

Introduction

Psychology as a field of practice and scholarship has been renowned and respected for years. Yet in many ways, there is a great deal of skepticism about the practice. Many people prescribe to the fallacious belief that psychology and therapy is made up of a series of mind games and tricks. Although recently more people are seeking counseling and therapy than in years past, there continues to be a stigma attached to the therapeutic process. Many still believe in the antiquated term “shrink” and thus expect therapists to have some underhanded approach to ultimately control the minds of clients. Despite the simplistic and erroneous nature of these beliefs, it is important to analyze therapeutic practices.

In analyzing the issue of repressed and recovered memories along with the associated techniques, it may in fact be important to analyze the risks and benefits of such practices. The concept of recovered memories refers to memories that come to consciousness before, during, or after therapy. Typically, clients who experience recovered memories are survivors of abuse in early developmental stages. Such trauma occurring at a young age theoretically causes individuals to repress memories of the trauma and potentially other events in that time period. In order to help their clients, some therapists employ techniques to recover such memories.

Literature Review

Literature on the topic of repressed memories ranges from one extreme to the other. One must carefully analyze the research to obtain a clear view of evidence and opinions surrounding this issue. What seems clear is the reality of false memories.

Additionally, significant studies support the existence of repressed or delayed memories. While clinicians and researchers fall on all sides of this debate, what must remain in focus are the survivors of childhood sexual abuse and trauma who are asking for help. Too often they are caught in the middle of this very heated dispute.

Techniques That Can Enable False Memories

The reality of false memories cannot be ignored. Many studies and experiments have been conducted proving over and over that the human memory is a very malleable, fluid function. Since the days of Freud, techniques have been employed by many therapists in attempt to help clients gain more understanding of themselves, often by remembering events from their childhood. Unknowingly, these therapists at times were leading clients into a made-up world.

Hypnosis is one such technique therapists have use with alleged survivors of child sexual abuse to help them recover memories. As research on hypnosis progresses, some studies suggest that it not only helps create false memories for the client, it also strengthens the client's belief in those memories (Nash, 1987; as cited in Loftus, 1995).

Additionally, interviewing techniques can also be used erroneously. Therapists may ask leading questions of their clients to try to "help" them recover memories (Loftus, 1993). In doing so, clients either give the therapists the information they believe the therapists want and/or actually create memories of events that never occurred.

Therapists have often, either intentionally or unintentionally, placed their own agendas ahead of their clients' needs. Some therapist may only view their clients through the lens of abuse and repressed memories. From this perspective, they press the issue and possibly encourage the development of false memories.

Bibliotherapy has been another therapeutic technique used with clients who may have delayed memories. Depending on the books that are suggested, this can also harm clients more than help. One such book, *The Courage to Heal*, was frequently suggested to individuals believing they suffered childhood abuse but could not recall the events. This book makes very bold statements regarding repressed memories and may lead its readers to convince themselves of abuse that never occurred. The book states, “So far, no one we’ve talked to thought she might have been abused, and then later discovered that she hadn’t been. The progression always goes the other way, from suspicion to confirmation. If you think you were abused and your life shows the symptoms, then you were” (Bass & Davis, 1988, p. 22; as cited in Loftus, 1995). While it may or may not be true that a belief indicates actual abuse, it is definitely true that one can create false memories of abuse. This process seems to be encouraged by some therapeutic techniques and pressure from therapists and others to remember.

Studies on False Memories

Lindsay et al (2004) reviewed eight articles in which eight studies were completed using 374 subjects. Each of these studies strove to test if false memories can be created in the subjects. They used variations of a procedure developed by Loftus and Pickrell (1995) in which the subjects’ families are contacted and stories of the subjects’ childhoods are obtained. In these experiments at least one anecdote was of a pseudo-event that never happened to the subject. Subjects were asked to try to remember the events. Of these combined experiments, 31% or 116 subjects reported memories for the pseudo-event.

A similar study conducted by Wade et al. (2002) used a slightly different twist. Obtaining childhood photographs from families of 20 subjects, the interviewers asked each subject to try to remember the events depicted in the pictures. However, one photo was doctored. It was a picture of a hot-air balloon with the subject's childhood photograph inserted in the basket to look as if the subject had experienced a hot-air balloon ride. Fifty percent (n=10) of these subjects reported remembering the hot-air balloon ride, though it never actually happened.

Lindsay et al (2004) altered this type of experiment again by using two events obtained by families plus one pseudo-event. The only pictures used in this study were class pictures of the clients' 1st or 2nd grade class, 3rd or 4th grade class, and 5th or 6th grade class. These class pictures coincided with the time frame of the narrative events. Out of the 45 subjects, 23 were given their class pictures to look at as they tried to remember these events. The others did not have photos at which to look. Remarkably, more than 20% of those without photos reported remembering the pseudo-event completely. More shocking is the 60% who had photos who reported memories for the false narrative. This study demonstrates that individuals can develop false memories by simply trying to remember an event with the encouragement and/or pressure of a counselor, family members, and therapeutic techniques (guided imageries were used in this study).

These last two studies are significant because therapists focused on repressed memories will often encourage clients to view pictures of themselves as children to hopefully trigger some memories of abuse (e.g. Dolan , 1991). These studies show, however, that viewing pictures of oneself while attempting to recover memories can help

create false memories in the client, especially when combined with family and therapeutic pressure to remember the event.

Studies on Recovered Memories

Given that false memories exist and therapists are often the catalyst for their development, can one then afford to ignore the existence of repressed memories? There is significant research, though not experimental, to suggest that repressed memories do exist. In addition, some researchers assert that childhood sexual abuse affects the individual into adulthood, whether memories are delayed or not (Brown, Schefflin, & Hammond, 1998). These survivors may experience dysfunction such as substance abuse, suicide attempts, depression, and personality disorders (Briere & Zaidi, 1989). This list could most likely be increased to include many other difficulties that result from childhood trauma. Remembering that a clinician's primary responsibility is to help the client, one cannot shy away from repressed memories, though one must tread carefully upon this fragile territory.

Establishing the existence of false memories seems a much simpler task than doing so for repressed memories. While one can easily create an experiment that shows the creation of memories for an innocuous pseudo-event, researchers cannot purposefully traumatize subjects in order to observe the possible response of repression. The lack of laboratory evidence for repressed memories causes some researchers to dismiss the whole subject as "unsubstantiated speculation" (Ofshe & Watters, 1993, p. 5). However, ignoring the wealth of case research and careful surveys of survivors of child sexual abuse is a disservice to future clients who may experience delayed or recovered memories.

Loftus might be considered a more conservative researcher in the field of repressed/recovered memories. Even still, in her study (1993) she found that 18% of the subjects reported no or partial recollection of childhood sexual abuse for a period of time. Other researchers have recorded larger percentages of individuals experiencing repressed memories. Briere and Conte (1993) report 59% of 450 subjects experienced amnesia for childhood abuse at some point prior to their 18th birthdays. Gold, Hughes, and Hohnecker (1994) surveyed 105 individuals where 80% of them stated there was a period when they had no memory of the abuse they survived.

Many of these surveys are criticized because the researchers did not determine if the statements of repressed memories occurred due to iatrogenesis. It is possible that many or most of the subjects in these combined studies (n=more than 300) created memories as a result of previous therapy they had received, however, it seems unlikely that this is true. In addition, these researchers did not determine if the subjects could verify their recovered memories of abuse through outside corroboration (Loftus, 1993).

While perhaps overly dismissive, these questions have prompted additional studies in this area. Feldman-Summers and Pope (1994) surveyed 500 psychologists and determined that more than half of them had been abused at some point in their lives. Of those reporting being abused, 40.5% stated they had been unable to recall the abuse at some point. Significantly, 46% of those who recovered memories were able to find corroboration for the abuse they survived. This corroboration came in many forms: abuser confession, forgotten diaries recording the experience, someone else knew of the abuse, the perpetrator was implicated in other cases of abuse, and medical records documented abuse.

An important article on this subject involves interviews conducted not with therapy clients, but with a community sample, therefore ruling out iatrogenesis. Using a two year time frame in the 1970s, Williams (1994) obtained records of documented child sexual abuse cases at a local hospital. Her research was conducted 17 years after the event and documentation, under the guise of a study about the life and health of individuals who had received services from that particular hospital. She was able to interview 129 women all of whom had documented cases of sexual abuse that occurred in the two year timeframe. The documented abuse was called the “index abuse.” Asking general questions and utilizing several inventories, the interviews gathered information about any kind of sexual abuse the subjects had experienced. The interviewers were unaware of the index abuse and the subjects were unaware of the purpose of the study.

The results from this study were that 38% of the women did not report the index abuse. It is possible they were simply embarrassed or did not want to disclose the index abuse, however, it does not seem likely. During the interview, the subjects talked about many personal experiences, including sexual experiences and seemed willing to do so. It was also determined that some of the women experienced so much abuse that they simply could not remember every incident. However, when controlling for this factor, it was still found that 12% of the women stated they had not ever experienced any childhood sexual abuse at all. Some were adamant about this, yet there was recorded evidence that they had experienced sexual abuse at least once according to the index abuse documented by the hospital.

Even when controlling for other variables, this research seems to support the existence of repressed memories. These cases were clearly documented and, therefore,

corroborated. Results of this particular study may actually suggest an underestimate in the occurrence of repressed memories. After all, many of these women reported the abuse 17 years earlier, yet many of them still seemed unable to remember the abuse. When considering the frequency of unreported childhood sexual abuse, one could speculate that memory repression may occur quite frequently. This becomes more possible when one takes into account family and other outside pressure to keep the abuse a secret.

Literature Summary

As noted previously, one must tread carefully when dealing with research around repressed memories. Strong emotions are connected to both sides of the issue. In particular, some members who disregard recovered and repressed memories as therapists' mind games or falsified testimony seem to have taken an extreme stand in their position about repressed memories. Often such skeptics appear in court where the issue of recovered memories will be discredited by professional testimony. In addition, such discrediting testimony classifies the victim disordered even when there is no diagnosis for any particular disorder despite the fact that neither this diagnosis nor its diagnostic criteria are mentioned in any form in any assessments, chart notes, insurance reimbursement forms, or other documents predating her report of having recovered memories of abuse (Pope, 1996, p. 128).

Case Law

The literature and research on the issue of repressed and recovered memories is indicative of the dichotomous beliefs regarding the veracity of such memories and ethics in therapeutic practices that encourage such developments. Thus, many legal cases have

focused on such events and practices and have shaped the psychology and counseling practice regarding repressed and recovered memories.

With strong arguments both in favor of and opposing the legitimacy of repressed memories and recovered memory therapy, the desire is to look towards court precedent for legal validation. Cases concerning repressed memories have been heard at both the state and federal level, however the case law has not served to authenticate or discredit repressed memories. This is likely because the courts' duty is to ensure due process for parties on both sides of a legal battle. Unfortunately, it is not their responsibility to approve of psychological diagnosis. In fact, when utilized in a court process, the final decision of whether or not repressed memories are considered true or false is often left up to the jury to decide.

Evidentiary Issues

The court takes precautionary measures as to the type of evidence that is allowed into a trial. This evidence includes information and testimony about recovered memories. In *State v. Quattrocchi*, 681 A.2d 879, (R.I. Sup. Ct. 1996), the court did not take a stance on the validity of repressed memories in a case where a woman brought suit against a man 15 years after the alleged incident, and the defendant challenged the admissibility of evidence of repressed memories. It did, however, hold that when repressed recollection testimony is offered in persecution for childhood abuse, the "trial court should exercise gate keeping functions and hold preliminary evidentiary hearings outside the presence of a jury to determine whether such evidence is reliable and whether the situation is one in which expert testimony is appropriate" (*id* at 884). Thus, what will be presented during any trial concerning repressed memories must undergo careful scrutiny before it is

admissible. A failure to do so would likely result in a trial error that may give grounds for a mistrial or an appeal by a defendant who has moved to suppress or exclude scientific evidence that has not been validated (*id.*).

Likewise, a defendant must be allowed to present evidence that possibly opposes the validity of a repressed memory. In the case of *Franklin v. Duncan*, 884 F.Supp. 1435, (N.D.Cal. 1995), involving a man petitioning for Writ of Habeas Corpus, the court found that his due process was violated because of an evidentiary oversight. The man was convicted of murder based mostly on the testimony of his daughter's recovered memories of a murder that occurred in 1969. The murder remained open until 1989 when the daughter contacted police and informed them that she was the only eyewitness to seeing her father commit the murder. She claimed to have recovered the memory one day while looking at her own daughter. The court held that father's due process rights were violated when he was not permitted to introduce evidence of a newspaper article concerning the murder to show the possibility that his daughter might not have actually seen the murder but read about it in the papers.

The basic standards that courts tend to follow when determining whether evidence provided by expert testimony is admissible were established in the case of *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993). Here the Supreme Court set out a list of non-exclusive factors that trial courts may consider in determining whether an expert's reasoning and methodology are reliable. These factors include: (1) whether the expert's technique or theory can be or has been objectively tested for reliability; (2) whether the technique or theory has been subject to peer review and publication; (3) the known or potential rate of error of the technique or theory applied; (4) the existence and

maintenance of standards and controls; and (5) whether the technique or theory has been generally accepted into the scientific community (*id.*). Additionally, the Federal Rules of Evidence under Article VII state that when scientific or other specialized knowledge will be of assistance in determining facts at issue, a qualified witness may testify in the form of an opinion or otherwise only if “(1) the testimony is based upon sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case” (28 U.S.C.A. § 702).

The case of *Discepolo v. Gorgone*, 399 F.Supp.2d 123, (2005) provides an example of the *Daubert* standards. In this case the plaintiff claimed she had recovered memories of sexual abuse, and that this abuse had been at the root of her Post Traumatic Stress Disorder (PTSD). Here the court held that a psychiatrist’s expert testimony alleging plaintiff suffered from and displayed symptoms of PTSD consistent with someone who suffered a sexual abuse stressor was admissible as reliable and relevant. The court found that the *Daubert* standards had been satisfied because “Dr. Pratt’s methodology (1) has been the subject of numerous studies (2) has been extensively peer reviewed (3) has been found to be substantially accurate as indicated by its inclusion in the DSM and (4) has been generally accepted in the medical community” (*id* at 127). Furthermore, the court noted that “the test of reliability of expert testimony is a flexible one depending on the nature of the issue, the expert’s particular expertise, and the subject of this/her testimony” (*id* at 125).

In *Isely v. Capuchin Province*, 877 F.Supp 1055, (E.D. Mich. 1995) the court allowed expert testimony on PTSD and Repressed memory in a case where the plaintiff

filed a civil action about an alleged period of sexual abuse while at seminary. Here again the expert testimony met at least four *Daubert* factors because the proposed expert had established a threshold of personal background qualifications and had demonstrated a sufficient scientific basis of support in the field of psychiatry for PTSD and repressed memories. Although the expert was permitted to testify as to her theories and opinions on PTSD and repressed memory, as to whether plaintiff suffered from wither concerning sexual abuse, and whether behavior was consistent with sufferers of repressed memory or PTSD, she was not permitted to give her opinion as to whether she believed plaintiff or believed that the incidents had actually occurred. This shows that the court was not trying to verify the recovered memories or legally authenticate the truth of recovered memories, but instead was remaining objective and leaving interpretation of the facts up to the jury.

This hesitation to take a stance on recovered memories is common in the courtroom. Once the evidence is admitted, it is the jury's responsibility to make a decision whether or not accept the validity of the recovered memory. As stated in *Franklin* "reliance by a jury on 'recovered memory' testimony does not, in and of itself, violate the Constitution . . . such testimony is admitted into evidence and is then tested as to credibility by the time-honored procedures of the adversary system" (884 F.Supp. at 1438). Similarly, in a case where the court was considering the tolling of the discovery rule for recovered memories, the courts noted that application of the discovery rule and existence of the corroborating evidence are questions of fact for the jury when there is conflicting evidence (*Moriarty v. Garden Sanctuary Church of God*, 341 S.C. 320, 339 (2000))

While the courts attempt to be objective in their holdings, there are times when the written opinions reveal the pervasive attitude of the court over the issue of recovered memories. The court of *Franklin* stated that “admissibility of the memory is but the first step; it does not establish that the memory is worthy of belief.” This court did admit that a “‘recovered memory’ phenomenon exists, but [therapists] can never establish whether or not the asserted memory is true” (884 F.Supp at 1438). It also eloquently opined; “The recognition that memory grows dim with the passage of time is part and parcel of the trial system . . . From the common sense perspective of the trial process, then, a memory which does not even exist for a long period of time and then is ‘recovered’ must be at least subject to that same rigorous scrutiny” (*id.*).

Other courts have not been so democratic in their opinions. The court of *Doe v. Maskell*, 342 Md. 684, 695 (1996) stated; “Repression of memories of past sexual abuse does not exist as a phenomenon separate and apart from the normal process of forgetting and because these two processes are indistinguishable scientifically, it follows that they should be treated the same legally and therefore, mental process of repression of memories of the past sexual abuse does not activate the discovery rule, so as to toll the limitations period”. While the court of *Bird v. W.C.W.*, 868 S.W.2d 767, 769, (Tex. Sup. Ct. 1994) simply stated “psychology is an inexact science” when it did not find a duty to protect a parent implicated in recovered memories of sexual abuse.

Discovery Rule

Maskell highlights one place where a judge’s personal bias surrounding recovered memory therapy may influence the outcome of the trial. This area is the tolling of the discovery rule. In the *Maskell* case the court did not uphold the Maryland discovery rule

for repressed or recovered memories. Maryland law states that “A civil action at law shall be filed within three years from the date it accrues unless another provision of the Code provides a different period of time within which an action shall be commenced” (MD. CODE ANN. art. Courts & Judicial Proceedings, § 5-101 (Repl. Vol. 1995)). The plaintiff had recovered memories of abuse by defendant more than three years after the incident, and thus the court held “repression of memories is an insufficient trigger to compel the application of our discovery rule . . .” (342 Md. At 686).

A Washington Court similarly did not allow tolling of the discovery rule for a case of repressed memory where the plaintiff, 26 yrs, alleged sexual abuse against her father when she was 3 and 4 yrs old (*Tyson v. Tyson*, 107 Wash.2d 72, (1986)). This court decided that the “tolling aspect of discovery rule should be applied in cases where the objective nature of evidence makes it substantially certain that facts can be fairly determined even though considerable time has passed since alleged events occurred” (*id* at 79). The posture of this court was obviously too skeptical concerning the issue of repressed memories, and thus it did not consider the facts sufficiently objective or determinative. The court stated “Psychology and psychiatry are imprecise disciplines” with very subjective methods, and further that “the purpose of emotional therapy is not the determination of historical facts, but the contemporary treatment and cure of the patient” (*id* at 78-79). It went on to say “the distance between historical truth and psychoanalytic ‘truth’ is quite a gulf. From what ‘really happened’ to what the subject or patient remembers is one transformation; from what he remembers to what he articulates is another; from what he says to what the analyst hears is another; and from what the analyst hears to what she concludes is still another” (*id* at 78).

It is important to reveal that the majority opinion in a case is not always shared by all members of the court, and in this case the dissent disagreed and argued that psychological evidence was more reliable than the majority considered it to be, and pointed out that courts have relied on expertise of mental health professionals in a wide range of contexts in the past.

The dissent in *Tyson v. Tyson* illustrates an outlook that has also influenced the tolling of the discovery rule in cases of repressed memories – one that may support the validity and use of recovered memory therapy. For example, in *Moriarty* the court allowed the respondent to toll the discovery rule in order to bring suit against church when her memories of sexual abuse at church day care center had been repressed when it held that “the discovery rule may toll the statute of limitations during the period a victim psychologically represses her memory of sexual abuse” (341 S.C. at 327), and under the discovery rule, “the statute of limitations is triggered not merely by knowledge of an injury but by knowledge of facts, diligently acquired, sufficient to put an injured person on notice of the existence of a cause of action against another” (*id* at 329). This court’s more lenient application of the discovery rule may have been due to its stance on repressed memories which is revealed when it stated that “repressed memories of sexual abuse, known as dissociative amnesia, can exist, and a plaintiff may attempt to recover damages when those memories are triggered and remembered” (*id* at 326).

This stance is reflected again in the case of *Vesecky v. Vesecky*, 880 S.W.2d 804, (Tex. Ct. App. 1994). The Texas Court of Appeals also upheld the tolling of discovery rule in cases of childhood sexual abuse when a woman brought suit against her father more than 3 years after the last alleged incident of abuse. It declared the “discovery rule

applies in childhood sexual abuse cases where psychological mechanisms prevent discovery” and that the rule “operates to delay accrual until plaintiff discovers, or through exercise of reasonable care and diligence should discover, nature of injury” (*id* at 806). In keeping in line with the evidentiary rules and leaving factual judgments to the jury, the court noted that when the plaintiff discovered or should have discovered injury is a question of fact to be submitted to jury (*id* at 805).

Duty to Third Parties

These legal procedure issues of evidence admissibility and limitations of the discovery rule might provide hints as to the court’s viewpoint on repressed memories, but the judicial system has also provided precedent as to the ethical duties a therapist has to third parties, specifically the alleged abuser, when using recovered memory therapy.

Doe v. McKay, 286 Ill.App.3d 1020, (1997), is an example where a patient’s father brought action against a therapist to recover for loss of patient’s society and companionship based on negligent treatment and misdiagnosis of repressed memory of sexual abuse. In this case the therapist actually brought the father into a session with the patient to try to get him to admit to the abuse. The Illinois Appellate Court held that in cases involving repressed memories of sexual abuse where the parent is brought into treatment process by the therapist, the therapist’s duty to the patient to use reasonable care in treatment process is extended to the parent (*id* at 1025).

Similarly to the *McKay* holding, the court in *Tuman v. Genesis Assoc.*, 894 F.Supp. 183, (E.D.Penn. 1995), found a duty to parents when the therapist negligently implanted false memories of satanic rituals, murders, and incest in a client’s mind. Here the parents sought out care for their daughter for bulimia and undertook a contract for the

therapist to treat their 20 yr old child. After the memories were uncovered, the daughter assumed a new identity and left Pennsylvania - cutting off all contact with her parents.

In allowing the parents to file an amended complaint for negligence, the court predicted that the Pennsylvania Supreme Court would conclude that in absence of any other statutory duty of care, a therapist owes a duty of reasonable care to a patient's parents where (1) therapist specifically undertook to treat patient for parents (2) parents relied upon therapist (3) therapist was aware of parent's reliance (4) it was reasonably foreseeable that parents would be harmed by therapist's conduct. (*Id* at 188).

The *McKay* factors for determining a duty of care to third parties were expanded by *Hungerford v. Jones*, 143 N.H. 208, (1998) in which the New Hampshire Supreme Court was asked to answer following questions:

(1) Does a mental health care provider owe a legal duty to the father of an adult patient to diagnose and treat the patient with the requisite skill and competence of the profession when the diagnosis is that the father sexually abused or assaulted the patient?

(2) Does a mental health care provider owe a duty to act with reasonable care to avoid foreseeable harm to the father of an adult patient resulting from treatment or other action taken in relation to mental health conditions arising from the diagnosis of past sexual abuse or assault by said father? (*Id* at 214).

The court answered affirmatively to both questions and held that a therapist owes an accused parent a duty of care in the diagnosis and treatment of an adult patient for sexual abuse where the therapist or the patient, acting on the encouragement,

recommendation, or instruction of the therapist, takes public action concerning the accusation (*id* at 215). In this case the public action was taken by the daughter in bringing charges against her father, and also by the therapist when she contacted authorities in support of her client.

To clarify, the court expressed that the duty of care to the accused parent is breached by the therapist when the publicized misdiagnosis results from (1) use of psychological phenomena or techniques not generally accepted in the mental health community, or (2) lack of professional qualification. (*id* at 215). Not only did the therapist in this case have very little experience with treating repressed memories, but the court considered recovered memory therapies to be “extremely controversial” and “criticized as being suggestive and resulting in false memories” (*id* at 213).

While this court did recognize the critical role of mental health professionals in identifying sexual abuse and protecting children from such abuse, it warned that we must be “vigilant in balancing these critical societal interests against the need to protect parents, families, and society from false accusations of sexual abuse” (*id* at 211). The fear is that false accusations cast doubt on true claims of abuse, and thus undermine valuable efforts to identify and eradicate sexual abuse. Therefore, therapists owe a duty to those potentially endangered by their conduct, and it found that the severity and likelihood of harm is compelling and clearly foreseeable when false accusations of sexual abuse arise from misdiagnosis. The potential for harm is magnified when, as alleged in this case: (1) the accused is the patient's father; (2) the therapist lacks appropriate experience and qualifications; (3) the therapist uses a psychological phenomenon or technique not

generally accepted in the mental health community; and (4) the accusations of abuse are made public. (*Id* at 213).

Almost in direct opposition to *Tuman* and *Hungerford*, the Texas Supreme Court has found no duty owed to a parent to not negligently misdiagnose a child due to the recovery of false memories of sexual abuse. The *Bird* case concerned a child examined by a psychologist who claimed to uncover recollections of sexual abuse by the father. Based on this information the mother attempted to modify child custody. When the child's recollections were determined to be false the assertion was dropped and the father sued for negligence claiming libel and slander. The court opinion acknowledged harm to a parent accused of sexual abuse as being foreseeable, however, concluded that predictability alone is not sufficient for creating a new duty to the parent (868 S.W.2d at 769).

The holdings of these cases present conflicting views, however, both sides use the same rationale for the holdings: the importance of protecting victims of sexual abuse. In *Bird* the court determined that a claimant's right to sue must be considered in light of the social utility of eradicating sexual abuse (*id*). Even though both the *Bird* and *Hungerford* holdings emphasize protecting victims of sexual abuse, the former does so by giving therapists more leeway and room for error in detecting abuse, while the latter does so by placing stricter standards on therapists when identifying sexual abuse.

Similar to *Bird* case, the court in *Zamstein v. Marvasti*, 240 Conn. 549, (1997) found no duty to a child's father for misdiagnosis of sexual abuse. Such a duty was found to be contrary to public policy of state which is to encourage reporting and investigation of suspected child abuse. Again in this case a mother was using psychiatric examination

in her custody modification action, and the Father's claims of a damaged relationship with his children and intentional interference with custodial rights were not found to be valid.

Legal Summary

When an area of science is as controversial as recovered memory therapy it makes sense that those on both sides of the issue would look to our legal system to validate their view. Upon reviewing the legal history, however, it seems that we are left with just as much uncertainty as when we started. Some courts may favor the use of recovered memories (*Moriarty v. Garden Sanctuary Church of God*), some may reveal attitudes against it (*Doe v. Maskell, Tyson v. Tyson*), but the bottom line is that courts are not outright approving or rejecting the use of repressed memories and recovered memory therapy. We must face the fact that the role of the judiciary system is not to make a final decision on how legitimate an area of science may be; this is indeed the job of the scientists in that field. Instead, the courts should provide an arena where evidence is presented in a fair and appropriate manner as seen by the cases centered on admissibility of recovered memories (*Discepolo v. Gorgone, Isely v. Capuchin Province, Franklin v. Duncan*). They also serve to set appropriate limitations on the timeline for bringing suits (*Vesecky v. Vesecky Doe v. Maskell Tyson v. Tyson Moriarty v. Garden Sanctuary Church of God*), in determining when to apply the discovery rule. While these court decisions ensure that civil rights of due process are protected, they do not serve to establish any guidelines for recovered memory therapy as a matter of law.

Lastly, the courts have addressed the issue of a legal duty to third party when there is possible negligence while using recovered memory therapies and techniques (*Zamstein v.*

Marvasti Bird v. W.C.W., Hungerford v. Jones, Doe v. McKay, Tuman v. Genesis Assoc.).

These cases do provide some ethical guidelines and possible legal ramifications for misdiagnosis of repressed memories, however, judiciary support can be found on both sides of the issue. Additionally, the ethics set out by these cases still do not authenticate or negate the legitimacy of recovered memories.

Ultimately, the case law surrounding recovered memory therapy and the use of repressed memories needs to be considered by therapists as a supplement to their scientific methods. The precedents provide helpful methods for some of the legal issues that may arise when using recovered memory therapy, yet, they will not provide a final answer as to whether or not repressed memories are real and recovered memory therapy is a valid therapeutic method. That debate is one that must remain within the field of mental health and not in the courtroom.

Therapeutic Techniques

Obviously this issue elicits strong responses from all sides. People of various backgrounds with a variety of beliefs may be intimidating to therapists and counselors alike. Although there are many skeptics, there are just as many professionals that employ effective techniques and practices that encourage clients to address issues and delayed memories that may arise during the therapeutic process.

Most therapists will find themselves in the position of working with clients who report recovered memories or delayed recall of memories of childhood sexual abuse. This can happen in two ways. Occasionally, a new client may present initially with questions about beliefs, memories, flashbacks or dreams that include images or sensations of childhood sexual abuse. More often, a client that the therapist is already

seeing for other presenting concerns, at some point in the therapy, begins to report memories, flashbacks, dreams or images. In either of these cases, the client is usually very disturbed by these “memories” or images and she or he may want the therapist to answer questions immediately, such as, “Am I going crazy?” or “Did this really happen?”

Even though the client may be pushing for answers, it is neither helpful nor appropriate for the therapist to jump to any conclusions in this situation. It is the therapist’s job to help the client tolerate the ambiguity and uncertainty, to create as much safety as possible in the therapeutic relationship, and to empower the client in discovering her own capacity for exploring her own experience and knowing her own truth.

Therapists can find ways to support the client without jumping to create premature closure or certainty. Both therapist and client need room for ambivalence and confusion. Both must tolerate doubt, ambiguity, and uncertainty. (Pope & Brown, 1996)

Issues of Power in the Therapeutic Relationship

Clients in a therapy situation are always vulnerable to the abuse of power by a therapist. Clients who are dealing with the frightening experience of flashbacks and nightmares may well be even more vulnerable. They are often so desperate to “make sense of it” or to “get well” that they will accept anything that a therapist says or suggests. This leaves clients equally vulnerable to therapists who profess certainty that nothing happened and to those that profess certainty that something specific did. In order to avoid the mistakes of either of these extremes, therapists must keep abreast of the latest research on trauma and memory, be aware of various treatment techniques, and carefully monitor their own reactions and self-care.

First and foremost, the therapist must remember that each client is an individual. As Pope and Brown (1996) stress, it is crucial that each client be assessed and treated as a unique person with her own individual history, responses, and ways of coping. There is no assembly line method for dealing with delayed memories. There are, however, certain concerns that are likely to come up while working with delayed or recovered memories, and an emerging consensus that a stage approach that involves creating safety and integrating memories (Pope & Brown, 1996) or safety, remembrance and mourning, and reconnection (Herman, 1997) works best as a general model.

Issues of informed consent and informed refusal are important in any therapy relationship, and they are particularly important when working with client reports of delayed or recovered memories (Pope & Brown, 1996, Pope & Vasquez, 2001). The purpose of informed consent is to start and maintain a dialogue between the client and the therapist. The goal of this dialogue is “empowered consent,” a term coined by Laura Brown (1994). Empowered consent involves the therapist working to present information to the client in a way that it is educational and accessible. It aims to “demystify” the therapy process (Miller & Stiver, 1997), and must include information about the potential risks and benefits of any treatment approach. “Empowered consent clarifies that the client is the ultimate arbiter of what is helpful and has the right to refuse any intervention, seek a second opinion, request that the therapist get consultation, or terminate treatment at any time without punitive consequences or having that refusal labeled as a form of pathology” (Pope & Brown, 1996).

This notion of empowered consent helps to create a climate of collaboration between client and therapist from the very beginning. It serves to minimize the power

differential that is always present in therapy and to strengthen the client's ability to resist suggestion or coercion in therapy or any other relationship. "When the therapist operates from this perspective, the likelihood of either avoiding dealing with traumatic memories or creating pseudo-memories will be reduced (Pope & Brown, 1996, p. 54). "When therapists see their clients as expert in themselves and expert in knowing their own experience, and see themselves as expert in the processes of creating safety and containment and facilitating change, then they have the parameters of a situation in which the risks of coercion and suggestion are greatly reduced," (Pope & Brown, 1996, p.58).

Safety

Many clients who report delayed or recovered memories of abuse experience the process as a severe crisis. Creating a climate of safety in which the client can explore what is happening to her is critical. The therapist must engage in careful screening, both at the initial contact with the client, and throughout the therapy process, for possible risks to the safety of the client and others (Pope & Brown, 1996; Herman, 1997). This screening should include an assessment of the risk of suicide, an assessment of the client's sense of her ability to maintain and contain herself between sessions, and an assessment of the safety of her current life circumstances (Herman, 19947; Pope & Brown, 1996; Rothschild, 2000).

The therapist should be familiar with standard assessment protocols for determining the risk of harm to self or others. The therapist can directly assess with the client her perceived risk, and her strategies for coping and reducing risk. The therapist and client can discuss coping and safety plans, internal resources such as oases, anchors,

and safe places (Rothschild, 2000), and the need for external supports such as phone check-ins between sessions.

It is important that the therapist and client have a clear and mutually agreed upon therapy contract that includes information about fees and sessions, but also agreements about the therapist's availability outside of sessions, how to contact the therapist in an emergency, etc. (Herman, 1997). Once again, it is important to engage the client in the process of determining what kind of therapist support will be most helpful while maintaining the client's sense of her own autonomous capacity for coping.

Conversations about what defines an emergency and what self-soothing strategies a client can develop and try before calling the therapist can be very helpful in this process (Pope & Brown, 1996).

A lack of safety in the client's current life situation may be a trigger for the delayed recall of past trauma. A client who is currently in an abusive relationship or having trouble determining if a relationship is safe, or a client who is living on the street, will need support in creating safety in her life before any other treatment can move forward (Herman, 1997; Pope & Brown, 1996).

Freyd (1996), in her discussion of Betrayal Trauma, describes the terror that many abused children feel that they will be abandoned if they tell the truth about abuse by a caregiver. A clear therapy contract provides assurances that the client will not be abandoned by giving concrete information about when and how to contact the therapist in an emergency. By specifying the client's right to care, it makes it clear that care is non-contingent, and does not depend on the client producing or retracting memories, sticking to an initial story, or following any particular course of action related to the abuser.

Another way to provide safety for the client is to assess the context of the delayed or recovered memories and any potential conflicts of interest, goals, and roles for the therapist and client. In assessing context, it is important to ask why the client is seeking help now and what might be influencing her understanding. Has a sibling recently reported abuse? Is the client being pressured to remember or deny abuse by other family members? Are the parents paying for therapy with a client and later this same client begins to see images of a parent abusing her? Is an HMO or PPO determining the length and type of treatment? The collaborative process of creating safety must continue throughout the treatment process. Some sense of safety within the therapy relationship must be present before proceeding with any other form of treatment. And safety will be revisited often throughout the treatment process.

Remembrance and Mourning

Judith Lewis Herman (1997) describes the second stage of therapy with trauma survivors as Remembrance and Mourning. Like others, she emphasizes that a client who is dealing with delayed or recovered memories may never have complete knowledge of what happened and must learn to live with that ambiguity. Current research on the brain and memory, especially traumatic memory, makes it clear that we are not capable of encoding or retrieving explicit memories before the age of three (Siegel, 1999). The part of the brain that is responsible for putting memories into narrative form, with a logical sequence, and orienting them in time and space (the hippocampus) does not fully develop before the age of three (Rothschild, 2000). Trauma that occurs before this time may interfere with the future development of the brain and hormones released during trauma may impair the functioning of the hippocampus later in life.

Herman (1997) reminds us that the therapist is not a fact finder and therapy is not a criminal investigation. She does believe, however, that the client must remember what she can, be allowed to mourn both what happened and what didn't happen, and attempt to integrate these memories into her life story. The therapist's role, Herman believes, is that of an open-minded, compassionate witness, not a detective.

Keshgegian (2000) describes the process as dialectical: "a survivor will often doubt her own experiences and/or be frightened to let go of the world, albeit dysfunctional, she constructed in order to survive" (p.41). She also speaks of the importance of having someone to "bear witness." Both authors stress the importance of the witness or bystander remaining in "moral solidarity" with the survivor. This stance of moral solidarity is not one of assuming that a particular action was or was not performed by a particular individual. It is, however, the acknowledgement that abuse does occur, that the client can know her own experience, and that any act of abuse is morally wrong.

The process of remembering is not simply a cognitive one. Remembering abuse also involves reliving the affective experience of the abuse. This reliving is necessary for integration and healing (Herman, 1997; Keshgegian, 2000; Rothschild, 2000). It is the responsibility of the therapist, however, to facilitate this process of remembering in a way that protects the client's autonomy and minimizes the potential for re-traumatizing the client. As mentioned earlier, the client must be given clear information on the risks and benefits of any treatment process. The client must also be in charge of the timing and pacing of the work. It is the responsibility of the therapist to monitor the client's state of autonomic nervous system arousal, and to assist the client in keeping this arousal within manageable levels (Rothschild, 2000). The therapist can help the client to learn the body

awareness necessary to monitor her arousal outside of the therapy session and the body and other self-soothing techniques necessary to manage it. The therapist can also assist the client in remembering and strengthening her own internal resources for coping (Rothschild, 2000).

During this process of re-experiencing the cognitive and affective memories, the therapist's role as ally and witness is crucial. The therapist provides not only a witness, but also a "witness," (Keshgegian, 2000). Miller and Stiver (1997) speak about this "witness" as "mutual empathy." They describe empathy as a complex process that includes motivational, cognitive, and affective components. This requires the therapist to be open to her own emotional arousal in the process of hearing about abuse and to be willing to allow the client to know that she is moved by it. In this way the client can "feel felt," and move out of the isolation that abuse so often creates.

The process of bearing witness and mutual empathy requires a great deal of therapists. Because of this, it is essential that the therapist attend to her or his own self-care. Pope and Brown (1996) emphasize the importance of therapist self-care in working with the client recovering memories of childhood trauma not only as helpful to the therapist, but also as another strategy for avoiding malpractice with clients. They, along with Herman (1997), also stress the need for adequate professional and collegial support and consultation and the therapist's need for her or his own therapy.

Reconnection

Therapists can empower clients who are dealing with delayed or recovered memories in many ways. Clients can be reminded that they are free to make their own decisions about what appears to them in images or dreams or flashbacks, and that the

therapist will not push them in particular directions. In therapy, the natural home of ambiguity, it becomes even more important to allow this fluidity and uncertainty.

Therapists can offer support for coping with the anxiety that comes from not having instant or convenient answers, protection from overwhelming and intolerable affect, respectful witness and mutual empathy.

Conclusion

The issue surrounding the validity of repressed memories and recovered memory therapies present ethical concerns for therapists. Moreover, it receives charged opinions from both sides of the debate by not only counseling professionals, but also students, scientists and researchers, as well as participants in the legal arena. At present it seems that the best approach a therapist can take concerning repressed memories is to stay informed of the latest scientific research and legal decisions that may affect their practice. Forming a well educated opinion as to whether or not one agrees with recovered memory therapy is a personal responsibility not to be taken lightly. Encountering clients believing they have repressed or recovered memories seems an inevitability for the practicing clinician. Knowing how to best help the client, doing no harm, and keeping oneself within the legal and ethical confines of the profession is a necessary challenge. Most importantly, clinicians must remain focused on how best to aid their clients in healing from wounds presented in the therapeutic relationship.

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