

Memory, Repression, and Child Sexual Abuse: Forensic Implications for the Mental Health Professional

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Childhood sexual abuse is prevalent in our society today. Over the last 30 years, mental health professionals have become increasingly involved in the assessment and treatment of adults who were sexually abused as children. The emergence of the phenomenon of recovered memories has divided both families and mental health professionals. The current debate over repressed memory as well as the prominent theories in this area are discussed. Recent legal developments of repressed memory litigation are discussed along with examples of legal cases that are most relevant to mental health professionals today.

Childhood sexual abuse (CSA) has become recognized as a growing problem that infiltrates society at every level. Since laws governing reporting were enacted in the late 1960s,¹ child abuse reporting has increased exponentially. While much of this is likely due to increased sensitivity to this volatile issue, some have argued that allegations of CSA may be best described as a growing mass hysteria.² Some psychotherapists contend that accusations of CSA should never be doubted, while others are much more reluctant in their acceptance of such accu-

sations. Irrespective of the truthfulness of the accusation, it appears likely that allegations of CSA will continue to affect mental health professionals, child protection workers, lawyers, judges, and law enforcement officials.

Children have been in a relatively powerless position with regards to reporting sexual abuse. Often the perpetrator is a family member, close relative, or neighbor. As a result, CSA often goes unreported and unnoticed. Incident rates of sexual abuse are often based on adults who report being sexually abused as children, and estimates of these rates have varied greatly. One review of the literature³ revealed estimates of abuse that ranged from 6 to 62 percent. A more recent national survey found that 27 percent of women and 16 percent of men

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reported CSA.⁴ Finkelhor *et al.*³ note that it is difficult to accumulate new knowledge in this field because of the shame and stigma associated with sexual abuse. The individuals involved (e.g., perpetrators, victims, and family members) are unlikely to cooperate.

This article describes the current state of affairs that exists within research and practice regarding adult memories of CSA. Memory and repression, and their relation to recovered memories of CSA, are initially explored. Research that investigates the different conceptions of memory is reviewed. Additionally, the iatrogenic effects of recovering memories of CSA are described. Unfortunately, iatrogenic effects are often posited as relevant to all recovered memories of abuse. As a result, there exists a tendency to doubt all memories recovered in therapy.

The literature that addresses the long term effects of CSA is detailed, and specific symptoms are reported. Therapists are often criticized when they posit a generic all-encompassing symptom description that is characteristic of adults who have experienced CSA. On the other hand, many argue that repressed memories do not exist and describe a false memory syndrome (FMS). This purported syndrome is introduced along with the political turmoil that accompanies it.

Finally, recent legal developments with repressed memory litigation are detailed. Relevant cases are explored and the implications for mental health professionals delineated. Conclusions and suggestions for future research are proposed.

The purpose of this article is to provide a balanced approach to the issues related

to sexual abuse and memory recovery in mental health treatment. Often these issues become politicized and polarized, thereby lacking an impartial review. Thus, we intend to discuss important issues as they relate to legal, therapeutic, and other professional endeavors within this realm.

Memory and Repression

Over the last decade, the phenomenon of "recovered memories" has emerged in the clinical treatment of CSA. Many adults who in therapy for reasons other than sexual abuse (e.g., depression, anxiety) have experienced the recovery of CSA memories. Some therapists maintain that traumatic experiences during childhood, such as CSA, are often repressed because they are too difficult to assimilate into one's experience. It is claimed that the repressed memory manifests through the current psychological symptoms the person is experiencing. Some⁵ even assert that psychological treatment for other disorders will not be effective until the sexual abuse is addressed. Thus, for the person to completely heal, this abuse must be remembered and "worked through." Claridge⁶ suggests that the traumatic experience must be remembered and integrated into the patient's self.

However, others claim that abreaction does not necessarily lead to a resolution of symptoms.⁷ Comstock⁷ describes memories as being state dependent and indicates that these states may tell us about how this patient is presently feeling and making sense of his or her life position. She posits: "Abreaction might wisely be viewed as a dynamic interplay

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between a present-day retreat from a demanding life situation and a preoccupation with the past that illuminates the point at which the patient is fixated" (p 25). She suggests that an interpretation of the connection of these memories from past to present by the therapist may facilitate resolution and identify the purpose they serve with regard to the patient's present state. She believes that this will assist the patient in living in the present and looking forward to the future.

In discussing therapists who help patients recall memories, Ofshe and Watters⁸ report: "For these therapists the repression concept is all powerful. In the end, repression does whatever therapists need it to do" (p 7). Ofshe and Watters continue by arguing that recovered memory therapy is doomed to repeat the same mistakes that Freud made early in his career. Freud used the techniques of hypnosis, leading, and suggestion (techniques also used by those of the recovered memory movement), which produced reports of CSA from his female patients. Initially, Freud thought that these accounts were quite accurate; however, over time he came to recognize that his methods were only producing false statements of abuse. Other researchers^{9 10} speculate that Freud abandoned these methods because he was unwilling to consider the implications, specifically those that had serious consequences for Freud's peers and colleagues in Viennese society. Moreover, it has been suggested¹¹ that Freud changed his mind to maintain the patriarchal order of Viennese society. This change of opinion by Freud is interpreted as a denial of the CSA experience and a blaming of the

child. His theoretical outlook would suggest that these memories are a result of an unresolved Oedipal or Electra complex.

The empirical support for repression in adults who were abused as children is lacking. Many of the studies used to support these claims are methodologically flawed.¹² Other studies^{12, 13} have shown that repression in adults who were abused as children is much less common than some claim and that the vast majority of the adults in their studies remembered the abuse throughout their life. Slovenko¹⁴ maintains that recovered memories are not a result of repression but an artifact of therapy. He contends that memory and mental imagery may become confused. Like other researchers, Slovenko questions the inability of repression to work in other traumatic experiences (e.g., with Holocaust survivors) yet work in situations of betrayal by a family member.

Loftus¹² suggests that forgetting, rather than repression, is a likely factor in many adults who do not remember CSA. While many would find this hard to believe, she states that "ordinary forgetting of all sorts of events is a fact of life but is not thought to involve some special repression mechanism" (p 522). She explains that if an event (e.g., abuse) happens before the offset of childhood amnesia, a person could not be expected to remember it as an adult. Loftus also discusses studies showing that people routinely fail to remember significant life events even a year after they have occurred. In one study, for example, 590 persons known to have been in injury-producing motor vehicle accidents during the previous year were in-

interviewed. Approximately 14 percent of this sample did not remember the accident a year later. In another study, 1,500 people who had been discharged from a hospital within the previous year were interviewed. More than one-fourth did not remember the hospitalization a year later.¹⁵ While these events were not tantamount to sexual abuse, it seems likely that they were significant in the lives of the individuals experiencing them and unlikely to be forgotten easily.

Barstow¹⁶ also suggests that reports of repressed memories should be expected to be inconsistent with reality, since memory is fallible. He notes that two eyewitness reports of an automobile accident are expected to vary somewhat, and descriptions that are exactly the same are met with suspicion and doubt by police officers.

One of the criticisms leveled at therapists who aid in the recovery of memories of CSA is that they may be creating the very memories they claim to be recovering.¹⁷ Pezdek,¹⁸ however, argues that this phenomenon of "creating memories" has yet to be demonstrated and goes on to state that:

the existence of the phenomenon [recovered memories] has been inferred from the fact that there might be an explanation for it. Just because illusory memories can occur does not mean that they do, and just because some 'recovered memories' are unlikely, does not mean that most recovered memories are therefore false (p. 340).

It becomes clear from both researchers and therapists that the question of the accuracy of recovered memories is not answered easily.

Current Theories on Memory

Memory studies have challenged, if not entirely disposed of, the idea that all events are stored with perfect accuracy in memory.¹⁹ Ross²⁰ suggests that memory is analogous to DNA processing, with the subsequent mutations, deletions, transpositions, and insertions that occur habitually. An overwhelming amount of research has clearly shown that memory is largely determined by our current beliefs and feelings. Marcus²¹ demonstrated this by measuring the stability and change in the political attitudes of high school seniors between 1973 and 1982. Results indicate that subjects' recall in 1982 of their 1973 attitudes was more closely related to their rated attitudes in 1982 than they had originally expressed.

Loftus²² describes memory in the following way:

Truth and reality, when seen through the filter of our memories, are not objective facts, but subjective, interpretive realities. Thus our representation of the past takes on a living, shifting reality; it is not fixed and immutable, not a place way back there that is preserved in stone, but a living thing that changes shape, expands, shrinks, and expands again, an amoebalike creature with powers to make us laugh, and cry, and clench our fists (p 20).

She asserts that individuals are unaware of these changes in their memories and, as a result, remain convinced that their memories are accurate. In fact, she describes a study²¹ wherein 84 percent of psychologists and 69 percent of nonpsychologists indicated that even though many of our long-term memories are inaccessible by normal means, they are there and can be accessed through hypnosis or other special techniques.

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Other researchers have also described memory as reconstructive rather than reproductive,^{18, 23, 24} while some believe that certain experiences in life (such as CSA) are so traumatic that the brain takes a “flashbulb” memory.²⁵ The result, then, is a permanent and unchanging memory record.

Neisser and Harsch²⁵ have addressed the issue of flashbulb memories and have demonstrated that memory can be fallible even while recalling traumatic experiences. Using the explosion of the space shuttle Challenger as the traumatic experience, they had subjects record their memories of the event both soon after and three years after the event. They found that most of the subjects were wrong about many aspects of their memories, and one-quarter of them were mistaken about every aspect of their memories. The most interesting result of this study, however, appears when looking at the accuracy of their confidence in their memories. Many were absolutely certain that their memories were accurate in every detail.

Terr⁹ provides an alternative way of viewing how memory works. She contends that memories for single, unexpected traumatic experiences are the most well remembered. However, she argues that as children experience recurring trauma, they begin to prepare for it by ignoring what is going on in their environment. She describes the child going numb and guarding against any thinking (a denial of sorts). This psychic and physical numbing has great ramifications for the child’s personality. Defensive mechanisms such as dissociation, splitting, and

denial are utilized to lessen the impact of the traumatic event. Finally, Terr suggests that traumatic memory is similar to other childhood memories as far as input, storage, and retrieval. Nevertheless, she claims that memories for traumatic events are clearer, more detailed, and longer lasting than ordinary memory. However, when trauma occurs over time, the defensive strategies noted above interfere with the memory process.

Terr⁹ was not unwilling to accept the notion of false memories occurring. She recites an oft-quoted anecdotal story indicating that Jean Piaget experienced false memories as a child. From the age of 2 until 15, Piaget could clearly visualize an attempted kidnaping from his pram. His nurse had chased away the would-be abductor and then taken him home. However, when Piaget was 15, this nurse returned to visit the family and informed them that she had lied about the incident to gain approval in the eyes of his family. Thus, even though the event had never happened, Piaget had a clear “memory” of the purported ordeal.

Finally, Terr²⁶ reports that the discrimination of false and true memories cannot be made simply by the amount of detail presented in the memory. Inaccurate details can be added to true memories of events because of the reconstructive nature of memory. She notes that defenses may play a role in the inaccuracy of these memories. She encourages: “Every case must be individually evaluated for corroborations” (p 172).

From this review of research on memory, it becomes clear that the distinction between true and false memories is tenu-

ous at best. Traditionally it has been believed that memory is *reproductive*, and accessing it is an issue of whether it can be retrieved from storage. However, current research indicates that memory is *reconstructive* in nature, and retrieval is influenced by current attitudes, feelings, and beliefs.

Possible Sources of Recovered Memories

Those who advocate the diagnosis of FMS have been further inspired by individuals who have later retracted memories of CSA obtained during therapy. These individuals often cite iatrogenic origins for their memories of abuse. Loftus¹² cites two possible sources that could lead to the production of false memories. First, popular writings such as *The Courage to Heal*²⁷ may be instrumental in persuading the unconvinced psychotherapy patient that they were sexually abused as a child.²⁸ Many therapists include this book as required reading for their patients. In the same vein as Gelinus'²⁹ notion of "disguised presentation," Bass and Davis²⁷ list numerous symptoms indicative of sexual abuse, some of which are low self-esteem, depression, sexual dysfunction, and suicidal ideation. It should be noted that these symptoms can also be indicative of a number of other psychological difficulties. Unfortunately, many therapists view almost any problem that a psychotherapy client presents with as suggestive of abuse. Bass and Davis argue that abuse has likely occurred even in the absence of a memory for the abuse. In fact they indicate that if the client is unable to remember the

abuse, then the client was probably abused. This would infer that childhood sexual abuse is the rule rather than the exception, an assertion commonly held among those of the recovered memory movement. Terr²⁶ criticizes this conclusion and notes that "Good clinicians base their diagnoses of early trauma on very specific post-traumatic symptoms" (p 172).

Bass and Davis²⁷ note in the preface to their book that "none of what is presented here is based on psychological theories" (p 14), yet they go on to provide numerous prescriptions of actions that have far-reaching effects on numerous people. A basic tenet of many mental health disciplines is the need for methods to be theory driven and not capricious in nature. Goldstein and Farmer¹¹ relate, after reviewing the literature on repressed memory, that nowhere is there found a word of caution regarding these practices. Furthermore, this literature does not present the possibility of making mistakes. Such a foundation increases the likelihood of a diversity of methods that fail to meet standards set out by the practitioners employing them.

The second source that Loftus¹² cites as leading to the production of false memories is the therapist. Many therapists press the issue of sexual abuse as a matter of routine. Yapko³⁰ notes: "A therapist who hunts relentlessly for a hint of sexual abuse may miss or misinterpret signs of more salient disorders requiring treatment" (p 18). In addition, the American Psychiatric Association³¹ has officially stated: "A strong prior belief by the psychiatrist that sexual abuse, or other fac-

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tors, are or are not the cause of the patient's problems is likely to interfere with appropriate assessment and treatment" (p 4). Nevertheless, Ross²⁰ argues that patients are responsible for their own memories, as they are responsible for their own feelings and behaviors. He suggests that individual patients with false memories should be treated like those with Munchausen's syndrome and the secondary gain evaluated.

Some of the tools used by these therapists to recover repressed memories of CSA are hypnosis and age regression. Bagley and Ramsey⁵ argue that all victims want to tell their "secret" but very few go about it directly. Therefore, techniques such as these appear to be used to access what the client is unable to tell the therapist. However, it is equally difficult to assess the impact of these techniques on the obtained memories. There has been an increasing effort made to determine how responsive memory might be to suggestion, but most of the research indicates that memory is reconstructive rather than reproductive.^{19, 23, 24} Thus, the accuracy of memory may be influenced by many factors, including suggestions and misinformation.²⁴

Many hypnosis researchers believe that hypnosis increases memory productivity, at the expense of memory accuracy, by inducing hypnotic subjects to place confidence in vague images that they would regard as too uncertain to treat as memories in normal waking states. The clinical literature paints a different picture of hypnosis. Clinical journals and textbooks abound with case histories of spectacular memory successes. Even though patient

self-reports about their childhoods are rarely subject to outside corroboration, clinicians have their own methods for validating memories. If the patient's memories are vivid, detailed, and intensely real to the patient and if the experiences remembered match the patient's clinical profile and explain the patient's symptoms and behaviors, the patient's experiences are treated as clinically validated. Some memories fit like tailor-made gloves and provide meaning and explanation for a whole cluster of symptoms, attitudes, moods, and behaviors that are otherwise perplexing.

In discussing memory and hypnosis, Barnier and McConkey³² found that hypnotizability, but not hypnosis, was associated with false memory reports; more high- than low-hypnotizable subjects reported false memories. Additionally, many therapists who use hypnosis do not understand it; in fact, a number of therapists believe in outright myths.²⁴ For example, Yapko²⁴ conducted a survey with 869 therapists in an attempt to understand their perspectives about the role of suggestibility in the psychotherapy process as well as how they view hypnosis as a tool for both retrieving and working with patients' memories. Of these 869 therapists, 92.2 percent had formal education beyond a masters level. Additionally, 43 percent indicated that they had received formal training in hypnosis. Nonetheless, 18 percent agreed with the statement: "People cannot lie when in hypnosis." Thus, it seems that there are many therapists even those who have received formal training in hypnosis, who are likely to accept as true whatever information is

obtained through hypnosis. In commenting on recovering memories through hypnosis, the Council on Scientific Affairs of the American Medical Association³³ stated:

Recollections obtained under hypnosis can involve confabulations and pseudomemories and not only fail to be more accurate, but actually appear to be less reliable than non-hypnotic recall. The use of hypnosis with witnesses and victims may have serious consequences . . . (p 1921).

Therapists bear an enormous responsibility to be careful in their methods and their assumptions regarding the existence of sexual abuse.

Long-Term Effects of CSA

While knowledge and consciousness of sexual abuse is growing in society and in the mental health literature, the connection between being sexually abused as a child and maladjustment later in life remains tenuous.^{34, 35} While various studies^{5, 36} have found greater psychological maladjustment in groups of abused patient as compared with nonabused groups. Briere and Runtz³⁷ point out that it is difficult to separate the effects of sexual abuse from the effects of some third variable. In fact, when Fromuth³⁸ controlled for the effects of family background, she found little difference between the abused and nonabused groups. Nash *et al.*³⁹ report CSA was associated with family pathology rather than with greater use of dissociation. They suggest that "Subsequent adult impairment may be an effect not only of abuse but of the context in which it was embedded" (p 282). However, they recommend caution and ques-

tion whether the relationship between familial pathology and abuse is due to perceptual distortions on the part of the subject or patient. Others⁴⁰ also contend that this relationship needs adequate clarification and further study.

Recent reviews of the literature^{41, 42} on the long-term effects of CSA include the following symptoms: anxiety, depression, eating disorders, feelings of isolation and stigma, poor self-esteem, relationship difficulties, sexual maladjustment, obsessive-compulsive behavior, and suicidal tendencies. Browne and Finkelhor⁴¹ report that adults who were sexually abused as children have impairment of some kind when compared with adults who were not abused. Twenty percent of the abused adults in this study were found to have serious psychopathology.

Other studies have found long-term sequelae to include helplessness and powerlessness,³⁴ suicide,⁴³ depression,^{40, 44} dissociation,³⁷ drug and alcohol abuse,^{45, 46} somatization,^{37, 43, 47} guilt and low self-esteem,^{48, 49} and sexual problems.^{40, 50} Many interpret these findings by describing a causal relationship between these symptoms and CSA. Essentially what these studies have found is a significantly greater number of symptoms in the population of adult victims of CSA when compared with a normal population. Significant findings, however, do not infer causality, and therapists and researchers alike must be careful with data such as these. Many researchers involved in the recovered memory movement appear to be describing symptomatology such as those mentioned above as indicative of CSA. Significant findings do not rule out

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other possibilities (e.g., the effects of family backgrounds cited by Fromuth),³⁸ and it is essential that the mental health provider be wary of this fallacy of reasoning.

Some authors discount the frequency of FMS because its validity is difficult to establish. Pezdek¹⁸ argues that even though potential causes for FMS have been explored, a "syndrome" in itself has not been adequately demonstrated. Barstow¹⁶ suggests that FMS does not display signs and symptoms that would allow it to fit the definition of a syndrome. He also cites the lack of research in the areas of diagnosis and treatment. Others¹¹ maintain that it is not the lay public that identifies, describes, and then names a syndrome; that responsibility is given to those in mental health fields. Such a phenomena is not easily proved, because concrete and objective evidence, which could undoubtedly prove the falsity of abuse recollections, is not easily obtained. CSA offenders may also view the publicity surrounding FMS as an opportunity to escape accountability for their actions.

The danger of discrediting valid allegations of CSA necessitates care when assessing each case of suspected abuse. Psychological trauma may be exacerbated if claims of abuse are met with counterattacks on integrity. Dawes⁵¹ suggests that questioning patients' memories is tantamount to questioning their interpretation of reality. On the other hand, the impact of false allegations on family members cannot be denied. Many therapists suggest the resolution of CSA include confrontation of the alleged perpetrator. However, as de Rivera⁵² describes,

most families are further destroyed by this confrontation, and little healing takes place. Persons who are recovering a memory of CSA typically block communication between themselves and their family. Goldstein and Farmer¹¹ assert that when every symptom is blamed on a repressed memory, eventual reunification is difficult because the abuse is seen as unforgivable.

The question of whether having the patient challenge the alleged abuser results in improved psychological adjustment remains to be established. A common belief by many therapists is that the truth or falsity of a patient's report in therapy is not a therapeutic question. Instead, the therapist examines the impact that these beliefs are having on the patient at the time. As Loftus¹² points out, a problem accrues when the move is made from the privacy of therapy to the public courtroom with these memories. It is at this point, Loftus maintains, that more solid evidence is needed. Unfortunately, we seem to lack the tools as a profession to differentiate the false from the true memories of abuse. Terr²⁶ suggests the following as a solution:

But one thing stands clear about the individuals search for his own memories. It will always be a solo search. Each case stands by itself. Though some memories may be false, many more are true with false components. And some are altogether true. We must refrain from taking a general stand on the truth or falsity of recovered memories from childhood, even as we learn more and more from the experts. Each case must be assessed individually, by ourselves, and with an open mind (p 247).

Comstock⁷ submits that any solution demonstrating the reliability of recovered memories will be complex.

Recent Legal Developments of Repressed Memory Litigation

There are obviously numerous potentially negative consequences for the person claiming to have recovered memories of CSA. However, there are also many repercussions for the mental health professional as well, especially in the legal arena. Recent statistics indicate that the number of repressed memory cases actually filed against therapists throughout the United States is somewhere between 120 and 800.⁵³ Additionally, some cases have already resulted in multi-million dollar verdicts in favor of the plaintiff.¹² Furthermore, it is likely that in the near future, repressed memory litigation will overtake cases involving therapists accused of having sex with patients as the most costly form of litigation.

In discussing this new type of litigation, Caudill⁵³ explains that there are currently four types of repressed memory cases: (1) cases in which repressed memory issues are a background issue and not the central focus; (2) cases in which the person about whom the patient has repressed memories is a present or former therapist; (3) cases in which the therapist is sued by the individuals accused of abuse by the patient; and (4) cases in which the therapist is sued by a patient who at one point believed that he or she had recovered repressed memories but now recants and alleges that these memories were implanted. Caudill claims that the most frequent type of litigation involves the latter two types of cases. He goes on to explain that when the therapist is sued by the individuals accused of

abuse, the patient is frequently on the therapist's side. This type of case becomes especially problematic because the patient has not waived confidentiality, and the therapist's defense can be significantly hampered.

The controversy over repressed memory has also resulted in a number of legal developments of which mental health practitioners need to be aware. Perhaps the most important involves the current standing of the statute of limitations. In most states, lawsuits alleging sexual abuse must be filed one to three years after the victim reaches the age of majority.⁵⁴ However, with the recent explosion of repressed memory cases, the courts have begun to recognize a need for an exception when the plaintiff had no knowledge of an injury during the limitations period. This exception is known as the delayed discovery rule, which has traditionally been used in the context of medical malpractice suits. The classic traditional medical case is when a patient discovers several years after surgery that the physician left a sponge in the wound during an operation.¹² In the context of repressed memory cases, plaintiffs argue that when memories have been repressed, an adult survivor does not know all of the facts that are essential to a cause of action. Thus, the application of delayed discovery is analogous to the traditional "hidden injury" cases.

Initially, due to a landmark case in the Washington State Supreme Court, it appeared that the delayed discovery rule would not be applied to repressed memory cases. In this case, *Tyson v. Tyson*,⁵⁵ the plaintiff accused her father of sexual

molestation between the ages of 3 and 11. Furthermore, she alleged that she repressed all memories of this abuse until she entered psychotherapy nearly 14 years later. In a (5 to 4) decision, the Court held that "the lack of empirical, verifiable evidence" in repressed memory cases, in addition to the potential for psychotherapy to distort the truth, made it impossible to determine the facts after such a long period of time. "Consequently, the court held that in these cases, the risks associated with permitting stale claims outweighed the unfairness of precluding potentially justified lawsuits."¹²

Although some states have followed the *Tyson* decision, the trend has actually leaned toward applying the delayed discovery rule to repressed memory cases. For example, in California, an appellate court applied the delayed discovery rule to a case that was very similar to the *Tyson* case.⁵⁶ In that case, there was a 19-year difference between the time of the alleged abuse and the time it was reported. Similar decisions have been reached by courts in a number of states, including Michigan, New Hampshire, and Rhode Island.⁵⁷

Important Legal Cases of Repressed Memory

An early and well-publicized criminal case of repressed memory demonstrates the extent to which repressed memory litigation can reach. This particular case involved the murder conviction and life sentence of a man who was accused by his daughter of murdering her playmate nearly 20 years earlier. This woman claimed that her memory of the event had

been repressed for nearly 20 years and was jogged when she looked down on her daughter one day who, at a certain angle, bore a striking resemblance to her murdered friend.* It is important to note that in this particular case the court accepted the plaintiff's claim that she had uncovered a repressed memory and, based on that uncovering, went so far as to convict the accused man of murder. This case is also unique in that it was the result of an incident that happened outside of a therapeutic situation. Most legal cases today are far more likely to be the result of something that happened in a therapeutic context specifically involving a patient and therapist.

Today, many clinicians have rejected the general acceptance of the accuracy of repressed memories. This rejection has largely been the result of legal developments such as the well-publicized case involving Cardinal Joseph Bernardin of Chicago.⁵⁴ In this case, Steven Cook filed suit against the cardinal for allegedly sexually abusing him 17 years earlier. Cook stated that his memory of the alleged abuse was repressed and had been recalled during and after hypnosis conducted by his therapist. Three months after the accusation, Cook dropped the charges, stating that he realized that the memories that arose during and after hypnosis were unreliable. This case, in particular, created a national outcry, with many people furious over the extent to which questionable memories could be

*The case, *People of California v. George Thomas Franklin, Sr.*, has been widely reported in a number of articles and journals, including the *New York Times*.⁵⁸

used to destroy reputations built over a lifetime.

As mentioned previously, an increasingly frequent type of repressed memory case is one in which the therapist is sued by the individuals whom the patient has accused of abuse. These types of cases are particularly alarming for therapists because they are being sued by person(s) whom they may have never even met. The *Ramona v. Ramona*⁵⁹ case in May 1994 is a notable example. In this case, a woman recalled in therapy that her father had abused her years earlier. The father alleged, however, that the therapists involved had used sodium amytal to influence his daughter falsely remembering that she had been abused as a child. Furthermore, he claimed that the therapists told her that sodium amytal is a "truth serum," which is, in fact, inaccurate. This case resulted in a \$475,000 award to the father as well as a statement by the jury foreman that the jury was uncertain as to whether the daughter had actually been abused by her father, but there was enough evidence to show that the therapists had reinforced memories that were false.

The *Ramona* case is especially significant for a number of reasons; in discussing these, Schneider⁵⁴ states:

First, it is apparently the first case in the country involving a jury award against a therapist for implanting false memories. Second, the case represents a departure from standard negligence actions. Usually, a therapist owes a duty of care to his or her *patient* only, and thus only a patient can sue for negligence. In *Ramona*, the patient's father was permitted to sue the therapist—raising the specter that anyone who is harmed by a false memory may, in the future,

recover damages. . . Finally, the *Ramona* case is significant not only because the patient's relative was permitted to sue the therapists, but also because the patient herself did *not* believe malpractice had been committed. In fact, the patient in the case still believes that her recovered memories are real, and she testified at trial on behalf of the therapists. That fact, however, did not prevent the jury from awarding substantial damages to her father (p 11).

The Court's Stance on Hypnotically Refreshed Memories

In light of the *Ramona* case, it is important to note the current stance that most courts are taking regarding the admissibility of hypnotically refreshed memories. Schneider⁵⁴ describes four general approaches that most courts are taking. The first approach, taken by at least half of the states who have ruled, suggests that a witness who has undergone hypnosis for the purpose of refreshing recollection is *per se* incompetent to testify as to any subject discussed while under hypnosis. An example of this type of case would be the 1989 Utah Supreme Court decision, *State v. Tuttle*.⁶⁰ In *Tuttle*, a truck driver was charged and convicted of murder on the basis of circumstantial evidence that placed him at the scene of the crime. Particularly damaging for the defense was one of the prosecution's witnesses who, under hypnosis, recalled vivid details of seeing the defendant at the crime scene. The court eventually ruled that hypnotically refreshed memories are inadmissible, noting that the scientific community currently rejects the notion that hypnotically refreshed recollections are reliable. More importantly, the court stated that hypnosis "makes *all* subse-

quent recollections suspect” and it therefore held that “testimony regarding anything first recalled from the time of hypnotic session forward is also inadmissible.”⁵⁴

Although the general trend has been to make all hypnotically refreshed memories inadmissible, some courts have taken a second approach that views these memories as admissible based on the fact that the injury can decide how much weight to give such testimony. Thus, this approach leaves the entire judgment up to the jury. A third approach involves the courts holding a pretrial hearing for each individual case to determine whether the testimony should be admissible. After taking all circumstances into consideration, the court decides whether or not the testimony will be admissible.

A fourth approach has been to determine admissibility based on whether or not certain procedural safeguards were taken regarding the hypnosis. Within this framework, the following safeguards must be employed as a prerequisite to admitting hypnotically refreshed memories: (1) the hypnotist must be a qualified psychiatrist or psychologist who has experience in the use of hypnosis; (2) the hypnotist should be working independently of either side involved in the litigation; (3) all of the information given to the hypnotist before the hypnosis session must be recorded; (4) the subject must describe the facts to the hypnotist as he or she remembers them before hypnosis; (5) all contact between the hypnotist and the subject must be recorded, preferably on videotape; and (6) no person other than the hypnotist and the subject should be

present during any contact between the two.

This approach was primarily based on a criminal case, *State v. Hurd*,⁶¹ and is obviously more relevant in the context of criminal trials. Repressed memory cases are quite different in that the patient is typically hypnotized for therapeutic purposes, and only later files a lawsuit based on the memories that were recovered. In discussing the strict application of these safeguards to repressed memory cases, Schneider⁵⁴ states that “. . . it simply is not fair to expect that safeguards . . . will be followed in cases where the hypnosis is performed for therapeutic purposes and there is no reason to believe, prior to hypnosis, that the hypnotically refreshed recollections might be needed in a lawsuit” (p. 9). As a result, most courts have not held strictly to the safeguards outlined above. For example, in a recent civil case involving hypnotically refreshed memories of CSA, the court acknowledged that strict adherence to such safeguards would be unfair, if not impossible.⁶² However, before allowing the testimony to be admissible, they still required the plaintiff to demonstrate that the following safeguards had been met: the hypnotist was appropriately qualified; the hypnotist avoided adding new elements to the subject’s description; a permanent record of the hypnosis was available to ensure against suggestive procedures; and other evidence be submitted to corroborate the hypnotically enhanced testimony.

Suggestions for Therapists

The cases discussed in this article have certainly called into question the validity

of recovered memories. The *Ramona* case is especially relevant, as many mental health professionals are now being brought into litigation by family members of the patients they are treating. In light of these cases, mental health professionals are advised to employ a number of safeguards. Perhaps most important is that hypnosis should be used only with extreme care and with an awareness of its limitations. When hypnosis is used, therapists should take the following precautions: (1) never conduct hypnosis unless appropriately trained to do so; (2) note carefully the patient's recollections prior to hypnosis; (3) avoid suggesting facts to the patient during hypnosis; and (4) videotape the session if possible.⁵⁴

Therapists are cautioned about the potential of malpractice lawsuits with patients who are recovering repressed memories of CSA. Malpractice lawsuits can also arise when the patient who recalled the abuse during therapy later retracts these allegations upon further reflection. In these situations, the therapist is often accused of committing malpractice by "implanting" the false memory, whether by hypnosis or some other method of suggestion. Schneider⁵⁴ notes that therapists are particularly vulnerable to malpractice accusations of this type for the following reasons:

First, most repressed memories are recalled during (or as a result of) therapy, thus establishing the causal link between the therapy and the recollection. Plaintiffs (and juries) may therefore reason that if the recollection is false, the therapy is to blame. Second, malpractice suits will usually be brought by patients who may have had their lives, and the lives of their families, torn apart by accusations that were later recanted. Juries are likely to be sympa-

thetic in such cases, and to look for a scapegoat to pay damages. Third, therapists may uncritically accept (and even promote) patient accounts of recalled abuse, because therapists traditionally are more concerned with a patient's subjective beliefs (and how those beliefs may contribute to psychological disorders) than with objective truth. Finally, at least some therapists have fallen prey to the belief that virtually every adult disorder results from traumatic childhood incidents, and that if a patient with an adult disorder cannot remember a childhood trauma, then the patient must be repressing the memory. *This belief may, in fact, cause therapists to unwittingly (and negligently) implant memories in suggestible patients* [italics added for emphasis] (p 10).

Conclusions and Future Research

Questions regarding the issue of false memories in therapy continue to go unanswered. In fact, it seems that mental health researchers have virtually ignored issues surrounding recovered memories and FMS, seemingly viewing it with uncertainty or disdain. Very little research has been done, and most research is anecdotal in its presentation.

One recent study, a review of 20 people who had recanted recovered memories of abuse, provides us with some preliminary data.²⁷ A majority of these subjects indicated that their memories were first recovered in individual therapy and they had no recollection of these events prior to this time. In addition, 90 percent of these subjects' therapies had involved some sort of memory recovery techniques such as hypnosis, regression, trance writing, or the use of sodium amytal. Many of these subjects also reported the influence of books or videos in the recovery of their memories. Group therapy was also de-

scribed as a treatment modality that involved pressure to not only remember but maintain memories of abuse. The authors postulate the effects of a group contagion on the memories of group members. They note the interesting finding that many group members reported identical memories as others in the group.

While this research is promising in its application, it lacks substantive data regarding the characteristics of individuals who recover and retract memories of abuse. The research literature has failed to provide objective data regarding these individuals as well as those that have recovered their memories and never retracted them. For instance, are there any differences that can be established via empirical methods? Are there differences in the relationships with parents and family members? The incidence of various psychiatric disorders, the examination of personality characteristics, and relationship issues are areas that need to be explored. Clinical assessment questions regarding these individuals remain unanswered.

Research such as suggested above would provide mental health and legal professionals with preliminary data regarding patients who recall memories of abuse in therapy. In addition, research may allow for a more accurate identification of those who may be more susceptible to recalling true versus false memories of abuse. Caution could then be taken when working with those individuals who may be more vulnerable to false memories of abuse. Unfortunately, without empirical research that examines these types of issues, discussions about CSA will

continue to take place in a polarized and politically controversial arena.

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