Standards for Informed Consent in Recovered Memory Therapy

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Malpractice suits against therapists for either instilling or recovering false memories of sexual abuse have increased in the last few years and some of the awards have been large. Failure to give informed consent, that is, failing to inform patients concerning the risk of recovering false memories, is one of the main allegations increasingly made against therapists in recovered memory cases. In the landmark case on informed consent, *Canterbury v. Spence* fashioned a standard of disclosure that focused on how material the potential warnings were to the patient's decision and specifically stated the standard would be set by the law, not by the profession. The court ruled that the "risk or cluster of risks" must be disclosed to the patient in a manner that meets the patient's "informational needs." A review of relevant literature shows that a substantial body of information existed by the early 1990s that warned psychotherapists about the risk of false reports of sexual and physical abuse. This article concludes that the "risk or cluster of risks" that must be disclosed to a patient recovering repressed memories in psychotherapy should have included warnings about recovering false memories.

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Malpractice suits against therapists for either instilling or recovering false memories of sexual abuse have increased in the last few years and some of the awards have been substantial. In the fall of 1995, a jury in Minnesota awarded nearly 2.7 million dollars to a woman who sued her psychiatrist for negligently implanting false memories of sexual abuse and for failure to give informed consent for such therapy.[1] On January 24, 1996, another Minnesota jury awarded a patient 2.5 million dollars against the same defendant. Failure to give informed consent for recovered memory therapy was again a central issue.[2] A few months later, two Oregon therapists settled out of court, one for 1.57 million dollars and the other for a confidential amount in a recovered memory therapy case.[3]

In November 1996, a Missouri family settled a false memory suit for 1 million dollars against a therapist and her sponsoring church.[4] The family contended the therapist implanted memories of incest in their eldest daughter, including memories of giving birth to her father's baby. The daughter's gynecological examination showed her to be a virgin. In December of 1996, a Florida woman settled her suit against a psychiatrist for 650,000 dollars.[5] Among the plaintiff's allegations of negligence was failure to give informed consent before retrieving repressed memories in psychotherapy.

On March 3, 1997, after 15 days of courtroom testimony, a psychiatrist in Wisconsin agreed to pay a former patient 2.4 million dollars in an out-of-court settlement of yet another recovered memory case.[6] Months later, a Texas woman in federal district court won 5.8 million dollars—the largest jury award to date in a recovered memory case.[7] She alleged, among other things, that her psychiatrists never elicited her informed consent for this type of therapy. In late 1997, an Illinois woman agreed to accept the largest published settlement award to date (10.6 million dollars) in a recovered memory suit. The suit, which was settled on the day of the scheduled trial, alleged that the defendants used improper psychotherapy and failed to obtain informed consent.[8]

In 1998, a nationally recognized recovered memory therapist settled a case, brought by a Minnesota

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plaintiff alleging implantation of false memories, for a figure approaching the limits of the therapist's malpractice coverage.[9] In July of that same year, a prominent expert in the field of personality disorders settled a case for an undisclosed amount after the initiation of trial testimony by a plaintiff claiming that he had fostered false memories in the course of treatment.[10] In December 1998, a therapist settled for the limits of her malpractice coverage with the father of a woman who had formed allegedly false memories of sexual abuse in the course of therapy and who had previously lodged criminal charges against her father as a result.[11] In August 1999, another Wisconsin jury awarded 875, 000 dollars in damages and subsequently 1 million dollars in attorneys' fees to a woman who had formed false memories of satanic ritual abuse in the course of therapy with a Wisconsin psychiatrist.[12]

This proliferation of judgments becomes even more striking when one realizes that before the 1990s, psychotherapists, especially those using psychodynamic techniques, had been almost totally immune from malpractice suits.[13] Currently, recovered memory therapy appears to be practiced less frequently than a few years ago, which should decrease future claims. Although statutes of limitation should limit older claims, numerous exceptions exist to such statutes.

For example, most states have laws that toll (delay) the statute of limitations from taking effect in the case of mental disability. Such exceptions to statutes of limitation are being used in suits against therapists if expatients can show their psychotherapy disabled them, making them unable to discover their injury. We are personally aware of such tolling claims recently prevailing in Texas and Illinois. If this trend continues, liability for improper recovered memory therapy, with its attendant claim of failure to give proper informed consent, will not disappear anytime soon.

Increasingly, one of the main allegations made against therapists in recovered memory cases is failure to obtain appropriate informed consent. We have been retained as experts or consultants in several of the aforementioned cases, charging the defendants with failing to give informed consent concerning the risks of recovering false memories in psychotherapy. In other words, former patients and their families are suing psychotherapists, saying that the therapists did not warn them that memories of sexual trauma recovered during therapy might be false.

In light of these developments, it seems appropriate to review the issue of standards for informed consent in recovered memory therapy. We begin by offering a working definition of "recovered memory therapy." Next, we review current thinking regarding the basic requirements for informed consent in psychotherapy. Based on this foundation, we propose the basic requirements for informed consent in recovered memory therapy. Then we examine the literature available to a recovered memory therapist since the 1980s and early 1990s regarding the tendency of patients to form false, confabulated, or erroneous beliefs in the course of psychotherapy. We conclude with an assessment of the minimum standards for informed consent that could have been expected of therapists at this time.

We have limited this discussion specifically to the issue of informed consent; but we note in passing that failure to elicit informed consent is not the only tortious conduct that may arise in the course of recovered memory therapy or for that matter any type of psychotherapy. In a word, informed consent is a necessary but not sufficient condition for a therapy to meet minimum standards of care.

Definition of "Recovered Memory Therapy"

Although the term "recovered memory therapy" is used widely, we are not aware of a formal definition of this technique that has been accepted universally. For this article, we will propose a working definition for recovered memory therapy that involves the following: (1) an assumption that patients may harbor "repressed" memories of traumatic experiences; (2) an assumption that these repressed memories may be recovered after a prolonged period of amnesia; and (3) an assumption that patients may gain relief from psychological disorders by attempting to recover, explore, and understand these memories with the assistance of a therapist. Although "recovered memories" may in theory involve any traumatic event, most involve sexual abuse—as in all the malpractice cases cited previously.

It should be noted that patients may recover memories during the course of the actual psychotherapy session or at times before or after the therapy session itself. However, if the therapist focuses on the exploration and understanding of these ap-

parently recovered memories, we will define the technique to be "recovered memory therapy" regardless of the precise time or setting in which the memories were recovered.

Informed Consent in Psychotherapy

The concept of informed consent in psychotherapy has been in flux. The status of informed consent in the late 1980s is outlined by Gutheil,[14] who described the essentials of informed consent for psychiatric practice in the 1989 edition of Kaplan and Sadock's influential *Comprehensive Textbook of Psychiatry*: The patient is expected to be informed of the risks and benefits of the proposed course of treatment, of alternative treatments, and of no treatment. Of considerably greater importance, however, is the necessity to convey to the patient the physician's readiness to listen to and discuss anything the patient might fear as a risk, side effect, or concern about the proposed treatment. Informed consent, then, is actually an ongoing process, a two-person dialog extending over time, rather than a form signed once and for all, never again to be discussed (Ref. 14, p 2111).

In June 1996, the American Psychiatric Association (APA) released *Principles of Informed Consent in Psychiatry* prepared by the APA's Council on Psychiatry and Law and approved by the Board of Trustees in June 1996 as a resource document for use by the APA's district branches.[15] It does not represent APA policy:

> Psychotherapy: Informed consent developed in the context of invasive procedures and has since been extended to treatment with medication. There has always been uncertainty as to the extent to which the doctrine of informed consent is applicable to psychotherapy. Although discussions about treatment may fit poorly into some psychotherapeutic approaches, recent changes in practice that emphasize short-term, problem-focused therapies are more accommodating (or even encouraging) of such interactions. Whether or not required by the law, it seems reasonable to encourage psychiatrists to discuss with their patients the nature of psychotherapy, likely benefits and risks (where applicable) and alternative approaches (both psychotherapeutic and non-psychotherapeutic) to their problems (Ref. 15, Section 7, p 6).

As the foregoing statement suggests, informed consent in the mental health fields, once reserved for somatic therapies such as electro convulsive therapy (ECT) or psychotropic medication, is no longer so narrowly applied. It probably is true that psychotherapists have not routinely elicited such consent in the past. However, the fact that such informed consent was not usually or customarily given may not be a viable defense. Unlike the standards of care in malpractice cases, standards of care for informed consent are based on what a "reasonable person" might consider as being material to his decision. In a landmark case on informed consent, *Canterbury v. Spence* (District of Columbia Court of Appeals),[16] the court fashioned a standard of disclosure that focused on how material the potential warnings were to the patient's decision and specifically stated that the standard would be determined by the law not by the profession:

> Thus the test for determining whether a particular peril must be divulged is its materiality to the patient's decision: all risks potentially affecting the decision must be unmasked. And to safeguard the patient's interest in achieving his own determination on treatment, the law must itself set the standard for adequate disclosure.[17]

Although not holding in all jurisdictions, the Canterbury decision explains:

> From these considerations we derive the breadth of the disclosures of risks legally to be required. The scope of the standard is not subjective as to either the physician or the patient; it remains objective with due regard for the patient's informational needs and with suitable leeway for the physician's situation. In broad outline, we agree that: [a] risk is thus material when a reasonable person, in what the physician knows or should know to be the patient's position, would likely attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy.[18]

Thus, the "risk or cluster of risks" must be disclosed to the patient in a manner that meets the patient's "informational needs." However, as a defense against their failure to give informed consent, defendants in false memory cases have pointed to the lack of published studies clarifying the frequency and nature of false memories of sexual abuse. They reason, after all, how can one inform a patient of a risk if that risk is unquantified?

In response to this argument, an expert may be called on to describe to the jury the information that a therapist had or should have had concerning the risks of recovering false memories of sexual abuse. This article details the mental health literature that was available and relevant to practitioners who would have considered giving such informed consent during the late 1980s and early 1990s, at the time when most recovered memory therapy was practiced. This literature includes such items as the historical tradition and culture of a practice, statements by profes-

sional organizations, ethical guidelines of the profession, and articles or treatises recognized and accepted as authoritative in the field. Regardless of the specialty, most juries accept the historical dictum of "*primum non nocere*" or "first, do no harm" as the springboard for all discussions concerning standards of care.

Standards for Informed Consent in Recovered Memory Therapy

The foregoing discussion would suggest relatively clear guidelines for informed consent in recovered memory therapy. Looking first at the potential benefits of this technique, we are unaware of any studies, beyond anecdotal reports, showing that recovered memory therapy is effective for the treatment of specific psychiatric disorders. On the other hand, a growing literature has documented the efficacy of various other types of psychological and biological therapies for many specific psychiatric conditions. Thus, current practitioners should inform patients that the efficacy of recovered memory therapy has not been documented to the same degree that other techniques have been. In addition, many articles and reviews have questioned the validity of the theory underlying recovered memory therapy, namely, that it is possible to "repress" or have dissociative amnesia for a traumatic event.[19–26]

Turning to the *risks* of recovered memory therapy, the mid-1990s have seen a flood of mental health and forensic publications concerning false memories, pseudomemories, and false allegations of sexual abuse that may arise as a result of recovered memory therapy. Thus, the standard of care today is that practitioners should fully inform patients about the fallibility of memory and the dangers involved with recovering memories of traumatic events, especially when most of the major professional organizations have issued warnings concerning false memories.[27–31]

Literature Regarding False Beliefs Before 1993

What constituted adequate informed consent before the recent professional publications? For example, what information about false memories of sexual abuse existed in the literature before 1993, when two well-known cognitive psychologists explicitly warned the therapist community concerning false memories?[32,33] Although few studies before 1993 had addressed explicitly the validity of recovered memories, a substantial literature readily available to therapists had already documented the fallibility of memories in general and the risk of false memories of sexual abuse in particular. In the following paragraphs, we offer a series of historical examples, observations by various authorities, and actual studies before 1993 that speak to the human tendency of false or confabulated beliefs about sexual abuse and other traumatic experiences. Although these various examples come from disparate sources and few individuals would have been aware of every one, it would be difficult to argue that a therapist practicing recovered memory therapy within the standard of care in the 1980s or early 1990s could have been ignorant of all of this literature.

To the extent that history should be an important guide, the witch craze contains important lessons concerning false memories of sexual abuse. Mental health practitioners should be aware of the role the witch craze played in the history of modern mental health treatment, especially as it applies to the dictum of *primum non nocere*. In times past, psychiatry departments often gave lectures on the witch craze, because it demonstrated so many important principles to those learning the practice of psychiatry, psychology, and counseling.

Although it is beyond the scope of this article to provide full discussion of the lurid, detailed, memories of satanic sexual activity that accused witches often recounted, the reader should be reminded of the extent of the carnage. For two centuries, the 16th and 17th, most of Europe was engaged in a systematized, officially sanctioned, "scientific" search for witches, resulting in the death-by-torture of countless innocents, mostly women.

The important lessons for mental health practitioners are that many accused witches apparently developed vivid memories of sexual behaviors that never happened. As Trevor-Roper wrote: "Again and again, when we read the case histories, we find witches freely confessing to esoteric details without evidence of torture, and it was this spontaneity, rather than the confessions themselves, which convinced rational men that the details were true."[34] Trevor-Roper estimated that for every victim whose story came out under duress, there were two or three who genuinely believed they were witches. Many of the accused who subsequently came to believe they

were witches developed bizarre memories of sexual events that never occurred. Other authors wrote of young women during the craze who described in lurid detail how they lost their virginity to the devil, although examination showed them to be virgins.[35]

Although the mechanism for such false memories has been understood in various ways by modern authorities, what is incontrovertible is that false memories concerning sexual matters were prevalent during the witch craze and led to serious injuries of innocent people. Few American therapists would be unaware of the false memories/false accusations leveled by several young women in Salem, Massachusetts, three hundred years ago. In fact, the Salem witch trials often were described in psychiatric histories because they are such a prototypical example of how the search for the roots of dissociative (or hysterical) behavior can lead to tragic consequences.

One hundred years ago, Sigmund Freud first proposed that repressed memory of sexual abuse causes certain neurotic illnesses, including hysteria. He based this "seduction theory" on his clinical experience of treating young women who apparently recovered memories of sexual abuse in the course of psychoanalysis. They recovered these memories with great displays of feeling (abreaction) and with apparent alleviation of symptoms. Nevertheless, after a lifetime of study, Freud rejected his own theory, admitting: "When, however, I was at last obliged to recognize that these scenes of seduction had never taken place, and that they were only phantasies which my patients had made up or which I myself had perhaps forced upon them, I was for some time completely at a loss . . ." (Ref. 36, p 34).

Freud based his conclusions on four considerations.[37] Unlike what he had previously thought, he observed that the patients did not get better with the treatment. In fact, their treatments became "interminable." Second, he noted that the unconscious mind cannot distinguish fact from fiction. Third, the incidence of implied father-daughter incest was improbable ("the fact that in every case the father, not excluding my own, had to be blamed as a pervert"(Ref. 37, p 953)), and fourth, he had never had patients speak about incest during "even the most confused delirium," (Ref. 37, p 953) a time when such memories, if true, might be expected to emerge from the unconscious.

Although Freud took 25 years to arrive at the conclusion that his patient had recovered false memories, after reading his initial case histories at least one contemporary of Freud was immediately skeptical that Freud himself had induced false memories in his patients. Moll, who was both medically and psychoanalytically trained, stated that he was "by no means satisfied with these clinical histories. They rather produce the impression that much of the alleged histories has been introduced by the suggestive questioning of the examiner, or that sufficient care has not been taken to guard against the illusions of memory" (Ref. 38, p 190).

Janet, also a contemporary of Freud, believed that hysterical patients could fabricate and agreed that it was a serious concern for physicians.[39] In 1925, Janet explicitly cautioned therapists about the imperfect state of knowledge concerning traumatic memories:

> Whereas some doctors never trouble their heads about traumatic memories and do not even know these exist, and whereas others fancy them everywhere, there is a place for persons who take the middle course and who believe they are able to detect the existence of traumatic memories in specific cases. The doctors comprising the last group need diagnostic rules. Unfortunately, the psychological phenomena now in question are still imperfectly known, and it is far from easy to give precise indications (Ref. 40, p 670).

Later in the 20th century, commentary from many other authorities reinforced Freud's and Janet's findings about the difficulty in distinguishing between fantasy and accurate memory. For example, in 1932 in a series of influential studies, Bartlett developed the concept that memory is reconstructive and subject to numerous distortions.[41] He advised professionals that human memory is distorted by current expectations, concerns, moods, attitudes, postevent information, and other factors likely to distort the accuracy of what we remember. In 1967, Sachs described a patient whose sexual fantasies turned out to be reality based.[42] However, he warned readers: "The difficulties we frequently encounter in distinguishing between fantasy and reality elements in the 'memories' of traumatic events brought to us by our patients, often seem insurmountable" (Ref. 42, p 1). Arlow, whose 1968 John B. Turner Lecture at the New York Academy of Medicine was later published, reiterated the difficulty most therapy patients have in distinguishing fantasy, memory and reality.[43] He cautioned, "This constant intermingling of fantasy and perception helps make it clear why memory is so unreliable, especially memories from childhood, because in childhood the process of intermingling perception and fantasy proceeds to a very high degree" (Ref. 43, p 37).

Several subsequent commentaries have focused on the risk of false information consciously or unconsciously generated by patients in treatment. For example, in 1979, Rosenfeld *et al.* wrote about the problems therapists have in assessing patients' reports of incest.[44] The authors warned of "the complex difficulties facing clinicians trying to assess whether a patient's report of incest is fantasy or reality" (Ref. 44, p 159).The authors concluded that "despite careful consideration and examination of material presented in therapy or evaluation, one may still be left questioning whether the reported events are reality" (Ref. 44, p 163). A similar issue was raised in 1985 by Jonas and Pope, who proposed that certain disorders be grouped together as "dissimulating disorders."[45] The article noted that patients with conversion disorder, somatization disorder, factitious disorder and malingering often display characteristics of borderline, histrionic, and antisocial personality disorders. The discussion concerning fabrication in such a diverse group of psychiatric patients underlined the potential for false patient reports of abuse, especially when patients reporting such abuse often have histrionic and borderline features.

In a similar vein, in 1986 Stevens wrote about the difficulty in detecting patients who simulate illnesses, pointing out the difficulty in distinguishing hysteria from malingering and warning physicians that in patients with hysteria, "A history of sexual assault should be regarded skeptically" (Ref. 46, p 244).

The mid-1980s also saw increasing recognition of the ability of suggestive techniques to produce false beliefs. For example, in 1985 the American Medical Association issued a position paper warning of the potential of hypnosis to create false beliefs:

> Review of the scientific literature indicates that when hypnosis is used to refresh recollection, one of the following outcomes occurs: (1) hypnosis produces recollections that are not substantially different from nonhypnotic recollections; (2) it yields recollections that are more inaccurate than nonhypnotic memory; or, most frequently, (3) it results in more information being reported, but these recollections contain both accurate and inaccurate details (Ref. 47, p 1921).

In 1989, Dinges and Orne echoed and amplified the American Medical Association's cautions about hypnosis.[48] They warned that "the hypnotized individual has a pronounced tendency to confabulate in those areas where there is little or no recollection; to distort memory to become more congruent with beliefs, hopes, and fantasies; and to incorporate cues from leading questions as factual memories" (Ref. 48, p 1516). They specifically highlighted the potential dangers of using "hypnosis or other techniques involving suggestions in attempting to elicit statements from children or adolescents concerning sexual abuse" (Ref. 48, p 1516). They summarize the risks and benefits of this procedure as follows:

> Sexual abuse is a repugnant act, and although there is a widely held view that false-positive detections of such abuse are vastly preferred to a single case remaining undetected, the nature of hypnosis is such that a false-positive is a far more likely outcome when hypnosis is used in this way. For a child, the consequences of losing one or both parents as a result of such a false-positive detection should be considered before taking precipitous action (Ref. 48, p 1516).

By the mid- to late 1980s, additional literature had arisen regarding false confessions of crimes or false reports by patients had appeared. False confessions during interrogations had led British psychologist Gisli Gudjonsson to publish a scale measuring interrogative suggestibility in 1985.[49] By 1987, he had shown the relationship between memory and suggestibility, finding that the higher an individual's suggestibility, the lower their memory capacity.[50] By 1990, Gudjonsson had published normative data on 100 cases of alleged false confessions.[51]

By the late 1980s, a burgeoning literature discussed the possibilities of false patient reports of abuse. For example, in a 1986 editorial, Eckert, an experienced forensic specialist, wrote about "the other side of child abuse and sexual molestation."[52] He warned readers that "In the general area of child abuse there have been many cases in which false accusation and/or allegation have been made for one reason or another" (Ref. 52, p 92). In 1987, Wong alerted professionals to the serious consequences of false allegations of child abuse and of the devastation such allegations cause to families.[53] Warning readers that 1.2 million of the 1.9 million cases of reported child abuse are found to be unsubstantiated (as opposed to false), the author said, "In our zeal to help and protect abused children, the number of casualties among innocent families must be appreciated and minimized" (Ref. 53, p 332). In 1988 in an article on multiple personality disorder, Spiegel cautioned therapists that "there will undoubtedly be times when therapists of these patients are taken in by fantasies of conscious stories of abuse that did not occur.

It is always best in the long run to obtain corroboration if possible"(Ref. 54, p 535). Issued as it was from a therapist often regarded as supporting the concept of recovered memories,[55] such a warning represents an important cautionary note about the possibility of false beliefs arising in the course of psychotherapy. Similar cautions were echoed that same year by Mantell who alerted readers to the possibility of false allegations of sexual abuse.[56] He noted, "both children and adults make false reports," adding, "I have encountered many cases in which child sexual abuse allegation have been shown to be false" (Ref. 56, p 618). He adds ". . .many children are exposed to suggestive questioning that can plant the idea of molestation in their minds. . ." (Ref. 56, p 620). Also in 1988, Perry *et al.* reported on the problems of confabulated memories or "pseudomemories" associated with suggestive therapeutic techniques including hypnosis and hypnotic age regression.[57] The authors described a 1980 case in which a woman, after hypnosis, confabulated a memory of being sexually assaulted; including the memory of being repeatedly stabbed in the vagina.

Also in the late 1980s, other prominent researchers published strongly cautionary statements about the fallibility of memory. Ofshe detailed the techniques that appeared to increase the likelihood that people who have falsely confessed will come to believe their confession.[58] He described a set of circumstances that closely parallel some aspects of recovered memory psychotherapy. Such techniques included repeated statements by the individual in authority that they believe the event happened, repeated claims that scientific evidence exists that the event happened, and the subject's being told that defects in memory indicate a psychiatric condition that would explain the lack of memories. Similarly, in 1989 Loftus reiterated that a substantial body of laboratory evidence pointed to the fact that human memory is inaccurate and that suggestive influence could readily create memory distortions.[59]

Starting in the late 1970s, a parallel literature provided a growing number of case studies and quantitative studies to support the commentaries summarized previously. In 1979, Cavenar *et al.* reported a series of patients with "hysterical psychosis," all of whom were struggling with sexual matters.[60] One of the patients had been on a date with a man she had known for several months when she stood up in a nightclub shouting she was being raped and began throwing various objects at the other patrons. In 1980, Bliss studied a group of 14 patients with multiple personality disorder, reporting they all "qualify for the diagnosis of hysteria as it has been denoted over the centuries" (Ref. 61, p 1396). He also warned clinicians that the domain of the personalities was filled with "illogic" and "magical thinking." He reports that "a fear, in one case, of molestation becomes a fact of rape. This patient was a virgin at marriage, but she has a dozen terrifying fantasies hidden in this domain that involve rape by her brother, father, and strangers when she was a young girl" (Ref. 61, p 1394).

In 1983, Phillips *et al.* reported on 20 patients who falsely reported the deaths of loved ones to assume the patient role.[62] These patients fit into numerous diagnostic categories but as a group the authors formulated the behavior as a form of dysfunctional care-eliciting behavior. Readers could not help but be impressed with the fact that clinicians were fooled easily by the patient's false reports and that the truth in such cases usually was discovered only after clinicians contacted outside sources, such as family members or coroners.

That same year, Sparr and Pankratz described a series of factitious post-traumatic stress disorder (PTSD) cases in which patients reported memories and flashbacks of traumatic events they had experienced in Vietnam.[63] When therapists checked for corroboration they discovered that none of the men had ever been in Vietnam. The authors advised readers that "Factitious disorders of all types are best discovered by careful clinical evaluation that includes verification of patient-supplied information" (Ref. 63, p 1018). Thoughtful professionals would have realized that PTSD is a particularly easy psychiatric disorder to simulate and the historical accuracy of patient's self-reported past trauma is difficult to ascertain in therapy.

In 1985, Hamilton described another series of bogus PTSD cases that he called "pseudopost-traumatic stress disorder."[64] These patients claimed a variety of PTSD symptoms including detailed horrific memories of their Vietnam combat experience. However, when their military records were obtained, their doctors discovered that none of the patients had ever been in Vietnam and they had never been in combat. The authors cautioned, "Like other diagnoses (such as migraine) which depend mainly on the

patient's report of symptoms, PTSD is readily susceptible to counterfeiting" (Ref. 64, p 353).

The mid-1980s saw a variety of additional reports describing false memories and false reports of various types in a wide range of settings. For example, in 1985 Pynoos and Eth studied the memories of children who attended a school that had been attacked by a sniper.[65] A number of children had erroneous memories and some of the errors were remarkable. One child had developed vivid memories of being shot at, although records indicate he was on vacation on the day of the attack. That same year, Bloecher *et al.* reported on nine individuals who had developed vivid, emotional, coherent, and strongly believed memories of being abducted by aliens from outer space and subsequently being released back on earth.[66] The similarities between recovered memories of sexual abuse and recovered memories of alien abduction, especially the similarities in the therapeutic techniques used to recover such memories, should give pause to any therapist whose patient is recovering memories. In 1986, Schumen described a series of false accusations of physical and sexual abuse concerning children.[67] He warned,

> In some quarters there is such a degree of sensitivity or outrage about possible child abuse that a presumption exists that such abuse had occurred whenever it is alleged. It is possible for a reverse skew to evolve, in which incest or other child sexual abuse can be over perceived and over alleged (Ref. 67, p 5).

In 1987, Matos and Marriott reported the case of a woman who fabricated reports of sexual abuse[68] and cautioned therapists to consider how they really "know if a reported sexual abuse actually took place or not. . . (Ref. 68, p 305).

Also in 1990, a unique study concerning sexual abuse was reported by Femina *et al.*[69] These researchers studied a group of 69 subjects treated during adolescence, some of whom reported abuse at that time and some of whom did not. They were reinterviewed nine years later as young adults. Of this group, 38 percent gave abuse accounts discrepant with those obtained earlier. A quarter of the subjects whose records showed severe childhood abuse denied or minimized experiences of abuse when interviewed as adults. Another 12 percent had denied abuse as adolescents but as adults alleged that they had actually been abused. Of the 38 percent with discrepant accounts, 16 percent agreed to another interview called a "clarification interview."

During the clarification interview, subjects were confronted with their records of abuse. All of the subjects known to have been abused as adolescents admitted they had remembered their abuse when first interviewed but denied it for various reasons. The most common explanations furnished by the subjects for initially denying their abuse were a sense of embarrassment, a wish to protect parents, dislike of the interviewer, and a desire to forget. This is the only reported study of its kind in the literature and it gave readers a good understanding of why people do not report distressing life events. The fact that none of the subjects had "repressed" their memories of abuse added further doubt to the theory that people could repress memories of traumatic events. Such evidence should have alerted therapists to the possibility that "recovered memories" of such abuse were bogus.

In 1991, Kenneth Lanning reported the experience of the Federal Bureau of Investigation (FBI) in investigating allegations of babies being bred and eaten, children murdered in human sacrifice, and Satanists taking over daycare centers—and the reactions of therapists to these allegations.[70] He stated that much of what had been reported by "victims" was extremely improbable, noting that "For at least eight years American law enforcement has been aggressively investigating the allegations of victims of ritualistic abuse. There is little or no evidence for the portion of their allegations that deals with large-scale baby breeding, human sacrifice, and organized satanic conspiracies" (Ref. 70, p 173). However, he observed that "the principal criteria for many professionals' acceptance of these allegations by victims is simple: Is it possible?" (Ref. 70, p 173). He concluded, "Mental health professionals must begin to accept the possibility that some of what these victims are alleging just didn't happen" (Ref. 70, p 173).

In 1992, Mikkelsen *et al.* reviewed the literature and presented their clinical experience with false allegations of childhood sexual abuse.[71] They specifically identified suggestive interview techniques and other iatrogenic elements as causes for false allegations. For example,

> An adolescent student in a private school seeks help for an eating disorder. The therapist has read articles concerning the frequency of sexual abuse in females with eating disorders. Despite a negative history of sexual abuse and what would appear to have been a stable family background, the therapist becomes convinced that there must have been an incestuous relationship between the girl and her father. Ultimately, she resorts to hyp-

notism. Under the influence of the hypnotic state and in response to distorting leading questions, the patient produces a history of sexual contact with the father that the therapist believes supports her theory. When the patient later states misgivings about the allegation she is told that it is common for victims to have ambivalent feelings about disclosure and is told that the allegations must be true (Ref. 71, p 565).

In summary, an abundance of literature dating back over a century has remarked on the fact that human beings frequently produce confabulated or false beliefs, including false memories of sexual abuse, in response to suggestive techniques such as interrogation, hypnosis, and psychotherapy. This extensive literature was readily available to therapists doing recovered memory work in the early 1990s. The literature provided convincing, clearly articulated, persuasive, unambiguous evidence that false memories and false allegations of sexual abuse were a significant potential risk of therapy. Any reasonable person entering therapy would likely attach significance to such risks in deciding whether to forego the proposed therapy. It would follow that even as far back as the late 1980s and early 1990s this "risk or cluster of risks" should have been disclosed to a patient recovering repressed memories in psychotherapy.

Conclusions

Informed consent is clearly required in psychotherapy and should include advising the patient about the potential benefits of the treatment, alternative treatments that may be available, and the potential risks of the treatment. Moreover, this consent should be an ongoing process, which continues throughout the course of treatment. Recovered memory therapy as we have defined it previously is subject to the same standards of informed consent as any other type of psychotherapy. Therefore, we suggest that therapists practicing this technique were and are obliged to tell patients what is known about the benefits and risks of the technique.

Our review of the literature finds no evidence beyond anecdotal reports that recovered memory therapy has beneficial effects, in contrast to many other psychological therapies, which are well supported by empirical studies. Conversely, we have documented extensive literature drawn from historical examples, review articles, and actual studies showing that human beings may be highly susceptible to false memories and false beliefs, including false memories of childhood sexual abuse. A great deal of this literature was already available to recovered memory therapists practicing in the late 1980s and early 1990s. Thus, therapists practicing recovered memory therapy at that time should have been aware of the possibility that patients might produce entirely false beliefs in efforts to recover supposedly repressed memories of childhood sexual abuse and other traumas. For the purposes of our question of informed consent, it is not even necessary to argue that recovered memory therapists should have believed all the foregoing reports. The therapists might have been very skeptical of the literature, but at the least they could have informed their patients that such a literature existed. In the language of *Canterbury,* all risks potentially affecting the patient's decision were required to be unmasked.

Failure to inform patients of these facts with regard to the benefits and risks of recovered memory therapy therefore would not constitute informed consent.

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