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Repressed Memory Accusations: Devastated Families and Devastated Patients

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SUMMARY

The survey of British families reveals that the disputed 'recovered memory' accusations are mostly made by adult women who allege that abuse began prior to their eighth birthday. Therapy was involved in the recovery of memories in the vast majority of cases; satanic ritual abuse was remembered in a minority of cases. The accusations are devastating to the accused and other family members. But family members are not the only devastated group. Data from a recent report on patients who received compensation from a crime victims' compensation fund after recovering extensive histories of abuse in therapy reveal that some patients' lives are devastated after 'memory' recovery. Their health declines, they lose their jobs, they get divorced, and in some cases they lose custody of their minor children. Although these data do not prove that it was the therapy itself that made the patients worse, they do ring alarm bells about treatment outcomes for some recovered memory patients, and show a pressing need for information on this topic.

Against a backdrop of what are undoubtedly thousands of genuine devastating cases of child sexual abuse in Great Britain, there is a twin tragedy. Hundreds of families, members of the British False Memory Society, have been devastated—by accusations of sexual abuse that they largely emphatically deny. It is this latter group of cases that Gudjonsson has elected to investigate. In doing so, he found that the accusations came mostly from females—daughters accusing a biological father, and sometimes a mother, of abuse that had allegedly been repressed for decades, and was recovered in association with therapy that the accusing daughter had received. Gudjonsson's analysis reveals important details about the accusations—that they are mostly made by one child within a family (90%), that the accusers are mostly female (87%), that the abuse is mostly that which began early, prior to the child's eighth birthday (70%), and that the allegations were devastating to the accused and other family members. The methodological weaknesses in this kind of survey are duly acknowledged, those primarily being that the accused person who filled out the survey might lack knowledge about some aspects of the accusations, and moreover might also be plagued by normal expected reconstructive memory problems. Nonetheless, the data provide important information about a cultural phenomenon of our times, and provide a good jumping point to make a few observations.

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In 8% of the cases, the accusation involved claims of satanic ritual abuse (SRA, and possibly more than 8% since another 18% were not sure if SRA was being alleged). In a comparable survey conducted in the US, the percent of accusations involving SRA was higher (18%). Why are these important? In the majority of the cases in the British sample, the disputed memories are simply that—disputed. There is little in the way of corroboration for the accusations, and the accused has virtually no way to 'prove' that the accusations are false (that is to prove a negative). However, when the accusations develop into satanic ritual abuse, we are in a somewhat better position to infer that the mental products are likely pseudomemories. After all, as Leif and Fetkewicz (1995) have noted, 'face validity' that a memory is a pseudomemory is apparent when people report 'satanic ritual abuse, murder, and other violent crimes that, if true, should provide physical evidence' (p. 414). The same can be said for memories of abuse occurring during a period of infantile amnesia or even earlier (as in pre-natal memories), and it is noteworthy in this regard that the British sample contained nearly 20% claiming abuse that began before the age of three. Of course the adult could conceivably be experiencing genuine memories that occurred later in childhood, despite having pseudomemories for the first year or so of life, but the presence of these dubious very early memories does raise some question about the potential for pseudomemory creation in the mind of that particular individual. And of course the adult could conceivably have experienced genuine abuse that was not satanic in nature, even if the ritual overlay was false. Yet, the presence of dubious satanic memories raises questions about the potential for pseudomemory creation in the mind of a particular patient.

Why else should we be suspicious about satanic allegations that involve multiple perpetrators, intergenerational cults, grotesque sexual assaults, human sacrifice, cannibalism, replete with consumption of blood, urine and excrement? The simple answer is lack of evidence when there should be. Lanning (1991, 1992) reports on failed efforts of law enforcement to find corroborated cases. Bottoms, Shaver and Goodman (1996) tried to obtain corroborated cases from the therapists who treat these 'survivors' and had little luck. In their study, 2,722 US clinical psychologists responded to a 1990–91 survey, and 802 of them claimed to have seen at least one ritual or religion-related case of abuse during the 1980s. Of these, 43% saw at least one child/ritual case (13% of all 2,722 respondents), and 38% saw at least one adult/ritual case (11% of all respondents). The total 'survivors' seen by this set of psychologists included 287 adult ritual cases and 457 child ritual cases. The clinicians in this sample were asked if they personally believed their clients' allegations of harm and whether they believed the ritualistic aspects of the allegations. Bottoms' *et al.* report: 'Overwhelmingly, our respondents believed their clients' claims, even in the absence of corroborative evidence.' (p. 25), a finding that investigators referred to as 'most striking'. The clinicians were asked to describe what they accepted as evidence for the ritual claims, and could offer little in the way of concrete evidence. They mostly cited their patients' reports or behaviors: one said 'only patient's disclosure via hypnotherapy', another said 'play behavior, drawings, fear of satanic symbols' and a third cited the Ritual Abuse Behavior Checklist which Bottoms' *et al.* called 'a dubious diagnostic checklist which includes many behaviors common to childhood'. As these investigators note in another chapter on this subject 'If hundreds of victims and perpetrators were involved, more corroboration . . . might be expected. If there was indeed torture and sacrifice of humans, murder, and cannibalism, more hard

evidence, such as victims' remains, should have been found' (Qin, Goodman, Bottoms and Shaver, in press). Of course, those who wish to cling to the authenticity of these satanic reports can find a way. One clinician in the US survey wrote 'For all patients, dissociated memories of abuse, previously unknown to patients, came to light during therapy. Specific details of abuse are difficult to list, because recollections by patients are partial and increase with duration of therapy. Much abuse is denied. Cult perpetrators are excellent at hiding/destroying evidence and doing ''unbelievable'' acts' (Qin *et al*., in press).

The role of therapy

Gudjonsson's survey of the British families reveals that therapy was involved in the vast majority of cases of disputed accusations. So it is natural to wonder about the beliefs and practices of the British therapists who might be treating these accusers. Some information about the beliefs and practices of a select group of educated, trained psychologists in Britain is available. While these chartered psychologists may not specifically be invovled with the particular accusing patients in the Gudjonsson sample, it seems reasonable to suggest that these 'elite' practitioners might be influential in the clinical community in Britain. The British Psychological Society conducted a survey of its practitioners, as part of the activities of a Working Party of the BPS assembled to study the 'recovered memory' problem. The report from the Working Party has been praised for its useful, although common-sensical advice to practicing clinicians. However, many of its conclusions have been controversial and the subject of criticism and debate (see for example, Independent Advisory Committee of the British False Memory Society, 1995; Andrews, Morton, Bekerian, Brewin, Davies and Mollon, 1995b).

One specific allegation concerns selective quotation of the results of a survey conducted by the Working Party of BPS members involved in therapy. For example, when therapists were asked whether reports of childhood sexual abuse (CSA) from total amnesia can be taken as essentially accurate, 38% said 'usually' and 6% said 'always'. This result was reported, along with the Working Party's inference that these recoveries from total amnesia are undoubtedly accurate because they represent high levels of belief among qualified psychologists, psychologists who had also admitted to the possibility of false memories. However, these same clinicians had been asked an additional question about whether clients' reports of having experienced satanic ritual abuse can be taken as essentially accurate; 38% said 'usually' and 5% said 'always'—virtually identical percentages. This curious coincidence was omitted in the initial report of the Working Party, and only emerged when a full account of the survey was published later (Andrews, Morton, Bekerian, Brewin, Davies and Mollon, 1995a). The survey also found that 10% claimed the use of hypnotic regression to uncover traumatic memories, and prior research on the beliefs and practices of British psychologists had also documented widespread use of risky practices (Poole, Lindsay, Memom and Bull, 1995).

Are patients getting sicker or better?

Thus we have evidence of a potentially deadly combination—a significant minority of trained mental health practitioners engaging in memory retrieval practices that

may be considered risky at best, a significant percentage believing their clients' claims of abuse, no matter whether those claims involve satanic ritual abuse or abuse that is less exotic. A minority of accusing patients appear to recover memories of a dubious nature. One might naturally ask whether the treatment is making the patients better? One opinion on this subject comes from studies of people who have retracted their abuse claims. While numerous accounts of retractors have been published (Loftus and Ketcham, 1994; Nelson and Simpson, 1994), one of the most ambitious is a study of 40 retractors, nearly half of whom had previously developed memories of satanic ritual abuse (Leif and Fetkwicz, 1996). After extensive examination of these cases, the investigators noted: 'As we collect more and more data on the types of therapies involved in recovered-memory therapy, we cannot avoid the conclusion that this is bad therapy. Enormous harm is being done to these patients and to their families. Patients get sicker instead of better, and huge sums of money are spent for years of therapy based on the erroneous assumption that the recovery of memories of sexual abuse in childhood is a healing process' (p. 432).

Of course the survey of retractors about their experiences is subject to the same methodological weaknesses from which the survey of accused individuals suffers. There can be major problems, for example, with retrospective reconstruction of events. We cannot know that the therapy made these individuals 'sicker instead of better' just because the retractors say it is so. Other methods are needed to determine these issues.

Crime victims—a source of information?

One recent study that has been used to bolster the claim that the therapy has made patients worse has received substantial publicity. The findings of the study are alarming, but contrary to some inferences, the study does not 'prove' that therapy made patients 'sicker instead of better', for reasons I outline later. The study does, however, suggest a novel method for how information about repressed memory allegations might be gathered.

By way of background, in the early 1990s, an amendment to the Crime Victims Act allowed for individuals to seek compensation from the State of Washington if they claimed they had repressed their memory for long-ago abuse but now their memories had returned. Between 1991 and 1995, 682 repressed memory claims were registered with the Crime Victims Compensation Program. Of these, just under half ($n = 325$) were awarded some compensation (Parr, 1996a, b). Two major reasons for denying the claim was that the 'crimes' occurred in another state and the claimant was not a resident of the State of Washington at the time of those alleged crimes, or else that collateral information revealed that the victim had memory for the abuse years prior to filing.

Staff employees working for the Department of Labor and Industries, which included a RN and a M.ED., reviewed 183 of these claims. Of these, 30 were 'randomly selected for a preliminary profile' (Parr, 1996a), and some of the reported findings are rather alarming. The sample was almost exclusively female (29/30 = 97%) and Caucasian (29/30 = 97%). Their ages ranged from 15 to 67 with a mean of 43.

The women (and one man) saw primarily Master's-level therapists (26/30 = 87%), although 2 saw a Ph.D., 2 saw a MD, and 6 saw a Master's-level therapist in

conjunction with a MD. The first memory surfaced during therapy in 87% of the cases. All 30 were still in therapy three years after their first memory surfaced, and 60% were still in therapy five years after the first memory surfaced.

Before the memories, only 3 (10%) had attempted or thought of suicide; after memories, 20 (67%) were suicidal. Before memories, only 2 (7%) had been hospitalized; after memories, it was 11 (37%). Before memories, only one woman (3%) had engaged in self-mutilation; after memories 8 (27%) had mutilated themselves.

Virtually all the memories (29/30 = 97%) contended they had been abused in satanic rituals. They claimed their abuse began when they were, on average, 7 months old. Parents and other family members were allegedly involved in the SRA in all cases (29/29); a majority cited birth and infant cannibalism (22/29 = 76%) and consuming body parts (22/29 = 76%); all remembered torture or mutilation (29/29), although none could be corroborated by medical exams.

Most of the patients had been employed before entering therapy (25/30 = 83%), many of them in the health-care industry (15/30). After three years of therapy, only 3 of 30 (10%) were still employed. Of the 30, 23 (77%) were married before therapy. Within three years of this time, 11/23 (48%) were separated or divorced. Seven (of 30 = 23%) lost custody of minor children (put another way, of the 21 who had children, one-third lost custody). All 30 were estranged from their extended families.

The average cost of a non-repressed memory claim was under $3,000. By contrast, the average cost for the 183 repressed memory claims was over $12,000, with one claim exceeding $50,000. In just over four years, the State of Washington had paid out more than 2.5 million dollars for repressed memory claims.

What should we make of these preliminary data? Of course, they paint a picture of individuals who got sicker, not better. But the data do not prove that it is the therapy that made the patients worse. These patients may have been ones who would have shown dramatic declines in mental health even without any therapy. Do the data paint a picture that is representative of all repressed memory cases? Of course not. While the investigators reported that they selected files randomly for more detailed examination, the high proportion of satanic abuse claims suggests a bias in this sample. It certainly does not remotely resemble the proportions seen in the British families or in their American counterparts. Of course the population of cases that might seek government funding for past crime victimization is not the same as the population from which the British families have been selected.

Despite these caveats, the method used by Parr (1996a, b) has some advantages over the retrospective surveys and with adaptation could produce a useful information that might inform the repressed memory debate. The 'crime victims' methodology does not rely on retrospective biases that might be present when therapists are asked about the effectiveness of their own personal methods, or when patients and former patients are asked to recall what went on years earlier in therapy. The 'crime victims' methodology does not suffer from the disadvantage of Gudjonsson's survey of accused family members, wherein accused family members may have little information about exactly what went on in the therapy conducted with their loved ones. The 'crime victims' methodology relies on an examination of medical records and other documentation, and a 'counting' of certain outcome measures (e.g., number of hospitalizations, number of suicide attempts, number of divorces). But the study needs to be done again, with proper controls and scientific checks. At the very least, greater assurance of random sampling of files is needed.

Multiple coders of information and reliability checks would be included in the improved version of this study paradigm. The repressed memory patients may appear to be getting worse, but compared to what? What has happened to other alleged crime victims, say of recent rape, or car jacking, or armed robbery, who pass through the system? Some prominent psychiatrists have worried that the repressed memory therapy is not helping patients. For example, this statement was recently made in a prominent journal: 'What seems to be happening in the recovered memory saga is not unlike what happened years ago with thalidomide: the premature release of an apparently promising medication produced such disastrous side effects that it had to be withdrawn' (Munro, 1996, p. 200). An improved study adapted from the initial ideas and contribution produced by Parr and her colleagues (1996a, b) would go a long way towards testing this hypothesis underlying the 'thalidomide' analogy.

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