

Commentary: How, When, and Whether to Use Informed Consent for Recovered Memory Therapy

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J Am Acad Psychiatry Law 29:148-159, 2001

Beginning with the groundbreaking 1994 case of Gary Ramona against the therapist who had induced his daughter to develop false memories of incest,¹ a steadily increasing tide of litigation against therapists has arisen, alleging damages from creation of false memories. In addition to other claims of negligent or inappropriate therapeutic practices, these lawsuits have prominently included claims of failure to provide warning of the potential for creation of false memories, and of harm that may result from such memories.

In support of these claims, Cannell *et al.*² (this issue) argue (1) that the dangers of “recovered memory therapy” are well established, (2) that knowledge of these dangers was widely available to “therapists” by at least the late 1980’s, and (3) therefore, therapists should have obtained informed consent for “recovered memory therapy” from clients since the late 1980’s. We will comment on these issues, raising related literature or concerns not fully addressed by Cannell *et al.*² In particular, we first emphasize the strength of the scientific literature documenting the risks of recovered memory therapy. Following this discussion, we address anticipated difficulties with of informed consent procedures.

What Is “Recovered Memory Therapy” and What Should We Warn Against?

To reasonably address specific issues regarding “recovered memory therapy,” it is necessary to

establish what is meant by the term. Cannell *et al.*² define recovered memory therapy in terms of the focus and assumptions of the therapist. That is, they suggest that recovered memory therapy is practiced when the therapy is focused on recovery and understanding of traumatic memories, with the assumptions that (1) such memories may be “repressed”, (2) that “repressed” memories can be reliably recovered, even after substantial intervals, and (3) that patients can obtain relief from symptoms through recovery, exploration and understanding of such memories.

This definition focuses on the goals and assumptions guiding therapy, rather than technique, raising the issue of the focus of the proposed informed consent. Should it warn the patient regarding the risks of the defining focus and assumptions, of the risks of specific techniques used for recovery and exploration of the memories, of the risk of development of false memories during therapy (generally, or specifically false memory therapy), of the risks of harm that may follow from recovery of memories (either true or false), or of some combination?

We suggest that warnings covering at least the following seven categories might be appropriate, including (1) the risk of no benefit, (2) the risk of foregone benefit, (3) the risk of developing false memories, (4) risks of recovery of false memories through specific therapeutic activities, (5) the enhanced risks of memory recovery procedures to specific patient categories, (6) the risk of harm through the *process* of recovered memory therapy, (7) the risk of other potentially iatrogenic disorders, particularly “multiple personality disorder” (MPD), and (8) the risk of harm resulting from “*recovery*” of traumatic memories (both true and false).

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What Evidence Do We Have of Risk?

The Risk of No Benefit

As Cannell *et al.*² point out, there is no current empirical support for the proposition that recovery of traumatic memories will provide therapeutic benefit. Further, therapies of all kinds, biological or psychological, fail for a subset of patients. Thus, clearly there is a risk of no benefit for recovered memory therapy, common to all therapies, and arguably more likely for this one.

The Risk of Foregone Benefit

Associated with the risk of no benefit is the risk of foregone benefit—or failure to benefit from a form of therapy that could more accurately identify the nature and/or source of the patient's current problem and/or more effectively treat the problem.

“Repressed memories” are typically diagnosed based on symptoms that, in fact, may result from any number of causes. Thus, pursuit of recovered memory therapy will be inappropriate in cases where symptoms reflect other processes. Although there is evidence to suggest weak (if any) relationships between a history of child sexual abuse and *some* of the symptoms regarded by recovered memory therapists as evidence of abuse,^{3,4} even weak evidence is lacking for many, if not most of the exhaustive list of symptoms claimed in the survivor literature.

Further, few symptoms are pathognomonic. The presence of such symptoms does not clearly establish that abuse has actually occurred. In other words, the probability of specific symptoms, given that abuse has occurred, is by no means equivalent to the probability of abuse, given the presence of those symptoms.⁵ In fact, the many symptoms identified as evidence of abuse in the survivor literature^{6,7}, can occur as symptoms of a variety of disorders with several alternative etiologies. Because there is no clear empirical basis to prefer a differential diagnosis of repressed memories of childhood sexual abuse (or other unremembered trauma) above alternative, perhaps both simpler and more probable, explanations, the risk of misdirected efforts is substantial for preferential pursuit of buried memories that may not exist. Arguably, a diagnosis of repressed memories of abuse is more likely than not to be in error, thus diverting therapeutic efforts away from the true problem, and from other more effective empirically supported treatments.

Some would argue, as well, that successful treatment does not uniformly require identification of the original underlying cause of the clinical problem. Instead, regardless of the initial etiology, it may be more important to understand the current controlling variables for a particular clinical presentation.⁸ In cases where the original underlying cause is no longer controlling the behavior, recovered memory therapy could be an unnecessary expenditure of time and resources, at the expense of more effective focus on coping with the current problem. For example, child abuse may have caused the person to develop poor interpersonal behavior, which in turn is currently causing difficulties. Clinical intervention in such cases would arguably be more effective when focused on interpersonal behavioral strategies than on recovery of lost memories of abuse.

The Risk of Developing False Memories

Cannell *et al.*² provide a variety of compelling anecdotal reports of false memories developed within and outside of the therapeutic context. Such anecdotal reports are important to demonstrate both (1) that false memories *can* be created in (and outside) the therapeutic context, and (2) the extreme implausibility, and even impossibility, of some of the constructed memories. However, we will briefly review and emphasize the weight of *scientific* literature documenting the fact that false memories can be created, the mechanisms (including specific therapeutic techniques) through which they can be created, and the fact that even memories of autobiographical events of extreme personal significance, ranging from the possible to the clearly impossible, can be distorted or created.

False Memories Can Be Created

Universal agreement exists among cognitive psychologists that false memories *CAN* be created. Laboratory demonstrations of the development of false memories have ranged from those for very simple recent events, as in Roediger's list learning paradigm⁹ where false memories for words strongly implied by the context (but not presented) are common, through the demonstrations of the “misinformation effect” leading to false memories of witnessed events,¹⁰⁻¹² to the relatively recent demonstrations of the creation of more complex and personally involving false, often mildly traumatic, autobiographical memories among children and adults.¹³⁻¹⁶

At this point, the fact that false memories can be created truly is indisputable.

False Memories Can Be Created Through Common Therapeutic Techniques

Laboratory demonstrations of the creation of false memories have begun with the power of the mere suggestion that an event may have occurred to create false memories. Thus, we will first briefly review the danger of therapist “focus” on the single hypothesis of repressed traumatic memories, and the suggestions (from subtle to coercive) that tend to accompany that focus.

Dangers of Specific Hypothesis Testing. Faced with a patient experiencing a particular constellation of symptoms, the clinician (like a physician) should engage in “differential diagnosis”, considering the full range of problems that might cause the symptoms, and systematically ruling them out until one remains. Instead, recovered memory therapists often jump directly from discovery of symptoms to the diagnosis of abuse, without full consideration of alternatives. Convinced of the repressed memory of abuse diagnosis, (s)he proceeds to focus all efforts on obtaining evidence to confirm it.

Freud, the original champion of the concept of repressed memories of abuse, clearly instructed therapists to search for confirmation of their expectations, rather than to systematically, and without bias, evaluate the various possible diagnoses.

If the memory which we have uncovered does not answer our expectations, it may be that we ought to pursue the same path a little further...If the first-discovered scene is unsatisfactory, we tell our patient that this experience explains nothing, but behind it there must be hidden a more significant, earlier experience (Ref. 17, pp 195-196).

In contrast to Freud’s advice, scientific research on clinical judgment has long ago documented the dangers of the “confirmation bias” in clinical diagnosis and judgment¹⁷—that is, the tendency to affirm the diagnosis one is considering. The confirmation bias has been documented even under circumstances where the clinician is asked to review an unknown patient’s file to evaluate whether the patient suffers from diagnosis “X”-without any contact with the patient, without any preexisting reason to favor diagnosis “X”, and in an effort to provide an unbiased assessment.¹⁹⁻²¹

Moreover, in addition to this well-established association of diagnostic hypotheses with confirmation biases in assessment, the biased interviewing/diagnostic efforts to test clinical hypotheses that tend to

accompany the hypotheses may also elicit self-confirming responses from patients. When testing a particular diagnostic hypothesis in interaction with a patient, clinicians or other interviewers tend to ask questions in a manner that elicits confirmation from the interviewee.²²⁻²⁴ In other words, the interviewers tend to ask leading and biasing questions, which tend, in turn, to bias responses in the direction of consistency with the diagnosis in question. Like the confirmation bias, these self-fulfilling interviewing techniques tend to characterize clinicians or interviewers with no prior conviction in the truth of the hypotheses they are evaluating. How much stronger would these hypothesis confirming processes be when a clinician has committed not to *testing* the hypothesis, but to finding proof that it is true?

Recovered memory therapy is focused on efforts to recover memories of sexual abuse or other traumata. Thus, the therapy begins with the assumption that clinically relevant buried memories are there to be found. It then proceeds with a number of leading and even coercive procedures shown in scientific memory research to produce confirmation of the hypotheses in the form of false memories of the event in question.

The Power of Belief. False memories may be created by first creating belief, which tends to occur in recovered memory therapy through both direct attempts to persuade the patient that (s)he was abused and through suggestions of varying degree of subtlety. Daniel Schacter and Elaine Scarry’s recent edited volume “*Memory, Brain and Belief*”²⁵ offers a variety of excellent chapters documenting the relationship between *belief* that something occurred, and *memory* for the occurrence. Generally, this point is also documented in the literature on reconstructive memory processes, which has shown that false memories of past events develop in response to current information (such as newly acquired information, or the activation of schemas consistent with the falsely remembered event or information).

Crombag *et al.*²⁶ showed the process by which beliefs may lead to false memories through interviews of Dutch citizens exposed to televised descriptions of an El Al Boeing 747 into a Dutch apartment building. The authors interviewed citizens months after the crash, asking them whether they remembered seeing the crash on TV. The crash had never been on TV, but many descriptions of it had been. These beliefs about how the crash occurred

were experienced as memories by the majority of those interviewed (55% and 66% in two separate studies). They not only reported having *seen* the crash, but also described it in detail. Clearly, these memories were nothing more than *beliefs* based on descriptions heard on TV.

Perhaps more relevant to the recovered memories controversy, research on the “retrospective bias” in autobiographical memory has shown that memory of the past can be distorted toward consistency with current beliefs and expectations.²⁷⁻²⁹ Similar effects have been found in studies of the “hindsight bias” For example, Neisser³⁰ compared John Dean’s testimony during the Watergate hearings to the Presidential Transcripts later released to try to determine the sources of errors in his testimony. Dean testified that he had warned the president, both that the cover-up would be exposed and that he might lose the presidency as a result. The transcripts later revealed no such warnings. Dean’s current knowledge of the outcome (or hindsight) led him to believe he had acted consistently with his current knowledge in the past, i.e., that he had warned the President that he may be destroyed by the Watergate situation, when in fact the transcripts showed that he had not.

Finally, theory and research regarding factors that promote false confessions (elaborated in more detail below), has shown that a person may best be led to falsely remember and/or confess to an offense when authoritative evidence (either physical or scientific evidence, or statements from authorities) exists to convince the accused that (s)he is indeed guilty.^{31,32}

Clearly, considerable risk for creation of false memories is associated with therapeutic interactions causing the client to *believe* that abuse must have occurred. Recovered memory therapy is founded on the belief that such memories exist. It begins with the therapist’s conviction that abuse explains the patient’s problems, and that memories of the abuse exist to be recovered. This belief is conveyed to the patient through direct and indirect suggestions in the context of a variety clinical procedures. These repeated suggestions, building on a foundation of readiness to believe created by already existing beliefs, motivation to find the truth, lingering doubt about what really happened, and desire to know, subtly or blatantly create in the patient the belief from which the “*memories*” are finally born.

Dangers of Common Memory Recovery Techniques. Belief in the likelihood of abuse creates readiness to remember, if not the “*memory*” itself. However, commonly employed memory recovery techniques have been shown to create false memories.

For example, experimental research with hypnosis, one of the common aids to memory recovery, has shown that although hypnosis does increase the amount recalled, approximately equal numbers of true and false memories are produced. Further, because hypnosis entails responsiveness to suggestion, the use of hypnosis to enhance memory may increase the subject’s vulnerability to leading questions and interrogative biases of the therapist, and thereby to production of suggestion-consistent pseudomemories. Hypnosis may also diminish capacity to discriminate between memory and fantasy.³³⁻³⁷

Hypnosis in the context of recovered memory therapy often involves hypnotic “age regression” in an attempt to reinstate the context of the suspected abuse. This technique, however, like hypnosis in general, is both unreliable as an aid to memory recovery, and risks development of false memories. There is no evidence that hypnotic age regression improves access to memories of past events. Instead, there is evidence that suggestions given to “age regressed” hypnotized adults can produce false, and even impossible, memories.³⁸

Likewise, laboratory research has shown that “guided imagery,” another commonly employed technique can implant false memories. Loftus and her colleagues termed this process “imagination inflation”³⁸. Loftus and her colleagues have experimentally created false autobiographical memories through guided imagery and imagination. However, imagination and visual imagery have been shown to produce false memories of having experienced or witnessed a wide variety of events.^{40,41}

Finally, Mazzoni and her colleagues⁴²⁻⁴⁴ have shown that bogus dream interpretations (i.e., the same interpretation given to all subjects, regardless of the dream reported, and with no reason to believe the interpretation applied to each individual subject) can lead to false memories for mildly traumatic suggested events. It should be noted, as well, that modern dream research has established that the content of dreams is less symbolic than Freud believed. Dreams tend to reflect what is happening in daily life.^{45,46} If a person is thinking about something during the day, there is a

good chance the person may dream of it at night. Thus, the consuming focus on issues of sex abuse created by therapeutic sessions, daily “homework” assignments, participation in survivor groups, among other influences of recovered memory therapy is virtually certain (at some time) to produce dreams regarding abuse—which, in turn, are virtually certain to be interpreted as “memories” by therapists and clients alike. Together, the risks of creation of false memories through hypnosis, guided imagery, age regression, and dream interpretation are well documented, both through scientific laboratory research and accounts of retractors.

Memories for Events of Extreme Personal Salience and Significance Can Be Confabulated

Most are willing to believe that memory can be inaccurate with respect to mundane details. On the other hand, many are highly resistant to the suggestion that people can confabulate memories for events that never happened—especially for such personally significant autobiographical experiences as sexual abuse from a parent, or satanic rituals, abuse, and murder.

The anecdotal examples provided by Cannell *et al.*,² by the many retractors and the lawsuits they have filed, and by the many other case histories noted throughout the history of therapeutic literature, and in volumes specifically devoted to false memories of abuse have provided clear evidence that extreme, implausible, and even impossible autobiographical “memories” -such as memories from the womb³⁸ or abduction by aliens⁴⁷ can be confabulated through therapeutic processes.

These anecdotal accounts, however, are supported by laboratory studies documenting mechanisms of autobiographical confabulation, as reviewed in the previous section. Although ethics of laboratory experimentation cannot permit demonstrations of implanted traumatic memories involving abuse or others with equivalent risks, they have clearly documented implantation of autobiographical memories of events that would have been personally salient and perhaps terrifying had they occurred, such as being lost and terrified in a shopping mall as a child,⁴⁸⁻⁵⁰ breaking a window and cutting one’s hand,³⁹ or being lost on a mountainside as dark approaches,⁴²⁻⁴⁴ but that are factually untrue, and sometimes impossible (such as memories ranging from the first day through the first few years of life).³⁸

Further, laboratory research on false confessions has shown that people can be led to confess to offenses, ranging from the trivial to the virtually impossible, that they did not actually commit.^{31,32,51-53} As Ofshe and others have pointed out, such false confessions are most likely to occur when (1) the suspect has unclear memory of the event in question, (2) when false evidence is presented against him or her, (3) when there are repeated statements by an individual in authority that the event happened, (4) when there are repeated claims that scientific evidence exists that the event happened, and/or (5) when the subject has been told that defects in memory indicate a psychiatric condition that would explain the lack of memories. (Note that most or all of these tend to occur in “recovered memory therapy”).

The implausible lengths to which such false confessions can extend in practice is, perhaps, best illustrated by the case of Paul Ingram, recounted in detail in both Wright⁵⁴ and Loftus and Ketcham.⁴⁸ Ingram was led, in part through the processes described by Ofshe,³² to first believe, and later to “remember,” that he had abused both of his daughters and his son, and that he had participated, along with local law enforcement officers and other pillars of the community, in satanic rituals, abuse and murder of babies (among many other implausible and untrue activities involving a variety of other parties). Notwithstanding all of the evidence to the contrary, some may persist in believing that Ingram did abuse his daughters. However, thousands of hours of investigation of the other members of the community and of the claims of Satanic activities clearly established at least those confessions as false.

Clearly, the laboratory evidence shows that memory for significant, mildly traumatic, and/or personally humiliating events one either experiences or perpetrates can be confabulated. This research, in combination with the anecdotal evidence regarding highly traumatic and/or implausible autobiographical events, provides clear and convincing evidence, notwithstanding their compelling subjective nature, that memories for highly significant, traumatic, deeply personal autobiographical experiences can be confabulated, through the same processes that create confabulation of more mundane memories of all kinds.

The Enhanced Risks of Memory Recovery Procedures to Specific Patient Categories

Cannell *et al.*² underscored the enhanced risks of confabulation among patients in specific diagnostic categories. We would like to further emphasize the probability that patients likely to undergo recovered memory therapy may be at greater risk of confabulation resulting from specific memory recovery procedures.

Scientific memory research has identified strong individual differences in susceptibility to confabulation. For example, hypnotizable persons are already more suggestible before they are hypnotized, and this suggestibility is further enhanced when hypnotized.³⁴⁻³⁷ Similarly, individual differences in susceptibility to suggestion were identified by Gudjonsson,⁵¹⁻⁵³ in his studies of susceptibility to false confession.⁵⁵ Further, Loftus and her colleagues noted that subjects scoring highly on the Dissociative Experiences Scale⁵⁶ were more susceptible to "imagination inflation."⁵⁷ Other studies have shown increased confabulation among those high in negative affect or acquiescence⁵⁸ and low in self confidence,⁵⁹ characteristics likely to be present at a higher rate in clinical populations. Given clear evidence of enhanced risks of confabulation among clinical populations generally, and among those who could successfully undergo specific procedures such as hypnosis, informed consent documents could reasonably be expected to include reference to the potential for enhanced risks in susceptible patient categories.

The Risk of Harm Through the Process of Recovered Memory Therapy

Although Cannell *et al.*² focused on the risks associated with development of false memories, it should be noted that the therapeutic process itself can cause substantial, and sometimes irreparable, harm to patients (as documented in reviews such as those of Loftus and Ketcham,⁴⁸ Ofshe and Waters,⁶⁰ and Pendergrast⁶¹). Recovered memory therapy can take years, and incur substantial financial cost. Further, like other forms of therapy, it may exacerbate or expand symptoms. The process of therapy encourages the patient to focus extensively on efforts to recover memories, during and outside of therapy. The patient may be encouraged to read survivor literature, to engage in memory homework, or to otherwise "try" to remember the assumed

abuse.^{6,48,60-62} The process encourages adoption of a victim/survivor identity, with potentially deleterious consequences for self-esteem and functioning. Even before memories are "recovered", belief in the abuse and distress at inability to remember it may increase anxiety and dysfunction. When therapists instruct them to cut off contact with non-believers, patients can become isolated from loved ones, and others who had provided emotional support. Preoccupation and distress resulting from these processes has, in some cases, resulted in dissolution of relationships, loss of employment, financial distress, and overall decline in functioning.

Further, harm through the therapeutic process is not restricted to patients. Having focused upon the possibility of abuse, the patient will typically impact family members through his or her own preoccupation and distress, and possibly through accusations and provocation of family conflict or criminal or civil complaints. Documentation of these effects and example case histories are available in Loftus and Ketcham,⁴⁸ Ofshe and Watters,⁶⁰ and Pendergrast,⁶¹ among other sources.

The Risk of Other Iatrogenic Disorders, Particularly MPD.

Although Cannell *et al.* focused on the risk of recovery of false memories, another iatrogenic risk is the development of MPD (Multiple Personality Disorder), or its more recent renaming as DID (Dissociative Identity Disorder). Most recovered memory therapists have endorsed the idea that MPD/DID is characteristic of incest survivors. Notwithstanding vigorous and cogent criticisms of the diagnosis by many in the psychotherapeutic and scientific community over the last 10 years, many recovered memory therapists continue to view the disorder as widespread, and to actively pursue evidence of it in their patients. For example, E. Sue Blume⁶³ has recently described the disorder as "not uncommon", even though the most liberal estimate in the literature puts its occurrence at 1%. Perhaps even more vigorous endorsement can be found in the recent book "Stranger in the Mirror: Dissociation: The Secret Epidemic of Our Time".⁶⁴ The authors suggest that over 30 million Americans suffer from dissociative disorders requiring treatment.

As with memory, the maxim “Seek and ye shall find” applies to the “discovery” of MPD or DID. Believing that trauma causes dissociative disorders such as MPD/DID, therapists can essentially coerce patients into display (if not actual development) of multiple personalities. As described in Pendergrast,⁶¹ some have even gone so far as to put the patient in restraints and refuse to release them until the additional personalities agree to “come out”.

Noted hypnosis researcher, Nicholas Spanos⁶⁵ argued that psychotherapists play a significant role in the generation and maintenance of MPD. They

routinely encourage patients to construe themselves as having multiple selves, provide them with information about how to convincingly enact the role of “multiple personality patient”, and provide official legitimization for the different identities that their patients enact.” (Ref. 65, p. 3).

In turn, the patients “learn to construe themselves as possessing multiple selves, learn to present themselves in terms of this construal, and learn to reorganize and elaborate on their personal biography so as to make it congruent with their understanding of what it means to be a multiple” (Ref. 65, p. 3). In other words, in addition to self-identification as a “survivor”, the patient may also self-identify as having MPD, and proceed to behave consistently with each role—with all the personal and social costs such identities entail.

In fact, failure to warn of the iatrogenic risk of MPD has recently appeared in civil claims against recovered memory therapists. An Arizona woman, pseudonamed Mary Smith, began therapy to help her deal with the ending of an abusive 10-year marriage. Soon, repressed memories of sexual abuse (including satanic ritual abuse) supposedly bubbled up, and Mary was further diagnosed and treated for MPD. Among other extreme personal and social costs of therapy and its sequelae, Mary’s children were removed from her care for many years.

Eventually realizing her pseudomemories were false, Mary brought suit against her therapists claiming her therapists

had a duty to inform Mary and Mary’s children about the risks involved in the diagnosis and treatment they made and utilized. In particular, Defendants had a duty to inform Mary of the controversy in the relevant community about the diagnosis of MPD and/or repressed memories or effects of early-age sexual abuse, the existence of repression, the use of hypnotic techniques in recovering memories, and the various methods used to “treat” MPD, and the risks of the treatment techniques they chose to use on her, including

the possibility that the techniques utilized had a capacity to produce false memories which seemed real to Mary (Ref. 66, p 9).

The Risk of Harm From Recovery of Traumatic Memories, True or False

The term “*false memory syndrome*” was coined to refer to

a condition in which a person’s identity and interpersonal relationships are centered around a memory of traumatic experience which is objectively false, but in which the person strongly believes...the syndrome may be diagnosed when the memory is so deeply engrained that it orients the individual’s entire personality and lifestyle, in turn disrupting all sorts of other adaptive behaviors (Ref. 67, p 16)

As Kihlstrom’s characterization of false memory syndrome suggests,⁶⁷ a primary risk of memory recovery, and in fact, of recovery of both true and false memories^{68,69} of various traumata, is the narrowing focus of identity, relationships, and lifestyle to virtual obsession with the trauma and its aftermath. The “*survivor*” identity and focus tends to be negative and to have a variety of ill effects on self-esteem, relationships, work, and lifestyle. The effects can be devastating, including loss of jobs, friendships, and family relationships—such as in Mary’s loss of her children in the earlier example.

The risks of recovered memory therapy are rather unique, however, extending indefinitely to members of the patient’s family and the extended community in which they circulate. As the Ingram case demonstrated, recovered “memories” can not only send immediate family to prison (as Ingram’s daughter’s did to him), they may also lead to the accusation and sometimes imprisonment of other members of the community (like Ingram’s daughter’s “memories” extended to other officers in the Sheriff’s department, and caused one of them to be imprisoned). Thus, a patient’s decision to undergo recovered memory therapy can expose countless others to risks ranging from personal distress or financial devastation, to loss of reputation or family, to imprisonment for life.

It should be noted that these risks are most troublesome when they occur in the context of recovery of *false* memories. However, similar effects may accompany *true* traumatic memories. Just as marital therapy may uncover potentially destructive true information regarding a spouse (such as infidelity), discovery of any true information may involve destructive potential.

Is Informed Consent a Solution to the Problem?

We agree with Cannell *et al.*² that the risks of “recovered memory therapy,” and of the associated therapeutic techniques, are well documented, both anecdotally and experimentally. Although one might reasonably debate *when* this evidence was widely known within the therapeutic community—and indeed whether even now it is well known in the broader therapeutic community (nonacademic clinicians, counselors, pastors, etc.)—the evidence has been available in the scientific literature for many years. Nevertheless, even though evidence suggests that warnings would be justified, one might yet question whether informed consent will provide sufficient protection to patients who might otherwise fall victim to creation of false memories. Several problems may compromise the use and/or effectiveness of informed consent.

The Problem of Compliance

Notwithstanding the weight of scientific evidence regarding confabulation of memories, even today, in this new century, substantial dissent remains in the therapeutic community regarding the harmful potential of recovered memory therapy—even to the point of apparently total denial of any form of potential harm. To see how resistant some therapists are to the weight of both anecdotal and scientific evidence, one need only look at a recent issue of an abuse survivor publication, and specifically a long essay by therapist E. Sue Blume⁶², reiterating her earlier position⁶ regarding the symptoms of repressed memories of sexual abuse, the causal relationship of sexual abuse to repression and dissociative disorders, and her faith in the accuracy of memories “recovered” in therapy. Blume argued in her 1990 book that repression is a virtually universal reaction to sexual abuse:

The incest survivor develops a repertoire of behaviors designed to preserve the secret...these behaviors are calculated or even conscious. They become automatic and, over the years, almost part of her personality. She denies that she was abused by repressing the memory of her trauma. This is the primary manifestation of “the secret”: incest becomes the secret she keeps even from herself. Repression in some form is virtually universal among survivors.” (Ref. 7, p 67)

Based on this theory, Blume strongly advocated the many clinical techniques for which there is now well-established evidence of the potential for creation of false memories. Would she, and others like her, agree to the necessity of informed consent for her form of

recovered memory therapy? We expect not! Based on her recent essay⁶², Cannell and his colleagues, along with the many scientific psychologists who have empirically established and documented the foibles of recovered memory therapy, would be dismissed as part of an unfortunate Backlash, and she would call them “*Lashers*” for short. She attacks the label “*false memory syndrome*” as being a political construct, and argues that no evidence exists for it. She pushes her claim that a vast body of research today supports the existence and validity of the kinds of memories she touted a decade ago. And, in sweeping disregard of scores of published findings, she asserts, “*trauma memory is not externally malleable.*”

Unfortunately, Blume is not alone in her resistance to the implications of the growing body of both anecdotal and scientific demonstrations of the dangers of the therapeutic techniques she endorses. Those who have self identified as recovered memory therapists are deeply committed to the concepts of repression, the causal role of trauma in creating dissociation, and the validity of such time honored techniques as hypnosis, dream interpretation, guided imagery and others. However, these techniques are also widely employed in the therapeutic community, among those who do not self identify as recovered memory therapists, or practice “*recovered memory therapy*”².

Given these strong and unshaken beliefs in the validity of the repression hypothesis and the effectiveness of recovered memory therapy on the part of therapists such as Blume and others, how much adherence can we expect to recommendations to employ informed consent procedures before engaging in their preferred techniques. Clearly, those like Blume who refuse to believe that false memories of abuse *can* be created, will be unlikely to warn their patients of the possibility. And even if such therapists do provide the informed consent forms, will they successfully convey the potential for danger to their patients, or will they subtly or blatantly discount those risks, even as they have the patient sign? If the therapist does initially convey the risks adequately, will their subsequent persistent efforts to recover the memories, their consistent statements to the patient that abuse has occurred, and their enthusiasm and obvious belief in the validity of any recovered “memories” undermine or eliminate the value of the warnings.

The Problem of Widely Divergent Therapeutic Communities

Ideally, the professional organizations under which therapists practice would issue a statement regarding

the importance of informed consent for any form of therapy and any therapeutic technique with potential to induce harm in the forms discussed herein. However, both dissemination of the scientific and anecdotal findings underlying the recommendation, and recommendations based on this literature, are quite variable between the widely divergent therapeutic communities practicing “*recovered memory therapy*” or its components.

Therapy is done by several different disciplines, under different parent organizations’ ethical and scientific standards, and under 50 different licensing jurisdictions. There is no current single standard of practice for informed consent by private practitioners. While there are licensing laws in a few states that describe informed consent requirements, standards for what level of detail differ and do not address the scientific issues described above. Further, recovered memory therapy and techniques are practiced by unlicensed pastors and counselors of various kinds. Thus, standards of informed consent (and the science on which they are based) promoted and disseminated by one discipline may be unknown or rejected among others.

The Problem of Successful Communication of Risks

If the therapist does sincerely believe in the potential risks of recovered memory therapy, and attempt to convey those risks to the patient, can (s)he successfully do so? At least three challenges face the therapist attempting to explain the risks, particularly of recovery of false memories.

The Problem of Belief

Therapists attempting to convey the idea that false memories might be developed in therapy will first have to successfully convince patients that false memories can be created, and more importantly that it could happen to that patient. Most of us are far more willing to believe that others can have false memories, or that others could develop such extreme false memories as sex abuse or satanic ritual activities, than we are to believe that our own memories are so fallible. Thus, it is important to develop and test informed consent procedures, to produce a method that succeeds in informing and convincing patients of both the risks and their personal vulnerability.

The Problem of Quantification

Risk communication may include any or all of the following: (1) the fact that a particular adverse outcome may occur, (2) the overall incidence of the outcome in question, and/or (3) the incidence specific to subpopulations, particularly those to which the patient might belong. Criteria for inclusion in informed consent procedures can vary from the inclusive extreme of any adverse outcome ever either anecdotally or scientifically documented (even if only once) to the more rigorous criteria of those outcomes shown to meet a particular frequency criterion. At this point, risk communication would necessarily be confined to statements identifying the possibility of various adverse outcomes of therapy. The literature provides no solid estimates of the number of patients undergoing recovered memory therapy, its constituent techniques, or of the incidence of adverse consequences—nor does it provide clear evidence of the odds and magnitude of benefit to be expected, against which risks can be evaluated.

The Canterbury standard (Canterbury v. Spence⁷⁰) for informed consent specifies that all risks a “*reasonable person*” might consider relevant to the decision to undergo treatment must be divulged. This criterion is not independent of the frequency with which particular adverse effects occur. How, one might ask, would a reasonable person weigh an unquantified risk when electing to undergo a treatment? The risk of the ultimate serious risk of death is greater than zero for many, and perhaps most, medical procedures, even those benign for more than 99% of the population. Yet, even this ultimate risk cannot be reasonably evaluated with no estimate of its likelihood, as compared to the magnitude and likelihood of benefit.

The Problem of Understanding

The final challenge to effective risk communication is the patient’s *understanding* of the risks, and ability to evaluate them reasonably. Whether or not risk is quantifiable, patients may be unable to understand them. Many patients are distressed and/or confused when they enter therapy, and perhaps ill equipped to reasonably evaluate potential risks. To facilitate patient understanding of the risks, we believe it may be desirable to actively discuss the risks with the patient. Many will otherwise fail to either read or understand much of what is presented in written forms, particularly as consent forms become more detailed.

It is also important to note that the *timing* of risk communication may be crucial to understanding and effective use of the information. Arguably, the risks of recovered memory therapy generally should be reiterated at various points in the process. Further, it is likely that the risks of particular procedures will be more usefully processed when addressed immediately prior to the procedure, rather than much earlier as part of a general consent form prior to therapy.

Conclusions

Cannell *et al.*² have raised the issue of informed consent in the context of a hotly contested arena of therapy and research. The specific arena of recovered memory therapy is one in which anecdotal and scientific evidence of risks of serious harm more than meet the Canterbury legal standard of risks a reasonable person might consider relevant to the decision to undergo the procedure. However, this discussion is sure to raise a number of issues within the various professional communities that remain unaddressed by Cannell *et al.*²

These include questions such as “What level of evidence is required to justify informed consent requirements for therapy of any kind, therapy of specific forms, or specific constituent techniques?” “Are anecdotal reports sufficient, or must there be laboratory corroboration? And if laboratory corroboration is required, at what point is the effect sufficiently well-established to require informed consent?” “What evidence of generalizability of laboratory results to clinical practice is necessary?” “Must risks, benefits, or both be quantifiable?” “What degree of agreement within the scientific and/or therapeutic community must exist before professional standards require adoption of informed consent procedures?” “If informed consent procedures are to be adopted, what should they be?” “Who should give consent for disoriented patients?”, among many others. Keeping such questions in mind, we believe that it is of vital importance to conduct research with the goal of developing informed consent procedures that will successfully convey the risks in question—including causing patients to understand and believe the risks can apply to them.

Notwithstanding scientific, professional and practical problems that remain to be addressed, we endorse Cannell *et al.*'s² conclusion that informed consent is appropriate prior to recovered memory therapy. Patients should, at a minimum, be afforded the

opportunity to learn of the potential for a variety of adverse effects to follow from recovered memory therapy, and from specific techniques involved in the process. Further, they should be apprised of the enhanced risks for patients in diagnostic or other categories associated with increased suggestibility.

Some patients will not be able to reasonably evaluate and understand the implications of this information. Others may be unable to believe the risks apply to them personally. However, the informed consent documents and discussions provide greater opportunity to understand the risks than patients' uninformed assumptions. Although quantified statements of risk are certainly preferable, we suggest that the harm resulting from creation of false traumatic memories is so great, both for the patient and potentially for many associated with him(her), that patients should be informed of the risks in the best available format—even when the warning is no more specific than the fact that the particular adverse effect can occur.

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