clarified that “The anonymised transcript dataset may be utilised for future research, dependent on future application for ethical approval for secondary data analysis.”
 - On p. 11, Appendix 3: Consent, clarified that anonymous data may be used in future studies.
3. Clarify how audio recordings will be stored and for how long on information sheet.
- On p. 10, Appendix 2: Information Sheet, clarified that audio recordings are deleted after transcription.
 - On p. 11, Appendix 3: Consent, clarified that audio recordings are deleted after transcription.
4. Consider making closed interview questions into open questions and removing limitation of 50 minutes for interviews.
- On p. 9, Appendix 1: Interview procedure, updated closed questions to ensure that they were all open questions (copied same across to Proposal).
 - On p. 10, Appendix 2: Information Sheet, clarified that interviews last approximately 1 hour.
 - On p. 11, Appendix 3: Consent, clarified that interviews last approximately 1 hour.

Thank you for your consideration of this project and for your suggested improvements.

Oisín Carey

Trainee Clinical Psychologist, MSc., BA (Hons)

Note: Section in red (**highlighted**) was changed from scoping to systematic review after supervisory discussion with Chair of Clinical Psychology Research and Ethics Panel.

MRP proposal re-submission

Nora Hennessy <@ucc.ie>
To: Oisín Carey <@umail.ucc.ie>

Wed, Dec 20, 2023 at 8:17 AM

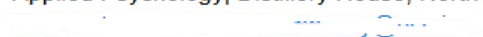
Dear Oisín,

Many thanks for this, you now have full approval.

All the best,

Nora

Nora Hennessy | Programme Administrator, DCLIN Psychology| School of
Applied Psychology| Distillery House, North Mall Campus |UCC |Ph: 



Appendix F: Participant Information Sheet

Information Sheet

Study title: Perspectives of Irish Clinical Psychologists on working with clients recovering previously-forgotten memories.

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Ask questions if anything you read is not clear or if you would like more information. Take time to decide whether or not to take part.

WHO I AM AND WHAT THIS STUDY IS ABOUT

I am a Trainee Clinical Psychologist completing my doctorate in UCC, and the current study will be part of my final thesis. The aim of this study is to gather information from practicing clinicians on their experiences of clients who recover forgotten memories and discuss this in therapy. While debates about repressed memories and the possibility of false memories abated in previous decades, modern trauma-informed understandings of dissociative amnesia in the context of possible abuse remain highly important in clinical practice. The current study is also being performed with awareness of Ireland's strong legal obligations to report abuse retrospectively, along with a cultural context of institutional concealment of abuse in recent Irish history.

WHAT WILL TAKING PART INVOLVE?

You will participate in an interview of approximately one hour in duration, and you will be invited to a virtual interview using video call. We will be talking about what experiences you have had of this clinically, what opinions you have of best practice in this area and how you would approach managing such cases. We will also discuss potential educational needs for professionals working with these kinds of clients. The interviews will be recorded and transcribed, with the interview itself being anonymised after completion, and redaction of portions of the transcript will be utilised if it should contain any personally-identifiable information.

WHY HAVE YOU BEEN INVITED TO TAKE PART?

You have been contacted due to your role as a practicing clinical psychologist who is currently participating in clinical supervision. We are seeking participants who have at least 2 years of experience working post-qualification to ensure experience of a broad range of client presentations. It is not necessary that you have worked directly with clients who report recovered memories, as we are seeking to represent a diverse range of voices.

DO YOU HAVE TO TAKE PART?

Participation is completely voluntary. You have the right to refuse participation, to refuse to answer any particular question asked, and to withdraw at any time during the interview. After the interview, you have the right to withdraw your data from the study for a period of 2 weeks post-interview. After this point, the interview will be anonymised and so will not be personally identifiable. There is no penalty for refusal to participate or to answer particular questions, or for withdrawal of data within the timeframe prior to anonymisation.

WHAT ARE THE POSSIBLE RISKS AND BENEFITS OF TAKING PART?

This research aims to provide a practice-based understanding of how clinicians work with clients reporting recovered memories, giving suggestions regarding best practice and possible educational needs for people working in the area. This will provide much-needed balance to academic discussions on the nature of memory and the role of therapy in relation to same, and is hoped to inform future educational opportunities provided to mental health professionals, in training or as part of continuing professional development. There is a risk of personally-identifiable information being provided in interviews, which will be managed through redaction at transcription stage. There is also a risk of personal narratives coming under critical attention, however this will be managed through respect for professional clinical judgement, and maintaining an open and flexible interview style in recognition of areas of genuine uncertainty.

WILL TAKING PART BE CONFIDENTIAL?

Interviews will be anonymised fully after transcription through assigning participants numbers, and removing location information about bases of practice, both from overall demographic information and from redacting key information provided during the interview. Confidentiality will only have to be broken if the researcher has a strong belief that there is a serious risk of harm or danger to either the participant or another individual (e.g. physical, emotional or sexual abuse, concerns for child protection, rape, self-harm, suicidal intent or criminal activity) or if a serious crime has been committed. Consent forms with an identifiable signature will be retained.

HOW WILL INFORMATION YOU PROVIDE BE RECORDED, STORED AND PROTECTED?

Interviews will be recorded using UCC's Microsoft Teams program, with the audio being deleted after transcription. The anonymised interview transcripts will be stored on UCC cloud storage for a period of not less than 10 years per the UCC Records Management Framework, and will only be accessible to the research team consisting of myself (doctoral trainee) and two members of UCC's academic staff. The anonymised transcripts may be utilised in future research studies. Anonymised and redacted transcripts will be stored on UCC-owned secure servers. Under freedom of information legalisation you are entitled to access the information you have provided at any time.

WHAT WILL HAPPEN TO THE RESULTS OF THE STUDY?

The transcripts will be analysed to identify themes across participants, initially for publication in a final doctoral thesis. The aim will be to publish the final research in peer-reviewed journals, with the possibility of conference presentations and use in teaching.

WHO SHOULD YOU CONTACT FOR FURTHER INFORMATION?

Lead Researcher: Oisín Carey, UCC Doctoral Student in Clinical Psychology

Academic Supervisor: Dr Gillian Murphy, Lecturer in UCC School of Applied Psychology

Clinical Supervisor: Dr Maria Dempsey, Lecturer in UCC School of Applied Psychology

Thank you for your time and attention.

Appendix G: Interview Protocol

The aim of this study is to advance understanding of recovered memories from the perspective of clinical psychologists working with clients reporting these experiences. The data collection process will include recorded individual semi structured interviews.

Each interview will have three sections: introduction, interview and conclusion:

Part 1: Introduction

The researcher will introduce themselves in the context of being a doctoral student in UCC, their particular interest in research on therapeutic practice in the context of recovered memories, and that familiarity with research into the complexities of human memory has generated a passion for safe and ethical therapeutic practice.

Participants will be welcomed and thanked for agreeing to meet with the researcher. They will then be given a study information sheet and a consent form to read, either physically if the interview is in-person or electronically if the interview is being conducted by video call. The researcher will read the consent form aloud before inviting the participant to sign it or add their e-signature.

Part 2: Interview

Each interview will begin with a statement of interest from the researcher in hearing what their experience of recovered memories in therapeutic contexts. This will be followed by a suggested starting point, e.g. ‘when you think about recovered memories now, what comes to mind for you?’ From here it is expected that the researcher will draw on the interview anchor points in a flexible way to enable participants to describe and consider more fully their experiences of client’s reporting recovered memories.

Interview anchor points

The main anchor points of the interview will centre on:

1. Exploring participant experiences of recovered memories in therapeutic contexts.
 - Your experience
 - What is your current role?
 - What kind of clients do you typically work with?
 - What, if any, experience have you of working with clients who report recovering memories that they had forgotten previously?
 - What, if any, experience have you of working with clients who report recovering memories of experiencing abuse that they had forgotten previously?
 - Have you ever worked with a client who you suspected of having a history of abuse that they denied?
 - ❖ How did you make sense of that?
 - ❖ [IF NOT] How would you work with a client like this, and how would you make sense of this presentation?
 - Your training
 - How did your training prepare you for working with clients like this?
 - ❖ How would you explore formulating this kind of client presentations?
 - ❖ What’s your perspective on how best to intervene therapeutically with a client like this?

- ❖ Were there other elements of training that inform how you think about these clients?
 - How did your training cover the area of clients who suddenly remember abuse that they had forgotten about for years?
 - What training have you completed on trauma and dissociative amnesia?
- 2. Perspectives on best practice and case management.
 - How do you typically approach the question of whether your client has a prior history of abuse?
 - How would you approach working with a client who reported no history of abuse but you had an intuition that this might not be true?
 - How would you approach working with a client who wasn't sure whether they had a history of abuse or not?
- 3. Determining what, if any, educational needs exist among practicing clinicians to support them working with clients experiencing recovered memories.
 - How was working with clients with recovered memories covered in your training?
 - Is there anything about this that you'd be uncertain or uncomfortable with if it did come up in-session?
 - How confident do you feel in your understanding of the legal aspects of this type of client work?
 - How would you describe a case like this to a supervisor or close colleague?
 - What do you think therapists need to know or to learn about working with clients with possible histories of abuse?
- 4. Exploring participant experiences and perspectives specifically with regard to clients recovering false memories of trauma/abuse.
 - Have you ever had concerns that a memory that was recovered was not accurate?
 - Would the inaccuracy of a person's memories impact therapeutic process/outcomes?
 - Do you think that memories are changed by memory retrieval and exploration?
 - Is preserving or accessing memories a priority?
 - What is your perspective on theories that false memories can be brought about by suggestive ways of practicing?
 - Are false memories a risk for you professionally? How can we help you with that?

Part 3: Conclusion

At the end of the interview the researcher will ask the participants if they have any questions they would like to ask, comments they would like to make or if there was anything in the interview that they would like to elaborate further on.

The researcher will also ask how the participant is feeling and what the experience of the interview was like for them. Participants will be thanked for their participation in the study and reminded that if when reflecting on the interview they have any questions or questions they can contact the researcher or his supervisor.

If they have any unease at the end of the interview process they will be guided to professional reading resources on the topic of recovered memories, reminded of the study policies regarding anonymisation and the right to withdraw from the research, and encouraged to discuss any additional arising issues in supervision.

Appendix H: Consent Form

Consent

Study title: Perspectives of Irish Clinical Psychologists on working with clients recovering previously-forgotten memories.

Consent to take part in research

- I..... voluntarily agree to participate in this research study.
- I understand that even if I agree to participate now, I can withdraw at any time or refuse to answer any question without any consequences of any kind.
- I understand that I can withdraw permission to use data from my interview within two weeks after the interview by emailing the Lead Researcher, Oisín, in which case the material will be deleted.
- I have had the purpose and nature of the study explained to me in writing and I have had the opportunity to ask questions about the study.
- I understand that participation involves an interview of approximately one hour on the topic of working therapeutically with clients reporting recovered memories.
- I understand that I will not benefit directly from participating in this research.
- I agree to my interview being audio-recorded.
- I understand that all information I provide for this study will be treated confidentially.
- I understand that in any report on the results of this research my identity will remain anonymous.
- I understand that the anonymised data from this study may be used in future research.
- This will be done by changing my name and disguising any details of my interview which may reveal my identity or the identity of people I speak about.
- I understand that disguised extracts from my interview may be quoted in a doctoral thesis, published academic papers, conference presentations, or reaching.
- I understand that if I inform the researcher that myself or someone else is at risk of harm they may have to report this to the relevant authorities - they will discuss this with me first but may be required to report with or without my permission.
- I understand that interview transcripts in which all identifying information has been removed will be retained in UCC cloud storage only accessible to the lead researcher and supervisors for a period of not less than 10 years per the UCC Records Management Framework.
- I understand that this anonymised data may be used in future studies on this topic.
- I understand that under freedom of information legalisation I am entitled to access the information I have provided at any time while it is in storage as specified above.
- I understand that I am free to contact any of the people involved in the research to seek further clarification and information.

Names, affiliations and contact details of researchers and academic supervisors

Lead Researcher: Oisín Carey, UCC Doctoral Student in Clinical Psychology, XXXXXX@ucc.ie

Academic Supervisor: Dr Gillian Murphy, Lecturer in UCC School of Applied Psychology, XXXXXX@ucc.ie

Clinical Supervisor: Dr Maria Dempsey, Lecturer in UCC School of Applied Psychology, XXXXXX@ucc.ie

Signature of research participant

Signature of participant

Date

Signature of researcher

I believe the participant is giving informed consent to participate in this study.

Signature of researcher

Date

Appendix I: Reflexive Thematic Analysis Analytic Stages and Audit Trail

Stages of RTA

In phase one, data familiarisation was achieved through repeated listens to the video recordings while correcting the auto-generated transcripts, followed by re-reading and memo-writing during early coding. In phase two, codes were generated manually in a line-by-line fashion using a table in Microsoft Word, aiming to capture both semantic and latent meaning units as perceived by the researcher in light of the research questions. Quotes capturing particular codes were also highlighted.

In phase three, initial themes were developed by clustering codes semantically in a spreadsheet in Microsoft Excel, based on semantic links and reflections on interview content. A miscellaneous category was retained for uncategorised codes. In phase four, themes and subthemes were revised to address overlap and incorporate previously unassigned codes, producing a thematic framework of five themes. Through email exchanges and discussion with the supervisory team, as well as iterative theme mapping, this framework was refined and reduced to three final themes.

In phase five, final names and definitions were assigned, and subthemes were reorganised to avoid duplication and consolidate around distinct central organising concepts, prioritising latent meaning. Phase six involved writing the analysis narrative, which was revised iteratively with supervisory feedback. These phases were not linear, and analytic movement between them, such as returning to the data during theme development, was central to the reflexive process.

An analysis audit trail was maintained in a flexible manner consistent with RTA. Memos were written for selected transcripts, and theme development was informed through coding maps, analytic journaling, and supervisory dialogue. Themes were refined through

two major iterations: first linked to codes, and later mapped to raw data extracts along with theme mapping. Quality assurance was supported through reflexive journaling and supervisory dialogue (Braun & Clarke, 2022).

Analytic Audit Trail

Stage 1: Familiarisation

Excerpt from Reflexive Journal: Immediately After Interview Completion

I was thrilled to be complimented at the end. I felt like I was struggling to control the conversation – directed towards dissociation and safety, not really talking about recovered memories or repressed memories. Focus was on reinterpretation of memories – psychological safety, nondirective approach. Therapeutic approach was unconventional – very long sessions, constant asking for permission, interpretation of in-the-moment sensations and affects. Dissociation at the forefront. He noted false memories – psychics projecting, therapists making guesses about their experience. People looking for an explanation – example of sleep paralysis being falsely interpreted as abuse memory. Description of symptoms that people might interpret as abuse signs, not necessarily? Strong focus on attachment and reparenting, childlike aspect of clients. I felt like I was colluding cos I agree with the framing. I don't know that we got to the heart of the issue about false memories – noted undergrad, agreed space to do a crash course at doctoral level... just seemed like a side issue to be brushed over (2 per 1,000 clients?). Meaning of recovered memories under question – repression vs suppression?

Stage 2: Coding

Excerpt of coding of interview (note bolding of illustrative quotes, line by line coding, suggested themes, and memo writing sporadically at different points)

Oisín Gearóid Carey (Umail) 6:42 'Cause, I think that that's really heartbreaking question then, isn't it that? That: did it really happen? And you know, is that a question that you would be asked or is it kind of the theme, or how does it tend to come out like that?	questions of memory validity in trauma survivors		
Participant 1 6:57 Unfortunately it does come up. So I I've one or two current people on my caseload like that – did it really happen. So, which I can understand within the context. So, the person that would be asking that question would be the alleged victim. And why they would say such a thing is that I, in my <u>my</u> opinion - now I hope you're OK with opinion! In my opinion, it's a case of they can't make sense of such a	questions of memory validity in trauma survivors	Trusting client perception of memories of abuse Handing over corroboration to appropriate agencies Reconstructive memory Memories outside of conscious awareness	I find this approach compelling – validate clients reporting abuse retrospectively and hand over the corroboration to the appropriate agencies (<u>Túsla</u> , <u>Gardaí</u>), etc. It takes the therapist out of the policing role. However, this doesn't acknowledge complicated social dynamics, e.g. abuse within the family, lost memories being recovered, etc. I find it intuitive that people will compartmentalize or segment
Raw Data	Coding	Themes	Memo-writing
harrowing experience. And so then when it begins to come into conscious awareness - and it's not necessarily that memories are fully forgotten - but when it comes into conscious awareness, they're trying to make sense of - did this actually happen? Did I have these actual	struggle to make sense of resurfaced traumatic experiences partial memory recall rather than complete forgetting questions of memory validity in		their memories so it doesn't impact their life, but in terms of mechanism I have no idea what this might look like. He acknowledges that memories are reconstructive, but doesn't seem to do anything with that knowledge, in fact going backwards and saying he trusts their memory despite this.

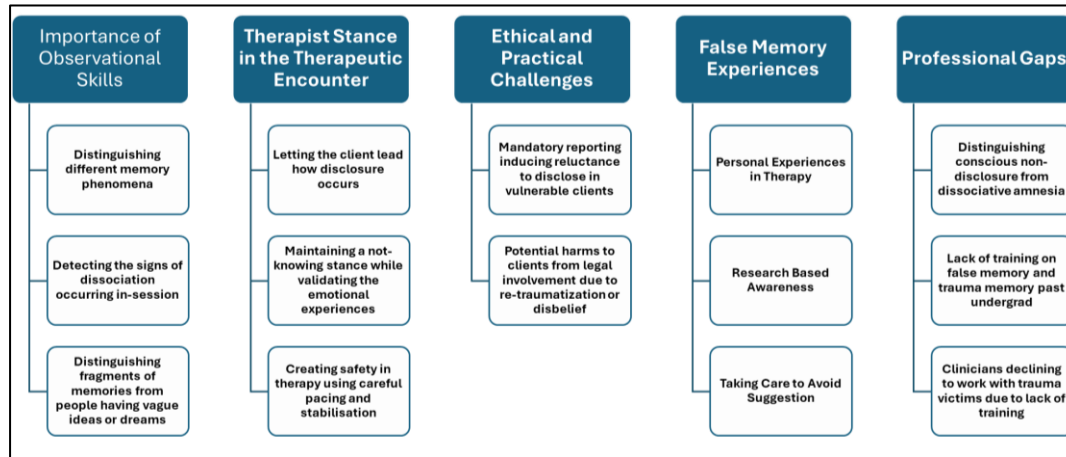
Stage 3: Developing Themes

Mapping Codes to Initial Themes

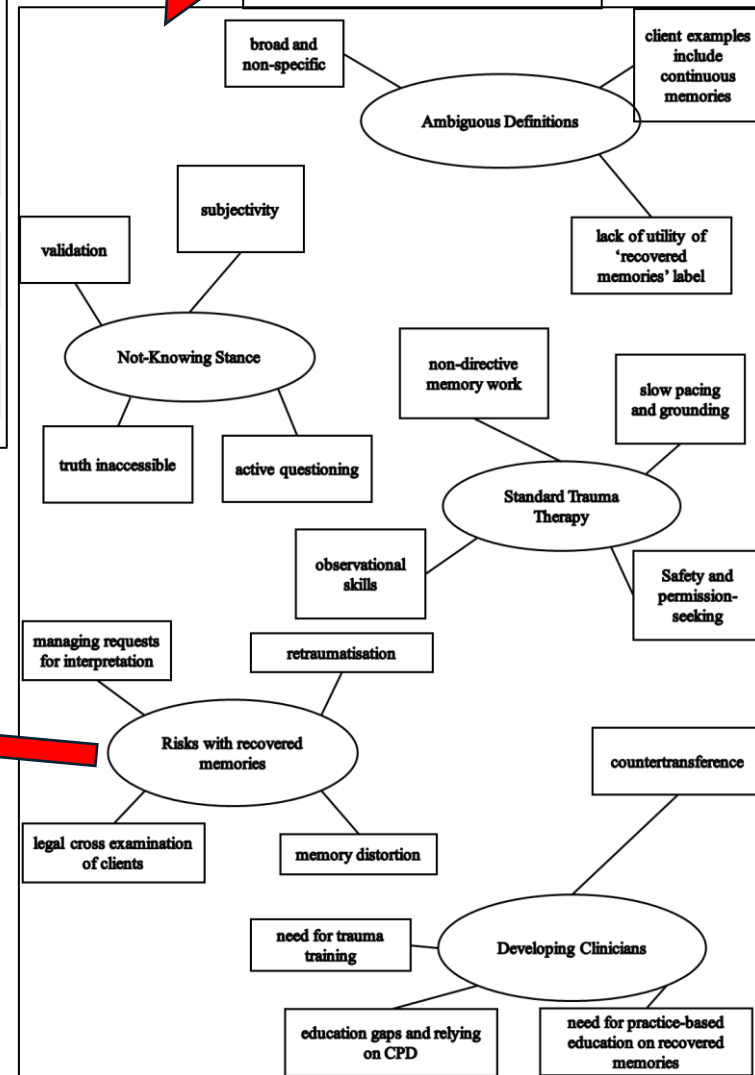
B	C	D	E	F	
Therapeutic Best Practice	Ethical Challenges	False Memory Experiences	Professional Gaps	Trauma's impact on client and on their recall	Uncategorized
Participant 3					
nindness in accepting clients' narratives	rejection of techniques like hypnosis for memory recovery	shift from denial to memory recognition	experience in adult mental health and child	exposure to clients with vague or fuzzy memories	recognition of
ding belief to avoid premature judgment of client stories	experience of the legal context and implications for trauma	occasional retrieval of previously forgotten	supervision experience with professional	clients with suspicions or feelings of abuse but lack	conceptualiz
nance of assuming the truthfulness of clients' memories	risk of clients being hurt by premature legal involvement	recovered memories of both traumatic and	broad experience with sexual abuse cases	recognition of the difference between vague memories	acknowledg
ist's stance of 'not knowing' in relation to trauma exposure	awareness of the potential misuse of recovered memory	avoidance of assuming the truthfulness of	clear triggers or catalysts leading to the	memory recall of traumatic events previously un	exploring the
ance of clients' accounts without questioning their veracity	past experience in court highlighting the risks of recovered	rejection of techniques like hypnosis for memory	participant did not reread BPS guidance	shift from denial to memory recognition of past	theory of me
pledging the authenticity of clients' stories without reservation	accusations of presenting memories as recovered in legal	concern about the harm of false memories	uncertainty about the effectiveness and	vagueness or clarity in recovered memories of a	encoding dif
ninded approach to client narratives	concern over legal misinterpretation of therapeutic work	rejection of therapy as a tool for recovery	uncertainty around memory processes in	newly recovered memories challenging prior self	universal hu
ed therapy process	avoiding coercion in memory exploration	therapist's personal stance against memory	acknowledgment of gaps in understanding	variety of memory recall experiences in trauma	sudden reco
on of therapy as a tool for recovering forgotten memories	recognition of potential overstatement in past therapeutic	BPS guidance inducing caution regarding recovery	lack of sufficient research on recovered	sudden memory recall triggered by specific even	recollection
on therapy as a means of making sense of life and understanding	challenges of working with recovered memory cases	awareness of the potential misuse of recovered	undergraduate and clinical training in memory	differences in individual memory recall of shared	recovery of i
ist's personal stance against memory recovery as a therapeutic	legal cases were specifically for court-ordered assessments	past experience in court highlighting the risks	gap between theoretical memory models	occasional retrieval of previously forgotten memories	nebulous na
Psychological Society (BPS) guidance document on memory	court-ordered assessment experience for legal cases	accusations of presenting memories as recovered	seeking insights from trauma experts rather	encoding difficulties leading to memory retrieval	philosophica
nance of being directive or leading in memory recall	risk of mixing up court-ordered assessment cases and the	managing client expectations about memory	cognitive science training in memory neg	recovered memories of both traumatic and non	debate betw
sis on creating space for client-led exploration	possibility of being called as a corroborative witness for court	recognizing that therapy may not resolve	lack of education on the interaction betw	intentional suppression of memories as a conse	distinction b
nance of imposing therapist beliefs on clients	difficulty determining what qualifies for mandatory reporting	validating emotional memories without as	absence of trauma-informed memory m	deliberate avoidance of trauma-related thought	memory rep
of Bessel van der Kolk and trauma clinics in Boston	uncertainty in reporting vague or belief-based abuse suspicions	impact of The Courage to Heal on therapeutic	self-directed learning to bridge gaps in a	understanding trauma memory shaped by war v	research foc
ne Cloitre's work on PTSD and trauma responses	concern about potential harm in formal reporting for unc	controversy around the role of The Coura	reliance on trauma research (e.g., WWII)	influence of VA clinics and PTSD research on un	speculative a
aging clients to talk about unclear or fragmented memories	clients' inability to withstand legal or investigative scrutiny	recovered memories movement context	learning about trauma memory through	attendance at sexual abuse conferences shaping	integration c
on bodily sensations and emotions during memory recovery	contrast between therapeutic exploration and formal inv	influence of media, workshops, and social	influence of VA clinics and PTSD research	distinguishing between discomfort and concrete	distinction b
ative therapeutic orientation combining multiple approaches	risk of retraumatization through aggressive questioning	people later in life querying the possibility	training in Emotion-Focused Therapy (EF	acknowledging that distressing sensations do not	contrast bet
oration of body psychotherapy techniques in trauma	risk of being overly directive or having an agenda in ther	harmfulness of clients assuming that their	historical context of clinical training dur	distinguishing between discomfort and actual at	rememberin
ness of emotional responses as a key therapeutic tool		therapy does not always bring clarity on p	clinical training placement at Dublin Rap	acknowledging that inappropriate behavior does	aside regard

Stage 4 and 5: Refining Themes, Naming Themes, and Identifying the Central Organising Concept

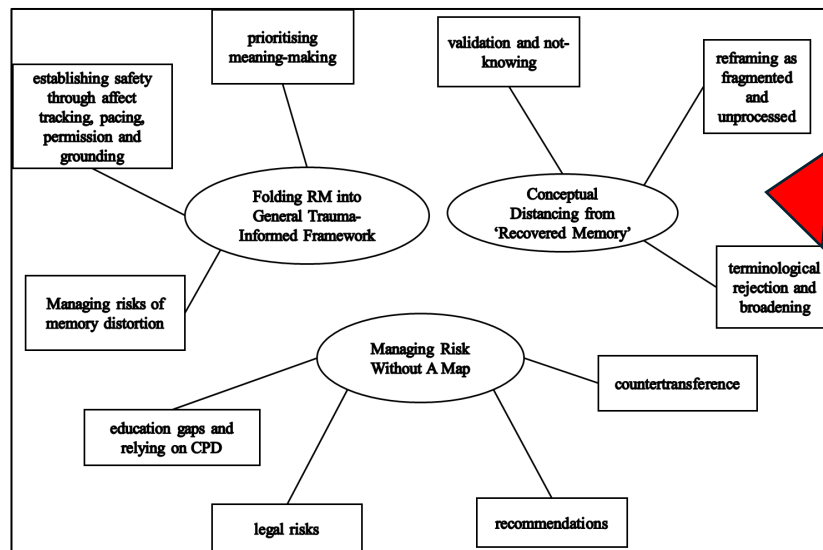
1: Initial Themes Draft



2: Revised Theme Map



3: Final Themes Map



Stage 5 & 6: Refining Themes and Drafting Report Iteratively

Paraphrased email exchange with supervisors

During theme refinement, supervisory dialogue played a key role in supporting reflexive distance from the data. One challenge involved participants frequently framing recovered memory phenomena within broader trauma therapy processes (e.g., dissociation, attunement, grounding), often without clearly distinguishing recovered from continuous trauma memories. In supervision after an initial draft of the analysis based on the second iteration of the themes, we discussed whether this pattern reflected a lack of conceptual clarity among participants, a methodological limitation of the interview prompts, or a broader therapeutic epistemology that absorbs memory ambiguity into trauma-informed practice. This dialogue prompted a re-examination of how themes were structured, leading to a more abstracted level of interpretation that honoured participants' sense-making while still aligning with the research questions and analytic aims (cf. Braun & Clarke, 2022, 2025).