

Retractors of false memories: the evolution of pseudo- memories

BY HAROLD I. LIEF, M.D.
AND JANET FETKEWICZ

The formation of pseudomemories and the subsequent methods used by subjects to eventually distinguish between true and false memories are the primary foci of this study.

A survey instrument was distributed to 100 "retractors" after an initial telephone interview with False Memory Syndrome Foundation (FMSF) staff. Forty respondents (40% of the subjects) who returned the questionnaire comprise our study population. The survey inquired about personal and family information, events surrounding the subject's accusations of sexual abuse, childhood history, and the subject's reflections on his or her experience. The process of the development of pseudomemories is highlighted.

Subjects also described their feelings and experiences in open-ended questions, including their subjective experience as memories evolved, factors influencing thoughts, feelings and doubts, the process of questioning memories, the process of restoring relationships with family members, and uncertainties about views of memories currently held.

We focus on the evolution of pseudomemories, especially the influence of the therapist; we explore the nature of therapy, one that makes an ill patient much worse and that eventually becomes so onerous that patients who still have some remaining reality-testing flee from therapy.

The controversy surrounding the recall of memories of incest that allegedly took place when the adult was a child or an adolescent has captured the attention of the public in rather dramatic fashion. Headline examples include Cook's allegations against Cardinal Bernadin,¹ the *Ramona* case,² and Eileen Franklin's testimony that her father had murdered her eight-year-old friend Susan many years earlier.³

A significant schism among mental health professionals has arisen as a consequence of very different beliefs and practices. There are therapists who claim that they have never seen a case where it is absolutely certain that the memory recovered is false,⁴ and there are those who state the opposite, that they have never seen a case where a recovered memory has been proved without any question to be accurate.⁵ Some of the recovered memory practices such as age regression, hypnosis, sodium amytal interviews, guided imagery, and access to past-life memories, as well as a belief in Satanic ritual abuse, have become a source of ridicule in the press and on television. There is a danger that all of psychotherapy, the good as well as the bad, may be jeopardized by the issues surrounding the recovery of memories.

As a consequence of studies demonstrating the vicissitudes of memory, researchers have expressed concerns regarding the reliability of recovered memories of sexual abuse (Neisser,⁶ Loftus,⁷ Lindsay and Read,⁸ Kihlstrom⁹). In his discussion of the case of Paul Ingram, Ofshe¹⁰ described an *in vivo* demonstration of suggestive interrogation, leading to Ingram's false belief of perpetration of ritual abuse acts.

Laboratory studies and research involving nonpatient subjects (Hyman, Husband and Billings¹¹) are often criticized as not being generalizable to therapy. It seemed to us that one way to understand the development of pseudomemories more clearly, a way that could not be criticized as being outside the realm of therapy, was to study those ex-patients who had alleged abuse as children or teenagers and then, deciding that

these memories were false, came forward with a public declaration of their change of mind. We believed that examining these people would shed light on the processes by which memories are developed, as well as those by which people change their views of reality and declare that their previous memories were false.

Formal studies of recanters are scarce. Nelson and Simpson¹² were able to contact twenty subjects by telephone. They term pseudomemories “visualizations.” In this way they make a distinction between false memories and memories that are reasonably accurate historically. Eighty percent of the 20 subjects stated that their visualizations or pseudomemories were first recovered in individual therapy, and 15% experienced them while hospitalized. The remaining subject experienced all of her visualizations after reading *The Courage to Heal*.¹³ Ninety percent of their subjects reported the use of one or more memory-recovery techniques; 85% of the subjects had been hypnotized. Eighty-five percent of the recanters said that therapists or group members had used suggestion directly or indirectly; some of these used the term “pressure.” Seventy percent read recovery- or abuse-related books, 60% shared flashbacks of abuse with group members, and half of them watched video tapes or movies related to recovery of abuse memories. There was a very high litigation rate. Sixty-three percent of their subjects had been involved in filing lawsuits against their therapists.

Individual case reports have been assembled, and the stories of the recanters have been told in the popular media—e.g., television talk shows and many magazine and newspaper accounts, such as first-person accounts (Gavigan,¹⁴ Pasley¹⁵).

Recently a number of professionals have written books containing case stories of retractors (Loftus and Ketcham,¹⁶ Ofshe and Watters,¹⁷ Wakefield and Underwager,¹⁸ Wassil-Grimm,¹⁹ and Pendergrast²⁰). Goldstein and Farmer²¹ published accounts

written by eight retractors who documented their experiences with pseudomemories.

As Wakefield and Underwager²² suggest, these stories represent the subjective retrospective experiences of a specific group of individuals, and as such they raise concern regarding generalizability. However, we believe there is value in these reports and in the patterns they demonstrate, especially in terms of therapeutic practices underpinning the evolution of their memories. Further, the accounts cited above are congruous with the patterns described in the FMSF Family Survey Data (Freyd et al.²³), as well as with the survey described in this paper.

The use of reports of retractors as documentation of false memory syndrome has been criticized (Berliner and Williams²⁴) as a simple choice to "believe" the recanting patient rather than the accusing patient. This criticism is unfortunate, especially since many retractors have experienced molestation or abuse as well as pseudomemories of sexual abuse.

The important distinction between the two is that the recanters have always remembered the real abuse by a person or persons not "visualized" in the pseudomemories. Further, Berliner and Williams have suggested that verification of reports of false memories is necessary in order to accept them as evidence of the phenomenon. Although this places us in the awkward position of proving a negative, we will attempt to provide data that address this criterion. "Face validity" that the recanters' memories are pseudomemories is apparent from the high percentage who report Satanic ritual abuse, murder, and other violent crimes that, if true, should provide physical evidence, and from the higher percentage of cases in which there are memories of abuse occurring during a period of infantile amnesia or even earlier (during fetal life or birth). Doubt of the historical accuracy of the memories is also

increased by the large number who accuse multiple perpetrators.

This paper focuses on some of the processes involved in the evolution of pseudomemories and on the demographic and family data that had developmental significance, as well as on significant therapy variables.

Method

Through the False Memory Syndrome Foundation we were able to locate several hundred retractors. To the first 100 retractors who agreed to participate, we mailed a detailed questionnaire. Of these, 40 returned the survey instrument. Many of those who did not participate reported by phone or letter that it was too emotional. A few were advised by their attorneys to decline; one had committed suicide.

The questionnaire included demographic data and the subject's own subjective analysis of his or her experience. The survey is composed of sections of questions covering these areas.

1. Personal/family information: Basic descriptive and demographic items; identification of stressors during childhood.
2. Events surrounding the accusations: Description of the processes involved in the development of false memories; basic content and characteristics of false memories; information about the therapeutic relationship and techniques used in therapy.
3. Childhood history: Retractor's impressions of family relationships; childhood, adolescent sexual experiences (including history of actual sexual abuse in childhood).

In addition to the specific questions under the areas listed above, we also asked the subjects to respond to six open-ended questions:

1. Describe your subjective experiences as memories evolved, your thoughts, feelings, doubts, etc.
2. Describe any contributing factors (events, media, etc.) which may have influenced your thoughts, feelings, and doubts.
3. What is your best judgment as to how you came to question your memories?
4. Describe the process of restoring relationships with accused and non-accused family members.
5. Often retractors have heard the idea that they have "repressed" their memories of abuse. What are your thoughts about this idea?
6. How do you know that your memories of abuse were false?

Results

Current family and personal information

Subjects, all Caucasian, ranged in age from 19 to 55; the mean and median year of birth was 1956. The mean age at the time of the subject's accusations of sexual abuse was 32; the mode, 38. Forty-five percent of the respondents were currently married, 22.5% were single, 30% were divorced, and 2.5% were widowed. Eighty percent of the subjects had at least one child.

Ninety-two and a half percent were high school graduates, 50% completed four years of college, and 17.5% attended graduate school. By self-report, 47.5% of the subjects were classified middle class, with another 25% reporting upper middle class status. Thirty-seven and a half percent of the subjects categorized their religious involvement as inactive or reported that they were unaffiliated with any organized religion. The remainder (62.5%) reported their level of religious involvement as somewhat active to very active.

**Childhood,
family and
personal
information**

Twenty percent of the subjects reported that their family's religious involvement was "inactive" or "none," and 75% reported the family's level of religious involvement as somewhat active to very active. By self-report, 28% of the subjects classified their family's socioeconomic level as middle class during childhood, while 35% reported upper middle class status.

Most of the retractors' parents are still married (55%); 30% are widowed; 12.5% are divorced. Five (12.5%) subjects are only children. The remaining 35 have one to six siblings. All subjects but one reported that during their childhood their fathers worked outside of the home full-time. Most of the mothers (55%) did not work outside of the home at all.

**Childhood
history**

Two of the 40 subjects were adopted, one at birth and the other at age six months. Most subjects reported an average to very high rating of elementary and high school achievement and conduct grades. Respondents were also asked to rate their general adjustment during childhood. Seventeen (42.5%) considered themselves "average" in their adjustment. Thirteen (32.5%) responded with "adjusted" to "very adjusted." Eight (20%) rated themselves "poorly adjusted," and only two (5%) considered themselves "very poorly adjusted" during childhood.

Ratings of peer relationships during high school were generally positive as well, with 31 (78%) subjects reporting average to very positive peer relationships (the most frequent response was "average"). Of the 35 subjects who attended college, 26 (74%) rated their college peer relationships as somewhat positive to very positive, five (14%) as average, three (9%) as somewhat poor, and one (3%) as very poor.

**The
accusations**

Fathers were most often accused (32, or 80%). Twenty-one mothers, 12 siblings, 12 grandparents, 13 extended-family members, 15 acquaintances and 10 "others" were also accused. Twenty-eight (70%) of the respondents remembered

abuse at the hands of more than one perpetrator. Of those 28, six accused two people, seven accused three, nine accused four, and six subjects accused five to seven individuals of sexual abuse. Interestingly, 18 (45%) subjects never confronted the accused. Twenty-one (53%) subjects did confront the accused, between two days and four years after memories were recovered.

Respondents reported that their remembered abuse began at ages that ranged from "prebirth" (three) and birth (seven) to age 17. Twenty (50%) subjects reported memories of abuse beginning at age three months to five years, and eight (20%) at ages six to seventeen. (See the following table.)

Ending ages of remembered sexual abuse ranged from four to 19 (mean age = 13), with three additional subjects reporting a belief that their abuse did not end, but continued as they received therapy. In other words, for these three subjects the abuse was thought to have been repressed even as it occurred. The average time span of the reported repression was 26 years. Twenty-nine (72.5%) of the accusations referred to many episodes of sexual abuse.

Subjects were asked to specify the nature of the accusations by indicating one or more of 16 types of abuse (for example, fondling, exposure, oral sex, intercourse, satanic ritual abuse). Thirty-eight (95%) indicated that they recovered memories of more than one type of abuse. Ten (25%) remembered that they were victims of 15 (five) to 16 (five) types of abuse. The most frequent accusations were fondling (33, or 82.5%) and molestation (31, or 77.5%). Nineteen (47.5%) subjects remembered satanic ritual abuse, and 15 (37.5%) subjects remembered murder.

**Therapeutic
experience**

For almost all of the subjects (37, or 92.5%), recovered memories arose during therapy. Thirty-three (82.5%) of the subjects stated that a direct suggestion was made by their therapist that they were victims of sexual abuse before memories were recovered.

Recovered-memory data

Accusation Age	Episode Frequency *	Age at start of Abuse	Age at end of Abuse	Number of Years Repressed **	Number of Days Between Memory & Confrontation
13	1	10.0	10.0	3.0	1095
15	3	5.0	17.0	28	365
18	3	3.0	13.0	15.0	300
19	3	3.0	15.0	16.0	180
22	3	1.0	5.0	17.0	did not confront accused
22	4	7.0	14.0	15.0	did not confront accused
23	3	3.0	10.0	20.0	548
25	3	0.0	13.0	25.0	21
26	3	14.0	15.0	12.0	did not confront accused
26	3	0.0	continuous	26.0	did not confront accused
27	3	0.0	8.0	27.0	did not confront accused
27	3	3.0	14.0	24.0	did not confront accused
28	3	0.0	13.0	28.0	did not confront accused
29	4	10.0	15.0	25.0	did not confront accused
30	3	0.0	15.0	30.0	did not confront accused
30	3	6.0	16.0	24.0	365
31	3	4.0	18.0	26.0	180
31	3	14.0	17.0	14.0	did not confront accused
33	3	2.0	continuous	33.0	180
33	3	0.5	14.0	32.5	did not confront accused
34	3	0.0	18.0	20.0	did not confront accused
34	3	3.0	15.0	14.0	365
35	1	17.0	17.0	18.0	did not confront accused
35	2	3.0	14.0	12.0	1480
36	1	4.0	7.0	32.0	2
36	4	3.0	12.0	33.0	did not confront accused
36	3	5.0	15.0	21.0	60
35	3	0.5	19.0	36.0	1095
38	3	5.0	14.0	33.0	180
38	3	-1.0	18.0	38.0	730
38	3	0.3	continuous	38.0	210
38	2	4.0	4.0	34.0	7
38	3	0.0	13.0	25.0	did not confront accused
38	3	5.0	12.0	33.0	365
40	3	-1.0	17.0	40.0	21
44	3	0.5	18.0	43.0	did not confront accused
44	4	10.0	10.0	34.0	did not confront accused
52	3	0.0	18.0	52.0	730
n/a					did not confront accused
n/a					

*Episode Frequency: 1=one episode; 2=few episodes; 3=many episodes; 4=too vague to tell.

**Number of Years Repressed: from start of alleged abuse to first recovered memory.

Nineteen subjects (nearly 50%) reported an increase in the frequency of visits with their therapist after they recovered memories of sexual abuse. Thirty-six (90%) subjects reported calling their therapist between sessions, with 15 reporting daily telephone calls to their therapist.

We questioned subjects about their reasons for seeking therapy, or presenting problems, in an open question. The most common presenting problems fell into the following cate-

gories: family or marital problems (16=40%); depression (12=30%); eating disorder (8=20%); anxiety- or stress-related issues (6=15%).

In a closed question, subjects were also asked to specify stressful events during the two to three years before they entered therapy. The most frequently cited problems were financial (18, or 45%), job-related stress (16, or 40%), and weight problems (15, or 37.5%).

The most common techniques used in the course of the subjects' therapy were deep relaxation (31, or 77.5%), age regression (30, or 75%), guided imagery (29, or 72.5%), dream interpretation (28, or 70%), and hypnosis (27, or 67.5%). Twenty-eight (70%) of the respondents participated in group therapy for incest survivors. Thirty (75%) reported reading *The Courage to Heal*, and 32 (80%) reported reading other self-help literature.

Thirty-four subjects (85%) reported that their therapist advised them on relationships and communication with family after the abuse memories surfaced. Of those 34 subjects, 27 reported that they had been advised not to communicate, or to cut off family completely. However, a total of 26 (65%) continued to communicate with their parents after they came to believe that they had been sexually abused (15 with both parents; nine with the non-accused parent only).

Forty percent of the subjects were given more than one diagnosis. The most common diagnoses were multiple personality disorder (18, or 45%), post-traumatic stress disorder (15, or 37.5%), and depression (8, or 20%).

Evolution of pseudo-memories

The first two of our open-ended questions dealt with the evolution of pseudomemories:

1. Describe your subjective experiences as memories evolved, your thoughts, feelings, and doubts.

2. Describe any contributing factors (events, media, etc.) which may have influenced your thoughts, feelings, and doubts.

In *Making Monsters*, Ofshe and Watters²⁵ devote a chapter to this subject, which they call "Creation of the Abuse Narrative." This generally involves a number of steps:

1. The therapist believes that a symptom or a group of symptoms is a reliable indicator of abuse and proceeds directly or indirectly, bluntly or subtly, to suggest that the patient has been abused (as was the case in 82.5% of our sample) and that early sexual abuse is the cause of the patient's psychopathology.
2. Even if they lack memories of abuse, if they have a certain set of feelings, these feelings are then interpreted as evidence of sexual abuse.
3. If the patient produces artwork or has dreams that in the therapist's mind indicate sexual abuse, this information is conveyed to the patient. Ultimately, in the mind of a recovered-memory therapist, almost any perception, thought, or emotion can be labeled a memory.
4. If the patient rejects the possibility that she has been sexually abused or that she has memories of sexual abuse, this "denial" is often used as evidence confirming the therapist's suspicions. Thus it doesn't matter whether one has memories or doesn't have memories—either situation provides ammunition for the recovered-memory therapist's assault on the truth.

Finally, as Ofshe and Watters²⁶ state (p. 93), "In all of the methods, the two important variables are the patient's emotional investment in the therapy and the therapist's confidence that these supposed pieces of memory (or indicators of memory) are valid."

Patients come into therapy because they are distressed by symptoms or by failures in relationships. The distress is often severe. The patients are frightened, angry, bitter, and frequently suicidal. One of the major themes that occurred in the self-reports of the recanters was their search for meaning in their lives. There was an enormous need for an explanation for their mental and emotional disturbances.

In this emotional state, the sickest of them crave magical solutions (instantaneous, effortless remedies). Those somewhat better integrated parentify the therapist, making him or her into an authoritarian, all-knowing and all-powerful parental figure. This creates an enormous positive dependent transference to the therapist, whose attention and support mean everything to the patient. The common advice to cut off contact with the family, as happened with 79% of our subjects, increases the patient's dependence on the therapist.

Usually the therapist rewards the emergence or recovery of memories by giving praise or granting perquisites. The most recent perquisite is one in which the usual boundary between therapist and patient is broken by allowing almost unlimited telephone contact. Thirty-six (90%) of our subjects reported telephoning their therapist between sessions. Fifteen of those subjects called their therapist daily. Sixty percent wrote to their therapists between sessions, and 80% reported that their therapist advised them on daily issues.

As the dependent transference deepens, the patient looks for approval from the therapist; approval gives the patient the same "lift" that a drug fix does. The key element in winning approval is uncovering memories. If the patient brings in memories, she will get the therapist's approval. If she does not, she often encounters disapproval or even threats. Several examples illustrate these points.

After the first two weeks in the hospital, I was concerned that I had no memories yet, so I pressured myself to start remembering. I had a feeling that my therapist would scold me or be disappointed in me

if I didn't remember something. I was scared not to remember. I had many, many doubts, but my therapist didn't respond well to my doubts. She seemed more interested, more responsive, and more sympathetic if I suspected abuse. When I finally "gave in" and started "remembering" abuse, I felt many emotions: very scared that I might be totally wrong, but relieved that I finally had something tangible to blame my problems on; inner peace (somewhat). My therapist and the staff at the hospital showered me with attention and care, especially after the memories emerged. The more traumatic the memories, the more attention I got. I felt loved. The attention was very gratifying. However, through it all I always had a bad feeling that these memories were all fabrications. I tried not to think about that, though, because I relished all the attention I got by being an incest survivor.

This quotation illustrates many of the themes. There is a conflict between her observing self, which produces doubts, and her participating self, engaged in the need for an explanation; the search for meaning generally wins out. It also illustrates the enormous dependent transference on the therapist and the staff, and it illustrates the nature of the reward system by which the therapist facilitates the process of recovering memories. The patient was rewarded with attention and care, and she mentioned that the more traumatic the memories, the more attention she got. This is certainly anti-therapeutic, and it illustrates the damage created when the therapist is cast and casts himself or herself in the role of parent or, even more, a magical caretaker with the power of making the patient better or sicker.

When I told him I did not think some of these things happened, he would tell me the only way I would get better was to trust him and my memories or I would go crazy. I became suicidal and had a number of hospitalizations. I was afraid that I would never get out of my depression if I didn't do this memory work. I never wanted to believe that I had been abused by my mother and I doubted it all the time. My therapist insisted that my mother was a sex addict. My doubts, I believe, kept me feeling so much shame. During this therapy, I was hospitalized eight times because I was so suicidal. When I doubted the memories I was told I was an MPD and that the real me was in denial. At the same time, I became increasingly very dependent on my therapist for all of my support. I had destroyed

my other relationships, and he told me that he was the only real support I had. Once he convinced me that I was an MPD, I was sure I was crazy, and quite honestly, I got a lot of attention in the hospitals for this. I also enjoyed all the attention given to me by my therapist.

I felt that we were in some kind of sick mind control that we couldn't get out of, and most of us wanted more because the therapist became everything to us. I wanted to get well so bad that I would have done just about anything. The best way I could describe group is by saying that [the therapist] created his own cult, with him being the high priest. It was his way or no way. I had doubts all the time, but I was told that this was my denial, my not wanting to get well. I believed the therapist. After all, who was I to question someone who was supposed to know everything. I looked at him as a god who could do no wrong.

Memory recovery seems to be the critical factor in whether the patient is rewarded with the therapist's approval. Since the search for repressed memory becomes the major (sometimes the only) focus of therapy, memory enhancement techniques are generally accepted by patients even if some doubt (the observing self) remains. The acceptance of memory work is facilitated by the recurrent theme that recanters report: a need to work harder in therapy, that therapy is a salvation, that without therapy they will go crazy but with therapy there is some hope.

It was easy to draw any detail or experience into the support of abuse or to be another aspect of it. The mind is incredibly malleable.

In addition to hypnosis (67.5%), guided imagery or "creative visualization" (72.5%) was often used as an aid to recovering memories.

I was falling apart emotionally, and I looked for a counselor to go with the word "codependency" in a Yellow Pages ad. My counselor told me that guided imagery or creative visualization was very powerful, effective therapy. She told me my mother's numerous marriages meant that I had probably been sexually abused and repressed it. We started guided imagery, which she said was like dreaming when awake and full of symbols and memories that could

be interpreted. I started being anxious around my daughter, afraid that I would have an impulse to sexually abuse her; my therapist pounced on this piece of information as proof of my own suppressed abuse. To recover and to keep from abusing my own daughter, she said I had to recover memories of and heal from my own abuse. I started doing guided imagery at home and "recovering" memories. But the anxiety around my daughter increased, so I got deeper and deeper and deeper into the therapy, trying to get back to "normal." Finally I went into a treatment center and was diagnosed with obsessive/compulsive disorder, placed on medication, and exposed to Alcoholics Anonymous. Both have helped me slowly return to sanity.

This apparently was a case of alcoholism and OCD that was missed entirely by the therapist, who had only one point of view. Obsessive compulsive ruminations are often misdiagnosed as flashbacks (Lipinski and Pope²⁷).

Sometimes it takes months before the patient "gives in" to the therapist's pressure. An example:

Just four months into therapy, after I had been reading books on sexual dysfunction, my therapist told me point blank, "You were sexually abused, probably by your grandfather." I freaked out, went into shock, locked myself in the bathroom. No memories, mind-searching for when, how, who, nothing. Nothing came. I was referred to therapist two. I argued with this therapist because I had no phobias, fears, sexual dysfunctions, although I did have abandonment problems and I don't like to be rejected. After arguing for two or three months with the therapist that I had no memories, I guess I broke. Then he got me to do hypnosis. I left thinking I had been satanically abused, hung up, raped, hot wax poured on me (no scars as such). Over the next few years I had lots of memories of hot wax poured on my face.

(She apparently tried to contact both therapists, but they were not available. She tried to commit suicide and ended up in the ICU. The memories of satanic incest increased. In hypnosis, she recalled that her mother abused her at four months, then her father, and then the satanic rituals began. Then it was uncles, brother, even movie stars, and included pornography and drugs.)

I would tell therapists now and again, "I think I am making it up." He'd tell me no, I wasn't. I was supposed to feel that way because memories were split off. My family life failed. I lost my business. I lost my health. I lived only for therapy, which was going to make me well. I had a memory of having a baby, age 13, killed in a church sacrifice. Went to research it out, talked to friends I knew in eighth grade. Only 60 people in the whole school, and no one remembered anyone being pregnant. Told therapist. He says, "Of course no one remembers a 13-year-old pregnant girl. They are all in denial." (All of these people went into denial, and of course I believed him.) One therapist told me I was MPD. She was someone referred to me by a group who had worked with SRA/MPD. If I had a stomachache she'd ask, "Who lives in the stomach? Would that person talk later?" When I complained that my husband wasn't helping me, the therapist colluded with it, took it and ran with it himself. Told me to leave husband. Afterwards, was told what a wonderful thing I'd done by leaving this man and I'd have a wonderful life, much better than I had had. I'd think, but what's wrong with my life, those years with my husband and kids. I left kids also. Seven months after, I was asking for a divorce. Therapist is telling me to get the divorce. All through this, I felt something is terribly, terribly wrong, but I couldn't place it. Most fears, doubts were blamed on being an MPD or programming from SRA, easy answers. After all, it was me that was sick and not the therapy or therapist. Ran out of money, kicked out cold turkey, praise God!

The preceding citation illustrates the unhappy outcome of this form of therapy in which a patient's personal relationships are destroyed. The problems the patient had on entering therapy had not been alleviated; rather, they had been enormously increased. A generalization that applies to all these patients is that the patients, even though ill before, have been made much worse by this form of treatment. They feel even more worthless and hopeless, and often become suicidal with or without MPD or SRA.

Despite the damaging therapy, many patients' observing self did not disappear totally. The following citation illustrates that the observing self remains somewhat intact, more so in some patients than in others. This case also illustrates the use of hypnosis as a means of generating pseudomemories.

As my memories evolved, I became increasingly confused. My therapist insisted that hypnotically induced memories were true memories. It didn't feel like regular memories to me. Certain aspects of the memories I knew were real, such as particular objects I visualized, etc., but these were pieced together haphazardly, interwoven into a scene of sexual abuse that didn't feel real. I felt always like I was making up a story. This is not to say that I objectively recognized this and was sensible about it. I told the therapist that during hypnosis I felt I was making up a story, trying to create a sexual abuse scene from the true memories I had before therapy of unrelated happenings and the various objects I visualized. Even during hypnotherapy my mind was telling me I was making up a story. They still insisted the memories were true. Along with confusion, I felt great anxiety at not being able to decide what in the world was real. I felt afraid of not believing the memories were true, because the therapists were positive they were, and I was said to need to come out of denial to get out of emotional pain, and also to protect others from my father. I felt like an orphan as my family underwent a change into perverts.

Responding to the question about what influenced the patient's development of pseudomemories, the most important influence was the therapist.

She [the therapist], an incest survivor herself, said to me during one of my earliest appointments, "Like an alcoholic can smell another alcoholic, an incest survivor can smell another incest survivor."

Of course the two therapists I saw were a great influence. I expressed many times that I thought my symptoms (bad self-esteem, sadness, anxiety, compulsive eating, etc.) stemmed from other traumas I clearly remembered, but they (without exaggeration here) rebuked me as being in denial each time. They were unrelenting in pressuring me to believe I'd repressed memories.

Any time I denied an abusive memory, my psychiatrist would become sullen and even hostile. Bringing new or worse memories of abuse to the psychiatrist would be rewarded with praise of my courage and hugs all around.

I received a great amount of attention from the staff and psychiatrists at the psychiatric hospital. My acting-out behavior—attempted escapes (dramatic too!) and wrist slashing—brought lavish attention and great sympathy about what had happened to me as a child.

The majority of respondents mentioned groups as a significant influence. Twenty-eight (70%) of the subjects participated in a survivor group. Another 22 (55%) belonged to a twelve-step group. Sometimes these were not in group therapy, but with other patients on the service.

I was even introduced to four other women who were SRA survivors and encouraged to be friends with them. It was an unbelievable roller coaster ride.

I think the biggest influence was the people that were in group therapy. That was our life, those were our friends, our family. If we had doubts, there was always someone from group to tell us we were in denial, that we needed to trust our therapist in order to get well. Having [the therapist] threaten me if I ever left didn't help matters either. He told me that if I ever left, he'd call my parents and tell them everything.

Group therapy members were a big influence, because some were going through the same ordeal and were suffering in similar ways. Together we were dutifully trying to overcome our doubts. One told me that she had trouble believing her repressed memories are real but feels more convinced when she hears me talk about mine.

Other influences were books, films, television, and talk shows. Thirty-two (80%) of the respondents read self-help literature. These books included *The Courage to Heal*, *Sybil*,²⁸ *Selling Satan*,²⁹ and *Michelle Remembers*.³⁰ Others reported seeing films such as "Rosemary's Baby" and "When Rabbit Howls." One respondent mentioned the television film "Amelia's Story," which was shown to a group of patients on the first night of her hospitalization. Another required movie was "Nuts" with Barbra Streisand. One other respondent reported being influenced by the "Sixty Minutes" segment dealing with the Eileen Franklin story. Of all these, *The Courage to Heal* was most commonly read and was viewed by many retractors as having the greatest influence.

The main influence on my life was my doctor. He became a controlling force, telling me to only trust him, he would never hurt me, never leave me. He provided reading materials, books, articles on MPD, PTSD, Satanism. He had me hospitalized often to keep me in control. There I met several women with the same diagnosis. We

would share stories and compare notes. We became close friends. We watched mostly talk shows that supported our views, especially "Geraldo." I was asked to appear on "Geraldo" as an "expert on Satanic cults," but my physician told me my family would hunt me down and kill me if I did this. I constantly scanned the airwaves to support my ridiculous fantasy, make sense of my life. Horribly enough, there was plenty out there.

Following the birth of my first child, I drank alcohol regularly. On one occasion, while drinking, I watched the movie "Sybil." Interestingly, my personality resembled Sybil's personality. What an amazing coincidence!!

Discussion

A number of themes emerged from studying the answers to the open-ended questions as the recanters described the process of developing pseudomemories. These themes are:

1. There was enormous positive dependent transference on the therapist. His or her attention and support meant everything to the patient. Usually the therapist rewarded the emergence or recovery of memories.
2. The subjects needed an explanation for their mental and emotional disturbances; there was a search for meaning.
3. The subjects believed they needed to work hard at therapy; that therapy was salvation; that without therapy they would go crazy; with therapy, there was some hope. Eventually, of course, the hope led to disillusionment and demoralization as they became sicker and sicker.
4. In most instances the therapy was a form of miscarried therapy—stated more bluntly, a form of malpractice. The subjects or patients were already ill and then were made much worse.
5. The subjects felt even more worthless, hopeless, and suicidal, with or without MPD or SRA.

6. The observing self did not disappear totally. Each of us has a participating self and an observing self, and this observing self, to some extent, remained intact. This is an item that varied from subject to subject.
7. In the process, there were some who made their identity out of becoming a survivor and/or a victim.

The striking nature of the patient–therapist relationship was evident in the closed questions as well. Retractors described therapy that failed to address their presenting problems and instead fostered a dependent relationship. Treatment in these cases was diverted toward the recovery of memories of sexual abuse.

This type of therapeutic relationship, the reliance on questionable techniques, cultural influences, and patient vulnerabilities all play a part in the recovery of pseudomemories. In the assessment of recovered memories, these factors must be taken into consideration. Many retractors reported having had memories of events that, if accurate, are likely to have been verifiable. Abuse by more than one perpetrator (in this study, as many as seven), Satanic ritual abuse, and extremely violent abuse clearly would fall into this category.

Almost half of our subjects reported memories of SRA. As Spanos has noted, reports of Satanic ritual abuse are important to researchers because of the absence of supporting data for these events. Repeated acts of ritual abuse by many perpetrators and the level of conspiracy required to support these acts simply have not been substantiated (Victor;³¹ Lanning³²).

Very early childhood memories were often reported, with 23 subjects reporting that their remembered abuse began at age three or earlier. These events would have occurred during the span of infantile amnesia.

Because of the devastation to the lives of retractors and their disillusionment with therapy, some have turned to the courts. A number of cases involving suits by retractors against their former therapists are in progress. Some of them listed by Anita Lipton of the FMS Foundation are as follows:

Burgus et al. v. Baughman, Braun et al.

Gavigan et al. v. Connors et al.

Mark et al. v. Zulli et al.

Pasley et al. v. Therapist.

Roberts v. Los Altos Hospital et al.

Shanley v. Peterson et al.

Smiley v. House of Hope, Inc., et al.

There is no evidence that there are 150 cases of recanters suing their therapists, as was reported by Katy Butler in the *Family Therapy Networker*.³³

At this point it is difficult to know the precise number of lawsuits that have been filed, let alone those that are being considered. (The senior author has been an expert witness or consultant in two cases against pediatricians accused of sexual molestation by patients on the basis of recovered "repressed" memories. Both were decided in favor of the doctors.)

The Ramona case³⁴ opened the possibility that someone other than the aggrieved patient has the legal right to be a plaintiff. The Althaus case (*Althaus v. Cohen*³⁵) in Pittsburgh added ammunition to this possibility. However, the parents were joined in the lawsuit by their teenage daughter, who had originally brought suit against them (the judge had thrown out the case). The Althaus family was awarded \$272,000 by a Pennsylvania jury in December 1994.

Another example of a third-party suit is one initiated by the parents of a 23-year-old woman who entered therapy and

while under hypnosis with her unlicensed therapist believed she had discovered repressed memories of sexual abuse by an older sibling. The Sullivans (*Sullivan v. Cheshire*³⁶) sought recompense under various theories for the loss of their daughter's society, for the intentional and reckless infliction of emotional distress, and for the injury to their family relationship.

Two other cases have been decided in favor of retractors: *Abney et al. v. Spring Shadows Glen Hospital et al.*³⁷ and *Halbrooks et al. v. Moore et al.*³⁸ The Abney case was settled with no published opinion. In the Halbrooks case, Ms. Halbrook was awarded \$90,000 for past medical expenses, lost wages, mental anguish, pain and suffering. These cases cited inaccurate diagnosis (including victimization by satanic ritual abuse) and improper exposure to support groups.

Conclusion

It is our hope that the schism between the recovered-memory therapists, on the one hand, and skeptics of recovered memory, on the other, can lead to an understanding that the major issue is good therapy versus bad therapy. As we collect more and more data on the types of therapies involved in recovered-memory therapy, we cannot avoid the conclusion that this is bad therapy. Enormous harm is being done to these patients and to their families. Patients get sicker instead of better, and huge sums of money are spent for years of therapy based on the erroneous assumption that the recovery of memories of sexual abuse in childhood is a healing process. This is based on Freud's original idea that abreaction of these traumatic events would be curative. The methods of 1895 didn't work then; why should we expect them to work a century later?

Often the recovered-memory debate is reduced to a discussion concerning therapeutic versus forensic approaches to

treatment. Unfortunately this argument diverts attention from the issue of appropriate practices regarding recovered memories of sexual abuse. While the debate rages on, the retractors described in this paper are attempting to rebuild their lives.

Notes

1. Woodward, K.L., Annin, P. and Cohen, A., "Was it real or memories?" *Newsweek*, March 14, 1994, pp. 54-55.
2. *Ramona v. Isabella*, Superior Court of California, In and for the County of Napa, Case No. 61898 (Special Verdict, May 13, 1994). In this case, the plaintiff sued his daughter's therapists for harm he suffered as a result of techniques used in her therapy. A jury found two licensed therapists negligent in providing health care by implanting or reinforcing false memories of sexual molestation by the plaintiff's father.
3. Although Eileen's father was found guilty, the verdict was overturned on appeal because every bit of Eileen's supposed eyewitness testimony had been printed in newspapers in the months and years following the murder. The case has been exhaustively researched by H.N. McLean in *Once Upon a Time in America: A True Story of Memory, Murder, and the Law* (New York: Harper Collins, 1993). Although apparently it played no part in the appeal, McLean points out that Eileen's mother and her sister Janice had often discussed their suspicion that George Franklin had been the murderer. Janice had actually talked to the police about her suspicions, making it improbable that Eileen had repressed memories of the murder.
4. Calof, D., "Making Memories," *Frontline*, PBS, April 4 and 11, 1995.
5. Pope, Jr., H.G. and Hudson, J.I., "Can Memories of Childhood Sexual Abuse Be Repressed?" *Psychological Medicine*, 25, pp. 121-126, 1995. Pope and Hudson set forth two criteria for determining the proof of "true positives": evidence that the traumatic event actually occurred, and the demonstration that the victim actually developed psychogenic amnesia. The authors conclude that the studies that purport to demonstrate the development of psychogenic amnesia or "repression" for sexual abuse that occurred years earlier are not convincing because of methodological errors.
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16. Loftus, E.F. and Ketchum, C., *The Myth of Repressed Memory*, St. Martin's Press, New York, 1994.
17. Ofshe, R. and Watters, E., *Making Monsters: False Memory, Psychotherapy and Sexual Hysteria*, Scribner's, New York, 1994.
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21. Goldstein, E. and Farmer, K., *True Stories of False Memories*, Sirs Publishing, Boca Raton, FL, 1993.
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26. *Ibid.*, p. 93.
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34. *Supra* note 2.
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37. Abney et al. v. Spring Shadows Glen Hospital et al., District Ct., Harris Co., Texas, Case No. 93-054106.
38. Halbrooks et al. v. Moore et al., District Court, Dallas Co., Texas, Case No. 92-11849.