




1996

Therapists' Liability to the Falsely Accused for Inducing Illusory Memories of Childhood Sexual Abuse - Current Remedies and a Proposed Statute

Joel Jay Finer
Cleveland State University

Follow this and additional works at: <https://engagedscholarship.csuohio.edu/jlh>

 Part of the [Evidence Commons](#), and the [Law and Psychology Commons](#)

How does access to this work benefit you? Let us know!

Recommended Citation

Joel J. Finer, Therapists' Liability to the Falsely Accused for Inducing Illusory Memories of Childhood Sexual Abuse - Current Remedies and a Proposed Statute, 11 J.L. & Health 45 (1996-1997)

This Article is brought to you for free and open access by the Law Journals at EngagedScholarship@CSU. It has been accepted for inclusion in Journal of Law and Health by an authorized editor of EngagedScholarship@CSU. For more information, please contact library.es@csuohio.edu.

THERAPISTS' LIABILITY TO THE FALSELY ACCUSED FOR
INDUCING ILLUSORY MEMORIES OF CHILDHOOD
SEXUAL ABUSE—CURRENT REMEDIES AND A PROPOSED
STATUTE

JOEL JAY FINER¹

A father hired a private investigator after his [adult] daughter reportedly uncovered a repressed memory and accused him of incest. The investigator [visited] the therapist complaining [of] nightmares and trouble sleeping. *On the third visit, the therapist told [her] that she was an incest survivor. 'She [said] I could not remember because my brain had blocked the memory that was too painful to deal with.'*

She read the list of symptoms of incest survivors, [shook] her head yes as if this was confirmation of her diagnosis. She recommended incest survivor groups. *In the fourth session, the diagnosis of probable incest victim was confirmed [based on] "classic symptoms" of body memory and sleep disorders. When [I claimed] no memory of such events, the therapist assured me that this was often the case.*²

I. INTRODUCTION	47
II. RECOVERED MEMORY: CURRENT LITIGATION	49
A. <i>Suits By Survivors of Childhood Sexual Abuse</i>	49
B. <i>Suits By Patients Against Therapists</i>	54

¹Professor of Law, Cleveland-Marshall College of Law; B.B.A., City College of New York; M.A., LL.B., Yale University. Copyright, Joel Jay Finer 1997.

This Article was supported by a grant from the Cleveland-Marshall Education Fund which allowed me the time to research and write it.

I appreciate the valuable feedback from the following colleagues (who read an early draft): Susan Becker, Patricia Falk, and Veronica Dougherty. Journalist-friend Michael Drexler was also very helpful. Mr. Aaron O'Brien, a law student, provided valuable help with line-editing of an early draft. Very special thanks to my spouse, Joan G. Finer, who helped in many tangible and intangible ways. The support of a special person, C.M., made an important difference as well.

Finally, this work might not have been written without the encouragement of my colleague, Professor Stephen J. Werber, the Journal's faculty advisor and Ms. Kate Ryan, Editor-in-Chief of the Journal of Law and Health. Ms. Ryan's extraordinary patience and superb handling of my several revisions of this work is deeply appreciated.

²Elizabeth F. Loftus, *The Reality of Repressed Memories*, 48 AM. PSYCHOLOGIST 518, 530 (1993). Reconstructed for consistency of pronouns and tightening of material, as cited material combines speech and new text. Nothing of substance has been changed.

Note: all italics herein are supplied by this author unless otherwise indicated.

	C. <i>Suits By Accused Child Molesters Against Therapists</i>	56
III.	DEVASTATING IMPACT OF FALSE ACCUSATIONS	64
IV.	PREMISES OF RECOVERED MEMORY THERAPY	66
V.	REPRESSION AND MEMORY RECOVERY	68
	A. <i>Input/Perception</i>	68
	B. <i>Storage</i>	70
	C. <i>Retrieval/Recall</i>	75
VI.	RISKING INDUCEMENT OF FALSE MEMORIES OF ABUSE	82
	A. <i>Untenable Diagnostic Assumptions of Recovered Memory Therapy</i>	83
	B. <i>Suggestive Aspects of Recovered Memory Therapy</i>	85
	1. <i>Situational Factors</i>	85
	2. <i>Hypersuggestive Practices</i>	90
	a. <i>Hypnosis and Drugs</i>	90
	b. <i>Guided Imagery and Visualization</i>	91
	c. <i>Use of "Support" Groups</i>	92
	d. <i>Communications by Therapist</i>	93
	C. <i>Inducement of Illusory Memories</i>	93
VII.	THE BOWMAN & MERTZ/ (HARVARD LAW REVIEW) THESIS	98
VIII.	UNDUE SUGGESTIVENESS IN OTHER AREAS OF THE LAW	101
IX.	ANALYSIS OF LEGAL DOCTRINE	102
	A. <i>Physicians' Duties to Third Parties</i>	102
	1. <i>Tarasoff</i>	102
	2. <i>Communicable Diseases</i>	105
	3. <i>Other Duties to Third Parties</i>	106
	B. <i>Negligent Infliction of Emotional Distress</i>	108
	C. <i>Reckless Infliction/Tort of Outrage</i>	110
	D. <i>Defamation</i>	112
	E. <i>Other Arguably Relevant Doctrines</i>	115
	1. <i>Informed Consent</i>	115
	2. <i>Harm to Family</i>	115
	3. <i>Contract</i>	117
X.	THE CONCEPT OF DUTY	117
	A. <i>Foreseeability of Harm to Plaintiff</i>	119
	B. <i>Degree of Certainty that Plaintiff Suffered Injury</i>	119
	C. <i>Proximity of the Injury to the Conduct</i>	119
	D. <i>The Moral Blame Attached to the Defendant's Conduct</i>	119
	E. <i>The Policy of Preventing Future Harm</i>	119

F. <i>The Extent of the Burden to the Defendant and Consequences to the Community of Imposing Liability</i>	120
XI. REASONS FOR PROPOSED LEGISLATION	121
XII. AVOIDING A CHILLING EFFECT ON TREATMENT OF POSSIBLE ABUSE-SURVIVORS	122
A. <i>Leaving Room for Ordinary Error</i>	122
B. <i>Desirability of a Bright Line Rule</i>	124
XIII. PROPOSED STATUTE	125
XIV. COMMENTARY ON PROPOSED STATUTE	128
XV. SOME EVIDENTIARY CONSIDERATIONS	131

I. INTRODUCTION

No issue in law and psychiatry has engendered such controversy as the current debate over whether experiences of childhood sexual abuse (CSA) are subject to repression for decades and eventually "recoverable" in therapy long after the event.³ One principal legal issue has been whether such "recovery" justifies the application of the "recent discovery" basis for tolling the statute of limitations, an issue which becomes significant when an adult psychotherapy patient sues her ostensible molester (often her father or other family member).

When these actions first reached the courts, many jurisdictions accepted the claim that the experience of childhood sexual victimization was subject to repression and subsequently recoverable in reliable detail decades later. Soon after these suits were entertained, highly credentialed and widely respected scholars and researchers questioned certain premises of the repressed memory/recovered memory school. Some questions that have been raised are: a) whether there is a process of repression that removes early traumatic experiences from conscious awareness; b) whether the experiences remain relatively intact in the untapped repressed memory or are subject to unconscious revision and distortion over the years (confabulation); and c) whether such memories can be recovered years later in therapy or, on the other

³See Gary M. Ernsdorff & Elizabeth F. Loftus, *Let Sleeping Memories Lie? Words of Caution About Tolling the Statute of Limitations in Cases of Memory Repression* 84 J. CRIM. L. & CRIMINOLOGY 129 (1993); R. Christopher Yingling, Note, *The Ohio Supreme Court Sets the Statute of Limitations and Adopts the Discovery Rule for Childhood Sexual Abuse Actions: Now It Is Time for Legislative Action!* 43 CLEV. ST. L. REV. 499 (1995); Norrie Clevenger, Note, *Statute of Limitations: Childhood Victims of Sexual Abuse Bringing Civil Actions Against Their Perpetrators After Attaining the Age of Majority* 30 J. FAM. L. 447 (1991/1992); Ann Marie Hagen, Note, *Tolling the Statute of Limitations for Adult Survivors of Childhood Sexual Abuse*, 76 IOWA L. REV. 355 (1991); Jorge L. Carro & Joseph V. Hatala, *Recovered Memories, Extended Statutes of Limitations and Discovery Exceptions in Childhood Sexual Abuse Cases: Have We Gone Too Far?* 23 PEPP. L. REV. 1239 (1996).

hand, the suggestive techniques used in some therapies are likely to create illusory memories of CSA.

In view of the emerging scholarly questions, courts have begun to push the pendulum in the other direction, and are increasingly declining to accept recovered memory claims as a basis of tolling statutes of limitations.⁴

Legal actions have also been brought against therapists by persons accused of child molesting by adult patients.⁵ These suits have challenged the concept of repression, contending that the therapist, by use of hypersuggestive techniques such as hypnosis and guided imagery, induced pseudomemories of childhood abuse in the minds of the accusing patients.

While sexual abuse of children has always been a real and horrific phenomenon⁶ (a fact unrecognized until relatively recently), *the issue this Article will explore is whether, and under what circumstances, a person wrongly accused has, or should have, one or more causes of action against a therapist for culpably inducing the pseudomemory.*⁷ To refine and make more rational legal actions by persons falsely accused of childhood sexual molestation (arguably justified under existing legal doctrine), this Article will propose specific legislation authorizing a lawsuit under codified circumstances and conditions.

The recommended statutory provisions *authorize a lawsuit where gross and irresponsibly hypersuggestive techniques and verbalizations are utilized by a therapist; techniques that create substantial risks of inducing specious memories and false accusations of odious sexual crimes purportedly committed by the plaintiff.* Liability would not be imposed for ordinary negligence. Nor would it be imposed where the patient presented with some memories of CSA. Certain screening devices are proposed to prevent a non-meritorious suit going forward even to pre-trial discovery stages. Additional devices including *in-camera* examination of materials are designed to protect the privilege of confidentiality to the extent appropriate. Finally, in any suit by a person claiming to be falsely accused, the therapist may prevail, not only if the plaintiff fails to prove the charges, but also if the therapist can establish that the plaintiff was indeed culpable of CSA.

⁴See *infra* notes 8-40 and accompanying text.

⁵See *infra* notes 41-78 and accompanying text.

⁶See *infra* notes 79-82 and accompanying text.

⁷On the subject of suits by falsely accused plaintiffs, see Cynthia Grant Bowman & Elizabeth Mertz, *A Dangerous Direction: Legal Intervention Sexual Abuse Survivor Therapy*, 109 HARV. L. REV. 549 (1996); Shelia F. Rock, Note, *A Claim for Third Party Standing in Malpractice Cases Involving Repressed Memory Syndrome*, 37 WM & MARY L. REV. 337 (1995); Rola J. Yamini, Note, *Repressed and Recovered Memories of Child Sexual Abuse: The Accused as "Direct Victim,"* 47 HASTINGS L.J. 551 (1996); Jeffrey A. Mullins, Note, *Has Time Rewritten Every Line?: Recovered-Memory Therapy and the Potential Expansion of Psychotherapist Liability* 53 WASH. & LEE L. REV. 763 (1996).

For fine treatments of the law relating to the subject of "repressed memories" and "recovered memories" see, e.g., Shelia Taub, *The Legal Treatment of Recovered Memories of Child Sexual Abuse*, 17 J. LEGAL MED. 183 (1996); Julie M. Kosmond Murray, Comment, *Repression, Memory, and Suggestibility: A Call for Limitations on the Admissibility of Repressed Memory Testimony in Sexual Abuse Trials*, 66 U. COLO. L. REV. 477 (1995).

It is important to note at the start, that applying the recommended remedial principles (principles of justice for a wrongly accused person and a shattered family) should have very little, if any, effect on the very important work of providing treatment for *actual* victims of childhood incest. The vast majority of victims either have always realized that they were victims or at least have fragmentary memories of sexual victimization when they enter therapy. Where the accusing patient is in one of those categories from the start of therapy, no lawsuit is authorized against the therapist under the principles and rules set out below.

II. RECOVERED MEMORY: CURRENT LITIGATION

A. Suits by Survivors of Childhood Sexual Abuse

As noted above, in recent years, courts have permitted lawsuits claiming CSA to be brought years after the occurrence of the alleged abuse. The threshold issue has been whether to treat the statute of limitations as having run or as having been tolled during a period where the experience of abusive behavior was "repressed" in the memory. A number of courts permitting such suits have utilized the "delayed discovery" exception to the statute of limitations. Such courts hold that, since the plaintiff did not *discover* her injury⁸ until she recovered her memory, often in the course of psychotherapy, the statute of limitation did not begin to run until such recovery.⁹

Courts permitting actions on the theory of discovery analogize to the "delayed discovery" rule as it operates in medical malpractice, product liability, and like cases. A patient who was unaware that sponges were left in his body cavity during surgery fifteen years earlier, and learns of it for the first time during present surgery, is not barred by the statute of limitations. So, too, it is said that the patient in therapy had no awareness of the child abuse until the repressed memory emerged in therapy. Often, these repressed memories osten-

⁸Throughout this Article the female pronoun will be used to refer to the patient. This usage reflects both the facts that the considerable majority of sexually abused children and of patients electing psychotherapy are female. The gender designation of the therapist will vary.

⁹*See, e.g.,* Hewczuk v. Sambor, 803 F. Supp. 1063 (E.D. Pa. 1992) (applying Pennsylvania law); Hoult v. Hoult, 792 F. Supp. 143, 145 (D. Mass. 1992) (applying Massachusetts law); Johnson v. Johnson, 701 F. Supp. 1363, 1367 (N.D. Ill. 1988) (issue of fact as to when plaintiff knew or should have known) (applying Illinois law); Evans v. Eckelman, 265 Cal. Rptr. 605 (Cal. Ct. App. 1990) (suit against foster parent); Farris v. Compton, 652 A.2d 49, 52 (D.C. App. 1994) (suit by adult sisters against brother); Phillips v. Johnson, 599 N.E.2d 4, 7 (Ill. Ct. App. 1992) (suit by niece against uncle); Doe v. Cherwitz, 518 N.W.2d 362, 364 (Iowa 1994); Sheehan v. Sheehan, 901 S.W.2d 57 (Mo. 1995) (en banc); McCollum v. D'Arcy, 638 A.2d 797, 799 (N.H. 1994) (suit by fifty-year-old plaintiff against parents); Osland v. Osland, 442 N.W.2d 907 (N.D. 1989); Ault v. Jasko, 637 N.E.2d 870, 872 (Ohio 1994).

sibly come to light during hypnosis or when other suggestive techniques are employed which create a substantial risk of inducing "false memories."¹⁰

Over half of the states have enacted or amended legislation since the mid 1980s, addressing, and usually lengthening, statutes of limitations, as well as dealing with other issues regarding CSA claims.¹¹ The latest wave of legislation tends to embody provisions designed to protect against frivolous or fraudulent claims, provisions for example, requiring corroboration,¹² pre-trial certificates of merit,¹³ and at least preliminary shielding of the identity of the accused defendant.¹⁴

As the number of CSA suits multiplied, and as scholars and researchers gave some of the issues their attention, books were published warning of the dangers of accepting "repressed" memory claims.¹⁵ The significant concerns were: a)

¹⁰The use of the term "false memories" is not meant to impugn the integrity of the patient. Because of the power of certain suggestive techniques, such as hypnosis, the patient is completely convinced of the veracity of the memory. False memories may be considered "honest lies."

Sometimes the perceived memories come to consciousness outside or prior to therapeutic involvement, a situation which does not implicate the issues addressed herein.

¹¹See ALASKA STAT. § 09.10.140 (1994); ARK. CODE ANN. § 16-56-130 (Michie Supp. 1995); CAL. CIV. PROC. CODE § 340.1 (West Supp. 1996); COLO. REV. STAT. ANN. § 13-80-103.7 (West Supp. 1995); CONN. GEN. STAT. ANN. § 52-577d (West 1991); GA. CODE ANN. § 9-3-33.1 (Michie Supp. 1995); ILL. ANN. STAT. ch. 735, para. 513-202.2 (Smith-Hurd 1992); IOWA CODE ANN. § 614.8A (West Supp. 1995); KAN. STAT. ANN. § 60-523 (1994); ME. REV. STAT. ANN. tit. 14, § 752-C (West Supp. 1995); MASS. GEN. LAW ANN. ch. 260, § 4C (West Supp. 1995); MINN. STAT. ANN. § 541.073 (West Supp. 1996); MO. ANN. STAT. § 537.046 (Vernon Supp. 1996); MONT. CODE ANN. § 27-2-216 (1995); NEV. REV. STAT. § 11.215 (1993); N.J. STAT. ANN. 2A:61 B-1 (West Supp. 1995); N.M. STAT. ANN. § 37-1-30, as amended by Act of Apr. 5, 1995 N.M. LAWS 626; OKLA. STAT. ANN. tit. 12, § 95 (West Supp. 1996); OR. REV. STAT. § 12.117 (1995); R.I. GEN. LAWS § 9-1-51 (Michie Supp. 1995); S.D. CODIFIED LAWS § 26-10-25 (1992); UTAH CODE ANN. § 78-12-25.1 (Michie Supp. 1995); VT. STAT. ANN. tit. 12, § 522 (Michie Supp. 1995); VA. CODE ANN. § 8.01-249 (Michie Supp. 1995); WASH. REV. CODE ANN. § 4.16.340 (West Supp. 1996); WYO. STAT. § 1-3-105(b) (Michie Supp. 1995).

¹²See, e.g., COLO. REV. STAT. ANN. § 13-80-103.7; N.M. STAT. ANN. § 37-1-30(A)(2) (claim must be corroborated by "competent medical or psychological testimony"); OKLA. STAT. ANN. tit. 12, § 95(6) (requiring "objective verifiable evidence [that] should include both proof that the victim had psychologically repressed the memory of the facts upon which that claim was predicated and that there was corroborating evidence that the sexual abuse . . . actually occurred").

¹³CAL. CIV. PROC. CODE § 340.1(e)(1) (West Supp. 1996).

¹⁴CAL. CIV. PROC. CODE § 340.1(k)(1) (West Supp. 1996).

¹⁵The works include: ELIZABETH LOFTUS & KATHERINE KETCHAM, *THE MYTH OF REPRESSED MEMORY: FALSE MEMORIES AND ALLEGATIONS OF SEXUAL ABUSE* (1994); MICHAEL D. YAPKO, *SUGGESTIONS OF ABUSE: TRUE AND FALSE MEMORIES OF CHILDHOOD SEXUAL TRAUMA* (1994); RICHARD OFSHE & ETHAN WATTERS, *MAKING MONSTERS: FALSE MEMORIES, PSYCHOTHERAPY AND SEXUAL HYSTERIA* (1994); see also LAWRENCE WRIGHT, *REMEMBERING SATAN* (1995).

the uncertainty regarding the phenomenon of repression; and b) the extremely suggestive techniques utilized by some incest survivor therapists. The scholars expressed considerable worry that apparent memories of abuse could be false or illusory.

As doubts were expressed about the authenticity and reliability of "recovered memories" of CSA, and as earlier and recent research came to judicial attention, courts increasingly expressed concerns about reliability, and began requiring corroborating evidence,¹⁶ and admitting expert testimony.¹⁷

Courts and individual judges have been more *explicitly questioning* the reliability of claims of "recovered memory."¹⁸ For example, the Tennessee Court of Appeals observed:

we find that there is simply too much indecision in the scientific community as to the credibility of repressed memory. In general, psychologists have not come to an agreement as to whether repressed memories may be accurately recalled or whether they may be recalled at all. Therefore, it goes without saying that the judiciary does not have the resources needed to make an accurate ruling on the validity of a psychological theory about which professionals in the field disagree. *Also, there is considerable doubt about the reliability of memories that are recalled with the assistance of a therapist or psychoanalyst.*¹⁹

In a dissent to a decision holding that the statute of limitations was tolled where memory was "repressed" and later "recovered," Justice Wright of the Ohio Supreme Court argued, after perusing the literature, that

the methods used by psychologists and psychoanalysts to retrieve repressed memories are unreliable and are not sufficiently established to have gained a general acceptance in the fields of either forensic or clinical psychology. . . .

¹⁶See *Meiers-Post v. Schafer*, 427 N.W.2d 606 (Mich. Ct. App. 1988); see also *Olsen v. Hooley*, 865 P.2d 1345 (Utah 1993) (expressing concern that the methods used to revive the memories "may induce memories of events that never happened"); *Petersen v. Bruen*, 792 P.2d 18 (Nev. 1990).

The supreme courts of Texas and Michigan have required that the claim of CSA be objectively verifiable. *S.V. v. R.V.*, 933 S.W.2d 1 (Tex. 1996); *Lemmerman v. Fealk*, 534 N.W.2d 695 (Mich. 1995).

¹⁷See, e.g., *Commonwealth v. Crawford*, 682 A.2d 323 (Pa. Super. 1996). See generally *Monica L. Hayes, The Necessity of Memory Experts for the Defense in Prosecutions for Child Sexual Abuse Based Upon Repressed Memories*, 32 AM. CRIM. L. REV. 69 (1994).

¹⁸In *Kelly v. Marcantonio*, 678 A.2d 873 (R.I. 1995), the Rhode Island Supreme Court held that before it could determine whether a specific "repressed recollection" tolled the statute of limitations, the trial court need first determine whether the theory of repressed recollection constitutes a "scientifically accepted and valid theory." *Id.*

¹⁹*Hunter v. Brown*, No. 03A01-9504-CV-00127, 1996 WL 57944 (Tenn. App. Feb. 13, 1996).

[T]here is little agreement among scientists, about whether a repressed memory can be retrieved and, if it can, whether the memory retrieved is an accurate product.²⁰

He referred to "a growing body of evidence indicating that many of these 'repressed' memories of sexual abuse may be implanted in patients' minds, unwittingly or otherwise, by therapists' suggestions."²¹

In some cases these questions arose under doctrines such as *Daubert* and *Frye*, requiring scientific evidence to meet tests of reliability²² and/or acceptance in the appropriate scientific community.²³

The Texas Supreme Court recently reviewed at length studies on memory in general and recovered memory in particular. It concluded that there is no reliable way of distinguishing accurate from false memories of CSA.²⁴

The available scientific and clinical evidence *does not allow accurate, inaccurate, and fabricated memories to be distinguished in the absence of independent corroboration.* [It found that] *the preconceptions of the therapist, the suggestibility of the patient, the aleatory nature of memory recall, and the need to find a clear culprit for a diffuse set of symptoms may lead to false memories.* Or they may not.²⁵

In addition to the therapist's "possible confirmatory bias, her technique to recover memories may have increased [the patient's]. . . suggestibility."²⁶

In another recent case rejecting the claim that repression and later recovery of memory tolled the statute of limitations the Supreme Court of Maryland wrote: "After reviewing the arguments on both sides of the issue, we are unconvinced that repression exists as a phenomenon separate and apart from the normal process of forgetting. Because we find these two processes to be indistinguishable scientifically, it follows that they should be treated the same legally."²⁷

²⁰Ault v. Jasko, 673 N.E.2d 870, 875-76 (Ohio 1994) (citations omitted).

²¹*Id.* at 876.

²²*Daubert v. Merrell Dow Pharms., Inc.*, 509 U.S. 579 (1993).

²³*Frye v. United States*, 293 F. 1013 (D.C. Cir. 1923).

²⁴*S.V. v. R.V.*, 933 S.W.2d 1 (Tex. 1996).

²⁵*Id.* at 56-57 (quoting from AUSTRALIAN PSYCHOLOGICAL SOCY, BD. OF DIRECTORS, GUIDELINES RELATING TO THE REPORTING OF RECOVERED MEMORIES § C.I. (1994)).

²⁶*Id.* at 59.

²⁷*Doe v. Maskell*, No. 102, 1996 WL 426528 (Md Ct. App., July 29, 1996). The Supreme Court of Pennsylvania also recently held that the discovery rule was inapplicable for an action based on ostensible recovered memory of CSA. *Pearce v. Salvation Army*, 674 A.2d 1123 (Pa. Super. Apr. 17, 1996); *but see Shahzade v. Gregory*, 923 F. Supp. 286, 287-88 (D. Mass. 1996); *see also Isely v. Capuchin Province*, 877 F. Supp. 1055, 1066 (E.D. Mich. 1995). *Cf. Logerquist v. Danforth*, No. 2 CA-CV 96-0046, 1996 WL 563863 (Ariz. App. Div. 2 Oct. 3, 1996) (of some interest is the court's agreement "that a plaintiff who allegedly was sexually abused as a child but during minority repressed all memories of the abuse until adulthood should have the opportunity to invoke the discovery rule,"

In an aggravated felonious assault case where the victims had no memory of the ostensible assaults for several years, but "recovered" their memories in psychotherapy, the New Hampshire Supreme Court refused to admit the testimony of the alleged victims.²⁸ The court, after considering a wide range of studies and evidence, concluded that "*the phenomenon of memory repression, and the process of therapy to recover the memories, have not gained general acceptance in the field of psychology and are not scientifically reliable.*"²⁹

Accordingly, the testimony was precluded by the *Frye* test requiring that evidence submitted as scientific must be accepted in the scientific community.³⁰ Other courts in criminal prosecutions have required the trial judge to "exercise a gatekeeping function and hold a preliminary evidentiary hearing outside the presence of the jury in order to determine whether such evidence is reliable and whether the situation is one on which expert testimony is appropriate."³¹

The most celebrated criminal case using repressed/recovered memory testimony was George Franklin's prosecution for a murder committed twenty years earlier. In 1969, the body of an eight-year-old girl, Susan Nason, was found with its skull crushed. In 1989, Eileen Franklin-Lipsker, the defendant's daughter, claimed remembering for the first time, witnessing her father murder her friend, Susan. Although Franklin-Lipsker testified that the memory returned while looking at her own eight-year-old daughter in a certain light, she had given several other versions of the circumstances of the recall, including attributing it to hypnosis while in therapy. Ms. Franklin-Lipsker testified from her "recovered memory" that she had witnessed her father rape her friend and bludgeon her to death.

In 1995, Franklin's conviction was set aside on the ground that news accounts, including many of the details testified to by Ms. Franklin-Lipsker, were erroneously excluded. Her testimony could have been influenced by such news accounts, including a televised video of the crime scene. The state declined to re prosecute.

while prefacing that proposition with the words "[a]ssuming the trial court determines that evidence of the repressed memory is admissible. . . .").

²⁸State v. Hungerford, Nos. 94-S-045 to 94-S-047, 93-S-1734 to 93-S-1936, 1995 WL 378571 (N.H. May 23, 1995) (J. Groff).

²⁹*Id.* at *1.

³⁰While reliability of recovered memories is central to the present analysis, the substantive and procedural issues regarding application of doctrines of *Daubert*, *Frye*, etc., are only indirectly relevant.

More to the point is the state of scientific, experimental, clinical, and neurological evidence on issues of reliability. Particularly important to the present thesis is the impact of certain practices by therapists on such reliability; even more central are the kind of practices that create a substantial risk of producing false memories in the mind of the patient.

³¹State v. Quattrocchi, 681 A.2d 879, 884 (R.I. 1996).

B. Suits by Patients against Therapists

Over 300 patients have retracted charges against parents and others. "Retractors have come forward with well-validated accounts of suggestive, abusive therapy that led to bogus memories," and to several malpractice suits against therapists, where 22 retractors have won judgments and legal settlements ranging from \$120,000 to more than \$5 million.³²

In one such case, a jury awarded plaintiff \$2.6 million, after she testified that the therapist diagnosed multiple personality disorder and told her she must have been repeatedly sexually abused by relatives.³³ The therapist told her she could not remember the abuse because it was repressed, but to be helped she would have to recover such memories.³⁴

In a Colorado suit by a patient who sought therapy for treatment of depression, the therapist used hypnosis and a number of other suggestive techniques to help the patient "recover memories" of being incestuously abused by her father. Eventually the patient had glimmers of memories that escalated into recollections of weekly sexual assaults until she "remembered" that her parents sold her into child prostitution. When she expressed doubts about the reality of these memories, the therapist suggested that such doubts proved the severity of the trauma. "She told me that one of every three women are incest victims. . . . I questioned everything. . . . But she would get angry and say, 'Why don't you just accept this? You want to get better, don't you?' Little by little, I began to believe it."³⁵

Thereafter, the patient deteriorated into psychotic depression, attempted suicide, and required hospitalization. "By then, I wanted to die," she said. "If my father did this to me, I didn't want to live."³⁶ Following his daughter's accusations, the father suffered four strokes. At the trial for malpractice brought by the patient, the defendant made no claim that the father had actually committed the abuses, or that the memories were authentic.³⁷

University of Pennsylvania psychiatrist, Dr. Robert Sadoff writes of a Minnesota case in which

a jury found that a psychiatrist had . . . failed to obtain the requisite informed consent from the patient before embarking on an

³²Katy Butler, *The Latest on Recovered Memory*, FAMILY THERAPY NETWORKER 36 (Nov./Dec. 1996).

³³Paul Gustafson, *Jury Award Patient \$2.6 Million: Verdict Finds Therapist Humenansky Liable in Repressed-Memory Trial*, STAR TRIB., Aug. 1, 1995, at 1B.

³⁴*Id.*

³⁵Sue Lindsay, *How Therapy Drove Women into the Hospital: Jane Brennan Talks About "False Memory" Suit She Won and the Power Therapists Have*, ROCKY MOUNTAIN NEWS, Nov. 5, 1995, at 6A. (Five other patients of that therapist have brought suit).

³⁶*Id.*

³⁷Harry MacLean, *Some Therapists Who Claim to Recover Memories May Actually Induce Them*, DENVER POST, Dec. 9, 1995, at B7.

experimental course of treatment when there were safer, more effective, and proven methods available. *The patient alleged that all of her recovered memories were false, implanted by the psychiatrist during therapy sessions which sometimes included hypnosis, sodium amytal, and inappropriate suggestive reading materials. She recovered memories of sexual abuse purportedly inflicted by her mother, father, grandmother, uncles, neighbors, and many others with whom she had come into contact. The psychiatrist diagnosed her as having multiple personality disorder with one hundred personalities, some of which were male, some female, some children, and some animals. The most bizarre recovered "memories" were those involving satanic ritual abuse in which the patient recalled numerous babies being served buffet style.*³⁸

The veracity of claims that a person was sexually traumatized as a child, profoundly forgot or repressed the experience, yet recalled it years later³⁹ depends on the validity of the theses that: a) repressed memories occur and are recoverable; and/or b) the process of attempting recovery does not itself produce false memories of childhood sexual trauma.

This Article will examine the claims regarding repression of traumatic experiences, and consider the issues around retrieval or recovery of purported memories, issues of undue suggestiveness in circumstances and techniques.⁴⁰

³⁸Robert Sadoff, M.D., *Child Abuse and Repressed Memory Testimony*, 1 QUINNIPIAC HEALTH L.J. 79, 85-86 (1996). For a general review of suits against therapists by retractors and accused persons see, e.g., Taub, *supra* note 7, at 208-13.

³⁹And in adequate detail to know the nature of the abuse and the identity of the abuser, who is then accused of molestation.

⁴⁰One summary of the assumptions that "flow from the notion that one can repress memories of prior experience and then subsequently resurrect them in pristine form—an idea that has virtually no support in controlled scientific studies in either basic or applied psychological research," was formulated from a number of works by Professor Elizabeth Loftus, critical of the recovered memory movement:

- (1) We are more prone than not to banish traumatic experiences from consciousness completely, because they are too horrifying to contemplate;
- (2) We usually do not remember these forgotten experiences by any normal process, but only through special psychotherapist techniques;
- (3) These counseling interventions produce reliable and valid recovery of memories;
- (4) Before re-emerging to conscious awareness, the forgotten experiences cause miserable symptoms and problems in living for many people;
- (5) "Psychoarcheological" excavations and reliving the forgotten experiences supposedly cure diagnosable mental conditions such as depression, chronic anxiety, panic attacks, bulimia/anorexia, personality disorders, and others too numerous to mention.

Elizabeth F. Loftus et al., *Patient-Psychotherapist Privilege: Access to Clinical Records in the Tangled Web of Repressed Memory Litigation*, 30 U. RICH. L. REV. 109, 111-12 (1996).

C. Suits by Accused Child Molesters Against Therapists

The *Ramona* case⁴¹ was the first, and most cited, case in which an accused father successfully sued therapists involved in the treatment of his adult daughter. The daughter, Holly Ramona, presented to the psychologist and eventually to a recommended psychiatrist, with an eating disorder (bulimia), but with no memories or beliefs that she had been sexually abused. Subsequently, the patient began to have flashbacks of sexual contacts with her father. The therapist apparently told the patient's mother that seventy to eighty percent of sufferers of bulimia had been sexually abused. The patient was put in weekly group sessions, facilitated by the therapist, which emphasized the probability of sexual victimization.

At the suggestion of the therapist, Holly was eventually given sodium amytal. In the resultant altered state of mind, Holly accused her father, who was not then present, of having repeatedly raped her as a child. The patient's subsequent expressions of doubts about such abuse were met with assurances by the psychologist and psychiatrist that it was impossible to tell lies under the influence of sodium amytal, absent special training.

The two psychotherapists then invited the father to the hospital so the daughter could confront him with the accusations. Influenced in part by the accusations, the father's wife filed for divorce, seeking custody of the couple's two minor daughters. Holly Ramona brought suit against her father.

While Holly's suit was pending, the father sued the therapist and the psychiatrist. A jury awarded the father \$475,000 (without deciding whether the abuse had actually occurred).⁴²

About forty *Ramona*-type suits have been filed nationally by accused family members against therapists.⁴³ More than a handful of these suits have produced jury awards or substantial settlements.

The legal theories asserted by plaintiffs have included: negligent or intentional infliction of emotional distress, malpractice, failure to obtain informed consent, civil conspiracy, defamation,⁴⁴ interference in filial relations, breach of contract (with the parental third-party payer), failure to warn,⁴⁵

⁴¹*Ramona v. Isabella*, No. C61898 (Cal. Super. Ct., Napa County May 13, 1994).

⁴²These factors have been garnered from Kathy Butler, *Clashing Memories, Mixed Messages*, L.A. TIMES, June 26, 1994, at 12; and Richard Cole, *Suit Won Against 2 Therapists*, PHILA. INQUIRER, May 15, 1994, at A3.

While there are a number of additional and significant complexities to this case, the essential facts, for purposes of illustrating the type of suit involved, are as stated in the text.

⁴³Anna Snider, *Accused Abusers Fight Back: Novel suit says therapists instilled false memories of incest*, 47 N.J. L.J., Nov. 18, 1996, at 1.

⁴⁴See Associated Press, *Doctor Loses \$350,000 Slander Suit: Analyst Told Family Parents Abused Woman*, ROCKY MOUNTAIN NEWS, Dec. 20, 1994, at 31A.

⁴⁵E.g., Plaintiff-parent is claiming in a New Jersey suit that therapists had duty to warn parents about possible accusations against them, citing a *Tarasoff*-type case in New Jersey (*i.e.*, *McIntosh v. Milano*, 403 A.2d 500 (N.J. Super. Ct. Law Div. 1979)) and another

fraud, and misrepresentation. In state after state, courts are beginning to examine the legal bases, if any, for suits by plaintiffs (accused by patients of child molestation) against therapists for implanting false memories in the minds of the accusers.⁴⁶

Insurance companies are now exercising caution in evaluating providers and the therapists they recommend. They look for networks which recommend therapists who would not "force a memory of childhood sexual abuse on a patient who otherwise shows no overt signs of having been abused."⁴⁷

The judicial opinions at this point on legal issues associated with suits against therapists by persons accused, vary in significant facts and relevant law, but none unambiguously addresses the paradigm fact situation under generally applicable legal doctrine. Two *appellate* opinions address the viability of a suit against a therapist treating an *adult* patient.

In *Doe v. McKay*,⁴⁸ the Illinois Court of Appeals held that valid causes of action were stated in a complaint by a patient's father against a therapist under the following alleged facts: *in the presence of the plaintiff-father*; a) the daughter, at the therapist's direction, accused plaintiff of sexually abusing her at age eleven; b) the therapist-defendant repeatedly told the daughter that plaintiff might further harm her, and told the father that; c) his daughter had recovered a repressed memory of the sexual abuse, he was repressing the memory of his acts, and he ought to begin psychological treatment at the defendant's facility. The complaint stated that the daughter thereafter told plaintiff that the defendant arranged the session for its shock effect in order to force a confession. The father denied, in the complaint, that he had ever sexually abused his daughter.

The trial court had dismissed the father's claims that the therapist had: a) negligently treated the daughter (thus not violating any duty of care owed to the plaintiff or depriving the plaintiff of his daughter's society and companionship); and b) intentionally interfered with the parent-child relationship. (Other claims were still pending in the trial court.)

The appeals court, after indicating the factors generally relevant to whether a legal duty exists,⁴⁹ found that valid causes of action were stated under Illinois law:

New Jersey decision holding a physician liable for failure to pass on genetic information (*i.e.*, *Safer v. Pack*, 677 A.2d 1188 (N.J. Super. Ct. App. Div. 1996)). Snider, *supra* note 43.

⁴⁶See, e.g., Paul B. Johnson, *Repressed Memory Cases on the Rise Nationwide*, IDAHO FALLS POST REGISTER, Jan. 30, 1995, see also Snider, *supra* note 43.

⁴⁷Michael Schachner, *'False Memory' Risk Surfaces Providing Mental Health Benefits Could Lead to Lawsuits*, CRAIN COMM., INC. BUS. INS., June 27, 1994, at 14.

⁴⁸678 N.E.2d 50 (Ill. Ct. App. 1997).

⁴⁹"In determining whether a duty exists, the court must weigh the foreseeability of the injury, the likelihood of the injury, the magnitude of the burden of guarding against it, and the consequences of placing that burden on the defendant." *Id.* at 52.

[A]s a general rule, negligence [can] not be founded upon the breach of a duty owed to some person other than the plaintiff

[H]owever, . . . derivative actions, such as those of a husband or parent for the loss of the wife's or child's society, demonstrate that the law has long recognized that *a wrong done to one person may invade the protected rights of one who is intimately related to the first.*⁵⁰

The court concluded that the "transferred negligence" doctrine was applicable: "*Key to this finding is the special relationship plaintiff shares with his daughter and the therapist's action to bring plaintiff into the treatment process.*"⁵¹

The court further stated: "Once plaintiff was immersed in his daughter's treatment process, as a quasi-patient himself, it was not only reasonably foreseeable, but a virtual certainty, that McKay's conduct would harm plaintiff's relationship with his daughter."⁵²

Applying factors relevant to determining whether a defendant has breached a duty owed to a plaintiff, the court observed:

*The risk and magnitude of harm to our society, namely, tearing a family apart without regard to the manner in which false accusations of sexual abuse are made, is so significant that it requires the protection of our law. A therapist's allegedly erroneous conclusion that a patient has been sexually abused by a parent endangers the parent-child relationship, but where the therapist draws the accused parent into the patient-child's treatment, accusations of sexual abuse are undeniably devastating and may not be made with impunity and disregard of the therapist's obligation of reasonable care.*⁵³
. . . We therefore hold that in a case such as this involving repressed memories of sexual abuse, where the parent is brought into the treatment process by the therapist, a therapist's duty to the patient to use reasonable care in the treatment process is extended to the parent.⁵⁴

⁵⁰The Doe v. McKay court relied on *Renslow v. Mennonite Hosp.*, 367 N.E.2d 1250 (Ill. 1977), a case widely cited in biomedical ethics as involving a preconception tort. In *Renslow*, eight years before plaintiff was born, plaintiff's mother was negligently transfused with incompatible blood. As a result, plaintiff was born with permanent physical damage. Plaintiff was permitted recovery.

⁵¹Doe v. McKay, 678 N.E.2d at 53.

⁵²*Id.*

⁵³"Defendants could have warned plaintiff and his daughter of the controversial nature of repressed memory therapy in separate sessions." *Id.*

Although the therapist possessed a Ph.D. in psychology, he was not licensed. It was unclear, because there were inconsistent provisions in the relevant statutes, whether he was practicing "clinical psychology" illegally.

⁵⁴*Id.*

The court concluded that Illinois recognized a cause of action for "direct interference with filial relationships and recovery for loss of society stemming from that interference."⁵⁵

While a number of cases (e.g., *Ramona*) have involved accusations made in a therapist's office against a family member, many others have not. Allegations such as intentional or negligent infliction of emotional distress were not before the Illinois court. Nevertheless the strong condemnation of the therapist's actions, the recognition that such accusation can destroy a family, and the attention given to the "special relationship" between the patient and the plaintiff suggest that a legal duty might well have been found even if the father had not been accused in the therapist's consultation room. On the other hand, there is law to support the proposition that "presence" is an important factor in determining legal liability for infliction of emotional distress.

The most recent appellate opinion regarding a suit by an accused person against a therapist treating an adult is *Russell v. Adams*.⁵⁶ In *Russell*, an adult patient's mother brought an action claiming that the therapist told the daughter that the mother was mentally ill and had "abused"⁵⁷ the daughter, and further that the therapist had recommended that the daughter sever all ties with her mother.

The court upheld dismissal of a claim of medical malpractice, and ruled that the statute of limitations had not run on the mother's claim of infliction of emotional distress. It reversed the trial court's dismissal of the mother's claim of negligent and intentional infliction of severe emotional distress without addressing "whether the complaint otherwise alleges the necessary elements of these torts. . . ."⁵⁸ In finding that a *malpractice* claim can be brought only by a patient,⁵⁹ the court made the following observations:

⁵⁵*Doe v. McKay*, 678 N.E.2d at 54; see also *infra* Part X; see also *Sullivan v. Cheshier*, 846 F. Supp. 654 (N.D. Ill. 1994) where parents of an adult daughter sued her therapist alleging that the therapist: 1) had implanted, through hypnosis, a false memory that her brother had molested her; and 2) had instructed his patient to break contact with her parents if they disagreed. In concluding that Illinois law permitted a suit for intentional interference with family relations, the federal court observed that two of the traditional rationales for precluding third party suits against therapists were absent: *i.e.*, "the availability of a tort remedy to the injured child, [and] the possible multiplication of claims. . . ." *Id.* at 660.

"In this case and cases like this, the child will not sue and claims will not be multiplied. Indeed, the gravamen of this particular sort of claim is that the damage inflicted by the defendant causes the inability of the child to sue." *Id.* at 661.

The *Sullivan* court characterized the claimed injury as "the excision of [plaintiffs'] daughter from their family." *Id.*

⁵⁶482 S.E.2d 30 (N.C. Ct. App. 1997).

⁵⁷The opinion and evidently the complaint, gives no indication of the nature of the alleged "abuse."

⁵⁸*Id.* at 33.

⁵⁹A point consistent with the thesis of this Article.

We are aware that the treatment of the emotional problems of the patient may, in some instances, have adverse consequences on the patient's relationship with others. . . . It does not follow, however, that the affected third party should have a cause of action for malpractice against the health care provider. Health care providers must "be free to recommend a course of treatment and act on the patient's response to the recommendation free from the possibility that someone other than the patient might complain in the future." In other words, "doctors should owe their duty to their patient and not to anyone else" so as not to compromise this primary duty.⁶⁰

The concerns expressed by the court are obviously of weight. It is not the thesis of this Article, however, that whenever psychotherapy disrupts a relationship or causes emotional pain to a third party, the injured party has a cognizable legal claim. Effective therapy produces changes, sometimes resulting in drastic changes in relationships between patients and others. Sometimes the patient's emotional growth makes an existing marriage, which may have rested on complementary neurotic symptoms, untenable. Sometimes a patient may justifiably conclude that continued contact with parents threatens his or her mental health.

For reasons articulated below, certain misconduct by therapists is so egregious and irresponsible and strongly tends to generate such devastating emotional, familial, and reputational injuries, that it is vastly different both in kind and degree⁶¹ from anything within a wide range of typicality.

In *Turman v. Genesis Associates*, a federal case applying Pennsylvania law,⁶² plaintiffs sued therapists treating their twenty-year-old daughter, Diane. They alleged that defendants had implanted false memories to the effect that plaintiffs belonged to a satanic cult and had ritually murdered Diane's twin brother, and that her father had raped and impregnated her. The defendants were alleged to have caused the daughter to make these allegations before a group and to have urged and assisted her in hiding to avoid harm from her parents.

Given that the parents paid for the therapy, the court declined to dismiss the claim for breach of contract. The negligence claim was found actionable based on a specific undertaking to the parents, together with reasonably foreseeable harm to them.⁶³

⁶⁰Russell v. Adams, 482 S.E.2d 30, 32-33 (N.C. Ct. App. 1997)(quoting Lindgren); Lindgren v. Moore, 907 F. Supp. 1183, 1189 (N.D. Ill. 1995)).

⁶¹Moreover even if the differences could be deemed "only" differences in degree, as Justice Holmes observed: "a man's fate . . . [often] depends on his estimating rightly, that is, as the jury subsequently estimates it, some matter of degree." Nash v. United States, 229 U.S. 373, 377 (1913).

⁶²Tuman v. Genesis Assoc., 935 F. Supp. 1375 (E.D. Pa. 1996) [*Tuman II*]; Tuman v. Genesis Assoc., 894 F. Supp. 183 (E.D. Pa. 1995) [*Tuman I*].

⁶³I predict that the Pennsylvania Supreme Court would conclude that in the absence of any other statutory duty of care, a therapist owes a duty of reasonable care to a patient's parents, where (1) the therapist

The court made these important observations:

[Defendants argue that] "[t]o allow a duty [to run to the parents . . . would place the defendant in the untenable position of having to choose between her duty to the patient and a duty to the relatives of the patient or to some other third party." I disagree *The therapist's two duties dovetail to a singular duty to provide reasonably acceptable mental health therapy to the patient.*

Further, *my narrow holding* does not subject therapists to negligence liability whenever parents experience emotional injury that may result when a child seeks mental health counseling. *There is a vast difference between using acceptable therapy to help a patient understand emotional wounds suffered as a result of her parents' inadequate caregiving,⁶⁴ and negligent techniques that create false memories of severely abusive parenting that necessarily injure the parents and the patient.⁶⁵*

Potentially most significant was the court's holding regarding the plaintiffs' claim of *intentional infliction* of emotional distress: "[r]egardless of whether Defendants owed plaintiffs any duty of care with respect to Diane's mental health counseling, *Defendants had independent duties not to intentionally inflict emotional distress upon Plaintiffs.*"⁶⁶

This holding, if generally followed, would in many cases, provide a basis for an action by persons falsely accused ("intentionally" includes the concept of "recklessly"). The arguable applicability of the doctrine of intentional or reckless infliction of emotional distress, and the closely related doctrine of torts actionable because of their *outrageous* nature are discussed below in Part IX(B)(C).

There have been several suits against therapists treating minor children.

specifically undertook to treat the child for the parents; (2) the parents relied upon the therapist; (3) the therapist was aware of the parents' reliance; and (4) it was reasonably foreseeable that the parents would be harmed by the therapist's conduct.

Tuman I, 894 F. Supp. at 188.

⁶⁴This is significant in terms of recognizing that not all parent or spouse bashing or blaming would be subject to a suit. Indeed such blaming seems to go on in many, if not most therapist-patient relationships. See Terence W. Campbell, *Therapeutic Relationships and Iatrogenic Outcomes: The Blame-and-Change Maneuver in Psychotherapy*, 29 PSYCHOTHERAPY 474 (1992).

⁶⁵*Tuman I*, 894 F. Supp. at 189. Since the 1996 opinion of the district court in *Tuman II*, the plaintiffs' daughter (the patient) has brought suit against the therapists. So have two other patients. The therapists are counterclaiming for damages based on their allegation that defamatory statements in the pleadings are not privileged.

⁶⁶*Id.* In a subsequent opinion, *Tuman II*, the court held that the failure to prove emotional injuries by expert medical confirmation warranted dismissal of this claim. *Tuman II*, 935 F. Supp. 1375. Regarding "claims for intentional infliction of emotional distress, the [Pennsylvania Supreme Court] imposed the requirement of expert medical evidence of the distress as a counterweight to the ease with which fraudulent claims of outrageous behavior could be brought." *Id.* at 1393.

In *Caryl S. v. Child & Adolescent Treatment Services*,⁶⁷ in the Supreme Court, Erie County, New York, the court upheld a cause of action by grandparents against a therapist treating their grandchild. The complaint, as construed, charged the therapist with "negligently" or with *gross negligence*, misdiagnosing the child as having been sexually abused by the grandparent, and with "[communicating] that conclusion to several persons and agencies, negligently, carelessly and recklessly," thus, causing plaintiffs foreseeable serious harm. The complaint was upheld, not as a defamation action, but evidently as one for negligent or intentional infliction of harm.⁶⁸

The determination of whether sexual abuse has occurred is made not only about the child *but also about the suspected abuser*. When, based upon that determination, a course of action is thereafter embarked upon by the professional, it is intended to, and necessarily does, affect both the child and his or her abuser, especially where a family relationship is involved. *A suspected abuser surely has the right to a reasonable expectation that such a determination, touching him or her as profoundly as it will, will be carefully made and will not be reached in a negligent manner.*

The possible harm to a child from a professional misdiagnosis in such circumstances has . . . been noted. The potential harm to the alleged abuser is equally great. Thus, *I conclude that, where the determination of sexual abuse is made by a professional treating a child, with subsequent actions taken based upon that determination and aimed, whether in whole or in part, at shaping not only the conduct and well-being of the child but also the conduct of the suspected abuser, or the relationship between them, a duty of care is owed not only to the child but also to the alleged abuser.*⁶⁹

Cases in which a therapist allegedly misdiagnoses abuse in treating a young child tend to occur in the context of statutory immunity. For example, when the therapist complies with a reporting statute, (requiring that therapists report cases of suspected child abuse to certain agencies) or completes an evaluation or report in connection with a judicial proceeding,⁷⁰ the therapist is typically *held immune from liability for ordinary negligence* .

⁶⁷*Caryl S. v. Child & Adolescent Treatment Servs., Inc.*, 614 N.Y.S.2d 661 (N.Y. Sup. Ct. 1994).

⁶⁸"[I]t is not the communication of the opinion in and of itself which is the gravamen of this action but rather the negligence in reaching that opinion." *Id.* at 664.

⁶⁹*Id.* at 667.

⁷⁰*See, e.g., Vineyard v. Kraft*, 828 S.W.2d 248, 254 (Tex. Ct. App. 1992); *May v. Southeast Wyo. Mental Health Ctr.*, 866 P.2d 732, 738 (Wyo. 1993); *Dominguez v. Kelly*, 786 S.W.2d 749, 740, 752-53 (Tex. Ct. App. 1990).

Two California cases in which the therapist, committed to the view that a child had been sexually abused, took steps beyond therapy and beyond reporting, to keep the father from contact or custody of the child, were resolved in opposite ways. *Schwarz v. Regents of the Univ. of Cal.*, 276 Cal. Rptr. 470 (Cal. Ct. App. 1990)(the father, as a third

In a Texas case not involving statutory immunity, where the psychologist was hired by the child's mother to examine the child for signs of abuse, the court *denied* the accused father recovery on a claim for *negligent* misdiagnosis.⁷¹

*[The] right to sue a mental health professional must be considered in light of . . . the social utility of eradicating sexual abuse. Evaluating children to determine whether sexual abuse has occurred is essential to that goal. . . . Young children's difficulty in communicating sexual abuse heightens the need for experienced mental health professionals to evaluate the child. Because they are dealing with such a sensitive situation, mental health professionals should be allowed to exercise their professional judgment in diagnosing sexual abuse of a child without the judicial imposition of a countervailing duty to third parties.*⁷²

Contrary to this case, however, and generally consistent with the views to be elaborated, is an opinion of the Colorado Court of Appeals.⁷³ A therapist counseling a child reported to county officials that the four-year-old child had been sexually abused by her father during a visit. Additionally, the therapist testified on behalf of the mother, in litigation over the father's visitation rights. The plaintiff-father (in a suit against the therapist) submitted an affidavit of a psychologist previously selected by both the mother and the father, expressing the views that

(1) there is no support in the literature for the assertion that a child's body language can provide an infallible indication as to a child's veracity; (2) psychological testing of the child disclosed that she so confused fantasy with reality that she could report fantasy as fact and use appropriate body language in doing so; (3) Bebensee [the defendant-therapist] did not undertake steps to assure that . . . [the therapist's] personal prejudices did not influence her. . . ; [4] Bebensee did not give any psychological tests to the child; [5] [she] made no investigation of the reports made by the child to other parties so as to determine whether they were consistent or inconsistent with the statements made to her; [6] she diagnosed [the father] . . . as a child abuser while refusing to speak with him; and [7] she disregarded the reports of other professionals.⁷⁴

party to the physician-patient relationship, had no right to sue); *James W. v. Superior Court (Goodfriend)*, 21 Cal. Rptr. 2d 169, 170 (Cal. Ct. App. 1993) (father had right to sue).

⁷¹*Bird v. W.C.W.*, 868 S.W.2d 767, 769-70 (Tex. 1994).

⁷²*Id.* at 769.

⁷³*Montoya v. Bebensee*, 761 P.2d 285 (Colo. Ct. App. 1988).

⁷⁴*Id.* at 287.

After examining factors relevant to the question of duty,⁷⁵ the court found:

[the therapist] owed a duty of due care to the father in this case. We reach this conclusion after considering both the great social utility of having therapists make reports of suspected child abuse and the significant risk of substantial injury that may occur to one falsely accused of being a child abuser. Certainly the harm that may result from negligent false accusations is readily foreseeable, while the burden of due care placed upon therapists is no greater than the duty that substantially all professionals are required to meet.⁷⁶

The court upheld against a motion for summary judgment the claim of negligent infliction of emotional distress, regarding the therapist's counseling the mother to deny visitation rights, and the role the therapist played at the hearing. The claims of negligence would not be upheld with respect to the reports to county officials, because immunity statutes provided protection for a good faith (albeit negligent) report of CSA.⁷⁷

The court found, however, that the defendant's actions, if they were as alleged, *would arguably constitute outrageous conduct amounting to intentional infliction of emotional distress* and further, that the reporting statute would not provide immunity for such a level of culpability.⁷⁸

As noted earlier, the basis of suit to be advocated herein, will not be mere negligent misdiagnosis or negligent acceptance of a patient's claim that she had been sexually abused in childhood; rather *it will require proof by the plaintiff that the patient upon initiating therapy had no memories of being sexually abused, and that only after the therapist recklessly and outrageously used hypersuggestive techniques that tended to induce an illusory memory, was the plaintiff accused of childhood sexual molestation.*

III. DEVASTATING IMPACT OF FALSE ACCUSATIONS

To be accused of sexually molesting a child is to be deemed a moral monster. The enormity of these crimes is such that murders, arsonists, and even rapists of adult women consider child molesters the scum of the earth and, in jail and prison situations, target them, above all others, for vicious assaults, rapes, and even death.

As one court has observed, "child abuser" is "*one of the most loathsome labels in society.*"⁷⁹ Those believed to be child molesters face a public opprobrium compounding disgust, detestation, hatred, fear, and sometimes homicidal

⁷⁵*Id.* at 287-89. See discussion of CONCEPT OF DUTY, *infra* at Part X.

⁷⁶761 P.2d at 288-89.

⁷⁷*Id.* at 288.

⁷⁸*Id.* at 289-90.

⁷⁹*Rossignol v Silvernail*, 185 A.D.2d 497, 499 (N.Y. A.D. 3d Dep't. 1992).

hostility. Indeed, given the recent widespread adoption of "Megan's Law," of all who have served their sentences, only child molesters are continually marked for monitoring and publicity, sometimes to entire neighborhoods or communities. Only child molesters are subject to chemical castration.⁸⁰

Compounding this uniquely demonizing stigma, which places an accused child molester far outside the perimeters of the human family, is the anguish imposed by virtue of the close familial relationship to the accuser (often a daughter). Further aggravating the horror of a false accusation is the not infrequent severance of family bonds involving parents-children; husband-wife; sibling-sibling; aunts, uncles, in-laws, and grand-parents. Accusations of CSA sabotage the shared history of entire families and massively threaten the very foundations on which family attachments rest.

Other consequences often include loss of livelihood, termination of friendships, and social and self-imposed isolation. Often, finding oneself to be a social pariah, the falsely accused person must change his domicile to a distant community.⁸¹

Nothing that has been said is meant to diminish the atrocity of sexual abuse of children. But, given the profoundly outrageous nature of such conduct, care must be taken to avoid a profoundly outrageous false accusation: one which brands an innocent person as *hostem generis humani*, an enemy of the human race.

The accused's denial of the allegation rarely prevents the harms to the accused. Those learning of the accusations typically assume that all criminals deny crime, that molesters above all will deny their enormities,⁸² and that in any event, where there is smoke there is fire.

As was once said of rape, accusations of child molestation claimed to have occurred decades ago, are easy to make and almost impossible to defend

⁸⁰"Megan's Laws" are laws enacted in several states, requiring registration and/or varying degrees of public notice in communities where convicted sexual offenders reside. The term refers to Megan Kanka, a seven-year-old girl who was raped and murdered by a paroled sex offender living in Megan's neighborhood. See generally Edward Martone, *Megan's Law: When a Sex Offender Moves in, is there a Duty to Warn the Community?* 81 A.B.A. J. 38 (1995).

Recent California legislation imposes chemical castration [with the drug Depo Provera] on those convicted twice of crimes involving sexual molestation of children. A.B. 3339, 1995-96 Reg. Sess., § 2 (Cal. 1995)(enacted 1996). Other states are considering similar legislation. See, e.g., Staff, *Iowa Governor Urges Chemical Castration of Repeat Child Molesters*, WEST'S LEGAL NEWS, Dec. 31, 1996, at 13883.

⁸¹The distinguished writer, Jack Olsen, in his work, *PREDATOR: RAPE, MADNESS, AND INJUSTICE IN SEATTLE* (1991) gives a chilling *true* account of a man erroneously convicted of rape, as a result of a deliberately fixed and fraudulent photo display (*of extreme suggestiveness*). The cost to the innocent man was the loss and destruction of all that was valuable in his life, a series of breakdowns and severe decompensation even after he was released.

⁸²Of course, actual molesters may "deny" their crimes in two senses of the word: a) they may explicitly reject an accusation knowing it is true; or b) they may have profoundly forgotten it.

against. To prove a negative is hard enough; to negate charges of conduct that allegedly occurred in private decades ago is a burden few can carry. And to prove it in a public arena, in social and workplace settings, where the accusation implicitly places the burden on the accused, is a monumental task.

The analogy to Salem may not be perfect, but it does resonate with certain truths. Falsely accused of doing the devil's work, by innocent agents of irresponsible instigators, in an atmosphere of hysteria and social abhorrence, the very charge itself so inflames that little attention is given by society to the question of guilt or innocence.

IV. PREMISES OF RECOVERED MEMORY THERAPY

The sexual abuse of children, more often female children, is far more prevalent than commonly believed.

Not surprisingly, estimates of CSA vary. Given that the kind of abuse connected with recovered memory therapy involves physical contact, and usually more than one episode, what do the studies indicate?

A study published in 1983⁸³ found that 38 percent of woman experienced at least one instance of contact CSA before age eighteen (4.5 percent by their fathers). Other studies have found 6 percent,⁸⁴ 34.2 percent,⁸⁵ (2 percent by fathers or stepfathers)⁸⁶ and up to 75 percent.⁸⁷ In a 1994 review of studies, Finkelhor⁸⁸ estimated that twenty percent of women in the United States suffered some type of CSA, that four to five percent were victimized by penetration or oral-genital contact, and that more than half of CSA is perpetrated outside the family.⁸⁹

The widely shared premises of recovered memory psychotherapists seem to be:

- Society avoids confronting the reality of sexual abuse of children, by a widespread societal denial.

⁸³DIANA E.H. RUSSELL, *THE SECRET TRAUMA: INCEST IN THE LIVES OF GIRLS AND WOMEN* 61 (1986).

⁸⁴See reference to Burnham study in S. D. Peters et al., *Prevalence in A SOURCEBOOK ON CHILD SEXUAL ABUSE* 15-18 (David Finkelhor & Sharon Araji eds., 1986).

⁸⁵David Finkelhor et al., *Sexual Abuse in the National Survey of Adult Men and Women: Prevalence, Characteristics, and Risk Factors*, 14 *CHILD ABUSE & NEGLECT* 19-28 (1990)(surveying 2626 men and women).

⁸⁶Total of contact and non-contact abuse.

⁸⁷Gail E. Wyatt, *The Sexual Abuse of Afro-American and White-American Women in Childhood*, 9 *CHILD ABUSE & NEGLECT* 507-19 (1985)(using a sample size of 248 woman in Los Angeles).

⁸⁸Finkelhor published a much-cited study in 1979 finding that 19.2% of women suffered CSA. DAVID FINKELHOR, *SEXUALLY VICTIMIZED CHILDREN* 42, 53 (1979).

⁸⁹David Finkelhor, *Current Information on the Scope and Nature of Child Sexual Abuse*, 4 *THE FUTURE OF CHILDREN* 31-53 (1994).

- Children who have been sexually abused often repress the memory of such abuse.
- Victims of CSA suffer, in adulthood, a variety of behavioral and emotional symptoms.
- It is possible, by observing symptomology of a patient, to diagnose CSA as a root cause.⁹⁰
- By a variety of techniques, employed in therapy over a period of time—e.g., bibliotherapy, suggested dream content, hypnosis, guided imagery, support groups—a repressed or buried experience of CSA, in patients who presented with no memory of CSA, can be brought to conscious memory, producing recall in significant detail regarding the patient's sexual exploitation in childhood.
- Vividly imagining sexual abuse with accompanying severe emotional distress is indicative of actual historic abuse.⁹¹
- The recovery of memory of CSA is therapeutically beneficial to the patient.⁹²
- It may also be therapeutically beneficial for the patient to confront the abuser⁹³ and even to bring a lawsuit against him (as a way of healing and obtaining validation).⁹⁴

⁹⁰Alternatively, a) when a patient presents with bulimia or with sexual dysfunction, either or both symptoms are erroneously taken indicate that the patient was a victim of CSA; or b) for some incest-abuse therapists, the premise is that most adult female patients are victims of CSA.

⁹¹See, e.g., OFSHE & WATERS, *supra* note 15, at 109. In response, Ofshe points out the defective reasoning involved: "if patients believe in the abuse narrative they will experience emotional pain. That pain can then be used as evidence for the validity of the abuse, which bolsters the belief." *Id.*

⁹²Some highly reputed therapists today take the view that the most effective therapy does not require or involve delving into the patient's ancient history; but instead involves working on present feelings, interactions, behaviors, etc. An eminent theorist-clinician rejects the "unpeeling" of key historical events, observing that "[p]ersonality is a process, not an onion." PAUL L. WACHTEL, *PSYCHOANALYSIS, BEHAVIOR THERAPY, AND THE RELATIONAL WORLD* (1997).

⁹³Lawsuits may be encouraged as a "hope for emotional justice, a very important step towards devictimization, [or as a] further source of validation." SUSAN FORWARD & CRAIG BUCK, *BETRAYAL OF INNOCENCE: INCEST AND ITS DEVASTATION* (1988).

Contrary to such advice, as most readers of this Article will realize, a patient is as likely to find emotional turmoil as to find new emotional strength in bringing a lawsuit against an alleged child molester. See also, Loftus et al., *supra* note 40, at 112, n.13.

The Canadian Psychiatry Association has observed:
poorly trained or misguided therapists have been urging patients, as a specific part of their therapy, to confront and accuse the alleged perpetrators of the abuse once they have been identified. As a consequence . . . members of the patient's family are most often identified and accused, where recovered memories are found to be false, family relationships are unnecessarily and often permanently disrupted.

June 1996 Position Statement: Adult Recovered Memories of Childhood Sexual Abuse, 41 CANADIAN J. PSYCHIATRY 305 (1996) [hereinafter *June 1996 Position Statement*].

V. REPRESSION AND MEMORY RECOVERY

The memory process can be conveniently separated into three temporal components: a) input/perception, b) storage, and c) retrieval/recall.⁹⁵

A. Input/Perception

Repression⁹⁶ is believed to be a psychological or neurological process by which events, usually quite traumatic, are removed from, or never enter, conscious thought, by virtue of a mechanism that may itself operate either by intention or automatically. It is unlike an event that is merely forgotten or an event that never enters the memory. Repression enables a person to continue functioning without being burdened by unacceptable thoughts and images. A person who experiences a particularly traumatic event may find it difficult or impossible to function normally while simultaneously maintaining memories of the event. The memories are simply too overwhelming. In order to cope and function in life, the victim buries (represses)⁹⁷ the memory, keeping the secret even from herself.

Theoretical/clinical psychologists Bowers and Farvolden express the view that whether or not traumatic thoughts and images are technically repressed, there may be a mental mechanism that keeps such thoughts from conscious awareness—an active avoidance mechanism that habitually and automatically keeps disturbing thoughts from entering the awareness.⁹⁸

The views of one authority, psychologist Richard Ofshe, have been summarized as follows:

repressed memory therapists confuse common memory phenomena such as normal memory decay, motivated avoidance, and selective amnesia with the idea of repression. For example, we have all had the

⁹⁴See ELLEN BASS & LAURA DAVIS, *THE COURAGE TO HEAL: A GUIDE FOR WOMEN SURVIVORS OF CHILD SEXUAL ABUSE* (1988); see also JOSEPH E. CRNICH & KIMBERLY A. CRNICH, *SHIFTING THE BURDEN OF TRUTH: SUING CHILD SEXUAL ABUSERS—A LEGAL GUIDE FOR SURVIVORS AND THEIR SUPPORTERS* (1992); and Kimberly A. Crnich, *Redressing the Undressing: A Primer on the Representaiton of Adult Survivors of Childhood Sexual Abuse*, 14 *WOMEN'S RTS L. REP.* 65 (1992).

⁹⁵The American Psychiatric Association speaks of input, storage, retrieval, and recounting. See Sadoff, *supra* note 38, at 79.

⁹⁶It appears to this author that in exploring the matter of repression, one or more of several issues might be under discussion: a) the triggers and processes of burying the experience; b) the impact or non-impact of influences during storage of the buried memory; c) the degree of effort necessary to access the memory; and d) the accuracy of apparent retrieval of the repressed memory.

⁹⁷Psychologists Kenneth S. Bowers and Peter Farvolden define repression as "motivated forgetting of information that is very threatening to one's self-esteem or self-concept." Kenneth S. Bowers & Peter Farvolden, *Revisiting a Century-Old Freudian Slip-From Suggestion Disavowed to the Truth Repressed*, 119 *PSYCHOL. BULL.* 355, 359 (1996).

⁹⁸*Id.* at 360.

experience of forgetting the details of an event over time, or even not thinking about an event for a long time because it is painful, guilt-provoking, or frightful. But a critical difference . . . between this "motivated avoidance" and repression is that a person who prefers not to think about a traumatic event, such as the death of a parent, will remember that the parent has died; if this person had instead repressed his memory according to the model of repression currently being promoted, he would be entirely ignorant of having attended the funeral and perhaps even of his [parent's] death. If asked about the [funeral], he would have said he was certain that there was none or absolutely sure that he did not attend.⁹⁹

Repression may be one of several alternative processes at the input/perception stage. Under some views of repression, the mind or brain registers the perceived event or experience more or less in accurate replication of all the sensory, emotional, and thought processes entailed.

Another process that may occur at the time of a traumatic event or events is "dissociation," a process at least as complex as repression (accordingly, there are variations among experts in basic definition and description). As one peruses the literature, one finds descriptions along the following lines (this author's amalgam): When the mind experiences a severe trauma, it may respond in a way that avoids fully experiencing all the qualities of the input. It does this by splitting off, in effect in separate compartments, different elements, such as feelings, beliefs, images, and memories. This may produce a protective blunting, or a numbing against the full impact of the physical and psychic pain. It may result in fragmentary memories of aspects of the event. In the more severe dissociative reactions, a person may experience an altered state of consciousness such as a fugue state, which even more profoundly avoids absorption of the reality of the event.

Depending on the degree of dissociation, recollections, if any, may be more or less distorted.¹⁰⁰ In the most severe cases there is a severe pathological history and symptomology such that an experienced psychotherapist could discern that one or more dissociative experiences had occurred. But paradoxically, in the most severe cases, the original trauma may not be subject to recall at all, or not to any reliable degree. Moreover, there would be no way to discern whether any ostensibly recovered memory was accurate. In less severe cases the patient may have some recall of traumatic episodes, even before initiating therapy.

The current debate centers on the cases (unknown in number but involving thousands of patients), in which patients present with no memory or even partial memory or belief that they were sexually abused as children, and with

⁹⁹ Murray, *supra* note 7, at 503-04.

¹⁰⁰ People who are traumatized may suffer post-traumatic stress disorder. One cannot be confident that an apparent memory expressed or experienced in "flashbacks" by such a person is valid. See *infra* Part V(B).

no symptoms justifying a diagnoses of CSA, yet eventually, as a result of the therapy, purport to remember having been molested.¹⁰¹

The section which follows, dealing with the storage stage of memory, addresses the heart of the disagreement regarding the concept of repression.

Many perceived experiences that register in the psyche or neuronal cells¹⁰² are subject to normal memory processes and normal or even deep forgetting processes. Purported distinctions between such forgetting and the process of repression, if such there be, become significant at the next stage of the memory flow chart—*i.e.*, the storage process.

B. Storage

The period between the perception and the recall of memories is the storage stage. Controversy over what, if anything, happens to the experience/memory in this stage is at the heart of the repressed memory debate between recovered memory therapists and their critics.

Ordinary memory processes, resulting from ordinary forgetting, are subject to a variety of distortive influences while in storage. The operation of various influences on memory storage and retrieval is called confabulation.¹⁰³ Confabulation is an unconscious dynamic in which the material in one's memory is altered by time, circumstances, new information, misinformation, values, prejudices, beliefs, rationalizations, and various adjustments, elaborations, and supplementations to "fit" or "fit-in" with psychic systems and

¹⁰¹There are other views of dissociation that treat it as consistent with recovering the memory of CSA. See JUDITH L. HERMAN, *TRAUMA AND RECOVERY* 101-02 (1992) (implicit).

In any event, Dr. Judith L. Herman, a Harvard psychiatrist and authority on abused children, describes the response of children to traumatic parental sexual abuse:

The abused child's existential task is . . . formidable. Though she perceives herself as abandoned to a power without mercy, she must find a way to preserve hope and meaning. The alternative is utter despair, something no child can bear. . . .

All of the abused child's psychological adaptations serve the fundamental purpose of preserving her primary attachment to her parents in the face of daily evidence of their malice, helplessness, or indifference. To accomplish this purpose, the child resorts to a wide array of psychological defenses. By virtue of these defenses, the abuse is either walled off from conscious awareness and memory, so that it did not really happen, or minimized, rationalized, and excused, so that whatever did happen was not really abuse. The child victim prefers to believe that the abuse did not occur. In the service of this wish, she tries to keep the abuse a secret from herself.

Id.

¹⁰²Aside from repression and dissociation at the perception stage, some experiences may simply never register, and thus not be subject to recall. These might include non-traumatic forms of abuse, as well as experiences below the ages of three or four years (which are subject to normal early childhood amnesia); they simply are not retrievable.

¹⁰³Confabulation actually affects all stages of normal perception, forgetting, storage and retrieval of memories.

psychic needs. In other words, distortive and reconstructive processes alter the material in the memory.

Were such processes known to be at work during long periods of forgetting, such as the ten, twenty, thirty or more years often seen in recovered memory cases, it would be manifestly irrational to treat such purported memories as accurate, absent detective work corroborating the claimed memory in its pertinent aspects.

But recovered memory advocates tend to explicitly or implicitly argue that incestuous abuse triggers repression, and that the phenomenon of repression is such that the repressed memory, unlike ordinary memory, is relatively insulated and immune from distortive-constructive influences during the storage stage (frozen in its pristine form) and sufficiently accurate in its graphic, emotional, and descriptive detail so as to justify confidence that the abuse did occur and the named perpetrator was the abuser.

Recovered memory therapists sometimes say, however, that whether the apparent memory of abuse is or is not accurate is of no concern to the therapeutic enterprise and/or that it is not their role to disbelieve a patient who arrives at a memory of childhood incest. In one informal study, eighty-one percent (of a random sample)

*said they invariably believe their clients. One therapist said, "if a woman said it happened, it happened." Another said, "I have no reason not to believe them." More than two thirds of the clinicians reacted emotionally to any use of the term authentic, feeling that what is authentic and what is not authentic is not the job of a therapist.*¹⁰⁴

Some recovered memory therapists or writers may be *purporting* to embrace the therapeutic premises of certain schools of psychotherapy which find therapeutic value in narrative, inter-psychic truth that fits and is therapeutically effective for a given patient under given conditions, regardless of historical truth.¹⁰⁵

¹⁰⁴Loftus, *supra* note 2, at 524.

¹⁰⁵Psychoanalyst Roy Schafer, for example, points out the divergence between the traditional notion of psychoanalysis as an endeavor in search of truth, and his conception of it as a creative narrative undertaking. Roy Schafer, *Narration in the Psychoanalytic Dialogue*, in ON NARRATIVE 25 (W.J.T. Mitchell ed., 1980).

Donald Spence, in a classic work on the subject, finds the search for historical truth outside the competence of a therapist. In certain portions of his work he endorses "narrative truth," where it may advance the work of therapy without departing in a psychoanalytically significant way from what has emerged. See DONALD SPENCE, NARRATIVE TRUTH AND HISTORICAL TRUTH: MEANING AND INTERPRETATION IN PSYCHOANALYSIS 160, 263-78 (1982).

It is doubtful that therapists oriented to narrative truth would invent or accept false and devastating traumatic events as furthering their work. Aside from the probability that radical untruth is outside the subtle variations of traditional narrative therapy, one would hope that *all* therapists would deem it appropriate to consider moral and ethical obligations to avoid unjustified injury to third parties.

In an authoritative reading of Donald Spence, Paul L. Wachtel explains Spence's views as follows:

Aside from the fact that it cannot be known whether a claimed recovered memory was forgotten or was repressed, *it is not clear that repression itself implies a memory retained in intact condition, insulated and immune from ordinary distortive processes of confabulation during the storage stage.* A number of scholars question the concept of uncontaminated storage of repressed memories.¹⁰⁶ Harvard neurological-psychologist Daniel Schacter writes:

The idea of an unchanging imprint of exactly what happened at the time of a trauma brings us perilously close to the *dubious notion that memory (or at least traumatic memory) is like a camcorder, preserving all aspects of an episode.* This idea is fundamentally misguided when applied to ordinary experiences and . . . it doesn't work well for traumatic episodes that people always remember. *It would be surprising, even extraordinary, if it were to apply to traumatic experiences that were buried, and then recovered years later. There is currently no scientifically credible evidence to support the idea.*¹⁰⁷

Studies of combat amnesia and of flashbacks led Bowers and Farvolden to conclude that accepting the concept of repression

does not commit theorists to the belief that recovered memories must be historically accurate in all particulars. *A memory, by virtue of having been repressed, does not somehow escape the distortions and constructive features of memories in general.* . . .¹⁰⁸

While Freud, in his early writings, seemed to embrace a frozen image concept of repression,¹⁰⁹ most authorities today have found little or no support for it.

If it holds together well, if it conveys a new understanding of the patient's life that is persuasive to the patient and helps him gain a greater feeling of coherence and a revisioning of his life story that opens new possibilities, it is a good interpretation. That it is not the one true story is not a flaw but a necessity. Our lives permit of many narratives. Consequently, according to *Spence*, "it seems more appropriate to conceive of an interpretation as a *construction* a creative proposition-rather than as a *reconstruction* that is supposed to correspond to something in the past."

PAUL L. WACHTEL, THERAPEUTIC COMMUNICATION: PRINCIPLES AND EFFECTIVE PRACTICE 188 (1993). On the concept of reframing as a moderate type of suggestion, see generally, *id.* at 185-205.

For an extended treatment of *Spence's* work, see generally, Marianne Wesson, *Historical Truth, Narrative Truth, and Expert Testimony*, 60 WASH. L. REV. 331 (1985).

¹⁰⁶See, e.g., OFSHE & WATERS, *supra* note 15. LOFTUS & KETCHUM, *supra* note 15, at 49-58.

¹⁰⁷DAVID L. SCHACTER, SEARCHING FOR MEMORY: THE BRAIN, THE MIND AND THE PAST at 263-66 (1996).

¹⁰⁸Bowers & Farvolden, *supra* note 97, at 361.

¹⁰⁹His early writings suggested that the image being frozen was one of actual abuse but later he concluded that the buried material was of fantasies and drives in early childhood.

Paul L. Wachtel, a renowned theoretical clinician, observed that under Freud and Breuer's theories, memories of traumatic events were encapsulated and "remained fresh," retaining in an unmodified way, their original significance and intensity.

Freud's description of the persisting influence of the past is reminiscent of the tales of woolly mammoths found frozen in the Arctic ice, so perfectly preserved after thousands of years that their meat could be eaten by anyone with a taste for such regressive fare. Freud was extremely impressed with the "freshness" and vividness of the memories revealed after digging through layers of resistance. Their lack of access to the usual associative pathways was seen as preserving them.¹¹⁰

One episode in the history of neurology is sometimes cited as support for the permafrost/video recording Freudian notion of memory. An eminent neurologist, Wilder Penfield, electronically stimulated certain areas of the brains of patients awaiting surgery. He reported that his patients expressed vivid recollections in graphic visual and other sensory imagery, of long forgotten events.¹¹¹

It is submitted that the Penfield studies, as now understood, do not constitute evidence to support the video recording/frozen "wooly mammoth" notion of repression.

Penfield concluded that experiences leave permanent imprints on/in the brain "as though a tape recorder had been receiving it all."¹¹² Many psychologists accepted Penfield's claim that everything that happens is permanently stored in the mind. Popular opinion, as well as popular introductory textbooks in psychology seemed to concur. But, aside from the

¹¹⁰PAUL L. WACHTEL, *PSYCHOANALYSIS AND BEHAVIOR THERAPY* at 28-29 (1977).

¹¹¹WILDER PENFIELD & LAMAR ROBERTS, *SPEECH AND BRAIN-MECHANISMS* (1959). Penfield's conclusions regarding memory storage are further elaborated in Wilder Penfield & P. Perot, *The Brain's Record of Auditory and Visual Experience*, 86 *BRAIN* 595 (1963); and Wilder Penfield, *Consciousness, Memory, and Man's Conditioned Reflexes*, in, *ON THE BIOLOGY OF LEARNING* 165 (K. Pribram ed., 1969).

Some scholars concluded that this episode suggests: "that whatever the exact means of storage and the exact process of recall, there are ways in which some record of past experiences can be stored for long periods of time without being subject to . . . wearing or fusing of memory traces. . . ."

WACHTEL, *supra* note 92, at 29.

Wachtel, while not addressing the recovered memory controversy, takes the view that the concept of repression is important so far as understanding a patient's selective memory and covered-up feelings, emotions, and various mental states. (*repression of the inner life*). He also expresses concern regarding the number of practitioners who cling to the "wooly mammoth" theory, focussing their work on material buried in the past (whether or not memories of events), rather than attending to patterns of self-defeating behaviors patients engage in currently in their relations to, and interactions with others. *See id.* at 346-49.

¹¹²Penfield, *supra* note 111.

fact that only 3.5 percent to 7.7 percent of Penfield's patients, forty patients in all, reported any such mental experiences,¹¹³ *Penfield failed to document that any of these experiences were memories of actual past events, rather than merely fantasies or hallucinations.*¹¹⁴

Moreover, a careful examination of the experiences reported by the forty stimulation-responders, have led researchers to conclude that "at most the electrically induced experiences were reconstructions or original hallucinogenic experiences in and of themselves,¹¹⁵ or dream-type synthetic constructions [rather than] . . . 'literal recalls.'"¹¹⁶ "A strong determinant of the content of these memories is the patient's mental content at the time of stimulation. These so-called memories then, appear to consist merely of the thoughts and ideas that happened to exist just prior to and during the stimulation."¹¹⁷

The "pristine," "frozen mammoth" hypothesis of repressed memories is without scientific or systematized empirical evidence to support it.¹¹⁸ Research has found no reason to believe that repressed memory "behaves" differently from forgotten memories; the former are probably no more immune from changes and distortions wrought by the confabulation process than the latter. While researchers have definitively established that there are many contaminants of ordinary memory, there is no conclusive way to establish, by ethically conducted experiments, whether repressed memory of abuse is subject to similar contaminants as ordinary forgetting and apparent remembering.¹¹⁹

¹¹³See Elizabeth F. Loftus & Geoffrey R. Loftus, *On the Permanence of Stored Information in the Human Brain*, 35 AM. PSYCHOLOGIST 409, 413 (1980).

¹¹⁴See generally SCHAFTER, *supra* note 107, at 76-78.

¹¹⁵Loftus & Loftus, *supra* note 113, at 414. Nothing could be pinned down as a detailed, concrete actual historical memory, and much was auditory, vague, or inconsistent with actual history or not possible. (E.g., remembering one's own birth).

¹¹⁶ULRICH NEISSER, *COGNITIVE PSYCHOLOGY* 169 (1967).

¹¹⁷Loftus & Loftus, *supra* note 113, at 414.

¹¹⁸See, e.g., David S. Holmes, *The Evidence for Repression: An Examination of Sixty Years of Research*, in *REPRESSION AND DISSOCIATION* 85, 96 (Jerome L. Singer ed., 1990).

¹¹⁹Repression is in part such a problematic concept because it is impossible to demonstrate experimentally in a laboratory setting. Any effort to do so-to generate real trauma-would transgress the boundaries of ethics and morality. SCHAFTER, *supra* note 108, at 272; Bowers & Farvolden, *supra* note 97 at 359.

A study by David Holmes of sixty years of research failed to discover a single case of authenticated repression: "there is no controlled laboratory evidence supporting the conception of repression." Holmes, *supra* note 118, at 96. The study is not without its critics, see, e.g., WACHTEL, *supra* note 92, at 133.

While the textual discussion suggests that there is little experimental evidence to support the idea of repressed *memory of historical events*, the concept of repression of emotions (e.g., fear, anger, sexuality) and other aspects of inner life plays an important role in the most respectable contemporary therapies. See generally *id.* at 87, 131-140.

Regarding the importance of the repression/pristine/"woolly mammoth" theory to recovered memory proponents; if memories retrieved in therapy by patients who presented with no such memory cannot be deemed reliable, at least in its incest-recalling aspects, then a recovered memory practitioner cannot justify his assumption that he has an incest survivor before him.

Given the absence of evidence, research support, or a strong theoretical or neurological foundation, it is untenable for any practitioners to simply assume the accuracy of apparent retrieved memories of CSA.

C. Retrieval/Recall

An issue which has concerned part of the repression/dissociation debate is whether there is a difference in recallability between *a single traumatic childhood episode of sexual abuse, and a series of episodes of abuse?* The significance of this issue lies in the fact that a substantial majority of cases of apparent recovered memories involves recollections of multiple episodes of molestation. Research suggests that forgetting or repressing a single entire traumatic episode is rare.

Dr. Schacter points out that

*[e]vidence concerning memory for real-life traumas in children and adults indicates that these events—such as the Chowchilla kidnappings, the sniper killing at an elementary school, or the collapse of skywalks at a Kansas City hotel—are generally well-remembered. Some forgetting and distortion occur, but complete amnesia for these terrifying episodes is virtually non-existent.*¹²⁰

Psychiatrist Lenore Terr argues that single traumatic events are readily recalled,¹²¹ but repeated episodes of trauma (e.g., a child subjected to many instances of abuse by her father), tend to be dissociated and therefore unavailable for recall.¹²²

There is considerable scholarship, however, that points in the opposite direction regarding repeated exposure to traumatic experiences.

[H]undreds of studies have shown that repetition of information leads to improved memory, not loss of memory. . . . [P]rofound amnesia is unlikely. People who have lived through repeated traumas in war generally remember these terrifying experiences all too well. . . . [W]ith

¹²⁰SCHACTER, *supra* note 107, at 256.

Many limited amnesias, in which people fail to remember a traumatic event such as committing a murder or being raped, are due to alcohol intoxication, brain injury, loss of consciousness, or even deliberate faking. There are only a few dramatic examples . . . in which forgetting is not easily attributable to those factors.

Id.

¹²¹LOFTUS & KETCHUM, *supra* note 15, at 57.

¹²²LENORE TERR, UNCHAINED MEMORIES: THE STORIES OF TRAUMATIC MEMORIES, LOST AND FOUND 87-89 (1994).

rare exceptions such as fugue states—which are generally of short duration—people do not forget an entire set of repeated traumas.¹²³

Psychologists Lindsay and Read reviewing many studies of memory and traumatic experiences conclude that

existing research on children's and adults' memory for physical traumas, murders, natural disasters, and so on, suggests that *memory for trauma follows the same principles as memories for mundane events*, and that, because of their salience, *traumatic events are more, rather than less, likely to be remembered. . . .*

We do not claim that it is impossible for survivors of repeated contact CSA to forget that they were abused. Rather, our point is that *evidence suggests that such forgetting is rare. Forgetting in ways that enable later remembering is likely rarer still.*¹²⁴

Regarding repeated sexual traumas, "the specific events become blurred in memory and are difficult to separate from one another."¹²⁵ This kind of failure to remember details of particular episodes would not

lead to amnesia for all the relevant experiences—the abused person would still recall the general event of being abused. But blurring and merging of details from repeated episodes might help explain why the memories of sexual-abuse survivors are sometimes patchy and incomplete.¹²⁶

Dr. Terr, a leading scholarly figure supporting recovered memory work in therapy, has, in her theoretical work, created an inconsistency that curiously acknowledged that recovery of memory in therapy is extremely unlikely. Dr. Terr has argued that single traumatic events are rarely forgotten, while a series of traumatic events are so dissociated as to never enter the memory in the first place and thus are unavailable for retrieval or recovery.¹²⁷ Accordingly, any clear or vivid memory purportedly retrieved during therapy is unlikely to accurately reflect reality.¹²⁸

The critical question as to whether repressed CSA can be recalled is answered, to the satisfaction of the advocates of recovered memory therapy, in seven studies which purport to show that persons who had been victimized

¹²³SCHACTER, *supra* note 107, at 257.

¹²⁴D. Stephen Lindsay & J. Don Read, "Memory Work" and Recovered Memories of Childhood Sexual Abuse: Scientific Evidence and Public, Professional and Personal Issues, 1 PSYCHOL. PUB. POL'Y & L. 846, 855 (1995).

¹²⁵SCHACTER, *supra* note 107, at 259.

¹²⁶*Id.*

¹²⁷Among those who have pointed this out are Bowers and Farvolden, *supra* note 97, at 358.

¹²⁸*Id.*

did not remember their sexual victimization. In six of the studies, groups of women who evidently remembered CSA were asked a variant of the question: "was there a time when you didn't remember the abuse?" Various percentages of respondents in these studies answered these questions affirmatively.¹²⁹ From this, some recovered memory therapists conclude that patients who have no presenting memory of CSA may well be actual victims.

However, Lindsay and Read observed:

The most global criticism of these studies concerns the ambiguity of the question respondents were asked, such as, 'Was there ever a time when you could not remember some or all of the abuse?' . . . The meaning of affirmative responses to this question is not clear: *Were respondents reporting periods during which they avoided thinking of the abuse or periods during which they would have been unable to recall it if asked? . . .* The question was phrased in different ways in different studies, but in all cases it is unclear how well the question mapped on to complete amnesia for a CSA history. *Even if it is assumed that most respondents were referring to complete amnesia for abuse histories rather than to avoidance, forgetting of details, or forgetting of particular instances, questions can be raised about people's ability to assess whether they would have been able to remember CSA during a period of time when they claim not to have remembered it.*¹³⁰

It would seem self-evidently questionable to ask people who remembered what they have forgotten to rely on their memory of their forgetfulness as proof of profound forgetfulness or repression.

¹²⁹In six studies, people were asked if they had ever experienced a period during which they could not remember CSA that they now remember. In Briere and Conte's (1993) questionnaire study of 450 women whose therapists were part of a sexual abuse treatment network, 59% of the 100% who reported CSA indicated that there had been a period during which they were unable to remember the first instance of abuse. In Loftus, Polonsky, and Fullilove's (1994) interview study of 105 women in a drug rehabilitation program, 19% of the 54% who reported CSA indicated a prior period during which they forgot the abuse. In Gold, Hughes, and Hohnecker's (1994) intake interviews of an unspecified number of women in a sex abuse survivors' treatment program, 30% of the (presumably) 100% who reported CSA indicated that there had been at least a one-year period during which memories of the abuse were "completely blocked out." In Sheiman's (1993) questionnaire study of 196 undergraduates, half of the 12% who reported CSA indicated that there had been a period during which they did not remember the abuse. In Feldman-Summers and Pope's (1994) questionnaire study of 330 therapists, 41% of the 24% who reported CSA indicated that there had been a period during which they could not remember some or all of the abuse. In Williams's (1994) prospective study of 129 women with recorded histories of an instance of CSA, 12% of the 62% who reported the recorded instance when interviewed seventeen years later indicated that there had been a period when they did not remember that instance of abuse. Lindsay & Read, *supra* note 124, at 855 (materials cited therein).

¹³⁰*Id.* (citations omitted).

Indeed, problematic in several of these studies is their failure to indicate what percentage of people purporting to recover memories of CSA experienced such recovery in therapy.

A further problem with the Briere and Conte's . . . study is that the respondents were all in therapy. If some of their clinicians were under the belief that repression of memory is common, they may have communicated this belief to their clients. Clients could readily infer that, if repression of memory is so common, it is likely to have happened to them This would, of course, inflate the estimates of the prevalence of repression.¹³¹

The importance of this query is also based on the evidence that *accurate spontaneous recall*, independent of therapy, of long buried or forgotten incidents is possible; in such situations there is not the influence, and suggestiveness of recovered memory therapy.¹³²

The research most frequently cited by advocates of recovered memory therapy is a study by psychologist Linda Meyer Williams.¹³³ The study, conducted in 1990 and 1991, consisted of interviews and detailed questions of 129 women with previously documented histories of CSA.¹³⁴ Thirty-eight percent of the women (forty-nine) did not recall the reported abuse or any abuse by the same perpetrator. Of those who did not recall the documented incident, two-thirds recalled abuse by other perpetrators at other times; one-third reported that they had never been abused (twelve percent of the total) (sixteen). Many intriguing insights regarding relationships between remembering, forgetting, identity of perpetrator, nature of abuse, age of victim, etc., were advanced by Professor Williams.¹³⁵ The implications of the study for treatment and forensic issues, while not explored by Williams, have become a bone of contention among those involved in the controversy.

Bowers and Farvolden ask about the Williams study:

Despite its superiority over strictly retrospective studies of child sexual abuse, it is not entirely clear whether and to what extent non-reported abuse in the Williams study was due to repression—as distinct from ordinary

¹³¹Loftus, *supra* note 2, at 521 (1993).

¹³²There have been a number of incidents of *sudden spontaneous recall*, several of which have been corroborated, and some leading to criminal convictions of the childhood molester. Butler, *supra* note 32; see also SCHACTER, *supra* note 107, at 265. Lindsay and Read observe, however, "if and when memory recovery is truly spontaneous there are far fewer grounds for concern about false memories." Lindsay & Read, *supra* note 124, at 847.

¹³³Linda M. Williams, *Recall of Childhood Trauma: A Prospective Study of Women's Memories of Child Sexual Abuse*, 62 J. CONSULTING & CLINICAL PSYCHOL. 1167 (1994).

¹³⁴The documentation was in hospital records from emergency rooms in a major Northeast city during the 1970s.

¹³⁵*Id.* at 1174.

*forgetting, infantile amnesia, embarrassment at mentioning the abuse incidents, and so on.*¹³⁶

Moreover, there is no indication that those who could not remember documented childhood abuse would ever remember.¹³⁷ One must, as Professor Williams herself cautions, take her findings as a modest beginning in the understanding of memories of CSA.¹³⁸ It surely does not support the notion that those who forgot would ever remember, or that they would remember in therapy or that, if high powered suggestiveness were used in therapy, what they remembered would be sufficiently accurate (as to perpetrator and nature of the abuse) to be a basis for abuse-survivor therapy and/or the making of an accusation (formal or informal) against a purported perpetrator.

Lindsay and Read sum up the Williams study:

Williams did not indicate how many of the 12% who reported no abuse history were under 4 years of age when the recorded instance occurred, so we cannot estimate the extent to which [normal] infantile amnesia contributed to these cases. William's results suggest that a substantial minority of victims of CSA do not report a particular instance when interviewed years later and that some survivors of a recorded instance do not report any CSA when interviewed about their CSA histories (probably because they do not recall the abuse). As Williams . . . noted however, *the findings do not support the idea that a large percentage of people with extensive histories of CSA are unaware that they ever experienced such abuse.*¹³⁹

Distinguished experimental psychologist and preeminent expert on memory, Dr. Elizabeth Loftus comments: "Perhaps the best way to think about the 38% in Williams sample who didn't remember is to say it simple. They don't remember."¹⁴⁰

If the present author may speculate, it may be that the women constituting the relatively high percentage who could not remember the documented instance of childhood sexual molestation, had been subject to a childhood pervaded by a multitude of experiences, as victims and witnesses of trauma,

¹³⁶Bowers & Farvolden, *supra* note 97, at 359 (citations omitted).

¹³⁷Elizabeth F. Loftus et al., *Forgetting Sexual Trauma: What Does it Mean When 38% Forget?* 62 J. CONSULTING & CLINICAL PSYCHOL. 1177, 1180 (1994) [hereinafter *Forgetting Sexual Trauma*].

¹³⁸Linda Meyer Williams, *What Does It Mean to Forget Child Sexual Abuse? A Reply to Loftus, Garry, and Feldman*; 62 J. COUNSELING & CLINICAL PSYCHOL. 1182, 1184 (1994).

¹³⁹ Lindsay & Read, *supra* note 124, at 857. Because recovered memory therapy often yields memories of repeated episodes of sexual abuses, and the 38% had prior to the reported abuse not been abused, the Williams study may be more probative evidence that a single episode, rather than a series of episodes may be forgotten.

¹⁴⁰*Forgetting Sexual Trauma, supra* note 137, at 1179-80.

abuse, and extreme stress. Such a history would tend to explain the inability to recall a particular documented instance of sexual victimization.

The problem, most authorities conclude *is not that victims of traumatic experiences cannot remember, but that they cannot forget!*

Why the concern over the profundity of the forgetting phenomenon, whatever the label? Apparently because critics of recovered memory therapy are concerned that if victimized patients could truly not remember it would support the thesis of permafrost repression and lend credence to the claim that recovered memories of once unremembered traumas are accurate.

Since there is no evidence to support the concept of a distortion-free storage stage, even if one accepts the proposition that experiences can be so deeply forgotten as to be immune to recall by ordinary triggers of remembrance, *it is simply a mistake to assume that a sudden insight, flashback, or cathartic experience is self-validating.*¹⁴¹

In any event, one can concede the possibility that memories once deeply buried (whatever the label), whether insulated from confabulation or not, can in some cases under certain circumstances be recalled with material accuracy.¹⁴²

The key point regarding purported recovered memories, is that there is no way to tell whether they are accurate in their material respects. Where there is an apparent recollection of CSA, one cannot tell whether it is significant distortion of an innocuous or, at worst, ambiguous event. One cannot tell because there are so many paths to material inaccuracy and significant distortion.

The "recall" might be illusory if repressed memories are subject to confabulation in the storage period. The evident recollection might be illusory because some original experience was received in a state of dissociation. The ostensible memory might be substantially inaccurate if the ambiguous memory was never completely forgotten, but in its partial awareness and partial forgotten state was subject to a variety of distortive processes. It might be inaccurate because the original trauma (perhaps different from the remembered trauma) produced post traumatic stress disorder with attendant distortive dissociative episodes.

Even if it could be said with some confidence that traumatic episodes when forgotten could be repressed (in the pristine storage sense), it would not follow that *any particular ostensible* recollection of a traumatic, sexually abusive episode was acceptable proof of a repressed trauma, rather than a manifestation of ordinary, albeit deep, forgetting, subject to numerous distortive processes over the years.

¹⁴¹Bowers & Farvolden, *supra* note 97, at 361.

¹⁴²After all, confabulation does not necessarily refer to processes so distortive as always to transform the underlying historical experience into an eventually remembered experience that is fundamentally false. Confabulation during storage may well affect only certain peripheral details, but leave the essentials of the original traumatic experience basically consistent with reality.

Finally, even assuming that a memory of a traumatic event can sometimes be stored in a frozen, unchanged condition, such a repressed memory would be highly resistant to making a "public appearance," *i.e.*, by manifesting itself in the patient's consciousness. It would seem to follow that the powerful cueing necessary to coax that memory out of its hibernating cocoon may well have a substantial distortive effect on what eventually comes to surface.¹⁴³

Given that: a) it is not known whether there is a confabulation-immune memory storage process; b) it cannot be determined whether a particular ostensible memory is actually the product of such a process or has one of several alternative explanations; and c) regarding any truly intact memory in deep storage (if such there ever be) the process of recovery may be significantly distortive, *a therapist must rationally acknowledge that he or she is simply in the dark concerning the accuracy of a "recovered memory."*

The readiness of some therapists to accept purported memories as self-authenticating, self-validating, and by virtue of their content unquestionably true is very troubling. Only some combination of an extreme confirmatory bias, denial, rationalization, unchecked premises, and willful blindness can begin to explain the untenable disregard of reason and research. These distortive processes contaminating therapeutic objectivity and openness may well be rooted in deeply felt sympathy for survivors of sexual abuse *but they fail to advance the objective of treating actual victims of CSA.*

Whatever the reliability or validity of recovered memory therapy, sexual abuse of children is one of the gravest hidden evils of society; it is the most contemptible form of exploitation of the helpless and vulnerable; it reflects an awful callousness, a complete absence of empathy or conscience; and it causes, in many victims, untold distress. It may produce emotional and interpersonal turmoil throughout their lives, creating psychic pain, dysfunctional behavior, and severely burdened efforts to get on with ordinary living.¹⁴⁴ Perhaps because it is a hidden evil with deleterious emotional consequences, most often perpetrated against female children, there is such a powerful desire by many therapists to expose it.

Some conclusions, drawn from materials herein, can now be drawn from a consensus of considered opinions.

- People who are sexually abused in the first few years of life are unlikely to ever remember the experience(s).
- People are unlikely to forget traumatic events occurring after the age of three or four.
- A single traumatic episode is much more likely to be remembered than profoundly forgotten, but there have been some documented instances of long delayed accurate recollection.

¹⁴³See generally SCHACTER, *supra* note 107, at 180.

¹⁴⁴J. McCaule et al., *Clinical Characteristics of Women With a History of Childhood Abuse*, 27 JAMA 1362 (1997).

- Regarding multiple traumatic episodes, particular aspects of any episode may be forgotten, but the existence of the stream of such episodes is likely to be remembered.
- Therefore, *it is a rare case in which a person will forget being traumatized in childhood* (at a time subsequent to the ages of normal childhood amnesia).

Thus,

- *"Only a very small percentage of people have hidden histories of CSA that they could recover through memory work."*¹⁴⁵

Where a person does appear to recall for the first time, experiencing trauma years earlier, the accuracy of such recollection is at least an open question, if not more suspect than not. No scientific method has been developed for determining whether such an apparent recollection is accurate or illusory.

An additional proposition to be elaborated below is that:

- The probability of an inaccurate or induced or implanted memory—a *false memory or pseudomemory*, is considerably increased by a therapist's utilization of highly suggestive, heavy-handed techniques of retrieval, as well as by several other socio-psychological and therapist-patient relational factors.

VI. RISKING INDUCEMENT OF FALSE MEMORIES OF ABUSE

In suits by patients against alleged abusers, suits brought after expiration of the statute of limitations, the profundity of recollection impairment (whatever the label) is indeed an issue.

The critical question for any suit by a falsely accused person against a recovered memory therapist is, however, "what are the conditions surrounding the memory retrieval process that make it likely that false memories will be induced?" The process of retrieval within the consulting rooms of recovered memory therapists, will be explored for its possible effects on the authenticity of recovered memories. The concern is with purported recoveries of memory in situations *involving gross and irresponsible suggestiveness on the part of therapists*.¹⁴⁶ No lawsuit seems justified where the patient has or purports to have, recollections of CSA prior to, or absent, suggestive communications in therapy, or even where some normal, typical professional observations and interpretations and inquiries have moderately suggestive tendencies. Only

¹⁴⁵See Lindsay & Read *supra* note 124, at 861-62 (1995).

We do not claim that it is impossible for survivors of repeated contact CSA to forget that they were abused. Rather, our point is that evidence suggests that such forgetting is rare. Forgetting in ways that enable later remembering is likely rarer still. Together, these findings and arguments imply that only a very small percentage of people have hidden histories of CSA that they could recover through memory work.

Id.

¹⁴⁶Professors Bowman and Mertz express disapproval of such practices, but question the frequency of employment of such techniques, *supra* note 7. Compare, however Lindsay & Read, *supra* note 124.

where the therapist creates substantial risks of engendering false memories and false accusations of atrocious crimes by misuse of powerfully suggestive techniques is a legal cause of action being recommended.¹⁴⁷

A. Untenable Diagnostic Assumptions of Recovered Memory Therapy

The initial difficulty, the predicate of a creation of a high risk of false memories of abuse, is in the diagnostic judgment. Notwithstanding authoritative observations that there are no strong diagnostic indicia justifying a conclusion of CSA (absent the patient's unprompted memory of some or all of it), recovered memory clinicians insist that they can recognize the symptoms in their patients.

While some of the popular books on sexual abuse have checklists of symptoms too numerous to enumerate,¹⁴⁸ the "bible" of the movement, *The Courage to Heal* by Ellen Bass and Laura Davis advises therapists that "[i]f sexual abuse isn't the presenting problem but your client has eating disorders, an addiction to drugs or alcohol, suicidal feelings, or sexual problems, these may be symptoms of sexual abuse."¹⁴⁹ This book and others along similar lines are often recommended by recovered memory therapists to their patients.

According to Dr. Sadoff, *some recovered memory therapists believe:*

that all patients who have eating disorders or experience sexual dysfunction must have been sexually abused as youngsters.¹⁵⁰ Sometimes, these therapists will communicate this message directly to the patient. . . . "You have symptoms which we know, from research, have been caused by early sexual abuse. You do not have those memories now, but through therapy I will help you uncover those memories so you can be helped." This is an outrageous statement yet a number of therapists believe it is helpful. . . . the therapist ignores the real cause of the symptoms, insuring that the

¹⁴⁷Borrowing one authority's taxonomy, the cause of action recommended herein is only in category four of the following list, and even then in only extreme cases:

"1) cases in which someone knows and has known all along that he or she was abused; 2) cases in which someone independently remembers repressed memories; 3) cases in which a therapist facilitates recall of repressed memories; 4) cases in which a therapist suggests memories of abuse." YAPKO, *supra* note 15, at 31.

¹⁴⁸See, e.g., E. SUE BLUME, *SECRET SURVIVORS: UNCOVERING INCEST AND ITS AFTEREFFECTS IN WOMEN* (1990). Some of the "symptoms of childhood sexual abuse mentioned on a thirty-four item checklist are compulsive behavior, gastrointestinal problems, headaches, eating disorders, drug or alcohol abuse, "feeling different," stealing, guilt, low self-esteem." Also suggested as indications are needing to tell secrets, inability to take risks, fear of losing control, and having "difficulty with water hitting the face." *Id.* at xviii-xxi, xix, 198-99.

¹⁴⁹BASS & DAVIS, *supra* note 94, at 849.

¹⁵⁰Dr. Sadoff points out that bulimia may well be rooted in demands of perfectionism placed on the patient as a child; sexual dysfunction might be rooted in a strict religious upbringing. And many other etiologies could be explanatory of such conditions. Sadoff, *supra* note 38, at 80.

patient will not get the help she needs. [Moreover] . . . the therapist posits a false cause, resulting in the patient battling for years with family and friends over events that never happened.¹⁵¹

According to most authoritative commentators, there are no firm, reliable strong diagnostic indicia¹⁵² of CSA. Regarding adult sexual dysfunction, believed by some abuse therapists to be such an indicator: "*sexual dysfunction is also associated with a variety of other background factors.*"¹⁵³

The assertions regarding the diagnostic significance of eating disorders as indicative of childhood sexual victimization have also been contradicted by recent studies.¹⁵⁴

¹⁵¹*Id.* at 82-83.

A second group of therapists are more subtle. They will indicate to the patient that she may or may not have suffered early sexual abuse, stating that the answer to this question will be uncovered in therapy. The suggestion, however, hangs heavily in the air waiting for the transference process to take over.

A third group will often ask leading questions, such as, "Have you ever been sexually abused as a youngster?" or "What are your earliest memories of sexual contact within your family?" A perceptive patient often understands that there is an inference that she was abused. Again, the process of transference can give rise to memories that are false.

A fourth group will recommend books to the patient to read, such as, *The Courage to Heal*, which tells these young women that if they think they have been abused then they have been abused. The book also names consulting lawyers and doctors who can assist in pursuing a legal remedy.

I am sure these therapists do not know the harm they cause.

Id. at 82-83.

¹⁵²Lindsay & Read, *supra* note 124, at 863.

¹⁵³Debra A. Poole et al., *Psychotherapy and the Recovery of Memories of Childhood Sexual Abuse: U.S. and British Practitioners' Opinions, Practices, and Experiences*, 63 J. CONSULTING & CLINICAL PSYCHOL. 426, 435 (1995) (citations omitted).

¹⁵⁴See Marcia Rorty et al., *Childhood Sexual, Physical, and Psychological Abuse in Bulimia Nervosa*, 151 AM. J. PSYCHIATRY 1122, 1122 (1994); Johann Kinzel et al., *Family Background and Sexual Abuse Associated with Eating Disorders*, 151 AM. J. PSYCHIATRY 1127, 1130 (1994) (childhood sexual abuse was "neither necessary nor sufficient for the latter development of an eating disorder").

A recent statement by the Canadian Psychiatric Association declares: certain therapists . . . use a list of symptoms that are said to indicate the likelihood of individuals having been abused. Common symptoms such as depression, anxiety, anorexia or overeating, poorly explained pains, and other bodily complaints have all been used as proof of alleged sexual abuse. There is no support for such propositions. Psychotherapy based on these assumptions may lead to deliterious effects. Increases in self-injury and suicide attempts have been reported in some patients given recovered memory treatment.

June 1996 Position Statement, supra note 93.

Dr. Elizabeth Loftus puts it most cogently: "*If everything is a sign of past childhood abuse, then nothing is.*"¹⁵⁵

A psychologist who bases conclusions on profoundly inadequate evidence and unscientific preconceptions is acting unprofessionally, substituting zeal for open-mindedness. There are few more obvious logical fallacies than the notion that: if A (e.g. childhood sexual abuse) produces B (a variety of emotional and functional disabilities) then where B is found, A must be the cause. (To act on such a fallacy is equivalent to a physician concluding that if a patient complains of headaches, she must have a brain tumor.)

Even with authoritative knowledge of the most probable emotional and behavioral consequences of CSA,¹⁵⁶ one cannot rationally diagnose sexual abuse if the cluster of presenting symptoms is substantially consistent with other etiological explanations.¹⁵⁷ Yet such unscientific diagnostic conclusions may be the instrument that significantly contributes to the patient's ultimately embracing erroneous beliefs and false memories.

This author has examined a large sample of the recovered memory literature and has failed to find (although it might exist in some obscure corner) any recommendation (with one exception)¹⁵⁸ that even where a patient presents with an apparent partial or complete memory of CSA, the therapist must not automatically accept the patient's assertion¹⁵⁹ as a premise on which to build, but rather should suspend judgment¹⁶⁰ and await developments in the course of open-minded therapeutic techniques.

B. Suggestive Aspects of Recovered Memory Therapy

1. Situational Factors

A patient may undertake therapy for an almost infinite number of reasons related to distress, unhappiness, failed relationships, or other perceived failures

¹⁵⁵Elizabeth F. Loftus, *The Repressed Memory Controversy*, 49 AM. PSYCHOL. 443, 444 (May, 1994) [hereinafter *Repressed Memory Controversy*].

¹⁵⁶American Medical Association Council on Scientific Affairs, *Scientific Status of Refreshing Recollection by the Use of Hypnosis*, 253 JAMA 1918 (1985) [hereinafter *Scientific Status of Refreshing Recollection*].

¹⁵⁷"CSA is associated with many adulthood psychological problems but some people with CSA histories do not have those symptoms, and many people who have those symptoms do not have CSA histories." Lindsay & Read, *supra* note 118, at 863.

¹⁵⁸See HERMAN, *supra* note 101.

¹⁵⁹"[U]ncritical acceptance of every single claim of sexual abuse, no matter how dubious, is bound to have an unintended and tragic consequence: *trivializing the true and ruthless cases of abuse and increasing the suffering of genuine victims.*" Loftus, *supra* note 2.

¹⁶⁰Freud recommended that psychoanalysts approach a patient with "evenly suspended attention" . . . "in the face of all that one hears." RECOMMENDATIONS TO PHYSICIANS PRACTICING PSYCHOANALYSIS (1912) (quoted in JANET MALCOLM, PSYCHOANALYSIS, THE IMPOSSIBLE PROFESSION 26 (1982)).

or behavioral difficulties. She feels that she is in need of help and that therapy can provide that help. Often, she enters therapy in some degree of emotional fragility and vulnerability.

Putting her faith in the therapist, the patient often forms an emotional attachment to her. She may give considerable credence to the therapist's interpretations or suggestions.¹⁶¹ The patient's emotional survival may depend on the success of the therapy. The therapist may be, in the mind of the patient, a last best hope for resolving intolerable emotional, inter-personal or psycho-social burdens and crises. She needs to believe in the healing powers of the therapist, to place her faith in the therapist,¹⁶² sometimes a faith akin to blind religious faith.

There may develop a transference relationship¹⁶³ to the therapist, a repetition of a strong attachment the patient once had to a childhood figure or even a powerful figure in adulthood. In "the transference," the therapist becomes, in the eyes of the patient, the source of love and wisdom, the omniscient provider of answers, and the one who cares deeply and affectionately for the patient and her well-being. There is, in any event, a marked imbalance in power and authority in the relationship.

In view of these phenomena, the patient is ordinarily receptive to even hints by a therapist of the underlying problem or cause. When a therapist begins hinting, strongly hinting, if not explicitly suggesting, that the patient's problems originate in childhood sexual victimization, the patient, seeking a cure and wanting to please the therapist and meet his expectations, will look hard in the suggested direction. Along with the directed search for memories may be the realization that incest victim status is socially acceptable today (rather than stigmatic) and can elicit many sources of supportive attention. At a subconscious level, finding an external cause for his or her distress may relieve a patient of feelings of personal responsibility or blame.¹⁶⁴ Moreover,

¹⁶¹Or she may resist them for some time, and even reject proffered interpretations.

¹⁶²See, e.g., OFSHE & WATTERS, *supra* note 15, at 111.

¹⁶³See, e.g., Sadoff, *supra* note 38, at 81-82.

During the course of therapy, a patient who wishes to please her therapist will often provide information the patient believes the therapist wants to hear. For example, when therapists write notes about a patient's dreams, the patient will often share more dream material because, at some level, the patient recognizes that the therapist is interested in dream productions. Similarly, when the therapist appears to be interested in early memories which may relate to recurrent symptomatology, the patient will often "find" early memories.

Id.

¹⁶⁴There is another factor contributing to the broad acceptance of recovered memories of sexual abuse—the *newfound readiness of many people to identify themselves as victims* and the readiness by others to accept, endorse and even sanctify that identity. . . . *To have been made a victim, or to be a member of a victimized group, was once a stigma. Now it is more likely to be cited as the central*

the apparent memory may serve as a screen memory covering up authentic memories of even more painful, *actual* events or feelings. There may also be some existing alienation toward family members having nothing to do with (non-existent) CSA.

According to Harvard psychiatrist Dr. Judith Herman (a respected proponent of incest survivor therapy) an actual incest survivor may be least trusting of a therapist and most resistant to confronting the fact of her childhood sexual victimization.¹⁶⁵

Such an observation ironically fortifies the *concerns expressed herein. For it implies that it takes heavier cueing, and a more suggestive search for truth to uncover actual victimization. Yet such techniques are even more likely to induce non-abused, and thus more trusting, less-resistant patients to generate specious memories.*¹⁶⁶

The therapist, by one or more of the techniques examined below, persuades the patient to remember episodes of sexual abuse. Once a patient sets out to find such a memory, ordinary processes by which people find what they are expecting and needing to find, take over. Doubts are "reasoned" away. Ambiguous fragments of memory (my father bathed me, my father hugged me once for an extra long time, my brother slapped me on the rump after I won the hundred yard dash) become hostage to the confirmatory bias in which neutral behaviors are interpreted as sexually abusive.

With a powerful cheering section encouraging production of incest memories, and disapproval, in words or silence, confronting denial of such memories,¹⁶⁷ even if other highly suggestive techniques were not used, it would not be surprising to discover that the therapist's expectations of recovered memories of CSA were met.

Some recovered memory therapists, as we shall see, tend to impose their preconceived agenda on patients, and will simply not take no for an answer.¹⁶⁸

explanation for a person's difficulties in life and as a justification for receiving special understanding and even compensation from those who have not been similarly victimized.

Walter Reich, *The Monster in the Mists*, N.Y. TIMES, May 15, 1994 at Section 7 (Book Review).

¹⁶⁵See HERMAN, *supra* note 101, at 138-39, 148.

¹⁶⁶See generally SCHACTER, *supra* note 107, at 80. The situation is reminiscent of a paradox in the entrapment defense: The extent of police prompting and enticing necessary to induce criminal behavior in a wary person, albeit predisposed to criminality, may have to be so great as to also induce an otherwise innocent person to commit crime.

¹⁶⁷*Cf.* Campbell, *supra* note 64.

¹⁶⁸Practitioners of recovered memory therapy sometimes make the illogical leap from the fact of societal denial of widespread child sexual abuse to the conclusion that patients who reject suggestions of their own victimization must be "denying" their personal history.

Indeed, they

concern themselves almost entirely with means of *reinforcing* incest suspicions, not with means of checking them against solid evidence pro or con. Their advice . . . is: "*never cast doubt on . . . [your] suspicions [of incestuous abuse].*" [In the words of Renee Fredickckson, a prominent recovered memory therapist] "You may be convinced that your disbelief is a rational questioning of the reality versus unreality of your memories, but it is partially a misguided attempt to repress the memories again."¹⁶⁹

They may convey to a patient who claims no memory of childhood abuse that she is "denying," or is repressing "in denial" of the reality of childhood incestuous victimization.

Examples abound in the literature. One of the leading contributors to such literature is prominent psychologist Christine Courtois, who writes:

In order to conduct effective incest therapy, the therapist must absolutely accept that incest occurs and that children are used and exploited by their adult caretakers. They must continually counter the personal tendency to defend the adult at the expense of the child or to otherwise deny, discount or dismiss the survivor's story. They must also abandon . . . [perspectives] which reinforce denial.¹⁷⁰

In other words *don't take no for an answer*. Bowers and Farvolden observe: "therapists who are guided by a commitment to the traumatic origin of adult neurosis *readily infer repression of abuse from a patient's resistance to such a proposal*. In other words, *the inability to recall abuse becomes evidence that it occurred.*"¹⁷¹

Dr. Herman, immediately after cautioning against unduly suggestive practices, nevertheless writes:

From the outset, the therapist should place emphasis on the importance of truth-telling and full-disclosure, since the patient is likely to have many secrets, including secrets from herself. The therapist should make clear that the truth is a goal constantly to be striven for, and that while difficult to achieve at first, it will be attained more fully in the course of time.¹⁷²

¹⁶⁹FREDERICK CREWS, *THE MEMORY WARS* 195 (1995).

¹⁷⁰CHRISTINE COURTOIS, *HEALING THE INCEST WOUND* 231 (1988).

¹⁷¹Bowers & Farvolden, *supra* note 97, at 368.

¹⁷²HERMAN, *supra* note 101, at 148. Perhaps the single most telling fact pointing to presuppositional attitudes is that throughout Dr. Herman's work, the patient, who is often uncertain of the basis of her symptomology, is often referred to as "the survivor."

This is by no means to suggest that the quoted material recommends approaches so hypersuggestive they could justify liability under this author's proposed statutory cause of action.

Therapists who simply assert "denial!" when a patient rejects a proffered theory are effectively making a mockery of a psychodynamic concept of real importance, but only when used under appropriate circumstances and in a much more subtle way.

Consider the observations of Professor Paul L. Wachtel, again, not explicitly concerned with recovered memory theory.

The useful directive [to therapists] that vigorous protest by a patient that he does *not* feel or wish something may be an indication that he really does but is conflicted, *can be used by a clinician to "prove" that his every wild guess or hunch is correct*; either the patient acknowledges the accuracy of the interpretation or he denies it, thereby "confirming" it. *This heads-I-win, tails-you-lose approach, however, is a caricature of the original clinical observation, not a legitimate application of it. . . . Even a particularly vigorous denial would not itself be sufficient evidence. If, for example, the patient were reacting to the therapist's continuing to push a pet interpretation that has been rejected several times before, his high-volume denial would be an appropriate reaction and not a signal to place a bet on the therapist's hobby horse.*¹⁷³

When expectations and verbal suggestion are accompanied by some of the techniques discussed below, the risk of producing a pseudomemory is substantial. These techniques reinforce the persuasive power of the factors described earlier by altering the patient's mental state with hypnosis or drugs, encouraging imaginative visualization of childhood molestation, putting the patient (who has not "acknowledged" childhood victimization) in an incest survivor's group, or by other profoundly persuasive processes.

Therapists specializing in memory recovery are sometimes psychologically preoccupied with incestuous abuse. They are in the business of finding it and treating it. As one insightful article observes: "It is psychologically [easy] . . . to get caught up in a confirmatory bias and to overlook or dismiss the possibility that one has implicitly engendered observations, which are then accepted as independent confirmation of one's views."¹⁷⁴

Notwithstanding the questionable ethicality and dubious therapeutic value of hypersuggestive techniques, there is room for moderately suggestive approaches, based on traditional and legitimate practices. It is not suggestion as such that warrants legal concern, for suggestion is unavoidable in therapy.¹⁷⁵ Whatever the "purist" conception of a suggestion-free therapy might be, suggestion of some sort or another has been used since Freud.¹⁷⁶

¹⁷³WACHTEL, *supra* note 92, at 134.

¹⁷⁴Bowers & Farvolden, *supra* note 97, at 371.

¹⁷⁵"It is impossible to engage in suggestion-free psychotherapy . . ." Bowers & Farvolden, *supra* note 97, at 369.

Suggestion's least imposing form is inquiring whether a particular interpretation tallies with a patient's current feelings. Cf. WACHTEL, *supra* note 105, at 179.

2. Hypersuggestive Practices

- Bibliotherapy.
- Hypnosis, drugs, and age regression.
- Creative imagining (guided imagery; visualization).
- Support (persuasion) groups.
- Inducement and interpretation of sexualized dreams.
- Leading and directive verbal cues.
- Interpretations that directly or indirectly assert or assume CSA.
- Questions that contain implicit or explicit factual premises.
- Positive emotional feedback (rewards) for "right" answers, negative emotional feedback for "wrong" answers.

a. Hypnosis and Drugs

Many therapists have profoundly erroneous beliefs about hypnosis. To illustrate;

In a survey of 869 therapists, seventy-five percent thought hypnosis was able to produce accurate recall when other methods were not successful, forty-seven percent agreed that "[t]herapists can have greater faith in details of a traumatic event when obtained hypnotically than otherwise, [and] *almost one-third accepted the myth that a "memory of trauma while in hypnosis must be true."*¹⁷⁷ (Twenty-seven percent did not believe that hypnosis could generate false memories.)

The widespread faith in hypnosis as a tool for recovering memories is contrary to research evidence.¹⁷⁸ Indeed, two researchers have characterized the beliefs reported in the above study as "*truly alarming misconceptions* about human memory and about the safety and efficacy of hypnosis as a technique for remembering childhood events"179

Under hypnosis, a patient is hypersuggestible and hypercompliant. Therapists' cues are readily accepted. Usually the subject will try to please the hypnotist, providing the behavior, beliefs, memories, or experience the therapist, directly or indirectly, intentionally or unintentionally, seeks.

A person under hypnosis is as likely to fantasize, to have erroneous memories, to confabulate, as to remember accurately. Such confabulation is an imaginative creation of details to make the fantasy more believable. Often what is produced is a combination of true and imagined events.¹⁸⁰

¹⁷⁶See Wachtel, *supra* note 105, at 179; Bowers & Farvolden, *supra* note 97, at 369-72.

¹⁷⁷See YAPKO, *supra* note 15.

¹⁷⁸See, e.g., *Scientific Status of Refreshing Recollection*, *supra* note 156.

¹⁷⁹Lindsay & Read, *supra* note 124, at 873.

¹⁸⁰See discussion in *Rock v. Arkansas*, 483 U.S. 44, n.17 59-60 (1987) (striking down a state's per se rule excluding hypnotically refreshed testimony as applied to a criminal defendant).

Psychologists Bowers and Farvolden note that the experience of being deeply hypnotized will more often than not "misrepresent and distort history."¹⁸¹

*[T]he use of hypnosis and hypnosis-like techniques (e.g. relaxation, body work, and guided imagery) to recover memories of abuse should cease and desist. The danger of suggesting false but compelling memories of abuse is real, and there is no way to discriminate false from true memories without leaving the consulting room and doing a great deal of detective work. . . .*¹⁸²

The AMA Council on Scientific Affairs took the position, regarding hypnosis "that recollections obtained during hypnosis can involve confabulations and pseudomemories and not only fail to be more accurate, but actually appear to be less reliable than nonhypnotic recall."¹⁸³ To the extent the hypnotist makes strong suggestions, implicit or explicit, the danger of false feedback is even greater.

In terms of the law regarding hypnosis, a majority of jurisdictions follow a rule of per se inadmissibility regarding testimony about matters remembered for the first time under hypnosis.¹⁸⁴ Many other courts hold that the party offering hypnotically-refreshed testimony has the burden of demonstrating, by clear and convincing evidence, that *inter alia*, no suggestive comments were made while the subject was under hypnosis.¹⁸⁵

b. Guided Imagery and Visualization

This recommended technique directs the patient to imagine:

that you were sexually abused, without worry about accuracy, proving anything or having your ideas make sense. As you give rein to your imagination, let your intuition guide your thoughts. . . . What kind of things are happening? Is there one or more person with you? Male or female? What types of touch are you experiencing? What parts of your body are involved? What do you see, feel or hear? How do you feel emotionally? Angry, scared, excited, confused? Once the patient reflects on answers to these questions, Maltz recommends that the therapist proceed by asking: "Who would have been likely perpetrators? When were you most vulnerable to sexual abuse in your

¹⁸¹Bowers & Farvolden, *supra* note 124, at 369.

¹⁸²*Id.*; see also Loftus, *supra* note 2, at 521 ("There is extensive literature seriously questioning the reliability of hypnotically enhanced memory").

¹⁸³*Scientific Status of Refreshing Recollection*, *supra* note 156.

¹⁸⁴See Murray, *supra* note 7, at 518. For an excellent review of the history and current status of the law regarding hypnotically refreshed testimony, see generally *id.* at 515-19.

¹⁸⁵Such courts follow the leading case of the New Jersey Supreme Court in *State v. Hurd*, 432 A.2d 86 (N.J. 1981).

life? Why would it have been important for you to forget what happened?"¹⁸⁶

Some recovered memory experts "openly suggest . . . that the process of discovering sexual abuse begins with the patient out and out *imagining* the abuse."¹⁸⁷ In a recent study, a significant percentage of subjects who were asked to *imagine* certain events or objects were likely to subsequently include those events or objects in their verbalized recollections of reality.¹⁸⁸ This research tends to show, as other scholars have opined, that *imagination exercises such as guided imagery create a high risk of generating, rather than retrieving, "memories" of CSA.*

c. Use of "Support" Groups

Patients including those who have not [yet?] had memories of CSA are urged by some recovered memory therapists to join incest survivor groups. While these groups can be powerful support and recovery mechanisms for *actual* incest victims, *a non-victim is exposed to a process akin to religious conversion.* Strong social pressure encourages recollection of incest. Support becomes encouragement, becomes persuasion, becomes urging, becomes insisting, that the patient produce details of her incestuous victimization. If and when she does, she is rewarded by praise, empathic understanding, and other forms of support.

Participants in these groups are searching together for past traumas, dedicated to recovering and relating new memories of abuse.

Consider the following description by Dr. Judith Herman:

The group provides a powerful stimulus for the recovery of traumatic memories. As each group member reconstructs [his or] her own narrative, the details of [the] story almost inevitably evoke new recollections in each of the listeners. *In the incest survivor groups, virtually every member who has defined a goal of recovered memories has been able to do so. . . .*

Women who feel stymied by amnesia are encouraged to tell as much of their story as they do remember. Invariably the group offers a fresh emotional perspective that provides a bridge to new memories. In fact, the new memories often come too fast. At times it is necessary to slow the

¹⁸⁶See OFSHE & WATTERS, *supra* note 15, at 92-93 (describing recommendations of recovered memory experts).

¹⁸⁷*Id.* at 93.

¹⁸⁸Cristine Russell, *Suggestion Said to Fuel 'Imagination Inflation,'* WASH. POST, Feb. 25, 1997, at Z11.

process down in order to keep it within the limits of the individual's and the group's tolerance.¹⁸⁹

Beyond the unacceptable degrees of suggestion and persuasion (if not coercion) imposed by some "support" groups, recent findings tend to show that memories are "contagious"—that people in groups will sometimes remember each other's remembered experiences.¹⁹⁰ Such findings tend to support the notion that false memories can be generated in group experiences.

d. Communications by Therapist

Merely on the basis of a suggestive history or set of symptoms, some therapists tell patients they definitely had a traumatic experience. Thereafter the therapist strongly encourages the patient to pursue such memories.¹⁹¹ Some therapists who practice incest detection make statements such as: "Your symptoms sound like you've been abused when you were a child. What can you tell me about that? . . . You sound to me like the sort of person who must have been sexually abused. Tell me what the bastard did to you."¹⁹²

C. Inducement of Illusory Memories

The fact that several hundred patients have recanted their accusations, some of whom have sued their therapists, *tends* to show that false memories were engendered.¹⁹³ The number of known retractors suggests that an untold number of pseudo memories have been induced.

Some recovered memory therapists persuade a patient who remembers some type of abuse from a particular, non-incestuous source, that s/he was *more severely victimized and that the perpetrator was a close family member*.¹⁹⁴

"In numerous autobiographical accounts by patients, the patient with no memories is convinced by the therapist that abuse is likely; [thereafter] the

¹⁸⁹HERMAN, *supra* note 101, at 224.

¹⁹⁰Philip Cohen, *Thanks for the Memories*, 153 NEW SCIENTIST 12 (Feb. 22, 1997).

¹⁹¹See Loftus, *supra* note 2, at 526.

¹⁹²*Id.*

¹⁹³Butler, *supra* note 32, at 36.

Recantations do not conclusively prove false memories, since all one knows is that people had the memories and then recanted. One cannot know, in any particular case if the memory was true or false or if the recantation was consciously or subconsciously motivated by factors other than falsity of the memory.

Nevertheless, the techniques reported by many retractors, some in testimony, strongly suggest that false memories are often induced. Indeed, in these cases there has been no corroboration of the memories of abuse.

¹⁹⁴A 1995 study by a prominent psychiatrist of forty retractors initially presenting with memories of some sexual abuse by a step-brother, stranger, or distant family member, were led to accuse innocent fathers or to remember murders sometimes in Satanic rituals. See H.I. Lief & J.M. Fetkewicz, *Retractors of False Memories: The Evolution of Pseudomemories*, 23 J. PSYCHIATRY & L. 411 (1995).

patient obligingly uses reconstructive strategies to generate memories that would support that conviction."¹⁹⁵

In a remarkable case, Paul Ingram¹⁹⁶ was arrested for child abuse and was pressured by detectives and a psychologist to admit his crimes. Eventually he began to confess to rapes, assaults, child sexual abuse, and participation in a Satan-worshipping cult that was said to have murdered twenty-five infants. Whenever an act of abuse was suggested to him, he would initially be unable to recall such abuse, then after making an effort, would supply a detailed memory.

Dr. Richard Ofshe, a social psychologist on the case, fabricated a story and related it to Ingram, to the effect that Ingram had forced his children to have sexual relations with each other in front of him. When Ingram couldn't remember, Ofshe asked him to imagine the scene and see it happening. Thereafter Ingram wrote an extended confession, supplying graphic detail about the event that never occurred.

Studies where patients remembered the most improbable ritual abuse show that most of the "victims" had no memory of the abuse before the therapy, but hypersuggestive techniques generated such memories.¹⁹⁷

While conceding the possibility of cases in which a patient has actually forgotten real abuse, as well as the possibility that in some such cases suggestive procedures might help such patients recover their memories, Dr. Schacter observes that "*unless a therapist can cite evidence that a specific memory-retrieval technique enhances accurate recall without promoting false recollections, it is inappropriate to continue to use unproven and potentially hazardous memory-retrieval techniques.*"¹⁹⁸

Dr. Schacter also observes that while no conclusive scientific proof demonstrates that false memories are creatable by suggestive techniques (noting that ethical studies could not be designed to prove or disprove the proposition) "*several separate strands, when considered together, support the conclusion that some therapists have helped to create illusory recollections of sexual abuse.*"¹⁹⁹

He cites the following "strands:"

- the experimentally documented malleability of memory in response to suggestive influences;
- evidence that hypnosis can produce compelling but inaccurate pseudomemories;
- failures to document satanic ritual abuse;

¹⁹⁵Loftus, *supra* note 2, at 528.

¹⁹⁶See WRIGHT, *supra* note 15.

¹⁹⁷*Id.* at 528.

¹⁹⁸SCHACTER, *supra* note 107, at 272-73 (1996).

¹⁹⁹*Id.*

- recoveries of memories for seemingly impossible events (past lives and alien abductions);
- growing numbers of therapy patients who have retracted their memories;
- the constructive nature of memories for emotional events; and
- the risky memory-retrieval techniques advocated by some proponents of recovered memory therapy.²⁰⁰

Patients of recovered memory therapists have also claimed to remember incidents at times of infancy and very young childhood, times which authoritative research has long shown is either not remembered or inaccessible to memory.²⁰¹ Indeed, the founder of the British False Memory Society, Roger Scotford, was accused of tickling his daughter's clitoris when she was nine months old, based on her "recovered memory."²⁰²

Some writers, such as Bowman and Mertz, imply that suggestive memory work is a rarity.²⁰³ But there is considerable data to the contrary.²⁰⁴ Indeed estimates are that "many thousands of patients" are exposed to hypersuggestive techniques designed to recover buried memories of CSA.²⁰⁵

In terms of the frequency of therapy-generated illusory memories, Dr. Schacter observes that while we do not know with certainty, "[i]t seems unlikely . . . that they can all be written off to just a handful of wayward therapists."²⁰⁶ "Risky therapeutic practices," Dr. Schacter declares, "need to be stopped."²⁰⁷

If an intensely emotional experience is brought about, some recovered memory therapist believe it reflects truth, even though there is no independent corroboration of it,²⁰⁸ and even though that belief has been rejected by a number of authorities.

²⁰⁰*Id.*

²⁰¹See, e.g., Isabelle Hollida Wakefield & Ralph Underwager, *Recovered Memories of Alleged Sexual Abuse: Lawsuits Against Parents*, 10 BEHAV. SCI. & L. 483, 489 (1992); Lindsay & Read, *supra* note 124, at 856.

²⁰²Paul Valley, *Accused*, INDEPENDENT, Nov. 16, 1996, at 8.

²⁰³See, e.g., Bowman & Mertz, *supra* note 7, at 613.

²⁰⁴One major study concluded, "these findings argue against suggestions by clinicians that clinicians who focus on memory recovery represent a minority culture within the United States. Poole et al., *supra* note 153, at 433. See also Lindsay and Read, concluding, after examining studies and other evidence, that "a nontrivial minority" of practitioners focus on searching for hidden histories of childhood sexual abuse in their clients. Lindsay & Read, *supra* note 124, at 851-52.

²⁰⁵Lindsay & Read, *supra* note 124, at 852.

²⁰⁶SCHACTER, *supra* note 107, at 272-73.

²⁰⁷*Id.* at 277.

²⁰⁸Bowers & Farvolden, *supra* note 97, at 367.

One scholar noted, for example, with regard to past combat experiences, that there is "[no] guarantee that a recovered emotionally charged memory accurately reflects a psychologically traumatic incident."²⁰⁹

Studies have shown that false memories can be implanted and then "recalled" at a later time. In one well-known research project, referred to as the "Mall study," Dr. Elizabeth Loftus first arranged to persuade several persons that at some time in their past they were lost in a mall, having become separated from a parent. In subsequent interviews involving a variety of true events and true memories, twenty-five percent of the subjects *recalled as if true the implanted story* about being lost in a mall, often embellishing the basic false facts with additional surrounding circumstances and emotional material, all of it unconsciously invented and illusory.²¹⁰

In another study, college students were given misleading information about events in their childhood, as well as told true incidents. In two such experiments, 20 percent and 25.5 percent of the students, respectively, provided false recalls with varying degrees of specificity and elaboration.²¹¹ While certain aspects of the study may not be indicative of the likelihood that false memories of CSA would be recovered in therapy, other aspects make the conclusion of false memories of CSA even more probable:

First, the social demands of therapy have several powerful features. *The therapist plays and may accentuate the authority role—authority and expertise influence the acceptance of misinformation. The demands to remember could be more intense in a therapy situation if the therapist presents remembering as crucial for healing. . . .*

Many adults . . . have memories and knowledge that may provide a basis for the construction of a false recall. For example, *many adults were physically punished as children, most were kissed and held (perhaps when they did not want to be), all were bathed, and all were seen in the nude by adults. Thus the personal history of any individual may contain the necessary building blocks for false recall of abuse. . . . [also] most adults have heard stories of abuse that could then serve as building blocks. . . .*

²⁰⁹L.C. Kolb, *Recovery of Memory and Repressed Fantasy in Combat-Induced Post-Traumatic Stress Disorder of Vietnam Veterans*, in HYPNOSIS AND MEMORY 265, 273 (H.M. Pettinati ed., 1988).

²¹⁰Elizabeth F. Loftus et al., *Reality of Illusory Memories*, in MEMORY DISTORTION: HOW MINDS, BRAINS, AND SOCIETIES RECONSTRUCT THE PAST (Daniel Schacter et al. eds., 1996); see also Stephen J. Ceci et al., *The Possible Role of Source Misattribution in the Creation of False Beliefs Among Preschoolers*, 42 INT'L J. CLINICAL & EXPERIMENTAL HYPNOSIS 304-20 (1994).

²¹¹I.E. Hyman, Jr. et al., *False Memories of Childhood Experiences*, 9 APPLIED COGNITIVE PSYCHOL. 181 (1995).

Searching for . . . memories [of CSA] by repeated questioning, by providing cues . . . or by discouraging doubt *may result in the creation of a false recall.*²¹²

Professional associations have raised questions about practices and conclusions of recovered memory therapists: The American Medical Association has concluded that "recovered memories of childhood sexual abuse [are] of uncertain authenticity . . . [and] should be subject to external verification. The use of recovered memories is fraught with problems of potential misapplication."²¹³ The American Psychiatric Association concluded that "[s]cientific knowledge is not yet prescient enough to predict how a certain experience or factor will influence a memory in a given person."²¹⁴ It further advised that "*clinicians should not exert pressure on patients to believe in events that may not have occurred.*"²¹⁵

Regarding the suggestive power of certain techniques, the psychiatrist's group warned that "memories . . . can be significantly influenced by a trusted person (e.g., therapist . . .) who suggests abuse as an explanation for symptoms/problems, despite initial lack of memory of such abuse."²¹⁶

The American Psychological Association's interim report on the subject, composed by a panel represented by opposing sides in the controversy, expressed guarded concerns about the practices of recovered memory therapy, noting that "it is possible to construct convincing pseudomemories for events that never occurred."²¹⁷

The literature, the interviews, and the practices prevailing among recovered memory incest survivor therapists strongly suggest that the recovered memory movement is, in not insignificant part, agenda driven. That the agenda involves a passionate concern regarding a major social evil does not justify its incongruent intrusion into therapeutic professionalism, an intrusion

²¹²*Id.* at 194-195. The distinguished child psychologist, Piaget, erroneously remembered an attempted kidnapping in his very early childhood. Years later he discovered that the story was fabricated by his nanny. Loftus, *supra* note 2, at 529.

²¹³AMERICAN MEDICAL ASSOCIATION, REPORT OF THE COUNCIL OF SCIENTIFIC AFFAIRS: MEMORIES OF CHILDHOOD ABUSE 8 (1994).

²¹⁴AMERICAN PSYCHIATRIC ASSOCIATION, STATEMENT ON MEMORIES OF SEXUAL ABUSE 2 (1993).

²¹⁵*Id.*

²¹⁶*Id.*

²¹⁷AMERICAN PSYCHIATRIC ASSOCIATION, INTERIM REPORT, WORKING GROUP ON INVESTIGATION OF MEMORIES OF CHILDHOOD ABUSE 2 (1994).

The ambivalent tone in the preliminary report of the American Psychological Association's Report seems to reflect intense existing divisiveness among the therapists (indeed it has been likened to religious warfare), and may also be the product of concern that strong standards would themselves become a basis for legal liability. For the view that professional standards should not be crystallized into law, see Robert F. Schoop & David B. Wexler, *Shooting Yourself in the Foot with Due Care: Psychotherapists and Crystallized Standards of Tort Liability*, 17 J. PSYCHIATRY & L. 163 (1989).

manifested by a powerful diagnostic bias indifferent to the creation of imaginary nightmarish biographies.

Psychologist Carol Tavris views the sexual abuse explanation for a variety of emotional difficulties as a very powerful idea for women generally:

[I]t is a brilliant metaphor for the abuse that many women . . . feel they have experienced in society—for their powerlessness, for their vulnerability, for things that have happened to them over their lives that they could not explain, but that occurred to them because they are women living today in modern America. It's a lightening rod for all the unarticulated frustrations and pains that many women still suffer.²¹⁸

The compassionate and professional treatment of actual victims of traumatic childhood abuse is unquestionably of compelling importance. It is a tragedy however, that creation of imagined victims may have brought a backlash that washes over many actual survivors. But such seem the wages of crying wolf.

VII. THE BOWMAN & MERTZ/(HARVARD LAW REVIEW) THESIS

Professors Cynthia Grant Bowman and Elizabeth Mertz, in a recent Harvard Law Review article,²¹⁹ advocate that the law reject any claimed right of a falsely accused person to sue a therapist. They contend that permitting such a suit would be more destructive of social values, good therapy, and the vital interests of victims of abuse than socially beneficial, even in terms of vindicating falsely accused persons.

Arguing that an accused's legal action against a therapist would most probably constitute an unwarranted intervention into a valuable therapeutic relationship involving a CSA survivor, the article postulates that either a memory is: a) true, with or without intervention of a therapist; b) false but not caused by a therapist; or c) false as a result of egregious conduct by a therapist.²²⁰ Because, it declares, which of these situations are in fact the case cannot be known, a lawsuit cannot be justified.

The position taken herein, however, is that a lawsuit is justified where the therapist engages in egregiously suggestive practices in treating a patient presenting with no memories of CSA.²²¹ Under the statute proposed below, plaintiff must show that the *accusation* proximately caused the ultimate harms.²²²

²¹⁸*Frontline: Divided Memories* (A PBS television broadcast, Apr. 4, 1995).

²¹⁹Bowman & Mertz, *supra* note 7.

²²⁰*Id.* at 582-83.

²²¹Bowman and Mertz agree that "heavyhanded suggestive techniques whether in investigative or therapeutic interviews, are generally problematic and are to be avoided when possible." *Id.* at 613.

²²²See *infra* PROPOSED STATUTE, Part XIII & COMMENTARY ON PROPOSED STATUTE, Part XIV.

The strong and understandable concern of Bowman and Mertz is that an actual child molester might sue a therapist, thereby victimizing and revictimizing an incest survivor, reasserting domination of her, and infantilizing her by denying her autonomy.

Reflecting these concerns, the proposed statutory remedy has several pre-trial and pre-discovery screening devices, a heavy substantive burden on the plaintiff, and the penalties of disciplinary recommendations and imposition of attorney fees for frivolous law suits.

In an extensive review of the law, Bowman and Mertz make a plausible argument that existing legal doctrine does not *precisely and literally embrace* a suit interfering with therapy at the instance of a third party, although there are circumstances, shown herein where courts have done just that.²²³

It should be noted that before *Tarasoff* the law did not embrace *that* type of suit either; a lawsuit here would require demonstration of a far greater degree of culpable incompetence than *Tarasoff* requires.

In any event, the law moves in response to new threats to important values. Few if any practices of therapists involve such gross departures from professional obligations as the use of powerful persuaders substantially risking creation of false memories and false accusations against an innocent person of sexual atrocities against a child. Few practices are so undeserving of the law's protection.

Bowman and Mertz recognize the psychotherapeutic enterprise to be fragile, nuanced, special and deserving of considerable protection from external intrusions. This is undoubtedly an appropriate view in most situations. Yet just a few years ago there were similar predominant views about the family itself. The notion was that family privacy should never be breached and that what went on within the walls of the home was no outsider's business. Since then, terrible abuses taking place within the confines of the family have been repeatedly revealed, leading to the conclusion that breaching the walls of family privacy may sometimes be necessary.

So with therapy. It is very special, true. But it is not sacred. Terrible abuses can occur within the therapist's office, such as sexual exploitation of patients by unscrupulous therapists using the imbalance of authority, transference and the vulnerability of the patient to gain physical intimacy.

Indeed as psychology professor Margaret A. Hagen of Boston University suggested, Professor Bowman seems more concerned about disrupting "the patient's relationship with the therapist, however injurious it may be," than with preserving the patient's relationships with her family.²²⁴

²²³ See, e.g., Bowman & Mertz, *supra* note 7.

²²⁴ Margaret A. Hagen, *Psychotherapists Must be Judged*, CHI. TRIB., Apr. 19, 1997, at 20. She concludes that: "[t]herapists, like the rest of the members of society, must be held accountable when their actions hurt other people. In our modern society, there is no more effective check on irresponsible behavior by psychotherapists than the third-party malpractice suit." *Id.*

Merely labeling a co-operative enterprise as "therapy," thereby invoking claims of specialness and virtually absolute confidentiality,²²⁵ cannot justify legal indifference to what happens in such a relationship. The walls of a therapist's office may no more be used to hatch out, with legal impunity, unjustified accusations of vile crimes against innocent parties than the walls of the home may be deemed legally impenetrable. Indeed, by continuing to use the word "therapy," a malignant process of instilling illusions of terrible sexual victimization is presumed to be part of a benign and health restoring process.

Throughout most of their article, in ostensibly balancing the equities, in looking at the costs and benefits of a suit by the accused perpetrator, Professors

²²⁵In a recent decision, the Supreme Court construed the Federal Rules of Evidence as embodying a psychotherapist-patient privilege. *Jaffee v. Redmond*, 116 S. Ct. 1923 (1996). In so doing it explicitly declined to define the scope of the privilege:

A rule that authorizes the recognition of new privileges on a *case-by-case* basis makes it appropriate to define the details of new privileges in a like manner. Because this is the first case in which this Court has recognized a psychotherapist privilege, it is *neither necessary nor feasible to delineate its full contours in a way that would govern all conceivable future questions [in this area]*.

Id. at 1932 and 1935.

While the Court rejected what it called a "balancing component of the privilege," it also declared that:

[a]lthough it would be premature to speculate about most future developments in the federal psychotherapist privilege, *we do not doubt that there are situations in which the privilege must give way*, for example, if a serious threat of harm to the patient or to others can be averted only by means of a disclosure by the therapist.

Id. at 1932 n.19.

The quoted statements, and others, raise significant ambiguities. For example, if the Court meant to be supportive of the *Tarasoff* doctrine, as seems to be the case, the question arises as to the discoverability of therapist-patient communications in a suit by a survivor of a patient's homicidal victim. If the reference to the *Tarasoff* situation meant to permit, if not endorse, the application of the *Tarasoff* doctrine, then, is the Court engaged in "balancing?" On the other hand, the quoted statement may mean only that a therapist is immune from liability to a patient for taking action to prevent harmful acts by the patient.

By leaving open the scope of the privilege, while approving of disclosures to prevent harm, the Court has left undecided whether other vital concerns might be placed outside the privilege, particularly vital social concerns that transcend the interests of a particular litigant. The phenomena of false accusations following highly suggestive practices is one that has become a matter of serious social concern beyond the interests of particular litigants.

Moreover, in rejecting a balancing component, the example the Court gave involved weighing the importance of a therapeutic communication of the outcome of particular litigation. In so doing, it did not reject consideration of the magnitude of the evil asserted by a plaintiff. Suppose, for example, that a patient, instigated by an actually malevolent therapist, "got even" with her father by phoning him and falsely claiming that her sister had just been killed in an automobile accident?

In any event, if the statute recommended herein is enacted, then whatever arguable obstacles may exist under privilege doctrines in a jurisdiction adopting it, will be superseded by the statutory provisions.

Bowman and Mertz *assume* that the patient has in fact been sexually abused by the plaintiff. Throughout, they regard the patient as an incest victim. Of course, where such is actually the case, then their arguments are obviously compelling. But *if one commences analysis without presuming knowledge of the outcome of litigation, then the situation becomes one of probabilities and fairness.*

An irrefutable presumption that patients have actually been sexually victimized in childhood would seem to allow nine innocent people and their families to suffer the impact of false accusations of unspeakable crimes, in order that one actual victim not have her therapy aborted by an actual molester.

Notwithstanding this author's differences with some of the critical premises and arguments, some of their expressed concerns are not without force and have been taken into account in the legislative solution recommended below.

VIII. UNDUE SUGGESTIVENESS IN OTHER AREAS OF THE LAW

The law itself recognizes the capacity of suggestiveness to produce invalid or undesirable results. It is hardly necessary to bring science, psychology, or theory to bear in support of the proposition that suggestive practices can induce a person to provide a response desired by the other. For example, the prohibition of leading questions on direct examination assumes that they would direct the witness to a response desired by the questioner.

Even more to the point, in order to prevent erroneous identifications and false convictions, the law forbids the use of identification techniques before trial (*e.g.*, line-ups) that are *so unduly suggestive as to be highly conducive to irreparable misidentification.*²²⁶

Paralleling Supreme Court observations regarding witnesses at a lineup (conducted outside the presence of defense counsel), a therapy patient is not likely to be "alert for," or "schooled in the detection of, suggestive influences"²²⁷ in the service of a biased therapist's crime-busting agenda.

Under the doctrine of entrapment, the law recognizes that there are circumstances where the idea of criminality may not be fairly ascribed to a defendant—*i.e.*, where the idea of the crime originated in the mind of the law enforcement officer, who implanted it in the mind of the defendant²²⁸ or where the idea for the crime was the product of "creative activity" of law enforcement.²²⁹ The defendant is said to have been induced, enticed, or persuaded into committing the offense.²³⁰

²²⁶Stovall v. Denno, 388 U.S. 293, 301-02 (1967).

²²⁷"[N]either witnesses nor lineup participants are apt to be alert for conditions prejudicial to the suspect. And, if they were, it would likely be of scant benefit to the suspect since neither witnesses nor lineup participants are likely to be schooled in the detection of suggestive influences." United States v. Ash, 413 U.S. 300, 331 (1973).

²²⁸Sorrells v. United States, 287 U.S. 435, 442 (1932).

²²⁹*Id.*

²³⁰Jacobson v. United States, 503 U.S. 540 (1992).

In their *zeal* to enforce the law, however, Government agents may not *originate* a criminal design, *implant* in an innocent person's mind the disposition to commit a criminal act, and then *induce* commission of the crime so that the Government may prosecute.²³¹

Under certain circumstances such crime inducing behavior mandates an acquittal.

Moreover, were a therapist culpably to convince a patient that she was molested by her father, and further convince her to give testimony to that effect, the therapist might be guilty of committing the *actus reus* of soliciting or suborning perjury (although the required *mens rea* would probably be absent).

The literature of false confessions reveals that not all are the product of raw coercion. Some are the result of strong suggestion or techniques of persuasion used with vulnerable suspects.

Under certain circumstances, techniques that merely tend to elicit confessions or admissions are forbidden.²³² These include highly suggestive statements made in the presence of vulnerable suspects.²³³

Finally, if some recovered memory therapists were attorneys, they might be subject to discipline for *coaching* a witness. Such therapists are effectively putting testimony in the mind of a complaining witness (in patient's suits against alleged molesters).

In sum, the law disfavors putting dangerous falsehoods in people's heads, at least those falsehoods which directly induce prohibited or actionable anti-social behavior.

IX. ANALYSIS OF LEGAL DOCTRINE

Does current legal doctrine support a cause of action by a plaintiff falsely accused of CSA against a therapist for inducing or implanting false memories of such abuse in the mind of the adult patient? Here, the caselaw will be examined.

A. Physicians' Duties to Third Parties

1. Tarasoff

In this part of the discussion of legal doctrine it is assumed that, as related above, the harm from false accusations of CSA is sufficiently severe and palpable as to be judicially cognizable.

In the landmark case of *Tarasoff II*,²³⁴ the California Supreme Court held that where a therapist has concluded, or "under applicable professional standards

²³¹*Id.* at 548.

²³²For example, where Miranda rights have not been waived. *See Rhode Island v. Innis*, 446 U.S. 291 (1980).

²³³*See Brewer v. Williams*, 430 U.S. 387 (1977).

²³⁴551 P.2d 334 (Cal. 1976) (en banc) [hereinafter *Tarasoff*].

reasonably should have determined, that a patient poses a serious danger of violence to others, she bears a duty to exercise reasonable care to protect the foreseeable victim of that danger."²³⁵ Such required protection might include warning potential victims or others of the danger.

This doctrine overrides any claimed sanctity of the therapist-patient relationship and traditional notions requiring privity for standing to sue, recognizing that a therapist has legal duties to third parties. Those who may be harmed (physically, in the *Tarasoff* scenario) by predictable acts of a patient, have a legally enforceable right to protection against injury caused by the negligence of a psychotherapist.

Of the many jurisdictions that have adopted the *Tarasoff* doctrine or a close variant thereof, some require, for therapist liability, that the reasonably foreseeable victim be "identifiable."²³⁶ In such jurisdictions, there tends to be a requirement that the patient *have threatened harm* to an identifiable victim.²³⁷ In some jurisdictions there is a duty on the part of a psychiatrist *who should have reasonably foreseen danger* from a patient to take steps to control the patient (such as by instituting commitment proceedings), whether or not the patient threatened harm.²³⁸ Some jurisdictions hold that where the psychiatrist fails to control the patient, the psychiatrist is liable to all who fall within the zone of danger.²³⁹

Tarasoff has been criticized for 1) its assumption that dangerous behavior is foreseeable, and for 2) its requirement, explicit or implicit, that a therapist act against the patient's therapeutic interest and 3) in violation of confidentiality. The first two criticisms do not apply in the falsely-accused plaintiff scenario because: 1) the harm is unquestionably foreseeable; and 2) there is substantial doubt whether the therapist is acting in the patient's best interest in inducing false memories and illusory beliefs of sexual victimization.

²³⁵*Id.* at 345.

²³⁶*Thompson v. County of Alameda*, 614 P.2d 728, 732-38 (Cal. 1980).

²³⁷*Id.* In *Brady v. Hopper*, 570 F. Supp. 1333, 1338 (D. Colo. 1983), *aff'd*, 751 F.2d 329 (10th Cir. 1984) the court held that absent a threat to an identifiable victim, a dangerous act was not foreseeable. *Id.*

²³⁸*Schuster v. Altenberg*, 424 N.W.2d 159 (Wis. 1988); *Lipari v. Sears, Roebuck & Co.*, 497 F. Supp. 185, 194-95 (D.C. Neb. 1980).

²³⁹See generally Robert F. Schopp, *The Psychotherapist's Duty to Protect the Public: The Appropriate Standard and the Foundation in Legal Theory and Empirical Premises*, 70 NEB. L. REV. 327, 328 (1991).

"A person falls within the zone of danger if they [sic] are foreseeably endangered by the defendant's conduct or if they [sic] are a member of a category of persons foreseeably endangered." *Id.* at 330. (summarizing *Hamman v. County of Maricopa*, 775 P.2d 1122, 1128 (Ariz. 1989)).

Regarding confidentiality in *Tarasoff*, it is breached by compliance with the primary obligation (warning a potential victim of a patient's dangerousness or testifying against a patient in a civil commitment hearing).²⁴⁰ Under a legal doctrine forbidding the implanting of a false memory, there would be no breach of confidence in complying with the primary legal obligation (to treat a patient with open-mindedness, integrity, and respect for the truth); there would, however, be a sacrifice of confidentiality where a lawsuit went forward charging violation of the obligation not to recklessly induce false memories.²⁴¹

Indeed, a *Tarasoff* warning or involuntary commitment may be counter-therapeutic as well as violative of patient confidentiality. Complying with the requirements of therapy, implicit in the cause of action recommended here, would avoid a probably counter-therapeutic result (persuading and treating a non-abused patient as an historical victim of childhood sexual molestation). Misdiagnosing a patient as a victim of CSA or implanting a false memory of CSA could hardly be considered therapeutic.

(The *closest* analogy to *Tarasoff* is not here recommended as appropriate to extend to the *Ramona*-type claim—*i.e.*, to hold that either where a patient reaches a false conclusion of CSA without significant influence by the therapist, or where the therapist negligently fails to diagnose the falsity of the plaintiff's self-generated false memory, that the therapist has a duty to either disabuse the patient of the erroneous belief, or to prevent the making of the accusation.)

Unlike *Tarasoff*, the false accusation action does not depend on finding a duty to act affirmatively to avoid foreseeable harm, based on a special relationship (although a special relationship is often manifest in these scenarios). A *Ramona*-type lawsuit involves positive acts by the defendant-therapist generating the harm to the plaintiff. The duty to the falsely accused plaintiff is to avoid grossly irresponsible behaviors that would turn a patient into a powerful psychic weapon—destroying reputation and family, and imposing emotional anguish.

Consider other situations where a physician might by *act rather than omission*, render a patient more dangerous: e.g., prescribing drugs without a concomitant warning against driving, terminating lithium treatment (or prescribing CNS stimulants) regarding a manic patient with a history of

²⁴⁰"We conclude that the public policy favoring protection of the confidential character of patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins." *Tarasoff*, 551 P.2d at 347. John M. Adler, *Relying Upon the Reasonableness of Strangers: Some Observations About the Current State of Common Law Affirmative Duties to Aid or Protect Others*, 1991 WIS. L. REV. 867, 890, n.7 (1991); Vanessa Merton, *Confidentiality and the "Dangerous" Patient: Implications of Tarasoff for Psychiatrists and Lawyers*, 31 EMORY L.J. 263, 294 (1982); cf. Kenneth E. Labowitz, *Beyond Tarasoff: AIDS and the Obligation To Breach Confidentiality*, 9 ST. LOUIS U. PUB. L. REV. 495 (1990) (AIDS).

²⁴¹The statute recommended herein would require an *in camera* examination of otherwise confidential materials. For an analogous procedure regarding a *Tarasoff* suit see *Mavroudis v. Superior Court*, 162 Cal. Rptr. 764 (Cal. Ct. App. 1980).

dangerous behavior; and culpably and actively exposing a third person to an infectious disease (e.g., by assuring such person of the absence of danger of contagion).²⁴²

The discussion will return, of course, to an obviously major distinction between a *Tarasoff* suit and the proposed suit—i.e., under *Tarasoff*, the law is dealing with a homicidal or physically assaultive act, while different sorts of harm are implicated here.

2. Communicable Diseases

It would advance the literature very little to rehearse the case law on the duty of a physician (or hospital) to warn family members that the patient is suffering from a contagious disease. While such a doctrine is by no means universal, several cases so hold.²⁴³ Earlier cases held that a physician may not mislead a family member or others into believing a person is free of contagion.²⁴⁴

Warning others that a patient has a contagious disease does not create liability for breach of physician-patient confidentiality.²⁴⁵ In 1958, in *Berry v. Moench*, the Utah Supreme Court held that a physician's duty to preserve the confidentiality of patient information is subject to a conditional privilege to disclose what is reasonably necessary to protect a sufficiently important

²⁴²See, e.g., *Jones v. Stanko*, *infra* note 244. Cf. the *Dram Shop* and the "social host" Doctrines. See, e.g., ILL. REV. STATS. ch. 43, para. 135 (1961); N.Y. GEN. OBLIG. LAW § 11.1101 (McKinney 1978); OHIO REV. CODE ANN. § 4399.01 (Anderson 1985).

²⁴³*Shepard v. Redford Community Hosp.*, 390 N.W.2d 239 (Mich. Ct. App. 1986) (hospital had duty to disclose infectious condition of patient to members of family); *Gammill v. United States*, 727 F.2d 950, 954 (10th Cir. 1984)(dicta)(physician may be liable for failure to warn those exposed to patient of patient's infectious illness but not liable to unforeseeable baby-sitter).

Notwithstanding the precedent for requiring a warning to those who might contract a disease from a patient, recent consideration of similar issues regarding AIDS patients have led several state legislatures to prohibit disclosure of the medical condition of such patients, even to actual or potential sexual partners. Such legislation is apparently motivated by a strong and justifiable concern regarding the privacy of AIDS patients, and confidentiality of their condition, particularly in view of the fear-engendering, severely stigmatic and ostracism-producing consequences of disclosure.

²⁴⁴*Edwards v. Lamb*, 45 A. 480 (N.H. 1899)(physician liable to plaintiff's wife for negligently assuring her it was safe to care for patient's wounds); *Skillings v. Allen*, 173 N.W. 663, 664 (Minn. 1919)(physician liable to patient's parents for assuring safety to them of visit to patient and of taking child home, where child had scarlet fever); *Davis v. Rodman*, 227 S.W. 612 (Ark. 1921)(facts closely analogous to *Skillings*); *Jones v. Stanko*, 160 N.E. 456 (Ohio 1928)(physician liable to care-giving neighbor for assuring him that patient's condition was not contagious (where patient had smallpox)); *Wojcik v. Aluminum Co. of Am.*, 183 N.Y.S.2d 351 (N.Y. Sup. 1959). Indeed one case held that a physician had a duty to advise a spouse of her husband's cause of death even though not a contagious disease, so that the survivor could avoid exposure to a common environmental danger. *Williams v. Daniel*, 854 S.W.2d 865 (Tenn. 1993).

²⁴⁵*Simonsen v. Swenson*, 177 N.W. 831 (Neb. 1920).

interest.²⁴⁶ The court explained: "Where life, safety, well-being or other important interest is in jeopardy, one having information which could protect against the hazard, may have a conditional privilege to reveal information for such purpose."²⁴⁷

It has also been held that a physician is liable to a third party where the physician fails to give the patient proper advice about avoiding the spread of the disease:

Such precautions are taken not to protect the health of the patient, whose well-being has already been compromised, rather *such precautions are taken to safeguard the health of others. . . . If a third person is in that class of persons whose health is likely to be threatened by the patient, and if erroneous advice is given to that patient to the ultimate detriment of the third person, the third person has a cause of action against the physician. . . .*²⁴⁸

A therapist who culpably implants false memories of CSA renders his or her patient harmful. The patient is carrying a harmful (social) virus; contact with (accusations toward) highly vulnerable people (the patient's family) operates to spread and implant the toxin, indeed to spread it in ways harmful far beyond the harm to the patient. Like a carrier of a very devastating illness, the patient is most likely to pass on this pathology, or a paradoxically related pathology, to members of the family.

3. Other Duties to Third Parties

Plaintiffs who contract a venereal disease, such as genital herpes, from their spouses have recovered from defendants who transmitted the disease to the spouses in extramarital sexual relations.²⁴⁹ *Has not a therapist caused the toxic condition in an adult patient who in turn, in personal interaction with the plaintiff family member and others, transmits the toxic accusation, which ultimately strikes the plaintiff directly and through the reactions of others?*

While it is sometimes said that a person should not be held liable for the acts of another, absent the traditional justifications for *respondeat superior*, there are important exceptions to that rule where vital social interests are at stake. Under Dram Shop Acts, for example, the defendant who sells alcohol to an intoxicated person becomes liable for injuries to third parties caused by virtue

²⁴⁶Berry v. Moench, 331 P.2d 814, 817 (Utah 1958).

²⁴⁷*Id.* at 817-18.

²⁴⁸DiMarco v. Lynch Homes, 583 A.2d 422, 424 (Pa. 1990).

²⁴⁹Mussivand v. David, 544 N.E.2d 265 (Ohio 1989) (a person who has a venereal disease (here, a male) who has sexual relations with a married person (in this case a wife) but fails to inform that person of his condition, is liable to the third-party spouse (the husband) who contracted the disease before the infected spouse is aware of her own infection).

of the intoxication.²⁵⁰ Where a therapist effectively induces a false memory of CSA that the patient had not previously remembered at all, *it is similar to intoxicating or inflaming the patient to act in a manner dangerous and injurious to a confluence of interests of great social and legally protected value.* Like alcohol, some of the methods of extreme suggestiveness, severely distort mental processes of the patient, and untenably render the patient a danger to the innocent accused person and "safety" of the family.

Courts have found physicians liable to third parties physically injured in vehicle accidents where the defendant failed to warn his patient about the dangers of driving under prescribed medication;²⁵¹ and where a doctor, negligently failing to diagnose epilepsy, advised the patient that he could drive;²⁵² and where a physician advised a severely distraught, emotionally overwhelmed patient to drive to the hospital.²⁵³

Here again, culpable acts or omissions involving medical matters (rather than mere failure to control a patient) led to physicians' liability to third parties.

²⁵⁰See, e.g., ILL. REV. STATS. ch. 43, para. 135 (1961); N.Y. GEN. OBLIG. LAW § 11.1101 (McKinney 1978).

Ohio's Dram Shop Act provides:

A husband, wife, child, parent, guardian, employer, or other person injured in person, property, or means of support by an intoxicated person, or in consequence of the intoxication, habitual or otherwise, of a person, after the issuance and during the existence of the order of the department of liquor control prohibiting the sale of intoxicating liquor as defined in section 4301.01 of the Revised Code to such person, has a right of action in his own name, severally or jointly, against any person selling or giving intoxicating liquors which cause such intoxication, in whole or in part, of such person.

OHIO REV. CODE ANN. § 4399.01 (Anderson 1985).

In some jurisdictions where one who sells or socially provides liquor to minors, and where the intoxicated minor thereafter causes injury to another, the seller is liable for the injuries suffered by the third party.

For decisions imposing social host liability based upon liquor control statutes forbidding sale or distribution of alcohol to minors, *see, e.g.,* Brattain v. Herron, 309 N.E.2d 150 (Ind. Ct. App. 1974); Coulter v. Superior Court of San Mateo County, 577 P.2d 669 (Cal. 1978); Walker v. Key, 686 P.2d 973 (N.M. Ct. App. 1984) Sutter v. Hutchings, 327 S.E.2d 716 (Ga. 1985); Longstreth v. Gensel, 377 N.W.2d 804 (Mich. 1985); Congini v. Portersville Valve Co., 470 A.2d 515 (Pa. 1983); Koback v. Crook, 366 N.W.2d 857 (Wis. 1985).

²⁵¹See, e.g., Gooden v. Tips, 651 S.W.2d 364 (Tex. Ct. App. 1983); Kaiser v. Suburban Transp. Sys., 398 P.2d 14 (Wash. 1965) (cause of action exists against doctor who did not warn bus driver-patient of drowsiness associated with medication for nasal condition who then had accident resulting in plaintiff's injury); Duvall v. Goldin, 362 N.W.2d 275 (Mich. Ct. App. 1984) (doctor's failure to diagnose or properly treat epilepsy may foreseeably create risk of harm to third party).

²⁵²Freese v. Lemmon, 210 N.W.2d 576 (Iowa 1973); *but see* Davis v. Mangelsdorf, 673 P.2d 951 (Ariz. Ct. App. 1983) (dismissed for failure to state a cause of action against physician for advising an epileptic patient to discontinue anticonvulsant seventeen years before auto accident injuring plaintiff).

²⁵³Myers v. Quesenberry, 193 Cal. Rptr. 733 (Cal. Ct. App. 1983).

(Harm and the general type of harm in these cases was foreseeable, although particular plaintiffs were not.) These cases find liability to third parties, not on the basis of failure to warn third parties of an illness, but by virtue of advice given or not given to the patient. Because of the physician's culpability, the patient is rendered foreseeably dangerous.

B. Negligent Infliction of Emotional Distress

Suits for infliction of emotional damages have been suspect in the law. Early in the evolution of tort doctrine, courts rejecting such suits expressed the concern that claims for emotional damages were too easy to claim, too subtle to measure, too subject to false or fraudulent claims, too speculative, and all-told, too burdensome and risky to society. More recently, courts have allowed recovery under certain conditions.

Recovery for pain and suffering, though subjective,²⁵⁴ has long been permitted when accompanying physical injury. More recently, claims for infliction of emotional distress have been upheld where plaintiff suffered physical harm. Many courts permit recovery where there is physical harm to a third party, and plaintiff, alleging emotional harm, was in the zone of physical danger (or in some jurisdictions, a bystander concurrently witnessing physical harm to a third party).

Given that California, in *Ramona*, was the first state in which damages were awarded against a therapist to a family member charged by his daughter with CSA, a brief look at California law is warranted. Two lines of cases seem to form the corpus of the relevant California law.

One line of cases begins with *Dillon v. Legg*,²⁵⁵ in which the California Supreme Court allowed recovery for emotional distress to a parent who witnessed a child being killed by the negligent defendant, even though the parent was not injured or in the zone of danger.²⁵⁶

A second line of cases granted emotional distress damages to persons, other than a patient, who were found to be a "direct victim" of a physician's malpractice. In *Molien v. Kaiser Foundation Hospitals*,²⁵⁷ the patient-wife was misdiagnosed as having syphilis. At the request of the physician, she informed her husband of the diagnosis so that he could come in for the necessary blood

²⁵⁴Damages for emotional harm were considered "parasitic," that is, recoverable only when attached to another tort. William L. Prosser, *Intentional Infliction of Mental Suffering: A New Tort*, 37 MICH. L. REV. 874, 874-79 (1939).

²⁵⁵441 P.2d 912 (Cal. 1968) (en banc).

²⁵⁶From this developed a line of cases determining when bystanders could recover emotional damages. While subsequent cases were subject to criticism because they introduced uncertainty into matters of liability, being based simply on the notion of reasonable foreseeability, the California Supreme Court in *Thing v. La Chusa*, limited, but did not overrule *Dillon*, holding that to recover for emotional harm the plaintiff must be present at the scene and aware that the injury is taking place. 771 P.2d 814 (Cal. 1989).

²⁵⁷616 P.2d 813 (Cal. 1980) (en banc).

tests. Both spouses suffered extreme emotional distress, indeed hostility, suspicion, anxiety, and eventually, such marital discord that the wife divorced the husband.

In a suit by the husband against the physician, the court reasoned that the alleged malpractice was directed at the husband-plaintiff as well as the wife, and that therefore the husband was the "direct" victim.²⁵⁸ The doctrine of "direct victim" became an alternative to granting recovery for negligent infliction of emotional distress to a bystander at the time of the injury-producing event.

The *Molien* line of cases included an action awarding damages to parents where a psychologist misdiagnosed their child as suffering from acute brain syndrome, the parents being foreseeably harmed, emotionally.²⁵⁹ Similarly, parents recovered where a defendant-physician failed to make a prenatal diagnosis of Down's Syndrome, the father being a reasonably foreseeable victim by virtue of his participation in "the reproductive life of the marital couple."²⁶⁰

California may be retreating from the *Molien* doctrine, in the sense of distinguishing it from recent fact patterns where "direct harm" is arguable.²⁶¹ However, in distinguishing one of the cases, the court described *Molien* as permitting the non-patient husband to recover because *the doctor assumed "a direct duty toward the husband; [i.e.,] the doctor directed his patient, the wife, to advise the plaintiff-husband of the diagnosis."* Contrary to arguments made by Bowman and Mertz, to the effect that *Molien* is no longer precedent for recovery by falsely accused relatives,²⁶² even the italicized narrow description of the *Molien* holding would support recovery against a therapist who encouraged a patient to confront a relative with accusations. *In both situations, the negligent therapist has caused the patient to involve a third party in a way that caused psychic anguish to that party.*

Admittedly, however, *Molien* went further in permitting damages for negligent infliction of emotional distress than the considerable majority of other jurisdictions.

²⁵⁸*Id.*

²⁵⁹See *Accounts Adjustment Bureau v. Copperman*, 204 Cal. Rptr. 881, 884 (Cal. Ct. App. 1984).

²⁶⁰*Newton v. Kaiser Hosp.*, 228 Cal. Rptr. 890, 894 (Cal. Ct. App. 1986) (recovery was based on prenatal malpractice and permitted to both parents).

²⁶¹In *Marlene F. v. Affiliated Psychiatric Medical Clinic, Inc.*, the mother of a minor child had standing to sue a psychotherapist who sexually molested the child-patient, for negligent infliction of emotional distress. 770 P.2d 278 (Cal. 1989) (en banc). As later interpreted, however, the mother's recovery was explained by the fact that the therapist was treating both her and the child. *Burgess v. Superior Court*, 831 P.2d 1197 (Cal. 1992). See also *Huggins v. Longs Drug Stores Cal., Inc.*, where parents who suffered emotional distress were denied recovery against a pharmacist who negligently prescribed a toxic dose of medication that they gave to their child. 862 P.2d 148 (Cal. 1993).

²⁶²*Bowman & Mertz, supra* note 7, at 569-74.

As will be argued below: a) what is apparently left standing of the *Molien* doctrine would support the action contemplated herein; and b) such an action would be supported by other doctrines and by the jurisprudential concept of "duty" properly understood and applied.

Most courts will not allow recovery for emotional harm *simply on proof that the plaintiff was a reasonably foreseeable emotional victim of negligence*, although there are some jurisdictions that do permit such recovery,²⁶³ particularly where the claim has some intrinsic "guarantee of genuineness."²⁶⁴ When one is accused of a heinous crime against a child, the genuineness of an emotional distress claim cannot be doubted.

Given the strong causal links between the implanting of false memories, the making of accusations, and the inevitability of a multiplicity of emotional harms, the policies otherwise limiting recovery for negligent infliction of emotional harm (to guarantee genuineness and to prevent recovery based on false claims or speculative injuries) are inapplicable to an action by an accused father. Nevertheless as shall be argued below, *mere negligence, even if it could suffice in an action claiming emotional harm, should not be sufficient to hold a psychotherapist liable, given the desirability of degrees of freedom in the therapist-patient relationship.*²⁶⁵ Moreover to intrude on the right to confidentiality in the psychotherapist relationship, a showing of more aggravated egregiousness than mere negligence should be required. The next question is whether the law supports an action for intentional or reckless infliction of emotional harm.

C. Reckless Infliction/Tort Of Outrage

Courts have been more willing to allow recovery of damages for infliction of emotional distress where the defendant has "intentionally, recklessly and/or outrageously" (rather than merely "negligently") caused severe emotional harm. Liability attaches only if the actor: "by extreme and outrageous conduct intentionally or recklessly causes severe emotional distress to another."²⁶⁶

²⁶³ See W. PAGE PROSSER ET AL., ON THE LAW OF TORTS 364-65 (5th ed. 1984) [hereinafter PROSSER & KEETON]. Also, in cases involving disease phobia, courts permit recovery where the patient has been actually exposed to the feared disease. See *K.A.C. v. Benson*, 527 N.W.2d 553, 560 (Minn. 1995).

²⁶⁴ See, e.g., *Ferrara v. Galluchio*, 152 N.E.2d 249, *reh'g denied*, 154 N.E.2d 581 (N.Y. 1958) (patient developed cancerphobia after a physician told her that she might contract cancer from a radiation burn). Cf. *Heiner v. Moretuzzo*, 652 N.E.2d 664 (Ohio 1995) (no cause of action stated where patient alleged emotional distress from misdiagnosis of HIV positivity).

²⁶⁵ The requirement of outrageousness and recklessness has also been suggested in *Yamini*, *supra* note 7.

²⁶⁶ RESTATEMENT (SECOND) OF TORTS § 46 (1965); see, e.g., *Taiwo v. Vu*, 822 P.2d 1024, 1029 (Kan. 1991).

The requirement of outrageousness is said to substantially alleviate concerns that the claim of emotional distress is either false or insufficiently palpable²⁶⁷ to permit non-speculative or arbitrary damage awards. The accusation generates "emotional distress . . . of such extreme degree the law must intervene because the distress inflicted is so severe that no reasonable person should be expected to endure it."²⁶⁸ Given such a proof requirement, it is unlikely that recognizing the *Ramona*-type tort would open the floodgates to innumerable claims.

It is submitted that hypersuggestive practices by therapists committed to discovering childhood sexual molestation abundantly satisfy the test of outrageousness:

The prohibited conduct is conduct which in the eyes of decent men and women in a civilized community is considered outrageous and intolerable. Generally, the case is one in which the recitation of the facts to an average member of the community would arouse his resentment against the actor and lead him to exclaim "Outrageous!"²⁶⁹

False or fraudulent claims of emotional distress are not an issue when emotional stress inevitably accompanies being accused of a criminal and morally outrageous crime against a child.

There is an apparent requirement, however, under the outrageous infliction of emotional distress doctrine that the plaintiff be present at the time of the outrageous conduct.²⁷⁰ The rationales of the presence requirement are inappropriate in the aggravated *Ramona*-type case. Imposition of such a requirement is unnecessary to assure that the defendant foresees the imposition of such suffering; to guarantee that the suffering is genuine and severe; to avoid unlimited liability to unforeseeable plaintiffs; or to assure that an undue burden is not placed on a defendant.

That such a cause of action is valid absent plaintiff's presence has been recognized. A federal district court held that a cause of action for the tort of intentional infliction of emotional distress predicated on "extreme and outrageous" conduct would not be dismissed where plaintiff-family members (who were not present) claimed that the therapist-defendant "falsely convinced" the patient (a twenty-eight year-old daughter), by highly unreliable methods, that the father had sexually abused her as a child.²⁷¹

²⁶⁷In terms of the assessment or valuation of damages, the law has come to appreciate that "emotional trauma, is no more difficult to value than physical pain." John W. McNamara, Note, *Murder And The Tort Of Intentional Infliction Of Emotional Distress*, 1986 DUKE L.J. 572, 574 (1986).

²⁶⁸*Id.*; *Taiwo v. Vu*, 822 P. 2d at 1025.

²⁶⁹RESTATEMENT OF THE LAW OF TORTS § 46, cmt. 9 (1948 & Supp.).

²⁷⁰RESTATEMENT (SECOND) OF TORTS § 46 (2)(a), (2)(b) (1965).

²⁷¹*Lindgren v. Moore*, 907 F. Supp. 1183, 1189-90 (N.D. Ill. 1995). See also *supra* cases discussed in test accompanying notes 66, 67 and 73.

Moreover, the Restatement seems to contemplate situations in which a presence requirement might be inappropriate. A Caveat to Section 46 (2) provides: "The Institute expresses no opinion as to whether there may not be other circumstances under which the actor may be subject to liability for the intentional or reckless infliction of emotional distress."²⁷²

A recent decision by the Wyoming Supreme Court applied the Caveat.²⁷³ There, the husband and minor child of a woman who committed suicide sued the wife-mother's stepfather for causing her to take her life. Although the plaintiffs were not present during the defendant's acts, and did not witness the act of suicide, the court found that they "*were present in the immediate aftermath of the tragic results of Appellee's outrageous conduct, and the suicide was the final result of a continuing course of conduct instigated by Appellee.*"²⁷⁴

Finally, in a meaningful sense, a person falsely accused of CSA as a result of memories recklessly implanted *is an immediate and direct victim of the therapist's wrongdoing*. In other words, the *plaintiff's claim is not (simply) derivative*; it is not derived through a claim of a primary wrong done to someone else. (Although a wrong has been done to the patient, the patient, being unaware of her present victimization, has not objected.) Indeed while malpractice is involved, the *plaintiff's claim is not simply an extension of malpractice liability*, but a malfeasance toward the plaintiff.

Treating the patient as a conduit here does not deny that she has free will. It does, however, recognize the considerable vulnerability of many patients to the powers of the therapist.²⁷⁵ Although the patient may still have free will, her capacity to resist powerful suggestions of a therapist may be very much compromised. In such a situation, the accused person may be deemed constructively present when the outrageous conduct is executed. Moreover, where the therapist actually counsels some form of confrontation by the adult patient with the accused molester, the accused is directly targeted to suffer severe mental anguish.

D. Defamation

In a Texas case, parents of a patient successfully sued a therapist for slander where they had met with the therapist who repeated allegations of sexual abuse

²⁷²RESTATEMENT (SECOND) OF TORTS § 46(2)(a), (2)(b) (1965).

²⁷³R.D. v. W.H., 875 P.2d 26 (Wyo. 1994).

²⁷⁴*Id.* at 33-34.

²⁷⁵Law and ethics recognize the great vulnerability of psychotherapist patients. For example, a psychiatrist is forbidden, by the ethics of the American Psychiatric Association, to *ever* have sexual relations with a person who was once a patient. The American Psychological Association forbids sexual relations with a patient within two years after termination of therapy.

to the husband and four daughters of the patient. The daughter, having retracted her claims of abuse, testified at the trial.²⁷⁶

The law of defamation compensates for statements or acts that tend to injure a person in his reputation or profession or humiliate, shame, or degrade a person in the eyes of others. An actionable statement is one that tends to expose a plaintiff to ridicule, hatred, and contempt, "or cause him to be shunned or avoided."²⁷⁷ A false accusation of an infamous or disgraceful crime is slander per se (actionable even without proof of actual harm).²⁷⁸

Where a seventeen-year-old baby sitter was falsely accused of molesting the child (the defendant-parents distributed flyers throughout the neighborhood referring to him as a "sex offender"), the court, in upholding the babysitter's lawsuit,²⁷⁹ observed that "[t]here are few accusations more damaging or harmful to a young man's reputation than being called a sex offender or child molester."²⁸⁰ The false accusations reflect on his "integrity, character and good name and tended to expose him to public hatred, contempt and disgrace."²⁸¹

The "publication" requirement, as a condition to liability for defamation, means proof that the defendant made the defamatory statement to at least one person exclusive of the person defamed.²⁸² Actionable "publication" includes communication of the defamatory statement to a member of the plaintiff's family.²⁸³ Making the accusation by innuendo will suffice;²⁸⁴ and even though the plaintiff not be named, if the recipient of the communication would reasonably understand that the statement refers to the plaintiff, then the defamatory statement will be treated as "of and concerning" the plaintiff.²⁸⁵

If the patient publishes (disseminates) the statement to someone other than, or in addition to, the accused, the therapist would be liable for republication

²⁷⁶See Thom Weidlich, 'False' Memory, *Big Award*, NAT'L L.J., Jan. 9, 1995, at A6; Steve Blow, *Slander Case Shakes Family, Psychiatrist*, DALLAS MORNING NEWS, Jan. 11, 1995, at 25A; Nancy E. Roman, *Doctor Guilty of Slander in Bogus-Sex-Abuse Case*, WASH. TIMES, Dec. 17, 1994, at A1.

²⁷⁷PROSSER & KEETON, *supra* note 263, at 773.

²⁷⁸*Id.* at 788-89.

²⁷⁹Kennedy v. Jasper, 928 S.W.2d 395 (Mo. 1996).

²⁸⁰*Id.* at 400.

²⁸¹*Id.*

²⁸²RESTATEMENT (SECOND) OF TORTS at 577 states: "Publication of defamatory matter is its communication intentionally or by a negligent act to one other than the person defamed." The making of the accusation to the father is not, in and of itself, a publication of the libel or slander, but for reasons explored and to be explored, is an outrageously reckless infliction of emotional anguish.

²⁸³PROSSER & KEETON, *supra* note 263, at 798.

²⁸⁴*Id.* at 780-83.

²⁸⁵*Id.* at 783.

where the patient's publication is "reasonably foreseeable"²⁸⁶ or "a natural and probable consequence of the originator's actions."²⁸⁷ In most cases the therapist would either intend repetition or reasonably expect the patient to repeat the accusation.

The therapist might be considered the originator of the defamation if s/he used unduly suggestive words or gestures that communicated to the patient the belief, or created in the patient the false memory, reflecting the defamatory charge, either explicitly, indirectly, or by innuendo, that plaintiff sexually molested the patient in her childhood.

To maintain and reinforce one's investment in the newly discovered "memory" of CSA, the patient might well broadcast the accusation to friends, co-workers, and relatives, even prior to making the accusation to the one accused.²⁸⁸

Arguably, there is or should be a qualified privilege on the part of the therapist to communicate to his patient his conclusions regarding the patient's history, or deeper causes of the patient's emotional maladies. The relationship between therapist and patient is one that society especially values and protects. Indeed, communications within this relationship are ordinarily privileged from disclosure absent strong countervailing interests. Because therapists usually perform a valuable social service, communications should be protected from a defamation action unless they manifest a conscious indifference and reckless disregard of the plaintiff's rights.²⁸⁹ However, "no reasons of policy can be found for conferring immunity upon the foolish and reckless defamer who blasts an innocent reputation without making any attempt to verify his statements."²⁹⁰

Once the defendant establishes that the statements or innuendoes he communicated to the patient are in the context of a qualified privilege, sound interpretation of existing doctrine requires plaintiff to prove that defendant acted recklessly in reaching his conclusion as to the truth or falsity of the defamatory communication.

It is submitted, that given proof in any suit by a plaintiff asserting a false accusation, that a therapist employed hypersuggestive techniques with a

²⁸⁶See *Brown v. First Nat'l Bank of Mason City*, 193 N.W.2d 547 (Iowa 1972).

²⁸⁷See, e.g., *Davis v. National Broadcasting Co.*, 320 F. Supp. 1070, 1072 (E.D. La. 1970), *aff'd*, 447 F.2d 981 (5th Cir. 1971); *McKinney v. County of Santa Clara*, 168 Cal. Rptr. 89 (Cal. Ct. App. 1980); see generally RODNEY A. SMOLLA, LAW OF DEFAMATION § 4.13[2]1 (1986).

²⁸⁸See OPSHE & WATTERS, *supra* note 15, at 98.

²⁸⁹See *Dun & Bradstreet v. Robinson*, 345 S.W.2d 34 (Ark. 1961).

²⁹⁰PROSSER & KEETON, *supra* note 263, at 835.

The authors go on to say: "the best statement of the rule is that the defendant is required to act as a reasonable person under the circumstances, with due regard to the strength of his belief, the grounds that he has to support it, and the importance of conveying the information." *Id.* at 835.

patient who presented with no memory of sexual abuse, such as to create a significant probability of eliciting false memories or beliefs of CSA, a requirement of reckless disregard of the truth or falsity of a direct or indirect slander would be met.

E. Other Arguably Relevant Doctrines

1. Informed Consent

Before a physician may use either an experimental technique or a technique that embodies a material risk of an undesirable result, s/he must advise the patient of the material risk and obtain from that patient his or her informed consent to undertake the procedure. Damages awarded in some suits against therapists were based on the failure to obtain informed consent from the patient. (E.g., where the patient was the plaintiff. In at least one suit brought by an accused family member, the informed consent doctrine was the basis of recovery.) It would not at all be viable to require a therapist to obtain the informed consent of all who might eventually be accused, and, indeed, any such requirement would unjustifiably burden a therapeutic relationship before any harm to a third party resulted. Nevertheless, the therapist's failure to obtain informed consent from the patient for unduly risky or experimental procedures would be relevant to establishing gross negligence or recklessness, assuming other doctrines enabled a suit by an accused plaintiff.

Indiana has recently become the first state to enact an informed consent requirement specifically addressed to mental health professionals. Signed into law on April 17, 1997, at *Indiana Code* § 16-36-1.5-10, it provides:

"A mental health provider shall inform each patient of the mental health provider about:

- 1) the mental health provider's training and credentials;
- 2) the reasonably foreseeable risks and relative benefits of proposed treatments and alternative treatments; and
- 3) the patient's right to withdraw consent for treatment at any time."

2. Harm to Family

Damages to filial relations are compensable in few jurisdictions. The Illinois cases considered earlier were in the context of that jurisdiction's recognition of a cause of action for destruction of family ties. In most jurisdictions, damages for loss of consortium, the analogous harm, are recoverable only where there has been tortious physical injury or wrongful death inflicted on a close family member.²⁹¹ Moreover, most states have abolished suits for alienation of affections.

²⁹¹Regarding a jurisdiction disallowing recovery for destroying filial relations, an interesting issue is whether in assessing emotional distress, a jury may consider the distress resulting from destruction of family ties.

Here, however, there is a form of seduction by one having far greater psychological power and authority, followed by an accusation against a member of the family. The accuser's break from the family (if she had not broken before therapy) would not wholly describe the extent or severity of the harm. For the family beyond the wrongly accused member will also suffer profound suspiciousness, severance of ties, emotional disturbances, overwhelming grief, anxiety, humiliation, embarrassment, and social stigma. Over and over from the relevant literature on this subject cry the words "it was like tearing my heart out."

The massive destructive impact on families goes far beyond the consequences of alienation of affections. Given that such damages are not speculative or readily subject to fabrication, *but embody strong indicia of genuineness* from the nature of the outrageous and the accusatory assault on the family member or members, it would seem justifiable to permit such damages where it is otherwise concluded that a suit may be brought. (Alternatively, the foreseeable infliction of family devastation from the use of hypersuggestive techniques on a patient with no memory of CSA may itself be part of the outrageousness substantively justifying a lawsuit.)

An intact family is valued by our legal system and sabotaging its capacity to function in a healthy way is legally and constitutionally suspect. Of course, if one *assumes* that the family was a cover for abuse, then notions of protecting family values must be subordinated to compelling counter-considerations. If, however, the question is whether a plaintiff can establish a high probability that the accusations against him are false and that the therapist abused the sanctity of the psychological consulting room, then emphasis on the law's protections of intact families is powerfully pertinent.

In *Merkel v. Doe*,²⁹² a Court of Common Pleas struck down as unconstitutional an Ohio statutory provision that would have permitted a putative father to challenge the parenthood of a child living in an intact family. The court made the following observations:

[A]s a family, the Does have a constitutionally protected interest in maintaining the privacy and integrity of their relationship to one another and to their child. The Supreme Court has consistently protected the family unit from intrusion. . . . "Our decisions establish that the Constitution protects the sanctity of the family precisely because the institution of the family is deeply rooted in this Nation's history and tradition."²⁹³

²⁹²635 N.E.2d 70 (Ohio Com. Pleas 1993).

²⁹³*Id.* at 72 (quoting *Moore v. City of East Cleveland*, 431 U.S. 490, 494 (1976)). Other cases cited were, *Carey v. Population Serv. Int'l*, 431 U.S. 678 (1977)(individual right to decide whether to bear children); *Loving v. Virginia*, 388 U.S. 1 (1967)(right to choose whom to marry); *Griswold v. Connecticut*, 381 U.S. 479 (1965)(married couple's right to use contraceptives in the privacy of their home); *Prince v. Massachusetts*, 321 U.S. 158 (1944)(due process encompasses the family relationship); *Meyer v. Nebraska*, 262 U.S. 390 (1923)(right to choose child's education).

Finally, as the *Merkel* court noted, the Supreme Court has consistently sought to protect "the sanctity of the unitary family."²⁹⁴

Beyond the protection of the family,²⁹⁵ Ohio has recently recognized the right of a parent to recover damages reflecting a loss of consortium where a child is physically injured (a requirement considered herein as unnecessary to serve its ordinary rationales.) The court recognized the nature of the loss a parent suffers when deprived of the opportunity to interact with his or her child, and observed that the essence of the relationship and thus the measure of true losses are the "society, companionship, comfort, love and solace between parent and child. . . ."²⁹⁶

3. Contract

In *Tuman v. Genesis Associates*, considered in Part II(C), the court found that parents who paid for therapy, relied on promises, and suffered foreseeable emotional harm as a result of breach of those promises could recover. (The claim of intentional infliction of emotional harm was also found viable.) This was a unique holding. To this author it does not seem tenable to rest issues of liability for generating false accusations of unspeakable crimes on theories of contract.

X. THE CONCEPT OF DUTY

So there are several fairly strong doctrinal supports for the imposition of legal liability on a psychotherapist who culpably generates false accusations of odious crimes thereby causing a variety of harms, from emotional anguish to family devastation and/or to ruin of reputation. While some of the legal prerequisites for recovery under some of the doctrines are not present in a *Ramona*-type action, the essential evils at the core of such doctrines are implicated and the prerequisites (*e.g.*, presence, physical harm) make little sense applied to the present circumstances. Surely, the legal emanations from the core of the doctrines (not merely their peripheral applications or values)

²⁹⁴*Id.* at 74.

²⁹⁵Moreover, no position is taken as to whether all damages should be awarded to the falsely accused person, or whether other psychically-socially injured family members (of a given degree of proximity to the accused) should also have standing to sue. Nor need it be considered at this time, how damages are to be calculated in assessing harm to the falsely accused plaintiff (*e.g.*, from severed relationships).

²⁹⁶*Gallimore v. Children's Hosp. Med. Ctr.*, 617 N.E.2d 1052, 1057 (Ohio 1993).

Consortium damages are generally awarded to a parent, if at all, only where the injured child is a minor. In the present situation, where the wrong itself is directed at any relationship between the adult patient and her parent, the recommendation is that if a valuable relationship existed prior to the therapy, and the therapy creates a cause of action under legal tests advanced herein, there should be recovery, notwithstanding that the shattered relationship was one between a parent and an adult child. Of course, to the extent that there was pre-therapy estrangement, damages should be reduced or, where appropriate, entirely rejected.

would reject the claim that the egregious evils done to innocent persons should remain uncompensated.

Nevertheless, it is worth considering whether a jurisdiction that would not find liability under its existing doctrinal schema might well conclude that jurisprudential principles justify recognition of a duty in this situation, and in effect, creation of a new tort.

While in some quarters there is almost automatic opposition to the recognition of any new tort, such opposition is often generated by myths about a litigation explosion, political opposition often fueled by insurance pay-out considerations,²⁹⁷ influence of professional self-protective guilds, and misleading anecdotes about frivolous tort-actions resulting in large and irrational jury awards.

There are, admittedly, also serious and defensible scholarly concerns about extending recovery rights to all who might suffer reasonably foreseeable harm. This author does not contend that liability should extend to all who suffer reasonably foreseeable harm resulting from a defendant's negligent behavior.²⁹⁸ Nevertheless, there are time-tested jurisprudential principles that may well justify, in particular situations, the creation of new torts.

There is no universally accepted "objective" test for determining the existence of a duty. While many courts simply beg the question by asserting that a duty does or does not exist, the respected scholarly and judicial approach would consider and balance a number of pertinent factors.²⁹⁹

A California Supreme Court decision, *en banc*, gave careful attention to articulating factors relevant to recognition of a duty in our tort jurisprudence:

1) Foreseeability of harm to the plaintiff; 2) degree of certainty that the plaintiff suffered injury; 3) the proximity of the connection between the defendant's conduct and the injury suffered; 4) the moral blame attached to the defendant's conduct; 5) the policy of preventing future harm; 6) the extent of the burden to the defendant and the consequences to the community of imposing a duty to exercise care with resulting liability for breach; and 7) the availability, cost, and prevalence of insurance for the risk involved.³⁰⁰

²⁹⁷Albeit with the public bearing part of the ultimate cost.

²⁹⁸As an anonymous observer said: "on a clear day some courts can foresee forever."

²⁹⁹Prosser and Keeton speak of the defendant's moral blameworthiness, moral aspects of the defendant's acts, administrative convenience, relative capacity of the parties to bear the loss, and the policy of prevention of future injuries. PROSSER & KEETON, *supra* note 263, at 359. The *Restatement of Torts* lists the objectives of tort liability as compensation, determination of rights, vindication of parties, punishment of wrongdoers and deterrence of wrongful conduct. RESTATEMENT (SECOND) OF TORTS 90 (1979).

³⁰⁰Rowland v. Christian, 443 P.2d 561 (Cal. 1968) (*en banc*).

A. Foreseeability of Harm to Plaintiff

When a therapist uses heavy-handed suggestiveness, often in connection with hypnosis, recklessly creating a false memory, or false belief that a childhood figure sexually molested the patient as a child, it is surely foreseeable—indeed more than a fair probability—that the patient will confront the "molester" with an accusation, or at least tell other family members of his/her belief. Regarding foreseeability, while in some cases the therapist may have a particular individual in mind before engendering the false and firm belief, in some situations the powerful suggestions of CSA will leave the patient to supply the name of the "offender."

B. Degree of Certainty that Plaintiff Suffered Injury

It is virtually impossible to imagine a situation more certain to produce injury than the accusation of a sexual crime committed against a child. The injury is even more certain when: 1) the purported victim is one's own child or close relative; and 2) that child or close relative, now an adult, is the one leveling the accusation.

Personal emotional devastation, shattering of family ties, and the stigma of being thought a moral cretin, are almost as certain as they are severe. Economic damages, such as loss of employment, often follow as well.

C. Proximity of the Injury to the Conduct

Although the wrongly accused plaintiff is not physically present at the time and place of generation of destructive pseudomemories, the destructive consequences of false accusations are so highly probable that it can be meaningfully concluded that the plaintiff is present in the immediate and inevitable wake of the therapist's misconduct. In terms of proximity in time, there are virtually no significant intervening steps between the patient's infection with pathologically illusory memories of incestuous abuse and the flinging of the inevitable accusation against the parent(s).

D. The Moral Blame Attached to the Defendant's Conduct

A psychotherapist who recklessly ignores historic truth and persuades a patient that s/he was sexually violated as a child, without any support from authoritatively accepted indicative symptoms, is engaging in morally outrageous conduct toward the wrongly accused plaintiff. Indeed, such conduct cannot, by any stretch of reason or any defensible notion of the idea of "therapeutic," be justified as furthering or enhancing the patient's ultimate emotional well-being. Public views reflected in the media, opinions by a wide range of professional and academic experts, by community opinion leaders, and by professional associations, strongly support the proposition that recklessly generating false accusations of an odious crime against a child is morally indefensible.

E. The Policy of Preventing Future Harm

Subjecting therapists to compensatory and, where appropriate, punitive damages for recklessly engendering false accusations would inevitably reduce

the future incidence of such conduct. As a matter of policy it is desirable to inhibit such conduct. As in certain other areas of tort law, the imposition of damages against grossly irresponsible professionals should operate as a mechanism for quality control.

F. The Extent of the Burden to the Defendant and the Consequences to the Community of Imposing Liability

Under the proposal herein, the defendant is left a wide range of practices, even suggestive practices, for which no liability is authorized. Therapists can "pick up" on patients' beliefs of prior sexual abuse or even partial but unaided memories that they have been sexually abused, and even permit the patient to opine or consider sources of her fragmentary memories. Where the patient presents with no memories of sexual abuse, the therapist can invite consideration of possibilities, as long as heavy handed suggestiveness is not utilized.

Beyond that, in formulating the statutory proposal, this author was concerned about avoiding a chilling effect on legitimate treatment of actual abuse survivors, or indeed the danger of a legal regime that would deter therapists from taking on adult patients who might have been victims of CSA.

Given the extensive degrees of freedom that the suggested test of liability leaves to the therapist (see discussion below) it is submitted that the threat of liability, limited to outrageous and grossly reckless or irresponsible behavior, does not unduly burden a therapist legitimately practicing psychotherapy. It would be most unlikely that imposing liability for reckless hypersuggestiveness would reduce treatment of actual victims of incest.

In terms of the consequences to the community, consider first actual and potential patients, including actual incest survivors. They will not be denied a full and professional consideration of the sources, manifestations, behavioral and/or psychological dynamics of their difficulties, or denied any number of possibly effective remedial therapeutic strategies.

To the community, including the family of the patient, the consequences are healthy, positive, and harm-avoiding. Family members should be substantially less likely to be falsely accused of unspeakable wrongs, and much less likely to be exposed to unwarranted emotional anguish and severance of life-long ties. The authentic history of family relations will not be vulnerable to sabotage by pathological revision. And the peace and tranquility of the whole community would be less likely polluted by noxious and unwarranted accusations of heinous sexual crimes committed against infants,³⁰¹ toddlers, and older children.

Such practices are manifestly unworthy of legal protection. They are not only devastating to the wrongly accused and his family, but the very civility of society itself is polluted by unfounded charges run rampant.

³⁰¹"The claim is even made by recovery therapists that adults can be brought back to the age of one or two years old and remember incidents of sexual abuse, a claim at complete odds with serious scholarship on memory." Loftus, *supra* note 2, at 521.

Justice Brandeis' observations in another context seem equally applicable here: "*The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding.*"³⁰²

The therapeutic consultation room should not be converted into an investigative adjunct of the nearest grand jury. The patient's emotional health, sound functioning and freedom from distress, *i.e.*, the best interests of the patient, must be the professional therapist's only concern. Any other pre-conceived agenda involves exploiting the patient or treating her as a means, not an end in herself.³⁰³

XI. REASONS FOR PROPOSED LEGISLATION

Although the arguments presented above conclude that liability is warranted under existing legal doctrines and that in any event, traditional jurisprudential principles of torts justify judicial recognition of a duty here (*i.e.*, a new tort), the most sensible and rational solution would be legislative. Absent legislation addressing the problem of confidentiality, some courts might decline to override it, even if the statutory and common law scheme in the state permit overriding it, notwithstanding the extraordinary social policy justifications presented here. A statute may be necessary in many states to empower judges to consider confidential material *in camera*, and to require disclosure only where s/he determines that a *prima facie* case of liability has been made.

Moreover, statutory provisions can provide additional screening devices that would tend to weed out specious claims that might otherwise disrupt an ongoing valuable therapeutic process. Legislation can protect the therapeutic process against interference based on minor lapses of competence and debatable (rather than gross) deviations from ordinary standards of care. It can prevent a chilling effect that might inhibit treatment of actual survivors of CSA. A statutory remedy can authoritatively identify the circumstances where most of the abuses occur and leave other situations untouched.

Most significantly, legislation can empower and command an otherwise ambivalent judiciary to effectuate justice by providing an authoritative remedy for egregious inflictions of personal anguish and massive human losses.

³⁰²*Olmstead v. United States*, 277 U.S. 438, 479 (1928) (J. Brandeis, dissent).

³⁰³This is not to say that Bowman and Mertz support strong suggestiveness in therapy. Throughout their article, they make disapproving references to such practices, maintaining however, (contrary to a thesis herein) that the prevalence or high frequency of such practices has not been established. Bowman & Mertz, *supra* note 7.

XII: AVOIDING A CHILLING EFFECT ON TREATMENT OF POSSIBLE ABUSE-SURVIVORS

Because of the undesirability of creating: 1) a chilling effect on *appropriate* treatment of actual survivors of CSA;³⁰⁴ and 2) uncertainty on the part of therapists as to where the line between safe and legally dangerous conduct falls, several safeguards against these *possibilities have been built into the recommended legislation.*

A. Leaving Room for Ordinary Error

It is not an appropriate function of the law to manage, let alone micro-manage psychotherapy. The proposed remedy leaves room for some carelessness on the part of the therapist in negligently eliciting illusory memories of CSA. The law must allow a zone of risk and a zone of error, or indefensibly risk a chilling effect on generally legitimate practices. Therapists must be given room to breathe; room to fully explore the patient's psyche, room to interpret, and even room to suggest, within a wide range of arguably acceptable practices.³⁰⁵

There are other areas of the law in which doctrines have been developed that permit causes of action while recognizing that some leeway ought to be permitted the defendant—that is, *recognizing that there are values too important and vulnerable to override by a simple test of negligence or ordinary incompetence.*

A closely related example is where a therapist reports to authorities, as the law requires,³⁰⁶ incidents that have come to his or her attention regarding sexual abuse of a child. Under mandatory reporting laws, a therapist is immune from liability as long as the report was made in good faith (or absent gross negligence or recklessness).³⁰⁷

When a public official or public figure brings a defamation action, the first amendment requires proof that the falsehood was deliberate or published in

³⁰⁴ See generally Paul S. Applebaum, M.D. & Rosey Zoltec-Jick, *Psychotherapists' Duties to Third Parties: Ramona and Beyond*, 153 AM. J. PSYCHIATRY, 457, 461-62 (1996).

³⁰⁵ See Yamini, *supra* note 7, at 577-79. For example, in a discussion of the requirements for prevailing in a malicious prosecution suit, Prosser and Keeton observe, [t]he law supports the use of litigation as a social means for resolving disputes, and it encourages honest citizens to bring criminals to justice. Consequently the accuser must be given a large degree of freedom to make mistakes and misjudgments without being subject to liability.

PROSSER & KEETON, *supra* note 263, at 871.

³⁰⁶ On immunity for ordinary negligence in reporting sexual abuse of a child, see, e.g., *Montoya v. Bebensee*, 761 P. 2d 285, 288 (1988). Regarding the duty of a therapist to report to authorities information about a sexually abused child, see generally, Steven R. Smith, *Mental Health Malpractice In The 1990s*, 28 HOUS. L. REV. 209, 250-52 (1991).

³⁰⁷ Recent cases suggest that courts have been interpreting requirements of bad faith or gross negligence loosely, and that in fact, therapists have been held liable for mere negligence in reporting.

reckless disregard of its truth or falsity.³⁰⁸ This doctrine is designed to give breathing room to a significant social and political enterprise—*i.e.*, critical expression regarding government officials or important public personages. Without such a requirement, the law of libel would have a chilling effect on constitutionally protected activity.

A malicious prosecution suit to succeed must establish that the allegations in the original suit were brought in bad faith and without probable cause.³⁰⁹

"Good Samaritan" laws often provide that where a person who is not legally obliged to rescue another person does in fact attempt to render aid to one in peril, the would-be rescuer is not liable for ordinary negligence in the effort to assist. The plaintiff must show that the defendant-samaritan was grossly negligent or reckless in the manner of rendering aid.³¹⁰

In each situation,³¹¹ although the underlying activity has proximately caused harm, for various social reasons protective of the activity itself, damages can be recovered only where the activity is performed in a grossly negligent or reckless way.

That recklessly instilling false memories of CSA should be a tort for which a non-patient can recover has already been maintained in arguments above. The requirement of recklessness assures that indeed the tort, as committed, is an outrageous wrong.

³⁰⁸New York Times v. Sullivan, 376 U.S. 254 (1964).

³⁰⁹The requirement of both malice and the absence of probable cause is set out in PROSSER & KEETON, *supra* note 263, at 871. In the sense of improper motive, see *id.* at 883-84. "[T]he requirement in malicious prosecution cases that the defendant must act without probable cause may well meet the constitutional requirements [if the requirements in libel cases apply] that [the defendant] act recklessly in disregard of the truth." *Id.* at 885.

³¹⁰See, e.g., Moyer v. Grier, No. CIV.A. 89C-MR-90, 1989 WL 167405, *5 (Del. Super. Dec. 27, 1989) (Under Delaware's "good Samaritan" statute, a person voluntarily rendering emergency care is not liable for damages resulting from that care unless his conduct was willful, wanton, reckless, or grossly negligent. DEL. CODE ANN. tit. 16 § 6801 (1996)); Tatum v. Gigliotti, 565 A.2d 354 (Md. Ct. App. 1989), *aff'd*, 583 A.2d 1602 (Md. 1991); Theodore Eugene Jobst v. Butler Well Servicing, Inc., 372 P.2d 55 (Kan. 1977).

Similar protections against liability for ordinary negligence are provided in the few states that impose criminal or quasi-criminal penalties for failure to rescue. See, e.g., MINN. STAT. § 604.05 (1990); VT. STAT. ANN. tit. 12, § 519 (b)(1973).

³¹¹To prevail in a civil rights action against a public official or police officer requires a showing of bad faith, mere negligence is not sufficient. See, e.g., Bates v. City of Fort Wayne, Ind., 591 F. Supp. 711 (N.D. Ind. 1983); Madison v. Manter, 441 F.2d 537, (1st Cir. 1971); Reese v. York, 571 F. Supp. 1046 (N.D. Tex. 1983).

B. Desirability of a Bright Line Rule

To maximize predictability and avoid the necessity of litigating every case from scratch, a doctrine which creates or recognizes bright line rules is desirable.³¹²

Professor David Wexler takes the view that any rule imposing liability on psychotherapists should encompass a readily discernible triggering point, or bright line, so that a therapist can easily recognize when s/he is in (legally and professionally) dangerous territory. In discussing both *Tarasoff* and *Ramona* type cases, Wexler states:

In the *Tarasoff* area, . . . the intrusion on therapy may be markedly reduced if, as is the law in some jurisdictions, the duty to protect a third party is triggered only by a patient's specific threat against an identified or clearly identifiable victim. In such "crystallized trigger" jurisdictions, a therapist can basically put legal worries to one side and merely practice psychotherapy, unless and until the duty to protect is rather clearly triggered by the patient making the required threat. Perhaps therapists will, during therapy sessions, be able to relax more about *Ramona* liability if future courts construe the direct victim duty to be triggered only when a therapist makes to a patient a specific suggestion relating to an identified or clearly identifiable third person.³¹³

This author agrees with the importance of having a fairly clear line of demarcation between liability-endangering behavior and legally safe practices. That line, embodied in the proposed legislation below is where the therapist, treating a patient who has presented with no memories of CSA, uses hypersuggestive techniques with suggestive content in treating the patient.

Under the proposed statute, a therapist would not need to concern herself about liability in the following situations:

- a) where s/he was treating a patient who presented with at least some suspicion or memory that she had been sexually abused in her childhood.
- b) where the therapist did not employ hypersuggestive techniques with a patient who presented with no verbalized suspicions or memories of being victimized by sexual abuse in her childhood.

³¹²See, e.g., Bowman & Mertz, *supra* note 7, at 594-96. They hypothetically compare a bright line limiting standing to sue to family members, and a bright line simply forbidding third party suits against therapists for allegedly inducing false memories. To this author, the first bright line is a red herring, because it would have little or no tendency to make readily discernible the practices that are forbidden under given circumstances. (They find other reasons to reject their own hypothesized bright line and prefer prohibition of the lawsuits altogether.)

³¹³David Wexler, *Editorial, Therapeutic Jurisprudence in Clinical Practice*, 153 AM. J. PSYCHIATRY 453, 454 (1996).

c) where the therapist may have employed a *technique* that might ordinarily be considered hypersuggestive, with a patient presenting with no memory of CSA, but the therapist did not actually suggest, directly or indirectly, (prior to the patient's raising it) the possibility of CSA.

To put it otherwise, there would be no reason to fear liability where the patient presented with no memories, where the therapists refrained from hypersuggestive techniques, or where the therapist refrained from remarks regarding CSA in using otherwise hypersuggestive techniques.

XIII. PROPOSED STATUTE

- A. Liability of a therapist-defendant under this statute is limited to situations where the memory or belief results in an accusation of childhood sexual abuse against plaintiff made by the therapist or the patient.
- B. This statute is not intended to apply where the patient, prior to initiation of the present cause of action, has initiated a legal action in a court of law against the alleged abuser, based on claimed abuse, which action is presently pending.
- C. This statute is not intended to apply where a patient always remembered having been sexually abused or manifested at or near the commencement of the therapeutic relationship and absent suggestive techniques employed by defendant, an autonomous and unambiguous recall of being victimized by childhood sexual abuse.
- D. (1) A therapist shall be liable to a person accused by a patient or the therapist of childhood sexual abuse where the plaintiff proves, by a preponderance of the evidence, that
 - a) by the techniques employed and the statements made, the therapist was either
 - i) reckless regarding, or
 - ii) consciously risking or willfully blind to, his or her creation of a substantial probability that any "recovered memories" of childhood sexual abuse purportedly perpetrated by the plaintiff would be illusory and
 - b) the memories and accusations engendered by violation of D(1)(a) proximately caused plaintiff emotional damages and/or familial harms and/or reputational harms of a severe nature.
- (2) Where Part D(1) is violated,
 - a) the illusory nature of the memory and the falsity of the accusations shall be rebuttably presumed and need not be established by the plaintiff;
 - b) the causal connection between the illusory memories and the false accusations shall be irrebutably presumed.
- E. It is "reckless," within the meaning of Part D(1)(a) to use techniques and statements so unduly suggestive or persuasive

as to be highly conducive to the production in the mind of the patient of an illusory memory or belief that s/he was a victim of childhood sexual abuse perpetrated by the plaintiff.

- F. (1) Techniques which shall not be insufficient as a matter of law, to permit a factfinder to consider whether they are so unduly suggestive or persuasive as to be highly conducive to the production in the patient's mind of an illusory memory or belief that s/he was a victim of childhood sexual abuse by the plaintiff, include, but are not limited to:
- a) hypnosis accompanied by communications tending to induce, generate, or create illusory thoughts, beliefs, visual images, or memories of childhood sexual abuse;
 - b) drug-induced altered state of consciousness accompanied by communications tending to induce, generate, or create illusory thoughts, beliefs, visual images, or memories of childhood sexual abuse;
 - c) guided imagery accompanied by communications tending to induce, generate, or create illusory thoughts, beliefs, visual images, or memories of childhood sexual abuse; or
 - d) placement of the patient in a "support" group prior to any "acknowledgement" by the patient that he or she has suffered childhood sexual abuse, where a significant activity of such group involves persuasion of various members that they were in fact victims of such abuse.
- G. If "the patient" is actively defendant's patient at the time of the suit, the plaintiff must make a showing *in camera*, prior to filing the complaint and prior to discovery proceedings, that existing evidence would satisfy the burden of production in the contemplated litigation. For this purpose hearsay evidence is admissible.
- H. (1) Plaintiff must submit at the time of filing the complaint, and prior to discovery proceedings, certificates of merit executed by:
- a) the attorney for the plaintiff; and
 - b) by a licensed clinical psychologist or licensed psychiatrist selected by the plaintiff declaring, respectively, that:
 - i) the attorney has reviewed the facts of the case, as known; that the attorney has consulted with at least one clinical psychologist or psychiatrist whom the attorney has made knowledgeable of the facts of the case as known, and whom the attorney reasonably believes is knowledgeable regarding the requirements of Parts D, E, and F of the statute and that the attorney has concluded on the basis of that review and consultation that there is reasonable and meritorious cause for the filing of the action;

- ii) the consulted mental health practitioner is licensed to practice and practices in this state either clinical psychology or psychiatry and is not a party to the action;
 - iii) the practitioner is not treating and has not treated the "patient," and that the practitioner is knowledgeable of the facts of the case as known, and has concluded, on the basis of his or her knowledge, that in his or her professional opinion defendant has probably utilized techniques that were reckless regarding, consciously risking, or willfully blind to, a substantial likelihood that any ostensible "recovered memories" of childhood sexual abuse would be illusory.
- 2) A complaint under this statute may not be served upon the defendant, nor may discovery processes commence, until the court has reviewed the materials required by Parts G and H(1) herein, and has found, *in camera*, that there is reasonable and meritorious cause for the filing of the action. At that time, the complaint may be served upon the defendant. The duty to serve the defendant with process shall not attach until that time.
 - 3) A violation of Part H(1) may constitute unprofessional conduct and may be the grounds for discipline against the attorney.
- I. If the court finds, on the basis of the showing in Part G and/or Part H, that the necessary showing has been made to permit the case to go forward, then on appropriate motions, the court must consider, *in camera*, any discovery requests for otherwise confidential communications, information or records, and further be advised of any such communications, information or records which are requested that defendant seeks to protect from disclosure, prior to requiring such material to be released to plaintiff.

The court, after reviewing these matters *in camera*, shall authorize only that extent of disclosure that arguably indicates:

- a) the patient's relevant beliefs or lack of beliefs prior to the therapy; and
- b) that unduly suggestive techniques were utilized in the course of the therapy, and probably contributed substantially to the patient's memory or belief of an act or acts of sexual abuse committed by plaintiff against the patient during the patient's childhood.

Prior to any release of records, the court shall announce its intention to order particular disclosures and permit the parties to make appropriate motions and arguments.

- J. Where plaintiff has met the burden required by Part D of this statute, the jury must find in favor of the plaintiff, unless the defendant establishes by a preponderance of evidence that the plaintiff did in fact sexually abuse the patient; provided that the defendant may not introduce, as evidence toward satisfying this burden, any statements of apparent recovered memory made by the patient absent sufficient corroborating evidence to reasonably raise the issue for the finder of fact.
- K. Recovery shall include compensation for injury (where present) to reputation and for loss of consortium, if any; severance of family ties; emotional distress; and any tangible monetary losses (including but not limited to, lost employment, sick days, medical expenses), and, where established that the tort was intentionally committed, punitive damages.

XIV. COMMENTARY ON PROPOSED STATUTE

Re: Part A.

There is liability only where an accusation of childhood sexual abuse is made. There is no liability, under this statute for instilling the memory or belief as such, although that may well be malpractice.

Re: Part B.

Because of the undesirability of having two lawsuits involving very similar claims and functionally similar parties, the proposed remedy should not be available while a lawsuit brought by the adult patient against the parent is pending. Moreover, claims made in such a lawsuit have a qualified immunity from becoming the basis of another suit, at least unless and until the claims are rejected by a court or fact-finder. Indeed for an accused person to subsequently base a lawsuit on the accusations embodied in the patient's suit would require a showing of bad faith in a malicious prosecution suit.

Re: Part C.

While it is possible that a therapist: a) incompetently accepted a presenting assertion by a patient that she was an incest victim; and/or b) inappropriately and unprofessionally transformed a fragmentary memory of mild or moderate abuse into a full and illusory memory of severe abuse, it is submitted that a statute ought to draw a fairly bright line as to vulnerability to liability. Moreover, in view of the *possibility* of spontaneous, independent, and reasonable accurate recollections of deeply buried traumas, it would be appropriate to assure therapists of immunity to a suit where the patient presents with all or part of such recovered memory.

Re: Part D(1).

The key to the proposed cause of action is the creation by the therapist of *a substantial risk of inducing illusory memories*. The forbidden practices are akin to reckless endangerment of false memory creation. The statute, in effect, creates a rebuttable presumption that the elicited memory is false where hypersuggestive techniques are used. In making the determination under Part D(1), a court or jury would consider, to the degree provable, even by hearsay, the nature of the techniques employed to enhance "recovery" of memory.

(It should not be necessary to make any determinations whether the abuse sought to be uncovered was thought by the therapist to be profoundly forgotten or psychologically repressed.)

Re: Part D(3).

As in almost all tort litigation, it must be shown that the wrong *proximately caused* the harm. In rare cases this requirement might not be met. (*E.g.*, where, without contribution from any memories induced in therapy, the patient acquires the belief or knowledge independently that the plaintiff molested her as a child, and her accusations flow from that independent source.)

Also, there might be circumstances where it was not reasonably foreseeable to the therapist that accusations would be made against the plaintiff (*e.g.*, the therapist might have reasonably believed that the molester was deceased).

Additionally, other adult children of the plaintiff may have made accusations of child molestation, in which case, even if the patient's accusation is false and culpably engendered by the therapist, the amount of harm caused by the therapist's actions might be negligible.

Re: Part E.

This section defines a key term in the operational section (D)(1)(a), the term "reckless." Consistent with the emphasis in this Article, the conduct that justifies litigation and recovery is the use of extremely suggestive techniques that strongly tend to induce or implant pseudomemories of childhood sexual abuse. When such techniques are used with a patient that had no such memories prior to therapy, it is justified to effectively adopt a rebuttable presumption that the memories are culpably iatrogenic (caused by the treatment) and that the accusations they produced are false. The rebuttable nature of the presumption that the accusations are false is indicated by section J.

Re: Part F.

This Part sets out some of the most flagrantly suggestive techniques and provides that where any of these are established plaintiff's case should be treated as sufficiently weighty to overcome a motion to dismiss—*i.e.*, a motion based on the claim that a reasonable jury could not find for the plaintiff under Part D(1) on the basis of the evidence presented. The fact that one or more of the factors listed in this Part are found, does not, of course, require the jury to conclude that there is liability.

Re: Part G.

This provision is designed to avoid or minimize the possibility of certain undesirable results, identified and amplified by Professors Bowman and Mertz: *i.e.*, unnecessary or inappropriate interference with ongoing therapy. Since, however, the required showing must be made before, and as a condition to, commencement of discovery proceedings, all or most of the available evidence at this point would probably be in hearsay form.

Re: Part H.

This screening device is somewhat less onerous for the plaintiff and the judge, requiring a certification of merit by counsel and a licensed clinical psychologist or psychiatrist. This section applies where the suit is brought at a time the "patient" is no longer a patient of the defendant. While in this situation there is not the risk of interfering with ongoing therapy, there is nevertheless a risk of unjustifiably subjecting both the therapist and the former patient to a

lawsuit that may expose significant aspects of otherwise confidential information, re-victimize an actual victim, and target an ordinarily and socially valuable relationship.

The principal protections are, of course, the ultimate proof requirements in Part D(1).

Re: Part I.

In order to avoid unnecessary and unjustified disclosures of confidential communications, this Part requires that the court, where it has found that the requirements of Parts G and/or H have been met, review *in camera* any discovery requests for confidential matters, and any particular information or records requested. Only where and to the extent that the court finds that confidential matters are arguably relevant to the proof required to establish liability should it require disclosure.

There is precedent for this approach under the *Tarasoff* doctrine. In a suit alleging a breach of a psychiatrist's duty to protect a victim against a threatened danger by a patient, the California Court of Appeals held that the trial court appropriately first considered the requested, otherwise-privileged, information *in camera*, and where a *prima facie* case of violation of duty was made out, ordered disclosure of such records.³¹⁴

It is important that the court, in fashioning its ultimate discovery rulings, protect confidential therapeutic communications to the greatest extent consistent with permitting a plaintiff (who has overcome initial screening hurdles) to have a fair opportunity to establish that the accusations against him of sexually molesting a child were produced by highly suggestive and unprofessional techniques.

It has been argued (not without dissent) that confidentiality is a *sine qua non* to successful psychotherapy. There is much to suggest that trust is a vital element in successful psychotherapy. Trust is essential to any therapeutic alliance, to the process of unfettered emotional disclosure, and to believing in the therapist's unalloyed concern for the patient's emotional/behavioral well-being. Trust is essential to any fortified hope in the mind of the patient that relief from psychic distress, constructive behavioral change, and personal and interpersonal growth can eventually emerge from the therapeutic process.

The possibility of public disclosure of the therapeutic process may undermine trust, yet, as seen, at times there are powerful countervailing values. Under the proposal, disclosure comes about where there is a high probability that the therapist betrayed the patient's trust by acting out of motives or beliefs that ignored and jeopardized the patient's best therapeutic interests.

Re: Part I.

A therapist ought not to be liable to an accused person if in fact the plaintiff did abuse the patient. It would be outrageous if an actual molester could disrupt therapy and recover from a therapist even if the patient's memory was engendered by irresponsibly suggestive techniques.

³¹⁴Mavroudis v. Superior Court, 162 Cal. Rptr. 724, (Cal. Ct. App. 1980).

Thus, if the therapist can introduce corroborating evidence, that, together with the patient's memory of abuse, establishes such abuse by a preponderance of the evidence, the defendant-therapist should prevail in the lawsuit.

The corroborating evidence element might be met or partially met by testimony by a member of the family or other person who witnessed the abuse, from siblings who were also abused, from photographs, diaries, or school, hospital, police, or social welfare records.³¹⁵

XV. SOME EVIDENTIARY CONSIDERATIONS

In order to meet screening requirements, hearsay evidence will suffice. In most cases where the patient is still in therapy with the defendant, the plaintiff will have to rely on statements by the patient, to other relatives, to the plaintiff, and to her friends, regarding matters taken up in therapy. (It is possible that before any memories have been induced, the patient had mentioned to the ultimately accused abuser, something about the methodology.) It may be possible to learn enough about the defendant's techniques from other therapists familiar with such techniques, or from the defendant himself (who may give public talks, lectures, or interviews, or have published writings). (The ethics of employing a covert detective to pose as a patient involve issues obviously beyond the scope of this Article.)

It should not be sufficient (to satisfy screening requirements) for plaintiff to prove that no accusations were made prior to the patient's initiation of therapy with the defendant.

³¹⁵See generally Matthew J. Eisenberg, Comment, *Recovered Memories of Childhood Sexual Abuse: The Admissibility Question*, 68 TEMPLE L. REV. 249, 278 (1995).

