Clinically Based Risk Management Principles for Recovered Memory Cases

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Controversy over cases involving so-called recovered memories of sexual abuse has threatened to divide the mental health field, just as lawsuits based on recovered memories have sometimes divided children from parents and others. The authors review issues in this controversy, including the role of misdirected advocacy for recovered memory by some practitioners, the distinction between the actual events and patient's narrative truth as a factor in the therapeutic alliance, and the contrast between therapeutic and legal remedies. They recommend nine clinically based risk management principles to guide clinicians in dealing with cases involving recovered memory. They include the need for documentation and consultation; the value of psychotherapeutic neutrality, maintaining a calm perspective, and understanding the difference between historical and narrative truth; the incompatibility of the roles of treater and forensic expert; the risks of special therapies such as hypnosis; awareness of the roles of other professionals and the significance of the patient's family; and the importance of knowing when to end treatment. (*Psychiatric Services* 48:1403–1407, 1997)

Recent highly publicized litigation has been brought in cases involving so-called recovered memories, in which adults, usually in therapy, claim to have unearthed long-buried or repressed memories of sexual abuse during their childhood. The cases run the gamut of legal issues. For example, the case of *Ramona v. Ramona* (1) involved criminal charges against parents for childhood abuse recently recalled to memory by an adult child during the course of psychotherapy. The California Superior Court dismissed this case, then reversed the action, finding for the accused plaintiff, the patient's father, against the treaters (2).

In *Althaus v. Cohen* (3), a child who had complained of parental ritual abuse took back the complaint, and the court found for the child-recanter and the child's parents and against the treaters. Other cases have involved parental suits against treaters for malpractice, such as *James v. Superior Court* (4), which found for the patient-plaintiff; and suits against treaters for slander, such as *Khatain v. Jones* (5), in which parents successfully sued their daughter's therapist for slander after claims of abuse had arisen in therapy. The decisions in these cases have left many clinicians concerned and bewildered about how to deal with the implied risks and uncertainties associated with recovered memories.

Further complicating the existing risks and uncertainties is the empirical evidence about the mechanisms of memory, which, as is typical in any emerging science, reveals contradictory findings about how and what persons in various settings retain in memory or forget (6–11). Empirical studies often fail to distinguish whether allegedly repressed memories are genuinely repressed or simply not reported to researchers.

In addition, many therapies featuring recovery of memories have proliferated far from the mainstream, including therapy to recover memories of "past lives" and treatment for recovered memories involving the traumatic consequences of abduction by extraterrestrial aliens (12).

Several attempts at managing liability risks associated with recovery of memories constitute "cures" that may be worse than the alleged "disease" of inappropriate therapies. These efforts include stringent legislation governing informed consent in which only those forms of psychotherapy that have empirically proven effects on particular maladies may be used. Yet another well-meant approach—from the American Psychiatric Association's insurance risk managers—involves highly restrictive instructions on how to practice "careful psychotherapy" (13). Unfortunately, the recommended approach—cautioning patients about the APA's official position of professional uncertainty about the validity of recovered memories—constitutes a glaring example of defensive practice, a kind of "misinformed consent." Yet the question remains: what degree of informed consent is valid but also preserves the therapeutic alliance?

Another proposed reform involves

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tightening legal constraints on admissibility of evidence obtained through hypnosis or sodium amytal interviewing (14). Would-be reformers also show poor discrimination between ordinary psychotherapy and alternative, nonmainstream therapies such as past life regression. It is unclear at this point what goal these efforts at reform will accomplish.

This paper discusses risk management principles for clinicians who treat patients who recover memories of sexual abuse and for clinicians with patients who decide to sue someone, perhaps even the treater, because of a recovered memory.

Background

Before we address what we believe to be valid and clinically based approaches to malpractice prevention in this troubled area, it may be useful to outline the context in which this activity is taking place. Paradoxically, while psychoanalysis as a dominant theoretical framework and mode of practice may be in decline, belief in the supposed therapeutic effect of recovery of repressed memories, often a feature of psychoanalytic therapy, has apparently taken hold among a wide spectrum of practitioners. Unfortunately, many of these practitioners have sacrificed analytic neutrality and have undertaken a misdirected advocacy for recovered memory, in the cause of supporting abuse victims. Note well that we distinguish between the ideologic posture of the zealot who finds abuse in every case and the legitimate inquiry about abuse that belongs in every psychiatric history.

Some practitioners' advocacy for recovered memory has extended to significant interference with and intrusion into the patient's life, often in the form of multiple and extensive boundary violations. These trends have been coupled with growing public awareness of childhood abuse and the extent to which abuse has been unrecognized or underreported. Among zealous advocates, the pendulum swing has now reached an extreme in which almost every symptom of dysphoria is seen as proof of early abuse (15).

Beyond the advocacy problem, a second dimension of this complex issue is the lack of training and skill common among practitioners who are the most ardent advocates (although some highly skilled and senior clinicians are also involved in such advocacy). To the patient's quest for understanding of distress, the unskilled therapist supplies a clear answer—childhood abuse. This explanation provides a resolution to the patient's "effort after meaning" and a mechanism for understanding symptoms. Symptoms are explained by the use of "syndrome evidence," in which the presence of a particular current symptom is taken inappropriately as solid evidence of a past actual event.

This model for explaining the patient's problems, often presented along with a recitation of statistics suggesting a high incidence of child abuse, also seems to absolve the patient of responsibility for his or her own life. The treatment is likewise predetermined in all too many cases: enrollment in an incest survivor group—a "memory mill," or what one author has called the "incest-survivor machine" (16)—and validation, or, depending on one's attitude, contamination, by one's alleged peer group.

Confounding all this activity is the fact that all psychotherapy, by encouraging self-directed attention, involves voluntary or involuntary recovery of memory. The distinction among repression, suppression, avoidance, and simple forgetting or redirection of attention is often hard to establish. Thus many of the problems, fears, and recommendations about recovered memory overlap problematically with issues about psychotherapy itself. Hence any risk management guidelines for proper conduct should be constructed to leave appropriately conducted psychotherapy intact.

Other contextual factors that are important in considering recovered memory include the distinction between what is real and what is true and the distinction between the clinician's office and the courtroom as the setting in which patients seek to resolve their distress.

The distinction between the "real" and the "true" is the difference between the historical truth, or the events that actually happened, and the narrative truth, the more-or-less coherent story the patient tells himself or herself about the past that affords clarity and comprehension of personal history (15,17). In therapy, the patient's view of his or her life emerges. It is subjective and selective and can be erroneous or accurate, but its objective, factual validity cannot be determined without data external to the therapy itself. Hence everything a patient tells the therapist is "true" in the sense of coming from the wellspring of the patient's conscious and unconscious mind, but may or may not be "real" in the sense that a neutral observer or videotape of the scene when it occurred would report the same story. The patient's convincing demeanor and the plausibility of the narrative—even coupled with the therapist's own deep convictions—do not in themselves constitute objective proof of the reality of events.

The clinician's office and the courtroom are different worlds with different rules. The patient can expect the clinician to be an intuition-driven partisan whose empathic subjectivity allows the therapeutic alliance to grow. The therapist who doubts what the patient says is likely to invalidate the patient's personal experience and risk undermining treatment.

However, doubt is a major feature of the adversarial, evidence-driven world of litigation. Unsophisticated therapists often portray litigation as the route to healing, empowerment, and closure for patients with recovered memories—the patient must sue to heal, they suggest (18). In fact, over and above the reality that any case can be lost, the law is a "blunt instrument," and litigation can have many destructive effects—Bursztajn (19) called them "critogenic harms"—that have been underestimated by such treaters. These harms include arrest of therapeutic development at the point of suit; prolongation of closure while litigation is pending; entrenchment, at least partly for legal purposes, in the dead-end "victim" posture; revictimization as a result of the stresses of litigation; and, in some

cases, pathological attachment to the abuser through the "bonds" of litigation.

Risk management principles

Valid risk management principles in the treatment of patients with recovered memories must rest on a solid clinical footing and secondarily should be informed by awareness of the legal context. The following nine principles are offered as guidance for clinicians.

Documentation and consultation

Careful documentation of the case and consultation with other clinicians are timeless standbys of sound risk management that are highly relevant to cases involving recovered memories. Documentation records the therapist's rationale for the therapeutic approach. Careful recording of the events surrounding a patient's recovery of memory, of the therapist's questions and comments, and of the sequence in which memories returned may help the therapist avoid the appearance of having suggested that the patient experienced abuse. Peer or expert consultation can help to show that the therapist's treatment plan is within the standard of care.

Abstinence and neutrality

The principles of abstinence and neutrality, primarily associated with psychodynamic psychotherapy, are of particular value in cases of recovered memory, and their decline in more directive areas of psychotherapy is lamentable. The necessary "sitting back" that these principles require does not imperil empathy—indeed, it may make undistorted empathy possible—but it does prevent the therapist from advocating for the historical facts, rather than advocating for the patient's welfare. Only the latter is proper.

Psychoanalytic neutrality has a narrow meaning involving the analyst's position in relation to psychic elements—equidistant between the ego, id, superego, and reality. In this discussion, we refer to a broader clinical—and legal (20)—duty of neutrality, perhaps best defined as the therapist's obligation, in the absence of emergencies, to avoid intruding on the patient's life or imposing his or her beliefs or values on the patient. Yet neutrality itself, persistently maintained, may ultimately create in the patient a sense of being doubted.

In this context, a clinician may face the patient's query "Do you believe me?" Any possible answers, however reassuring to the patient, become irrelevant to the courtroom context, where the clinician's faith is not considered evidence. Some patients are reassured by a temporizing response from the clinician: "Let's accept that view now but remain open to deeper or different understanding as we learn more." Others may need to hear the therapist say, "Until you asked, I wasn't aware there was a question."

There is much to be said for the classic analytic contract in which the patient agrees to postpone major life decisions during the emotional flux of therapy or, at least, to bring these issues into therapy for discussion before making the decision. Going to court should be identified as one such issue. This course of action should be discussed to see if, indeed, the expected benefits outweigh the harms that may result. The patient who impulsively sues an elderly parent as a resistance to looking inward at dynamic issues is not being aided in the therapeutic growth process. As a general rule, the therapist should abstain from recommending litigation. The therapist must be able to tolerate uncertainty and to avoid prejudging the case.

The patient's completely cutting ties and contact with family members is another course of action that is sometimes suggested by overzealous therapists. Like litigation, this issue should be brought into therapy for discussion and its potential benefits and harms thoroughly examined.

Maintaining perspective

Despite the recognized horrors of sexual abuse, clinicians should not be swept away in the emotional storms associated with this issue. Remaining calm in the "therapeutic chair" permits the therapist to offer the greatest degree of help to the patient in working through past trauma. A frenzy of litigious advocacy fomented by the treater aids no one.

Therapists may be vulnerable to loss of perspective because of their own abuse histories, a phenomenon documented by Pope and Feldman-Summers (21). Although such an issue is technically no different from other conflicts in its role in countertransference and overidentification with the patient, our consultative experience suggests that the therapist's temptation to work out his or her own history of abuse through the patient may pose significant challenges.

Historical versus narrative truth

The clinician should maintain a delicate tension between exploring, with proper indications, the issue of past abuse versus suggesting that abuse took place. Of course, what actually happened is very important to the patient and to the clinical strategy employed. If abuse is corroborated, the patient must both recover from the harmful effects of this trauma and mourn the loss of the "good" aspects of the abuser, if a parent or family member is involved. If the abuse did not occur in reality, efforts might be directed to repair or preserve the relevant relationships, at the patient's wish. If the issue is uncertain, patients might be helped to bear the uncertainty and go on with the therapeutic work and with their lives. The clinician must be able to tolerate such ambiguity, as ultimately unequivocal facts may never come to light.

To show that the therapist has used careful judgment when exploring the issue of past abuse with a patient, the therapist should document in the case notes that he or she considered how to avoid suggesting that abuse took place before discussing the events with the patient.

Treater versus expert

The role of treater and forensic expert witness are clinically and ethically incompatible (22,23). However, if the patient decides to go to court, the patient's attorney may exert pressure to thrust the treater into the expert role. The subject is too extensive

to address here in depth, but some key points may be illuminating.

First, the clinician's obligation to do no harm may be in conflict with the fact that expert testimony at trial may, indeed, harm the patient's case, especially in the adversarial context of the court (24). Although forensic examiners should always warn the patient about this possibility, treaters do not and arguably should not do so, because treatment should follow its own course rather than be tied to litigation. The treater's willingness to accept the patient's view as true is in conflict with the expert's need for external corroboration; the very search for corroboration itself may well be experienced by the patient as disloyalty, disbelief, or abandonment of the therapeutic alliance.

The treater's benevolent wish to help the patient with his or her legal difficulties does not alter these considerations. Should the patient elect to go to court, independent forensic assessment should be sought, while the treater remains clinically available to help the patient cope with the stress of litigation. Indeed, the patient's decision to go to court should be explored as carefully as any other impulses to act that arise during the therapeutic process.

Second, an issue that commonly arises in liability cases is the precise role of the therapist whose patient alleges childhood abuse. In a claim against the therapist for negligent treatment, the plaintiff's attorneys often advance the argument that the therapist should have independently investigated the veracity of the patient's allegations or of the factual situation in which the abuse is claimed to have occurred. Then, presumably armed with "the truth" of the matter, the clinician could have dissuaded the patient from his or her erroneous views, sparing the supposed perpetrator the stigma and stress of being accused.

This role is inappropriate for a therapist, for several reasons. First, to dispense with the obvious, a clinician who hears of current abuse of a minor child is, of course, mandated to report it in every jurisdiction, even without certainty of historical truth. For past abuse allegedly recalled by an adult patient, however, the clinician's task is to do therapy—that is, to explore, understand, and work through with the patient the issues raised by these memories. Attempts to go outside the therapeutic frame of the dyad commonly represent a problem of the countertransference and are almost always ill advised, because they shift the therapist's focus into the external world where the number of variables confounds the therapeutic task.

Second, the therapist's investigations, as noted, may well represent a form of disloyalty to the patient. The patient may justly claim, "I am here to deal with my feelings about my mother, not with the kind of person my mother 'really' is; whose side are you on?"

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Finally, investigative involvement outside the office may be seen as a failure of empathy, in which the therapist has let lapse the duty to see the world through the patient's eyes. Patients who are so treated are likely to experience the therapist's investigative response as disbelief of their statements, as criticism, and as lack of faith in their intelligence or understanding.

Special therapies

Clinical hypnosis and sodium amytal interviewing are time-honored procedures that can be useful in clinical work. However, in the context of recovered memories, especially if the patient is contemplating litigation, the assessment of the risks and benefits of these procedures shifts; the therapist should avoid using these techniques, if only to avoid hopelessly confounding the patient's legal case (14).

Other professionals

Psychiatrists who work with other professionals should perform an independent assessment of patients who are referred to them and should not rely blindly on previous formulations or diagnoses made by the referring or collaborating clinician. Clinicians who act in a supervisory role are cautioned that supervisees may develop idiosyncratic theories of abuse and its sequelae. The supervisee's theories should be explored for their clinical rationale and validity. In case of irreconcilable differences, the supervisor may need to terminate the relationship to avoid vicarious liability.

Family members

The role of the patient's family is one of the most critical issues in recovered memory cases. Families have brought many suits involving recovered memory against clinicians. Although family members are often the targets of claims of abuse, they are usually considered nonparties to the legal case because they were not receipients of treatment. However, the court may grant them standing to sue the therapist based on various theories of litigation. Although the court's reasoning is often obscure, some of these cases appear to have been decided on the basis that the therapist's support for the validity of the patient's memories (and, regrettably, for the patient's decision to sue) creates a new duty to the parents, even though they are not the designated patients. This duty appears to be predicated on the parents' being foreseeably harmed participants in the treatment. One legal scholar has quipped that the duty arises when the therapist "reaches out and touches someone" beyond the patient, as when the treater arranges a confrontation between the family and their alleged accuser (Zoltek-Jick R, personal communication, 1997).

To avoid being sued by patients' family members, the clinician should clarify and document in the case record that if family members are brought into the treatment—for example, for a family meeting with the patient—they are present purely as adjuncts to the treatment of the defined patient, not as patients themselves. Should therapy for family members be indicated, they should be referred elsewhere for treatment.

If the patient in treatment emphatically binds the clinician to strict confidentiality, the clinician may face an ethical dilemma about his or her other obligations to the patient's family. If the family is accused of a heinous crime, should the clinician make efforts to get the patient to permit a family meeting? How far should such efforts go—should the clinician stop treatment if, after repeated requests, the patient refuses? Does the likelihood of family members' being accused publicly or sued for abuses recovered to memory pose some ethical duty to protect, warn, or inform the family, even at the cost of breach of confidentiality (25)? Does the clinician's pressure for a family meeting undermine valuable autonomous strivings by the patient? None of these questions currently have answers, but they should be raised with the patient before the matter comes to litigation.

Some therapists, especially younger therapists in a countertransference-based overidentification with a younger patient, may create or intensify their own difficulties and liability risk by rudely antagonizing and rebuffing family members who ask for information about the patient's case. Such family members should be politely and perhaps even regretfully informed by the therapist that the patient's confidentiality must prevail and that they should seek any desired information from the patient.

When to stop

If a patient rushes blindly ahead with the intent to sue a parent for long-ago abuse recalled in current therapy, and the therapist's advice militates against this course, therapy should not go forward until this difference of opinion is taken up as a treatment issue. In this situation, the patient has violated the therapeutic contract to explore in therapy the likely consequences of an action before acting or acting out. The patient should be reminded of this contract and be given an opportunity to weigh the alternatives. If the patient persists with the intention to sue, the clinician should refer the patient to another therapist, if necessary, and terminate therapeutic work with that patient.

Conclusions

Most therapeutic issues involving recovered memories should be worked out in therapy, not in court. Most patients should work through their past experiences, not obtain current revenge for them. The set of principles we have proposed is intended to guide clinicians in managing their risk by preserving the therapeutic frame in cases involving recovered memories. ♦

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