Posttraumatic Polarization in Psychiatry and Law

John O. Beahrs, MD

Psychological trauma heightens and rigidifies the penchant of humans for dichotomizing others into allies and enemies. With today's "adult delayed recall" controversy a case in point, traumatized individuals tend to unite into tightly knit in-groups that resemble cults and to denigrate others as enemies. This process creates new enmities where objective interests otherwise clash only minimally. The trauma response is reinforced by the neurobiology of avoidance and reenactment. Among all protagonists, polarized beliefs are mutually shaped by suggestive interactions that resemble hypnosis. The end result is to reenact and perpetuate the trauma response on a large scale. In the contemporary milieu, this process presents a formidable obstacle to cooperative problem solving. Discussion focuses on strategies by which clinical and forensic psychiatrists can help to master this obstacle. These strategies include balancing interests, extending the role of informed consent, and overall, striving to mitigate the unwitting reinforcement and transmission of the trauma response.

Members of traumatized groups are particularly likely to perceive others either as allies or as enemies, to treat them as such, and thereby to make them such. This polarizing process occurs even when opponents-to-be largely agree on factual issues and share common interests. Consider the adult recovered memory controversy.[1] There is surprisingly little substantive matter at issue within this debate. Most so-called "false memory" proponents recognize the prevalence of child abuse, the importance of prevention, and the value of psychotherapy for its pathogenic effects.[2] Most trauma therapy advocates acknowledge that memory is fallible and vulnerable to suggestion and that legal actions based on uncorroborated recall are problematic.[3, 4]

What, then, is at issue? Why is there such animosity between experienced professionals who share the same data and many social values? Why does one who strives for balance feel pulled so inexorably toward one or the other polar extreme, and why it is so difficult to resist this divisive pull? What can we clinicians, forensic psychiatrists, and the law do to mitigate this enemy-making process?

This analysis studies the polarizing process as a problem in itself. I conclude that: (1) shared traumas heighten humans'

Dr. Beahrs is Professor of Psychiatry, Oregon Health Sciences University, Portland, OR and serves as Chair, Committee on Adult Delayed Recall, American Academy of Psychiatry and the Law (AAPL). This paper was presented at the 28th Annual Meeting of the AAPL, Denver, CO, Oct. 25, 1997. The views in this paper are the author's own and do not necessarily represent those of the United States Department of Veteran Affairs. Address correspondence to: John O. Beahrs, MD (V-7-MHCV), Portland Dept. of Veterans Affairs Medical Center, PO Box 1035, Portland, OR 97207.

tendency to unite against internal "scapegoats"[5] or external "enemies"[6] and through attraction to shared ideals or charismatic leaders;[7–9] (2) hypnotic-like interactions mutually reshape the parties' psychological structures;[10] and whatever is at issue, (3) the ultimate result is to reenact, reinforce, and transmit the trauma response at all social levels—in families, professional organizations, and society as a whole.

Trauma-driven behavior works in two directions: *avoidance*, as if a matter of survival, and *reenactment*, as if a vital nutriment.[11] Altered perception, cognition, and recall resemble the phenomena of normal hypnosis.[10] When rigidified, these processes can usurp one's personal identity as a "false self."[12] They are highly contagious.[13]

Splitting and Cult Formation

Interpersonal Splitting Interpersonal splitting is a paradigm for posttraumatic polarization. It widely occurs in formerly traumatized patients, particularly those with borderline personality[14] and dissociative disorders.[15] Such patients idealize or devalue significant others and treat them accordingly. Unless others remain alert for this process, they are apt to respond in kind and end up finding one another in opposition. Whoever is idealized and devalued can shift capriciously. Thus, splitting is more than simply exaggerating others' objective attributes. It is commonly observed in traumatized families and in treatment settings, and it also extends to large scale social advocacy groups pitted against one another.

Trauma-Related Cultism Groups that deal with the sequelae of trauma often resemble charismatic cults, in three respects: (1) absolutizing one of many factors as *the* true cause or solution; (2) excluding contrary data and alternative explanations, both actively and passively; and (3) denigrating those who do not agree.[16] These telltale signs may remain even when a group has gained wide acceptance through numbers of adherents, internal consistency of its beliefs, and social appeal. They are less problematic in legitimate scientific debates and accepted religions that honor the legitimacy of others. Hence, as with simple splitting, there must be something about traumatization that feeds cultism in those it affects, independently of specific questions at issue.

Trauma probably predisposes one toward charismatic cults. Idealistic "lost souls" without firm personal boundaries are particularly vulnerable, and cult membership is maintained partly through relief from neurotic distress.[7] Cults often demonize prior affiliates, such as families, as out-groups, thereby traumatizing one's primary support systems.[17] Posttraumatic and dissociative disorders commonly result.[18] In summary, traumatization appears most likely to be both a cause and an effect of cult membership.

Biopsychosocial Roots of Posttraumatic Polarization

Potent biological, psychological, and social forces converge to reinforce the trauma response, accompanied by the social polarization that extends it into ever larger social systems. None of these forces can be neglected. They will be summarized in turn.

Neurobiology The neurobiology of trauma appears to antagonize that of attachment and affiliation and vice versa.[19] The former is mediated heavily by noradrenergic systems and the latter by endogenous opioids. Cult members experience "outsiders" with traumatic feelings and "insiders" with the warm glow of the closest kinship bonds. Superimposing these observations suggests a possible substrate for polarization: the attachment of traumatic affect to one group, and affiliative affect to another. Both processes reinforce one another.

van der Kolk and Greenberg[20] note the addictive quality of reenactment and review evidence that adrenergic arousal is coupled with a compensating opioid response. Traumatized individuals become physically sensitized to the arousal and dependent upon its associated relief, reinforcing the trauma response as a neurobiological vicious circle.

Trauma victims also experience expansive states, such as those associated with religious experience[21] and cult participation,[7] alternating with the traumatic ones. Both traumatic and expansive states are associated with dissociative symptoms, which appear to be driven in the first case by aversive push and in the second through attractive pull.[7, 12, 22] When associated with the experience of another person, either affect may promote hypnotic-like qualities in their interaction. The mutual suggestive influence that results sets the stage for traumatic self-reinforcement at the psychosocial level.

Hypnotic Transactions Interpersonal self-reinforcement occurs through transactions that resemble hypnosis.[10] This is the basic process: within heightened affiliative bonding known as "rapport", a "hypnotist" channels a "subject's" attention to the point that subject experiences hypnotist's suggestions as powerful experiential realities (e.g., hand levitation, complex hallucinations, painless surgery). Hypnotists enjoy an exhilarating sense of guiding and controlling, and subjects, a sense of relaxed receptivity or nonvolition.

Each of these senses is illusory. Hidden beneath the hypnotist's illusion of control is utter dependency on the subject's response for what to do next;[23] and hidden beneath subjects' nonvolition is fully intact awareness and intentionality.[24] A subject purposefully lifts his or her hand, for example, but experiences it as "just happening;" and at hidden levels that can be accessed, the hypnotically anesthetized surgery patient feels the pain and suffers.[25] These illusions reinforce one another in both parties as in a *folie à deux*.[10]

Psychological trauma and hypnosis have long been associated. Trauma leads to stable increases in hypnotizability,[26] spontaneous hypnosis is often observed in traumatized individuals,[27] and hypnotherapy has been used explicitly for over a century in the treatment of posttraumatic disorders.[28] Groups that are organized around specific types of trauma often manifest as hypnotic-like *folies à deux*, now driven by the coercive power of traumatic feelings.[29]

A trauma-driven *folie à deux* can conspire either to deny or to exaggerate the trauma. Some people deny or minimize their traumas to avoid painful affect, to

avoid opening a Pandora's box, or to preserve interpersonal bonding—overall, to preserve the *status quo*. Conservative elements in society are likely to support them, reinforcing a traumatizing conspiracy of denial.[30] Other traumatized individuals accentuate their distress beyond objective impairments to secure affiliative support, avoid retribution, or passively control[10, 29, 31]—overall, to overturn a *status quo*. Caregivers are at high risk of supporting symptom exaggeration because of their obligation to gain rapport, their wish to be liked and appreciated, the principle of beneficence, and the increased status given to beneficent healers.[6, 32]

In either case, actual fact is taboo. One who challenges the taboo, whatever its content, will be punished by the traumatized individual with intense traumatic feelings directed onto the betrayer of illusions.[33] Avoiding this emotional assault serves to enforce trauma-driven taboos, whether by denial or legitimization. The trauma response is reinforced in the first case by being off limits and in the second, paradoxically, by being exaggerated under guise of "treatment." At either pole, when like-minded groups absolutize their half-truths at the expense of the opposing corrective, a cult is born. Two groups are now locked in mortal opposition, further traumatizing all of the participants.

Tyranny and Traumatophobia The retraumatizing poles of denial or legitimization can extend to dominate entire societies. The former become authoritarian tyrannies, such as those that arose from the ashes of World War I and led to World War II and the Cold War. Their mirror image is avoiding trauma in any form: traumatophobia,[11] or fear of fear itself, which is prevalent in the contemporary United States. Authorities are weakened in order to prevent traumatizing abuses. At the same time, this process also undermines society's principal mode of conflict resolution—authority sufficient to break up fights and force negotiations.[34] With leadership undermined, social affairs are determined more by the passive control of sensitive individuals' symptoms[35] and emotions.[33] The default governing principle is "thou shalt not offend," and to confront trauma-driven taboos is usually to offend. Through avoidance, trauma rules unchallenged. On a large scale, "grievance groups" become a "new sovereignity"[36] leading to "a nation of victims."[31] Paradoxically, by striving to avoid active tyranny, passive tyranny results.[37] Either way, the real victor is traumatic reenactment on a huge social scale.

Absolutism Absolutist reasoning compounds the polarizing effects of trauma, whether by a tyrant's fiat or by protective legal decisions that exclude other legitimate competing interests. When absolute "rights" impinge on others, for example, groups are put into opposition and society thereby becomes Balkanized.[38, 39] The conflict over abortion illustrates the extreme traumatization to which such polarizations can lead.

The true victor is traumatic reenactment, which at all levels, acquires a self-reinforcing momentum of its own that easily overwhelms both the data and the legitimate agendas of the competing parties. To understand the ultimate source of

the dominating psychological power of traumatic reenactment, we must look toward its underlying adaptive functions.

Adaptive Functions The trauma response is an evolved extension of the "conditioned avoidance" seen in more primitive species.[40] It can be understood as "learned instinct": quasireflexive behaviors that permit organisms to adjust to a specific ecological niche without radical evolutionary change.[41] Traumatic avoidance serves self-evident survival functions. Reenactment probably promotes rehearsal of skills needed to survive future emergencies. If one survives a predator's attack, for example, one will better survive another if one's learned survival skills remain well practiced.

The psychological malleability bestowed by hypnotic effects can help one to win new sources of affiliative support, by more easily embracing a new group's norms as one's own. For heavily traumatized individuals, the value of this ability to win support may outweigh the corresponding sacrifice in autonomy. Cult-like enmeshment merges the perceived interests of group members. If a threat to one is perceived as a threat to all, the group is more likely to mount an effective coordinated defense. Because to misperceive others as friendly when they are not is more dangerous than its reverse, natural selection biases toward perceiving outgroups as enemies, probably all the more so in traumatized groups.

These processes were adaptive in ancestral environments that had stable alliances and enmities, but they are dysfunctional wherever role relationships are constantly shifting.[41] Today's milieu calls for greater autonomy and flexibility, but the trauma response is too deeply ingrained to yield willingly. Instead, traumatic avoidance and reenactment continue to reinforce psychiatric symptoms, impose new unanticipated sources of psychological trauma, and create new social enmities where they would otherwise need not occur.

Points of Intervention

Posttraumatic polarization has important implications for clinical and forensic psychiatry. Interventions can be directed at each level of the polarizing process. The balancing of opposites is the antithesis of absolutism, and it requires a high tolerance of uncertainty.[12] Hypnotic-like influence is employed neither to deny nor to reinforce trauma, but to access and challenge autonomous coping skills. Finally, patterns of traumatic reenactment are identified, confronted, and when possible, overturned.

Clinical Psychiatry Clinicians can combat absolutism by understanding their own biases, knowing and respecting alternative perspectives, and sharing this information with patients by extending the informed consent process beyond what is now customary. Knowing diverse psychotherapy rationales and methodologies is essential but contrary to current trends in resident education. Interpersonal splitting is mitigated by psychodynamic, cognitive, and interpersonal strategies.[14, 15] Watzlawick *et al.*[42] seek to neutralize problem-maintaining "terrible simplifications" (denial) and the "Utopia syndrome" (traumatophobia).

I recommend that clinicians master

hypnosis, not to become hypnotherapists but to better recognize and competently reshape the hypnotic elements always present within psychotherapy.[1, 10, 12, 35] Halleck[43] recommends gaining rapport with traumatic elements, then shifting toward ever more expectation of patient responsibility. Maximum patient responsibility lessens the risk of regressive *folies à deux* in favor of efficacy.[10, 29, 44] To achieve this expectation, therapists need strong leadership skills to confront denial and resist the passive control imposed by traumatizing feeling states.[33]

Traumatic reenactment can be defined as an addiction, implying a "chemical dependency" model with voluntary abstinence accompanied by developing new skills for self-soothing, social supports, and general mastery/competenency.[45] Along with the judicious use of antidepressant medications, all of these measures can help to counter the biopsychosocial reinforcement of the trauma response.

Forensic Psychiatry Forensic psychiatry can play a pivotal role in mitigating traumatic polarization. Cult-like elements in our profession present the most formidable obstacle,[16] especially when widespread. Some jurisdictions rely on standardized guidelines to enforce treatment standards,[46] while others give absolute immunity to an accepted minority.[47] The first approach tilts the balance toward majority absolutism, and the latter shields trauma-maintaining *folies à deux* from corrective alternatives. By failing to balance opposing perspectives, neither approach is able to confront the problem of professional cultism.

Forensic evaluators can discourage cultism at other levels, however. One way is to enforce high standards of informed consent, which preserves leeway for clinicians to practice as they choose as long as patients are fully aware of viable alternatives. The very process of informing can improve the therapeutic alliance, avoid self-reinforcing circularity, and help to shift responsibility onto patients for their own necessary role in treatment.[48]

By contrast, treatment is suspect the more that it absolutizes just one of many relevant factors, maintains a circular frame of reference that excludes other perspectives, and/or can be shown to further traumatize. There is increasing precedent for enforcing this principle. In *Osheroff v. Chestnut Lodge*, for example, defendants settled a plaintiff's claim that they had provided exclusively psychodynamic treatment while failing to inform the plaintiff of potent biological alternatives.[49] In *Ramona v. Isabella*[50] and retractors' suits against therapists who allegedly induced false memories,[51] therapists are now being held increasingly accountable for traumatizing patients' social networks.

A more difficult problem is balancing therapists' duty to protect with their need to stand firm against trauma-driven passive coercion. *Tarasoff*[52] and its progeny[53] succeeded at the first level and give therapists more leverage when patients threaten violence. Unbalanced, however, therapists become overly vulnerable to liability for patients' acting out, especially suicide, which undermines therapists' ability to overturn passive control

and increases the risk of regressive *folies `a deux*.[44] To restore the needed balance, patients can be held to their own duties, well defined in legal doctrine but rarely cited in today's climate.[54] Guidelines for balancing these issues are proposed elsewhere.[44, 55]

Finally, attention is now being given to the sometimes traumatizing effects of psychotherapy on third parties and society.[1, 32, 56] Because of the privacy of the psychotherapy process, this attention might not have occurred but for a few zealous trauma therapists who encouraged their patients to sue third parties for offenses allegedly remembered in therapy. There was already ample evidence that recovered memories should be viewed with caution[57, 58] and that psychological structures are malleable to suggestive influence.[10, 24] Considered objectively, this information might have been used to improve treatment (e.g., through the potential for reframing).[10, 12, 29, 42, 45] Instead, it was commonly ignored, actively excluded, and dismissed as a product of malice.

Corroborating this observation, retractors commonly report use of persuasive techniques by therapists[51] that parallel those used in cults and mass movements.[7, 9, 16, 17] Statutes of limitation were altered to encourage delayed recall litigation, and newly victimized third parties organized and fought back.[1, 2, 4] Legitimate psychotherapy and the real needs of victims are now on the defensive.[56] The overall message to forensic psychiatry is the need to remain alert for those telltale signs of posttraumatic cultism—oversimplifying and absolutizing, excluding and suppressing contrary data, and dealing with those who offer it as though they were enemies—and when these signs are found, to do our best to provide a conciliatory balance.[59]

Societal Focal Points Similar interventions can be applied to society as a whole in order to balance opposing perspectives and interests, not pit them against one another. Several proposals have been made to lessen the divisive effects of absolutism. In law, Fletcher[60] recommends shifting from today's absolutist standards to nineteenth century "reciprocity," in which litigants' interests are balanced. Regulations can be framed as "guiding principles"[38] or "presumptions"[12, 37] that can be overruled when competing principles dominate. All of these measures lessen posttraumatic polarization by bringing together competing priorities, as opposed to emphasizing one at the expense of another. Hopefully, the time is ripe to begin reconciling polarized factions toward a conciliatory balance that will benefit all.

References

1. Beahrs JO, Cannell JJ, Gutheil TG: Delayed traumatic recall in adults: a synthesis with legal, clinical, and forensic recommendations. Bull Am Acad Psychiatry Law 24:45–55, 1996
2. Loftus EF: The reality of repressed memories. Am Psychol 48:518–36, 1993
3. Brown D: Pseudomemories: the standard of care in science and the standards of care in trauma treatment. Am J Clin Hypn 37:1–24, 1995
4. Hammond DC, Garver RB, Mutter CM, *et. al*: Clinical Hypnosis and Memory: Guidelines for Clinicians and for Forensic Hypnosis. Des Plaines, IL: American Society of Clinical Hypnosis Press, 1995
5. Watzlawick P, Beavin J, Sikorsky MA, Mecia

B: Protection and scapegoating in pathological families. Fam Process 9:27–39, 1970
6. Alexander RD: The Biology of Moral Systems. Hawthorne, NY: DeGruyter, 1987
7. Galanter M: Cults and zealous self-help movements: a psychiatric perspective. Am J Psychiatry 147:543–51, 1990
8. Wenegrat B: The Divine Archetype. Lexington, MA: Lexington, 1990
9. Post JM: Narcissism and the charismatic leader-follower relationship. Political Psychol 7:657–88, 1986
10. Beahrs JO: Hypnotic transactions, and the evolution of psychological structure. Psychiatr Med 10:25–39, 1992
11. Terr L: Chowchilla revisited: the effects of psychic trauma four years after a school-bus kidnapping. Am J Psychiatry 140:1543–50, 1983
12. Beahrs JO: Limits of Scientific Psychiatry: The Role of Uncertainty in Mental Health. New York: Brunner/Mazel, 1986
13. Terr L: Too Scared to Cry: Psychic Trauma in Childhood. New York: Harper and Row, 1990
14. Kernberg O: Borderline Conditions and Pathological Narcissism. New York: Jason Aronson, 1975
15. Fine CG: Thoughts on the cognitive-perceptual substrate of multiple personality disorder. Dissociation 1:5–10, 1988
16. MacHovec F: Cults: forensic and therapeutic aspects. Behav Sci Law 10:31–7, 1992
17. West LJ: Persuasive techniques in contemporary cults: a public health approach, in Cults and New Religious Movements. Edited by Galanter M. Washington, DC: American Psychiatric Press, 1989, pp 165–92
18. West LJ: Pseudo-identity and the treatment of personality change in victims of captivity and cults, in Dissociation: Clinical and Theoretical Perspectives. Edited by Lynn SJ, Rhue JW. New York: Guilford, 1994, pp 268–88
19. van der Kolk BA: The separation cry and the trauma response: developmental issues in the psychobiology of attachment and separation, in Psychological Trauma. Edited by van der Kolk BA. Washington, DC, American Psychiatric Press, 1987, pp 31–62
20. van der Kolk BA, Greenberg MS: The psychobiology of the trauma response: hyperarousal, constriction, and addiction to traumatic reexposure, in Psychological Trauma. Edited by van der Kolk BA. Washington, DC, American Psychiatric Press,1987, pp 63–87
21. Freud S: Group Psychology and the Analysis of the Ego. Edited and translated by Strachey J. New York: Norton, 1979 (orig. pub. 1921)
22. Spiegel D: Multiple personality as a posttraumatic stress disorder. Psychiatr Clin North Am 7:101–10, 1984
23. Gill MM, Brenman M: Hypnosis and Related States: Psychoanalytic Studies in Regression. New York: International Universities Press, 1959
24. Spanos NP: Hypnotic behavior: a social-psychological interpretation of amnesia, analgesia, and "trance logic." Behav Brain Sci 9:449–502, 1986
25. Hilgard ER: Divided Consciousness: Multiple Controls in Human Thought and Action. New York: Wiley, 1977
26. Spiegel D, Hunt T, Dondershine HE: Dissociation and hypnotizability in posttraumatic stress disorder. Am J Psychiatry 145:301–5, 1988
27. Kluft RP: Varieties of hypnotic interventions in the treatment of multiple personality. Am J Clin Hypn 24:230–40, 1982
28. Breuer J, Freud S: Studies on Hysteria. New York, Basic Books, 1955 (orig. pub. 1895)
29. Beahrs JO: Dissociative identity disorder: adaptive deception of self and others. Bull Am Acad Psychiatry Law 22:223–37, 1994
30. Milburn MA: The Politics of Denial: Reactionary Rage. Cambridge, MA: Massachusetts Institute of Technology, 1996
31. Sykes CJ: A Nation of Victims. New York: St. Martin Press, 1992
32. Beahrs JO: The cultural impact of psychiatry: the question of regressive effects, in American Psychiatry—1944–1994. Edited by Menninger R, Nemiah J. Washington, DC: American Psychiatric Press, in press
33. Eckstaedt A: Ego-syntonic object manipulation: the formation of a submissive relationship. Int J Psychoanal 70:499–512, 1989
34. de Waal FBM: Peacemaking Among Primates. Cambridge, MA: Harvard University Press, 1989
35. Haley J: Strategies of Psychotherapy. New York: Grune & Stratton, 1963
36. Steele S: The new sovereignty: grievance groups have become nations unto themselves. Harper's Magazine 285(1706):47–54, July 1992
37. Beahrs JO: Paradoxical effects in political systems. Political Psychol 13:755–69, 1992
38. Howard PK: The Death of Common Sense: How Law is Suffocating America. New York: Random House, 1994
39. Glendon MA: Rights Talk: The Impoverishment of Political Discourse. New York: Free Press, 1994
40. LeDoux JE: Emotion, memory, and the brain:

the neural routes underlying the formation of memories about emotional experiences, such as fear, have been traced. Sci Am 270:50–7, 1994
41. Beahrs JO: The evolution of post-traumatic behavior: three hypotheses. Dissociation 3:15–21, 1990
42. Watzlawick P, Weakland J, Fisch R: Change: Principles of Problem Formation and Problem Resolution. New York: Norton, 1974
43. Halleck SL: Dissociation and the question of responsibility. Int J Clin Exp Hypn 38:298–314, 1990
44. Beahrs JO, Rogers JL: Appropriate short-term risk in psychiatry and the law. Bull Am Acad Psychiatry Law 21:53–67, 1993
45. Beahrs JO, Butler JL, Sturges SG, Drummond DJ, Beahrs CH: Strategic self-therapy for personality disorders. J Strategic Systemic Ther 11(2):33–52, 1992
46. Hyams AL, Shapiro DW, Brennan TA: Medical practice guidelines in malpractice litigation: a preliminary retrospective. J Health Politics Policy Law 21:289–313, 1991
47. Jones v. Chidester, 610 A.2d 964 (Pa. 1992)
48. Gutheil TG, Bursztajn H, Brodsky A, *et al*: Malpractice prevention through the sharing of uncertainty. New Engl J Med 311:49–51, 1984
49. Malcolm JG: Treatment choices and informed consent in psychiatry: implications of the Osheroff case for the profession. J Psychiatry Law 14:9–107, 1986
50. Ramona v. Isabella, No. 61898 (Cal. Super. Ct. May 13, 1994), Ramona v. Superior Court, 66 Cal. Rptr. 2d 76 (Cal. Ct. App. 1997)
51. Lief HI, Fetkewicz J: Retractors of false memories: the evolution of pseudomemories. J Psychiatry Law 23:411–35, 1995
52. Tarasoff v. Regents of the University of California, 551 P.2d 334 (Cal. 1976)
53. Mills MJ, Sullivan G, Eth S: Protecting third parties: a decade after Tarasoff. Am J Psychiatry 144:68–74, 1987
54. Beahrs JO: Legal duties of psychiatric patients. Bull Am Acad Psychiatry Law 18:189–202, 1990
55. Guthiel TG, Gabbard GO: The concept of boundaries in clinical practice: theoretical and risk-management dimensions. Am J Psychiatry 150:188–96, 1993
56. Choiniere M: The false memory syndrome debate: will the victim please stand up? J Contemp Health Law Policy 12:675–700, 1996
57. Bartlett F: Remembering. Cambridge, UK: Cambridge University Press, 1932
58. American Medical Association Council on Scientific Affairs: Council report: scientific status of refreshing recollection by the use of hypnosis. JAMA 253:1918–23, 1985
59. Kriesberg L, Northrup TA, Thorson SJ (editors): Intractable Conflicts and their Transformation. Syracuse, NY: Syracuse University Press, 1989
60. George P. Fletcher, Fairness and utility in tort theory. 85 Harv L Rev 537–73 (1972)