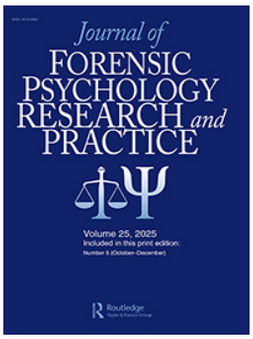

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A Case Study on Drug-Assisted Psychotherapy and Recovering and Retracting Beliefs of Abuse

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ABSTRACT

We present the case of a man, JK, who came to believe during therapy that he had been abused by his father, but later repudiated this claim. JK underwent narcoanalysis intended to uncover repressed memories, during which a psychiatrist used suggestive techniques to elicit memories of abuse. As a result, JK came to believe that he had been abused by his father. Later, after reading a newspaper article discussing the potential for psychiatrists to implant false memories, JK retracted this belief. This case study offers insight into the processes by which traumatic experiences can be both recovered and subsequently retracted.

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Retractor; memory wars; repressed memory; false memory; recovered memory

People who claim to have been abused in their childhood sometimes deny having experienced the traumatic event at a later time. Such denials can be inaccuratefor example, when victims avoid discussing the trauma due to shame or fear of the perpetrator (e.g., Bücken et al., 2023; Lyon, 2007). However, in some cases, these denials are accurate. This concerns people who accurately refute earlier claims of abuse that were often driven by suggestive therapy leading to false beliefs or false memories of abuse (memories of non-experienced events; Otgaar, Howe, et al., 2025).

Retractors are individuals who at a certain moment realized that their memories of trauma were fictitious and subsequently retracted their claims (Otgaar, Howe, et al., 2025). Here, we describe a unique case of the recovery and retraction of a sexually abusive experience. In this case, a person was exposed to drug-assisted psychotherapy and started to believe that he was abused by his father. Later, he retracted this belief, recognizing that the experience had not occurred. Notably, we had access to the clinical records of the psychiatrist who treated him, providing

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detailed insights into the therapeutic process. Before discussing the specific elements of this case, we first provide a brief overview of the clinical and legal context surrounding the recovery and retraction of traumatic experiences.

Recovering experiences

An important period in the scientific study of recovered and retracted memories began in the 1990s, when concerns emerged regarding the authenticity of memories of abuse recovered in psychological therapy (e.g., Loftus, 1993). Some scholars argued that these recovered memories were formerly repressed memories. The idea was that these repressed memories were unconsciously stored and, although consciously inaccessible, led to the development of mental health complaints (e.g., feeling depressed). Psychological therapy could unearth these unconscious repressed memories of trauma by using techniques such as hypnosis and dream interpretation. Other scholars (e.g., cognitive psychologists), however, argued that these techniques are inherently suggestive and may lead to the formation of false memories (e.g., Loftus, 1993; McNally, 2024). They stated that in some cases, recovered memories in therapy were in fact false memories (e.g., Battista et al., 2023; Otgaar et al., 2019).

This debate, known as the "memory wars" (Crews, 1995) centers on the validity of the concept of repressed memory. Although the debate has been around for several decades, it endures for several reasons. First, suggestive therapeutic practices continue to take place in some clinical settings, leading to a risk of false recovered memories (e.g., Patihis et al., 2014; Schemmel et al., 2024; Zappalà et al., 2024; see also Patihis & Pendergrast, 2019). Second, non-trivial proportions of therapists, but also members of the general population, endorse the notion of unconscious repressed memory (e.g., Anderson et al., 2025; Otgaar et al., 2022; Radcliffe & Patihis, 2025). Third, related terms such as dissociative amnesia remain in use within clinical and legal discourse, reinforcing the perception that repressed memory is a valid construct (e.g., Mangiulli et al., 2022; Otgaar, Howe, et al., 2025; Salkeld & Patihis, 2025; Staniloiu & Markowitsch, 2024).

Considerable scientific attention has been devoted to the recovery of memories and under which circumstances such memories can be either true or false (e.g., Dodier et al., 2024; McNally & Geraerts, 2009). In some cases, individuals who have recovered memories of abuse at a later stage retract their memories, oftentimes because they realize that their recovered memories were false (e.g., Ost, 2017). Such retractions raise important questions about why these memories were recovered in the first place and which factors contributed to their subsequent recantation.

Retraction of experiences

The academic literature on the retraction of experiences of abuse is diverse, encompassing both qualitative case reports and quantitative studies (for a review see Otgaar, Mangiulli , et al., 2025). In general, this body of work on retractors can be divided into three themes: (1) The formation of memories before retraction, (2) The characteristics of retractors' experiences, and (3) The retraction itself.

The formation of memories before retraction

A central theme in research on retractors concerns the role of therapy in recovering memories of abuse. Survey studies have shown that the vast majority of retractors reported recovering memories of abuse during therapy (Nelson & Simpson, 1994: 95%, $n = 19$; Lief & Fetkewicz, 1997: 92.5%, $n = 37$). Moreover, many indicated that it was the therapist who suggested that they had been abused (Lief & Fetkewicz, 1997: 82.5%, $n = 33$).

Some studies examined the processes that might have led to the recovery of these alleged memories of abuse. Specifically, De Rivera (1997, 2000) argued that retractors' experiences could be explained by three models. The first, the *mind-control model*, posits that false memories emerged in therapy because retractors placed full trust in their therapists – even when they were (falsely) told that they had repressed memories of abuse. The second, the *narrative model*, suggests that retractors constructed personal narratives to make sense of their identity and to explain their mental health difficulties. Finally, in the *role-enactment model*, De Rivera (2000) argued that some retractors adopted a particular role – such as that of an abuse survivor – and interpreted their psychological symptoms through the lens of this role.

Characteristics of retractors' experiences

DeGloma (2007) investigated the accounts of retractors and noticed that they sometimes used symbolic language to refer to traumatic events. For example, it was noted that retractors used terms such as "brain-washing" or "mental torture" to describe the way therapists attempted to persuade them into believing that they were abused.

Similarly, Ost et al. (2001) drew a parallel between retractors and individuals who falsely confess to crimes. They argued that the processes underlying the recovery of false abuse memories resemble those involved in false confessions. In both situations, people may internalize misleading information and become genuinely convinced that the event occurred.

The Retraction

Some studies have focused specifically on the retraction process and strategies related to recovery and retraction. Ost (2017), for example, examined which strategies were used by retractors to verify their memories, such as interpreting "physical" evidence (e.g., body-related sensations or unexplained pain, as signs of past abuse). Relatedly, the most important reason for why people retract their memories was the presence of external evidence such as media reports imposing doubt on the authenticity of the recovered memory (Li et al., 2023; Ost, 2017).

In addition, Ost (2017) and Li et al. (2023) discovered that retractors' accounts varied on how much they believed and remembered the false event. That is, some retractors did not seem to report any memories of the abuse, but strongly believed that the event had occurred, while others had vivid recollections of the abuse. This distinction between belief and recollection suggests that retraction may involve different cognitive profiles: some retractors retract a belief they had accepted as true, others retract memories they had vividly imagined.

An important critique of the literature on retractors is that it largely relies on self-report (see Otgaar, Howe, et al., 2025; Reviere, 1997; Vos, 2024). Specifically, it is often unclear what truly happened in the therapeutic sessions as discussed by retractors. It might be the case that when retractors attempt to retrieve what ostensibly happened in therapy, they might have misremembered or misunderstood details of these sessions. Here, we report on a unique case that remedies this limitation. We discuss a case of a retractor for which we had access to and permission to use the therapist's notes of the sessions. This case provides a rare opportunity to observe, in detail, the suggestive therapeutic practice that may have contributed to the recovery of a potentially false experience of abuse.

The case

The case involves a 54-year-old man, referred to here as JK, from the United Kingdom, who contacted the first author to share his experience as a retractor. JK reported that he had access to his medical records, including notes from a psychiatrist documenting that he had undergone drug-assisted psychotherapy. According to JK, this therapy led him to falsely believe that he had been abused by his father. An interview was subsequently arranged to allow him to provide further details about his experience and to share his medical files for examination.

Method

The Interview. The interview took place on December 11, 2024, and was conducted by the first and last author. Prior to the interview, JK provided

informed consent, granting permission for his account and psychiatric files to be used for academic purposes. The file was verbatim transcribed using the software Amberscript[1] and the resulting text was compared with the audio-visual file to check for any potential errors. The interview started with asking JK for a free recall on what he wanted to tell us about his story. After the free recall instruction, JK provided an account of what allegedly happened and if necessary, the first and last author asked follow-up questions for further clarification.

Files. The psychiatric files consisted of 157 pages and contained various documents such as notes about medication and notes from different therapists. Of particular interest were the notes of a psychiatrist making use of drug-assisted psychotherapy. Before examining these case files, we created a secondary data preregistration on how to look at these specific files (see https://osf.io/rx3cz). We listed several research questions: (1) Which aspects of the files could be related to false beliefs and/or false memories? (2) Are the files in line with the story of the retractor? and (3) Do the files provide new information not disclosed by the retractor? We also formulated several hypotheses: (1) We expected to see indications of suggestive therapeutic techniques and psychopharmacological substances undermining agency, which could foster the formation of false beliefs/memories, (2) We expected the case files to be mostly in line with the retractor's story, and (3) We did not know whether the case files contained any new undisclosed information.

We created a coding file containing several variables (e.g., relevance to the case) and an accompanying coding scheme defining each variable (see https://osf.io/dwmhb/). To establish interrater reliability, a second rater (the second author) independently coded 20 files (12.7%). A file was considered relevant if its content related to the recovery or retraction of a belief or memory – for example, records describing drugs or medications administered to JK or the psychological therapies he received. Before establishing interrater reliability, the two coders met and discussed the coding file and coding scheme. In the first round of coding, they obtained a Cohen's Kappa of 0.50 (95% CI [0.17, 0.83]. After this first round, the coders discussed discrepancies and disagreement and decided that files including any form of therapy or drugs were relevant for the case on retraction. In the second round of coding, a Cohen's Kappa of 0.90 (95% [0.71, 1.00] was achieved (see https://osf.io/dwmhb/files/osfstorage).

Results

The Interview. The interview lasted 52 min. During the interview, JK (54 years old) shared that his father passed away when he was 12 years old. He reported

[1]https://www.amberscript.com/en/

experiencing this event as traumatic, and JK suggested that because of the loss of his father he became more introverted and anxious. Furthermore, he described that he had a facial flushing condition making his face turn red, which also led to anxiety.[2] Because of these issues, his mother eventually sent him to a psychiatrist. He reported that he thought that he was about 18 or 19 years old at that time. JK reported that he told the psychiatrist about the facial flushing and quite quickly, the psychiatrist prescribed him medications including benzodiazepines such as diazepam and temazepam, and antidepressants such as Prozac. JK stated that already then, he was on a cocktail of drugs. According to JK, the psychiatrist told him that he would not become addicted to these drugs.

During early therapy sessions, JK reported that he initially spoke about his father in a positive way. However, at some point, the psychiatrist began suggesting that his problems were the result of a repressed memory of abuse by his father. JK stated that the psychiatrist explained that his task was to recover these memories, warning that he would likely experience a breakdown, after which the psychiatrist would "rebuild" his personality.

Initially, JK was unable to recover any memories of abuse of his father. JK then reported that the psychiatrist started narcoanalysis in which he intravenously injected JK with a barbiturate. The psychiatrist insisted that this procedure would help him to recover the repressed memories of abuse. JK declared that he saw images of wolves during these drug-assisted therapeutic sessions, which made the psychiatrist suggest that the sexual abuse might have been organized, and that -besides his father- other men might also have been involved.

Although JK did not recover any specific memories of abuse, he reported that he developed a therapy-induced belief that he had been sexually abused by his father. He also shared this belief with his brother, who expressed skepticism, noting that he had often been with JK and could not understand how the abuse could have occurred. JK further reported that disclosing this belief strained his relationships with his mother and brother.

JK stopped the therapy with the psychiatrist due to a lack of financial resources. Furthermore, he noted that somewhere in the late 1990s or early 2000, his brother showed him a newspaper article on psychiatrists implanting false memories in their patients.[3] The exposure to this newspaper article made JK realize that this was exactly what also happened to him, thereby retracting his false belief of sexual abuse. JK attempted to sue the psychiatrist but when he and his lawyer found him, they discovered that he was broke and that there was no possibility of suing him. Finally, JK stated that he joined the British

[2]There is indeed a link between blushing and anxiety (Nikolic et al., 2020)

[3]JK handed us the newspaper article and we identified the article being from the Guardian (1998): https://archive.org/stream/TheGuardian1998UKEnglish/Jan%2012%201998%2C%20The%20Guardian%2C%20%23331%2C%20UK%20%28en%29_djvu.txt

False Memory Society, where he interacted with other retractors and learned that some had been treated by the same psychiatrist.

The Files. When inspecting the case files, it was noted that 14 files were either duplicates of other files or were unreadable (some files contained handwritten notes), leaving a total of $N = 143$ source documents to analyze. More than half of these files (i.e., 55.9%, $n = 80$) were considered relevant for the case, while 44.1% ($n = 63$) were not relevant to the case (e.g., a vaccination certificate). Importantly, all documents that were coded as relevant for the case were in line with the story of JK. The files spanned a period between 1990 and 2004, and evidence was found for a wide variety of medication that JK had used (e.g., diazepam, sertraline, temazepam; see Table 1). In addition to his treatment with the psychiatrist, the records indicated that JK had also consulted other therapists from different practices, who prescribed medication (for example, for facial blushing) or provided cognitive-behavioral therapy for depression. It should also be noted here that we identified 15 files stemming from the psychiatrist that JK mentioned during his interview. These records, dated between 1990 and 1994, described several therapeutic techniques – specifically, methods used to recover memories of trauma in JK. The following excerpts illustrate what the psychiatrist documented:

- *"Plan to add drug-assisted psychotherapy, i.e. narcoanalysis, as detailed in my previous letter, to uncover some traumas"*
- *"Further elements of the trauma he sustained when he was younger emerged unexpectedly"*

Table 1. Overview of various types of drugs/medication mentioned in the case files.

Mentioned medications/drugs	Class they belong to
Prozac	Antidepressants
Paroxetine/Seroxat	
Sertraline	
Sinequan	
Venlafaxine	
Diazepam	Benzodiazepines (sedatives)
Temazepam	
Amylobarbitone	Barbiturates (sedatives)
Clonidine/Catapress	Alpha Agonists (anti-hypertensives)
Propranolol	Beta Blockers
Minocin	Antibiotics
Doxycycline	
Oxytetracycline	
Clarithromycin	
Erythromycin	
Zincomed	Nutritional supplements
Epogam	
Lansoprazole	General medications and painkillers
Co-dydramol	
Alcohol	Recreational substances

Note. Drugs/medication in italics were prescribed and mentioned by the psychiatrist who applied the drug-assisted therapy with JK.

- *"There is a possibility that his trauma has been more extensive than I imagined"*
- *"I will next be seeing [JK] after Christmas and then I will be seeking to extract the traumas from his childhood"*
- *"We have uncovered a number of traumas from his early years, including a history of emotional, physical, and sexual abuse."*

Furthermore, Table 1 also indicates which medications were prescribed by the psychiatrist. As shown, the psychiatrist prescribed a wide range of drugs to treat JK.

Discussion

The current article reports on a unique case study of a retractor. Specifically, we described the case of a man, JK, who underwent drug-assisted psychotherapy and subsequently came to believe that he had been abused by his father. At a later stage, he retracted this belief. A distinctive feature of this case is the availability of JK's medical records, including – amongst others – documentation from his psychiatrist detailing the specific techniques used to facilitate memory recovery. In the sections that follow, we examine how JK's account and his medical files correspond to the existing literature on the recovery and later retraction of traumatic memories.

The uniqueness of this case especially concerns the access to the medical files of JK. In this way, it was possible to verify JK's story with what was reported in the files. This is relevant since scholars have criticized the work on retractors because it primarily relies on self-report (e.g., Vos, 2024). The fact that we were able to inspect these files provided us with the opportunity to closely examine which therapeutic techniques were applied to JK and whether these techniques might have led to a false belief of sexual abuse. We found that the files relevant for the retraction case were in line with the story provided by JK, thereby supporting our second hypothesis. For instance, JK's claim that he underwent narcoanalysis was substantiated by the psychiatrist's records.

Another distinctive element of this case was that JK, in fact, underwent drug-assisted therapy termed narcoanalysis. This controversial drug-assisted therapy, historically employed in psychiatric settings to facilitate memory recovery, has been associated with the risk of eliciting false trauma-related beliefs or memories (Kubie & Margolin, 1945; Moenssens, 1961; Vaswani et al., 2024). In the files, we could confirm that JK was administered amylobarbitone during these procedures – a short-acting barbiturate also known as amobarbital or sodium amytal. Amylobarbitone was initially used to induce a sedated, semi-hypnotic state in the treatment of catatonia or for diagnostic clarification, but it gained notoriety in the mid-20th century as a so-called "truth serum" (Nichols et al., 2012). Although widely employed in psychiatric,

forensic, and military contexts, this label is both misleading and unsupported. Experimental and governmental reviews, including CIA trials, concluded that the drug did not reliably elicit truthful information. On the contrary, concerns have long been raised that sodium amytal may increase suggestibility and foster the development of distorted or confabulated memories, particularly in therapeutic settings that lack appropriate safeguards (Piper, 1993). By the 1990s, its use was already regarded with caution in psychiatry and law, with prominent critiques warning against its continued application for diagnostic or interrogative purposes (Nichols et al., 2012).

In addition to undergoing narcoanalysis, the case files revealed that JK received a wide range of psychotropic medications, some of which have memory-undermining effects (e.g., Kloft et al., 2021). For example, JK's records show prolonged use of benzodiazepines (e.g., diazepam, temazepam). Acute use of benzodiazepines causes anterograde amnesia, and long-term use has similarly been found to be associated with episodic memory impairments (Curran, 1991; Savić et al., 2005). In addition, experimental evidence suggests that acute benzodiazepine use may increase recollection-based reports for both true and false autobiographical memories, likely through enhanced emotional salience at retrieval (Pernot-Marino et al., 2004). In fact, while sodium amytal interviews have largely disappeared from clinical practice, they have in some contexts been replaced by benzodiazepine-assisted interviews (e.g., Mushtaq et al., 2014; Vijayan et al., 2025), raising comparable concerns. Such pharmacological effects further reduce the validity of autobiographical recall during or following treatment. Given the combination of memory-impairing medications and the use of suggestive procedures such as narcoanalysis, it is plausible that JK developed false trauma-related beliefs while in a pharmacologically and psychologically vulnerable state.

Apart from the potential adverse effects of narcoanalysis on believing and remembering non-experienced events, we also found evidence of non-pharmaceutical suggestive practices by the psychiatrist; findings consistent with our first hypothesis.[4] Specifically, in the files of the psychiatrist, we found several statements indicating that he attempted to retrieve memories of trauma in JK, although JK did not have any memories of the abuse before entering therapy. Words such as "uncover some trauma," "elements of the trauma … emerged unexpectedly," "his trauma has been more extensive" suggest that the psychiatrist attempted to suggest to JK that he was (sexually) abused, while JK had no recollection of this prior to therapy. Such suggestive tactics can increase the likelihood of forming false beliefs and false memories (e.g., Arce et al., 2023; Scoboria et al., 2017). These suggestive tactics, combined with JK's statement that the psychiatrist believed that JK harbored

[4]In the files, we also found evidence that he received cognitive-behavioral therapy which JK did not mention during his interview (see also our third hypothesis). We will not elaborate on this further as it is not related to the recovery and retraction of abuse.

repressed memories of abuse can be regarded as a dangerous mix potentially leading to false beliefs and/or memories of sexual abuse (Otgaar et al., 2019). Specifically, because JK was seeking help, he might have been especially susceptible to accept help from his therapist, even if this "help" contained suggestive therapeutic techniques (Loftus, 1993).

It is noteworthy that JK did not create (false) memories of the alleged abuse but formed (false) beliefs. This distinction is theoretically significant, as it aligns with frameworks such as the nested model, which posits that when an individual judges a fictitious event to be plausible, false beliefs are formed first, and only subsequently can false memories emerge (Scoboria et al., 2004). In JK's case, he attempted to recover memories of abuse but could recall only vivid yet bizarre images, such as wolves, which his psychiatrist interpreted as symbols of organized abuse. JK explicitly stated that he had falsely believed he had been abused by his father, underscoring that his experience involved belief formation rather than memory creation.

Furthermore, his case on (false) beliefs of abuse aligns well with research on retractors, showing that experiences retrieved in therapy are not by definition recovered *memories* but could reflect recovered *beliefs* as well (Ost, 2017). This observation is certainly relevant as the term *recovered memories* is perhaps used most often when experiences were recovered in therapy that were absent prior to treatment. However, this case and empirical research suggest that the reality is likely to be more nuanced, with therapy-elicited recovered experiences being evaluated as memories and/or beliefs.

A further noteworthy observation was that JK mentioned that he retracted his belief after reading a newspaper article that was given to him by his brother. Based on the case files and his interview, this retraction seemed to have happened some six years after the therapy has ended. The article was about psychiatrists implanting false memories in their patients. This process of retraction is well in line with research showing that external evidence (such as newspaper articles) is the most important reason for why people retract experiences of abuse (Ost, 2017; Otgaar, Howe, et al., 2025). Specifically, the presentation of this external evidence (and not having therapy anymore) likely created uncertainty in JK's belief, making him realize that nothing happened and that his belief was false.

Although JK's story and his medical files represent a unique case study, one might argue that this case is from the 1990s and early 2000s, thus representing a somewhat outdated case. Such an argument would, however, be premature for several reasons. First, we want to emphasize that although several interventions have demonstrated efficacy in reducing trauma-related mental health symptoms (e.g., Wright et al., 2025), it is equally important to acknowledge that therapeutic outcomes are not universally positive. In some instances, treatments may prove ineffective or even harmful. Moreover, there is evidence that suggestive techniques – may it be

intentional or inadvertent – are sometimes employed in clinical practice (e.g., Schemmel et al., 2024; Zappala et al., 2024). To date, much of the literature on potential suggestive therapeutic practices relies on self-report, limiting its evidentiary strength. The current case study adds a critical contribution to this literature by presenting objective documentation that such practices can and do occur, thereby strengthening previous concerns that were largely based on subjective accounts.

Second, the observation that JK underwent drug-assisted therapy aligns with a broader current trend in therapy in which substances such as psychedelics are increasingly being scrutinized for their clinical use in trauma treatment by potentially changing memories (Kangaslampi & Lietz, 2025). Specifically, recent work has stressed that psychedelics might have the potential to increase false beliefs (McGovern et al., 2024) emphasizing the importance of studying whether psychedelics might promote the formation of false autobiographical memories (Kangaslampi & Lietz, 2025). In a recent case report, researchers reported on two individuals who received treatment involving the psychedelic drug called psilocybin and recovered supposedly repressed memories of trauma due to the drug (Peck et al., 2025). The case was presented as an example of the possibility of psychedelics recovering repressed memories of abuse, while almost no attention was paid to the possibility that these recovered memories might have been false. Clearly, future research is needed to examine the potential of psychedelics and other drugs to affect true and false memories (e.g., McGovern et al., 2024).

In conclusion, the present case study illustrates a notable example of a retractor, highlighting that distinct processes may underlie the recovery and subsequent retraction of alleged abuse experiences. By incorporating objective evidence, we identified suggestive therapeutic practices combined with drug-assisted therapy that may have contributed to the formation of false beliefs of abuse. Cases in which individuals report initially "recovered" beliefs and/or memories of abuse and later retract them offer valuable insights into the authenticity of recovered memories in therapeutic contexts. While such cases are often met with skepticism, the current case study demonstrates that, when supported by objective evidence of therapeutic practices, therapies can indeed play a role in fostering false beliefs of abuse.

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

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Data availability statement

The data that support the findings of this study are openly available in Open Science Framework at https://osf.io/dwmhb/

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