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The False Litigant Syndrome: "Nobody Would Say that Unless It was the Truth"

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COMMENTARY

**The false litigant syndrome:
“Nobody would say that
unless it was the truth”**

BY ALAN W. SCHEFLIN, J.D., M.A., LL.M.
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I. False defendants

1. **Introduction** Thomas Shay, Jr., stood before the jurors, on trial for conspiracy and for aiding and abetting an attempt to blow up his father's car.¹ His father had discovered a suspicious black box on the driveway, which apparently had become dislodged from the underside of the car. The police were summoned to the scene, and as the box was being removed, it exploded. One police officer died and another was severely injured.

The evidence against Shay was quite compelling. In fact, he not only admitted his guilt, he virtually bragged about it. The prosecutor was quite happy to introduce Shay's own admissions as conclusive proof of his guilt. Substantial physical evidence supported the truth of the admissions.

Shay, however, stunned the court when he sought to show that his statements were the product of a disordered mind. This was not the typical insanity defense plea, which would have failed because there was no evidence that Shay was

incapable of distinguishing between right and wrong. To buttress his plea that his admissions should not be accepted as a truthful confession, Shay sought to introduce psychiatric evidence to prove the extraordinary claim that he was not capable of telling the truth. Shay's defense rested on his ability to prove that his psychological condition manifested itself in his uncontrollable impulse to tell whopping lies.

Shay's lawyer attempted to show that his statements were conflicting, did not match the evidence completely, and were uttered, in the words of the court, "in order to fulfill a compulsive need for attention even though they were false." According to the court, the defense "elicited testimony from several witnesses that Shay Jr. regularly told the same grandiose stories, often changing significant details each time he told them; repeatedly sought out the media to talk about the bombing even though it was not in his interest to do so; made comments concerning the police investigation which were not confirmed by the police; and expressed abnormal interest in the media attention he received as a result of his statements."

To help explain this defense, Shay's lawyer asked the court to permit Dr. Robert Phillips, a psychiatrist, to testify that Shay suffered from a recognized mental disorder known as "pseudologia fantastica," a condition that caused Shay

to spin out webs of lies which are ordinarily self-aggrandizing and serve to place him in the center of attention. Put otherwise, coping for Mr. Shay, given his personality structure, entails seeking attention, tailoring his words to the audience, creating fantasies in which he is the central figure, and through which he attempts to enlist his audience. . . . Mr. Shay's stories are an attempt to draw others into his fantasy world in order to meet the interpersonal needs which were not met during his childhood.

The legal question before the district court was whether to permit Dr. Phillips to testify about this factitious disorder. The trial judge refused to let the jury hear the psychiatric testimony, claiming that the jurors had enough evidence of

Shay's grandiose statements and fantasies to decide for themselves whether to believe his admissions were or were not reliable. The psychiatric testimony, according to the judge's reasoning, would essentially intrude impermissibly on the jury's exclusive province of assessing the credibility of witnesses.

Shay appealed his conviction to the court of appeals, which provided him the relief he sought. Concerning the admissibility of the psychiatric testimony, the court noted that it could be admitted even if it influenced an assessment of credibility. The cases excluding testimony have been more narrowly focused—they involved “the more limited proposition that an expert's opinion that another witness is lying or telling the truth is ordinarily inadmissible . . . because the opinion exceeds the scope of the expert's specialized knowledge and therefore merely informs the jury that it should reach a particular conclusion.” The trial judge could have limited Dr. Phillips's testimony so that it did not cross over this line.² Furthermore, the Federal Rules of Evidence, in Rule 608(a), permit opinion testimony concerning a witness's character. Thus, in the words of the appellate court, “truthful or untruthful character may be proved by expert testimony.”

The court of appeals then turned to the factor that the trial judge found to be crucial: whether the psychiatric testimony would be beneficially informative to the jury. On the issue of the factitious disorder, the court was clear that the jury

plainly was unqualified to determine without assistance the particular issue of whether Shay Jr. may have made false statements against his own interests because he suffered from a mental disorder. Common understanding conforms to the notion that a person ordinarily does not make untruthful inculpatory statements. . . . Dr. Phillips would have testified that, contrary to this common sense assumption, Shay Jr. suffered from a recognized mental disorder that caused him to make false statements even though they were inconsistent with his apparent self-interest. Thus, Dr. Phillips was prepared to offer specialized opinion testimony, grounded in his expertise as a psychiatrist, that could have “explode[d] common

myths” about evidence vital to the government’s case. . . . While the record contains other evidence that Shay Jr. told lies and boasted to an unusual degree, this evidence, standing alone, is much less powerful than the psychiatric testimony that Dr. Phillips was prepared to offer. Moreover, the court did not express any concern that Dr. Phillips was unqualified or that his testimony was unreliable because it concerned some novel or ad hoc syndrome.

The case was sent back to the trial judge for an evidentiary hearing on the admissibility of the testimony of Dr. Phillips and a possible retrial.

The *Shay* case may appear an oddity, and indeed it is, in several ways. Not many litigants argue that they are mentally prohibited from telling the truth. But the *Shay* case is important for what is *not* rare about it. A court, after careful examination of the law and the psychiatric literature, concluded that factitious disorders are an appropriate topic for expert testimony, and that these disorders may be evaluated by juries in judging the credibility of the litigant.

Although a moderate literature exists on factitious disorders and their relevance to law, there does not appear to be any scholarship tracking the variety of forms in which factitiousness has an impact on the legal system in producing false litigants. Other papers in this issue provide intense archaeological-type probings of how the disorder arises and how it is manifested in behavior.

In this article we intend to focus on the narrow but increasingly more significant issue of retractors in malpractice actions against therapists. It is generally believed that people do not make confessions unless they are actually guilty. It is also generally believed that retractors who recant their earlier statements must now be telling the truth. Courts have allowed expert testimony to be admitted on the issue of why people will falsely confess. In this paper we argue that expert testimony on why people falsely recant should also be admissible.

Whether Mr. Shay actually committed the offense was not decided by the court. Mr. Shay is a false defendant, not because he is necessarily innocent, but rather because a substantial amount of the evidence used to convict him was supplied by him, and he is an untrustworthy source. His mental condition makes him an odd type of false confessor—he is not to be believed whether he is innocent or is guilty. In that regard, Mr. Shay’s case differs substantially from the more traditional cases of false confessors with which courts have dealt over the years.

2. False confessors

Police departments around the world are plagued with the problem of false confessions. As judges and lawyers well know, confessions, like eyewitness testimony,³ tend to be highly persuasive evidence.⁴ Fact finders, be they juries or judges, find confession testimony to be almost conclusive proof of guilt.⁵ Because the testimony has such an important impact, false confessions, which result in the imprisonment and possible execution of an innocent person, raise some of the most serious problems in the criminal justice system.

The issue of false confessions is not new. The use of torture⁶ and other interrogation techniques that increase the likelihood of false confessions was memorialized in the dreaded *Malleus Maleficarum*,⁷ published more than 500 years ago to aid in the extraction of confessions from accused witches. Despite its antiquity, the *Malleus* continues to be important in understanding current social perspectives.⁸

During the first half of this century, courts focused on the ingenious variety of physical tactics used by interrogators to extract confessions. But by the second half of the century, judicial emphasis shifted from the “third degree” techniques⁹ to the “fourth degree” methods using psychological techniques of social influence and persuasion¹⁰ and even trickery and deception.¹¹ Inbau and Reid,¹² authors of the most widely used training manual for police interrogators, have justified the use of social influence and deception tactics:

[Interrogations] frequently require the use of psychological tactics and techniques that could well be classified as "unethical". . . according to the standards usually set for professional, business and social conduct, but the pertinent issue [is] no ordinary lawful, professional or social matter.

[A criminal does not abide by a] code of fair play toward his fellow human beings. . . . Of necessity, criminal interrogators must deal with criminal offenders on a somewhat lower moral plane than that upon which ethical, law-abiding citizens are expected to conduct their everyday affairs (pp. 207–208).

A more unique justification for deception in interrogation is suggested by Jayne,¹³ who notes the irony that if a criminal tells the truth and confesses, he is prosecuted and punished, yet if a criminal is deceptive and lies, he may escape all responsibility. As Jayne observes, "while society does not encourage deception, it indirectly rewards successful deception" (p. 328). It is only by making the anxiety of deceiving more unbearable that the truth can be discovered. According to Jayne, "an individual will confess (tell the truth) when he perceives the consequences of a confession as more desirable than the continued anxiety of deception" (p. 332).

The famous *Miranda* case,¹⁴ known for its mandate that police read a suspect his or her "Miranda" rights before beginning an interrogation, was based upon extensive quotations from police manuals that described the most effective techniques for extracting confessions. The justices noted that "the modern practice of in-custody interrogation is psychological rather than physically oriented" (p. 448). The majority opinion quotes extensively, and disapprovingly, the police tactics suggested by Inbau and Reid and other text writers. Inbau and Reid were quick, however, in their response criticizing the Court for coddling criminals.¹⁵

Rogge,¹⁶ a former assistant United States attorney general, has chronicled how ancient witch-hunting guides, which later evolved into police interrogation manuals, formed the basis for the development of brainwashing techniques. Indeed, in

one well-established and frequently used text that teaches police interrogation techniques, the reader will find, under the heading “brainwashing,” the entry that “this is a very handy device.”¹⁷

Because jurors believe confessions, expert testimony is necessary to demonstrate how people can be led to give false confessions.¹⁸ Modern scholars now distinguish between three types of false confessions: (1) *coerced-compliant*, whereby the subject, after a period of intensive or extensive questioning, confesses to relieve or remove the overwhelming pressures generated by the interrogators; (2) *coerced-internalized*, whereby the subject, after a period of interrogation, actually comes to believe that he or she committed the crime and is therefore guilty; and (3) *voluntary*, whereby the subject, without any interrogation, goes to the police station and confesses to a crime he or she did not commit.

Coerced-compliant confessions

An apt illustration of the coerced-compliant false confession is the Peter Reilly case, in which police persuaded an impressionable young man that he had murdered his mother.¹⁹ Reilly had a deep-seated respect for police authority and was confused when he was accused of the murder. He loved his mother and had no reason to harm her, especially in the brutal manner that ended her life. The police questioned Reilly quite rigorously, asking him whether he would want to remember murdering his mother if he had actually killed her. Peter acknowledged that he would not want to remember it. The police then suggested that his failure to remember the crime was evidence that he had in fact committed it. Over and over the police carefully described the crime scene and asked Peter if he had any memories of it. Gradually, as the events assumed a familiarity because of repetition, and in response to his personal zeal in respecting figures of authority such as police officers, Peter said it all seemed like a dream, which the police interpreted to mean a faint but growing memory. Peter admitted that the police had no reason to lie to him, and he was clear that they were persuaded, after reviewing all of

the evidence, that he had killed his mother. Peter finally said that he must have killed his mother, because he could not remember not doing it. He could describe details, which the police had provided to him, but his confession was more an abdication than an assumption of responsibility. Memories of the crime scene assumed a dreamlike quality in his mind, with the content of those images completely supplied by police questioners.

After Peter's conviction, the local community rose to his defense and contacted Dr. Herbert Spiegel, a psychiatrist at the Columbia University Medical School. Spiegel had recently developed a test for determining hypnotizability, the Hypnotic Induction Profile (HIP). The HIP had been recognized in the hypnosis literature as a reliable measuring device. When Spiegel tested Peter, he discovered that Peter was a high-hypnotizable who could easily have been unduly influenced by the police questioning. According to the appellate court that reversed Peter's conviction:

To analyze the plaintiff's confessions and admissions, Spiegel employed a new profile test that measures the ability of people to concentrate under given test conditions. Although that test had been in development over a period of eight years, it was first accepted in the medical community after the publication of an article by Professor Ernest Hilgard in the February 1975 issue of *Annals of Psychology*. Spiegel was personally involved in the development of that test as principal investigator. On the basis of the profile test, Spiegel concluded that the plaintiff's confessions and admissions were obtained by either coercion or deception, given the plaintiff's personality and his susceptibility to influence by persons in positions of authority. In his testimony, Spiegel characterized the plaintiff as "a somewhat immature young man who has a serious deficit in his ability to identify who he is as a person. . . . As a result of this, he had difficulty in integrating his concept of self, and at the same time, has confusion and difficulty and a poor ability to integrate his conceptions of others; and this combination of being so terribly uncertain about who he is as a person and who he is relating to, especially people in authority, leads to a great deal of confusion and, certainly, a great deal of difficulty in trying to withstand any efforts at interrogation and to make critical judgments about the difference between a statement and an assertion or

a question. . . . [H]e can easily be confused; and he most certainly can easily accept as a fact something that he knows nothing about.”

Because the objective test developed by Spiegel was not available to Reilly at the time of his trial, the court found in favor of the admissibility of Spiegel’s testimony at a new trial. The rationale given by the court was similar to the reasoning in the *Shay* case:

The confessions and admissions went totally unexplained except in the testimony of the plaintiff himself. Since the confessions and admissions were an important element of the state’s case against the plaintiff, it is reasonably probable that a jury would accept Spiegel’s testimony and that such testimony would probably lead to a different result upon a new trial.

Peter was ultimately set free after all charges against him were dropped. The incredible story of his ordeal is captured in a fascinating book by Donald Connery, *Guilty Until Proven Innocent*.²⁰ The use of Spiegel’s testimony is considered a landmark event in the law of confessions²¹ and in the area of forensic hypnosis.²²

Wrightsmen and Kassir²³ identify the Bradley Page case²⁴ as an illustration of the coerced-compliant type of false confession. They note that “For apparently the first time a social psychologist was allowed to testify about social influence and coercion in the interrogation room.”

On November 4, 1984, Bradley Page, a college undergraduate, went jogging with his girlfriend, Roberta “Bibi” Lee, and their friend Robin Shaw. Lee became separated from the other two joggers and disappeared. The ensuing search attracted substantial local media attention. A month after her disappearance, Lee’s body was found near where she had been running with her friends. The next day, Page was questioned by the police for several hours. He ultimately confessed that he had struck Lee and left her unconscious in the woods. He also admitted he had gone back to the scene of the

crime that night, where he had sex with her dead body and buried her using a hubcap from his car. However, as soon as this confession was uttered, it was almost immediately retracted. Page blamed the confession on police coercion and his own guilt and confusion about letting Lee jog away by herself.

In his first trial, the jury acquitted Page of first and second degree murder, but could not reach a verdict on the charge of voluntary manslaughter. In the second trial, the jury convicted Page of voluntary manslaughter. On appeal, Page contended that the manslaughter conviction must be reversed because the trial court improperly restricted a defense expert's testimony on the psychological factors that allegedly caused Page to give a false confession.

According to the trial testimony, the case investigators, Sergeants Harris and Lacer, began questioning Page in a windowless interview room at 10:12 a.m. Page was advised of and waived his Miranda rights. The officers then questioned him for approximately one hour, asking general questions about his relationship with Bibi Lee, their time at school together, and the events that occurred on the morning she disappeared. According to Sergeant Harris, this initial interview was not meant to be "probing."

At the end of the initial interview, Harris left the interrogation room to get a tape recorder. He returned after about 20 minutes, and at 11:50 a.m. began taking the first of four taped statements from Page.

In this first taped statement, Page explained how he had met Bibi, and said they had been in love with each other. When he met Bibi in the morning to go running, he claimed she seemed upset to the point of being irrational. During the drive up to Redwood Park, the mood in the car was "painful." During the run, Bibi was silent and trailed behind Page and Shaw. Page remembered last seeing Bibi at the main drive-

way in Redwood Park. He ran about 100 more yards, looked back, and noticed she wasn't there. He and Robin looked for Bibi in the Redwood Park area, and when they did not find her, they ran back to the car to see if she had returned there. They waited at the car for five or ten minutes, and then Page drove around the area while Shaw waited where the car had been parked. Page drove throughout the area, but he never stopped, got out of the car, called Bibi's name, or honked his horn. The entire search took about 15 minutes. Page convinced Shaw to leave without Bibi, telling her he knew Bibi better than she did and that it was his decision. Page did not tell anyone about how Bibi had disappeared, but he did tell the officers that Bibi had once before stormed away and then avoided Page when he attempted to follow her.

The officers repeatedly questioned Page to determine if he was angry at Bibi for disappearing in the park. Page admitted he was upset at the "situation" and didn't want to "give into her." He added that "I told her that I couldn't deal with it the first time . . . she did it to me . . . so I just figured that I had to put an end to this kind of behavior sooner or later." Page specifically denied injuring Bibi.

After Page completed his taped statement at 1:10 p.m., Sergeant Harris asked Page if he would submit to a polygraph examination. Page agreed, and Harris took him to the polygraph office and introduced him to the polygraph examiner, Sergeant Furry. Furry administered an examination consisting of a pretest phase, the actual polygraph questioning, and a posttest interview. In the pretest phase, Furry explained to Page how the polygraph worked and told him he would have to be completely truthful in order to pass the test. During this phase, Page indicated that he did not know where Bibi's body was found or what injuries she had received.

After Furry formulated the test questions with Page, he began the polygraph examination with a "searching peak of tension" test. In this test, the examiner, without knowing specific

information about the case, asks a variety of questions to determine if there is a response. Here, Furry asked Page if he knew what part of Bibi's body was injured, listing each part—legs, head, stomach, etc.—individually. Page was instructed to answer “no” to each question. Eventually Furry turned to the “modified general question technique,” which involves asking irrelevant questions mixed in with questions deemed important to the case. The test measures deception based on the response to the relevant questions. Furry repeated this set of questions twice.

As Furry was asking this set of questions a third time, Page began making crying or “wailing noises” when Furry came to question number four: Did you yourself physically injure Bibi on November 4th? Page became so distraught that it was impossible to continue the test. However, when Furry removed the polygraph attachments, he noticed that Page did not exhibit any physical signs of crying.

Sergeant Furry completed two charts for the modified general question technique before Page broke down. Based on these charts, Furry concluded that Page had been deceptive in his responses to question four. As to Page's answers to question six, regarding whether he had seen Bibi after leaving Skyline Gate, Furry deemed the data inconclusive. Furry also felt there had been some response in the “searching peak of tension test” when he had mentioned injury to the head. Overall, Furry concluded that Page had tested deceptive for the entire test, and specifically told Page he believed he had “attempt[ed] deception” when asked if he had physically injured Bibi.

Furry told Harris and Lacer he believed Page had been deceptive during the examination. Page returned to the interrogation room at 3:15 p.m. and was left alone for about 25 minutes. When Harris returned to the room, Page had his head in his hands and was making a low moaning or wailing

sound, and was saying, "I really loved her, but I really loved her."

After Page composed himself, the officers continued their questioning. They repeatedly impressed on Page that they believed he had something to do with Bibi Lee's death. Harris said their suspicions were based on, among other things, his failing the polygraph test, only superficially searching for Bibi when she was first lost, convincing Robin Shaw to leave, and not telling anyone what had happened when he got back to Lothlorien. When faced with these accusations, Page said, "Well, if I did do something, I must have blacked it out. I might have blacked it out."

The officers again said they believed Page was lying and didn't buy his "selective amnesia theory." Lacer suggested that Page close his eyes to try to remember what happened. Page did so and after a moment said, "I remember hitting and kicking her, and wailing on her, or going off on her," but didn't remember when or where this occurred. This admission came at 4:10 p.m., or about six hours after Page had first come to the police station.

The officers tried to get additional details from Page, but he claimed that he did not remember any others. The officers said they did not believe him, and then told him Bibi's body had been discovered near the area where they had been jogging together. The officers did not tell Page precisely where the body was found or anything about its condition.

About 4:30 p.m., Harris decided to lie to Page by stating that Page's fingerprints had been found at the crime scene. Harris used a softening technique, stating that the crime might not be as serious as Page thought—it might be something less than cold-blooded murder, such as an accidental killing or a killing arising from a quarrel. Page still maintained that he must have blacked out. Shortly before 5 p.m., Harris decided to put additional pressure on Page by telling him a second lie.

This time Harris suggested they had a witness who saw Page's car south of the entrance to Redwood Park. Page responded that his car had not been down there, at least as far as he could recall, and that he must have blacked it out.

At 5 p.m. the officers decided to take a break to get something to eat; Lacer went to get food, leaving Harris alone in the interview room with Page. Harris and Page relaxed in their chairs, and Page began making casual conversation. He talked about his relationship with Bibi, how she was much brighter than he, and mentioned that he was frustrated with their sexual relationship because she had insisted on coitus interruptus as their only form of birth control. He also mentioned that he had a very difficult time after Bibi disappeared. Lacer returned at 5:30 p.m., and the officers continued their questioning. They went over their concerns about Page's story "again and again." About 10 or 15 minutes into the resumed interview, Harris told Page he believed he was lying. Faced with a direct accusation of committing the crime, Page was silent for a moment. He then said he remembered driving out of the parking lot to Roberts Park and turning left to go south on Skyline. He said that as he drove out onto Skyline, he saw Bibi running or jogging on the opposite side of the road, coming toward him. Page pulled to the opposite side and parked in a turnout in front of Bibi. He got out of the car, took her by the arm, and led her off the road up a little "hill area." As he led her off into a "tree area" he tried to hug and kiss her, to talk to her. When Bibi pulled away, Page became angry and backhanded her, knocking her to the ground. She fell "kind of around a tree." She seemed to be unconscious and her nose was bleeding. Page said he left Bibi there and went home.

Page claimed he drove back up to the same area later that night between 7 p.m. and 1 a.m. and found Bibi lying by the tree. He knew she was dead. He got a blanket from his car and lay down and had sex with her. When he was done, he moved her body closer to Skyline Boulevard, where he used a

hubcap to cover her with a layer of dirt, smoothing it over so as to give her a “decent burial.” The officers asked Page to repeat this story so they could take notes. He did so.

At 7:07 p.m. the officers began taking a second taped statement from Page. This time Page related essentially the same story he had just told the officers. However, many of his responses seemed somewhat confused, tentative or vague. For example, when the officers asked Page if he saw Bibi as he came out of the Roberts Pool parking area, he responded, “I guess I must of.” When asked if he had spoken to her when he first stopped her, he said, “I must of said something, I don’t know.” Page said he couldn’t remember being in his room after 7 p.m., and although he couldn’t remember how he got back to the scene of the killing, he “assumed” he drove. Page claimed that at the time he drove back to get Robin Shaw, he did not remember hitting Bibi and did not know where she was. Despite these indications of imperfect memory, Page was very specific regarding many of the details of the assault. Page completed his taped statement at 7:33 p.m. The officers told Page he would be arrested and held in custody for the murder of Bibi Lee. He then agreed to speak with a deputy district attorney.

Shortly after 9 p.m., Deputy District Attorney Aaron Payne and Inspector Kevin Leong arrived to question Page. They took a third taped statement from Page, who immediately recanted his confession. He told the questioners that his confession had been a product of confusion, fear, and imagination. He stated that he never saw Bibi after he left Robin Shaw at Skyline Gate. The interview ended at 9:48 p.m.

Page was left alone in the interview room until 11:25 p.m., when he knocked on the door and told Harris and Lacer he wanted to talk. The officers spoke with Page until about 1 a.m. and then began the fourth and last taped statement. In a rambling statement, Page mentioned a number of factors that had caused him to give a false confession: The officers

said they found his fingerprints at the scene and were convinced he was involved in the killing; the polygraph scared him; he felt guilty for not having helped Bibi; the officers had said he would sit in jail and rot away from the inside if he could not remember. Because of all these factors, the officers convinced Page that he might have killed Bibi. Consequently, with the officers' assistance, he "imagined" a scenario in which he could have killed her.

When asked to explain how he had come up with the details of the assault story, Page said the "two things" he knew about the discovery of Bibi's body were that she was found one-quarter mile south of Roberts Park and that at least the bottom of her was dressed. He surmised that since the dogs did not find her, she must have been buried. He also "assumed" she was found on the east side of the road. Page was arrested and charged with the murder of Bibi Lee.

At trial, Page testified about how the officers had crafted his memory by building on images and adding details. When his memory drew a blank, one of the officers said, "Well, you might remember after lashing out or going off or exploding." Page said he had an image of "going off." They asked Page if he had hit Bibi, and he said he pictured that. They asked if he kicked her, and he said he could imagine that. They asked if he had a branch, and he pictured that. They asked if he had a rock, and he put a rock into the scenario. Page claimed the process was "like making a movie."

As his final witness, Page called Elliot Aronson,²⁵ a professor of psychology at the University of California, Santa Cruz, to testify about the social influence factors that can lead to false confessions. The trial judge permitted Aronson to testify concerning these general principles of social psychology, but did not allow him to specifically relate these principles to Page's statements or to give his opinion concerning the reliability of the confession. According to the court:

. . . Aronson noted that when a trusted authority figure misleads or lies to another person, or puts that person under stress, or makes him feel guilty or doubt his own perceptions, it throws the other person off balance and makes him vulnerable to persuasion. Moreover, when a person is confronted with what seems like incontrovertible evidence that contradicts his own senses or memory, the person will struggle to make sense of the situation.

With respect to Page's interrogation, Aronson found a number of important factors at work: It was clear that Lacer and Harris were authority figures; Page seemed to believe they were being completely honest with him, and he seemed to be trying to please them; however, the officers lied to Page about the fingerprints and the eyewitness, and Page was struggling to make sense of this information.

Professor Aronson identified other factors in the taped statements affecting the reliability of the confession. First, Page seemed to feel guilty about having left Bibi in the park. According to the professor, Sergeant Lacer "made that guilt salient, in effect rubbed the defendant's nose in the guilt." Second, Page exhibited "a lot of stress and confusion" related to the ordeal of the previous five weeks. Third, the fact Lacer and Harris did not believe his story was in itself a very stressful event. Fourth, Page was alone in the interrogation with no support. And fifth, the police frightened Page when they told him he would spend the rest of his life in prison unless he "came up" with something.

According to Professor Aronson, "there is a lot of research in . . . the field of conformity compliance persuasion that shows that under these kinds of circumstances, people strive to make sense out of the discrepancies. They try to construct scenarios that link these disparate elements together. They're compliant. They tend to tell people what they think they want to hear, and they're susceptible. They tend to go along."

Page appealed his conviction on the grounds that Aronson should have been allowed to specifically discuss the particular elements in the taped statements that indicated the confession was unreliable, and should have been allowed to give his opinion regarding the overall reliability of the confession.

The California Court of Appeals upheld the trial judge's ruling that Aronson could testify only as to "the general psychological factors which might lead to an unreliable confession,

along with descriptions of the supporting experiments,” but he could not testify regarding either (1) “the particular evidence in Page’s taped statements which indicated that those psychological factors were present in this case,” or (2) “the reliability of Page’s confession, given the overall method of interrogation.”

Coerced-internalized confession

There is a semantical gap in the usage of the term “coerced-internalized” confession. In order to distinguish these confessions from the coerced-compliant ones, we have to identify the suspect as actually coming to believe the false confession is true. In these cases, capitulation is joined by conversion. One would therefore expect that recanting either is unlikely or is possible only after a sufficient amount of counter information had repersuaded or deprogrammed the suspect. Vrij²⁶ identifies this problem but states that “it is possible that suspects who make internalized false confessions in police interviews only believe during the police interview that they have committed the crime” (p. 141). We reject this clarification because it turns every coerced-compliant confession into a coerced-internalized confession from the perspective of the police. How can a conscientious police officer know whether the confession is truly believed at the time? Did Peter Reilly believe, at least at some level, that he might have killed or must have killed his mother? A better solution, in our view, is to require the internalization to survive the police interview and to last at least until counter social influence forces, or irrefutable facts, cause a recanting.

A problem with our definition of coerced-internalized confessions is that they are difficult to document because, with the suspect believing himself to be guilty, there are few reasons why the ultimate truth should later be revealed. The police, the courts, and even the suspect will consider the matter settled. There are few incentives to search for a truth all of the parties claim does not exist.

Wrightsmen and Kassin²⁷ cite the case of Paul Ingram as an example of a true coerced-internalized confession. There are good reasons, however, to reject their choice.

Paul Ingram was accused by his daughters of sexually molesting them.²⁸ He was arrested on November 28, 1988, and made incriminating statements on that same day. Ingram waived his right to counsel and made further incriminating statements during the questioning period. As the questioning continued, the allegations also expanded to involve participation in a satanic cult and satanic rituals. Concerned about the satanic cult aspects of the case, prosecutors hired a cult expert, sociologist Richard Ofshe, to offer them assistance. Ofshe, who had at the time been writing on the topic of false confessions, jumped to the defense side of the case and alleged that Ingram had been the victim of faulty police interrogation tactics, which included sophisticated social influence techniques used by a psychology professor assisting the police with Ingram's questioning. Ofshe did more than theorize; he conducted an experiment to test the ease with which false memories could be implanted in Ingram. While talking with Ingram, Ofshe casually suggested the possibility that Ingram had sex with his own son, claims that had not appeared as allegations in the case. Soon afterwards, Ingram reported dreams of sexual involvement with his son. Ofshe testified at trial that Ingram was another case of poor police interrogation methods leading to false confessions. Ingram was nevertheless found guilty and was sentenced to prison, where he remains. As a result of Ofshe's intervention, in July 1989 Ingram recanted his confessions and sought to have his guilty plea withdrawn. After six days of testimony, including that of many experts in addition to Ofshe, the trial judge denied Ingram's motion. Ingram was sentenced to prison, where he continues to serve his term. Ofshe, Lawrence Wright, and others later testified in 1996 at a parole hearing for Ingram, but their requests for a new trial or for his freedom were turned down.

On the surface, the Ingram case appears to satisfy the requirements for a coerced-internalized confession. However, to actually satisfy those requirements, it is necessary to demonstrate that Ingram really believed he was guilty but was actually innocent. Does the proof exist?

On the question of Ingram's belief in his own guilt, the evidence is strong enough. Ingram made incriminating statements on the very first day he was questioned, and he continued to make incriminating statements throughout the investigation. He waived counsel and pleaded guilty. He continued to believe in his own guilt until two weeks after he filed his guilty plea, when he was contacted by Ofshe, who told him, "You're innocent." Ingram responded, "No, I'm guilty."²⁹ Ofshe then spent time with Ingram, and several weeks later Ingram recanted. Given the amount of time that Ingram appeared to sincerely believe in his own guilt, he would meet one criterion of coerced-internalized.

The other criterion, that Ingram actually may be innocent, is far more problematic. If Ingram sincerely believes in his own guilt because he is in fact guilty, this is not a false confession. To demonstrate that Ingram is an example of a coerced-internalized confession, it will have to be shown that he is in fact innocent. Unfortunately the evidence points in the opposite direction.

At the hearing on Ingram's motion to withdraw his guilty plea, the trial judge, at the conclusion of all of the evidence and testimony, concluded that Ingram had committed the sexual offenses against his daughters. In his long written opinion, the judge made several important points.³⁰ First, he found that Ingram, who was himself a law enforcement officer and a friend of the officers who interrogated him, essentially confessed very early in the questioning. These statements were made before the involvement of the psychologist. Ingram described explicit details, including the means he used to avoid pregnancy. Second, the judge found Ofshe to be the

expert with the least credentials and the only one taking the position that the confession was false. The judge also found Ofshe's conduct in the case to be quite unusual, including the experiment he did with Ingram. Ofshe's testimony was unpersuasive according to the judge. Third, no explanation was provided for why the daughters would lie.

Ingram's guilt was upheld by the Washington Court of Appeals,³¹ and federal courts rejected his habeas corpus collateral attack.³² Ingram was later denied clemency by the Washington Parole Board.³³

The final arguments in support of Ingram's guilt may be found first in a passage from Ofshe about the Ingram case: "It is impossible for anyone other than those directly involved to know whether or not Paul Ingram" is guilty of the crimes.³⁴ Second, with regard to Ofshe's experiment with Ingram, at the parole hearing Ingram's son Chad spoke for the first time and recounted instances of being physically and sexually abused by his father. Ofshe, without ever speaking to Ingram's son, announced that the charges by Chad were an attempt to justify a life that had been a disaster.³⁵ Finally, a growing literature is calling into question the accuracy of Ofshe's scholarship, raising the issues of whether his presentation of facts is accurate and whether he substitutes his own beliefs and opinions for facts.³⁶

*Voluntary false
confession*

A dramatic example of the voluntary false confession occurred in the aftermath of the tragic kidnapping, and later the slaying, of the Charles Lindbergh baby in 1932. More than 200 innocent people confessed to the police that they were guilty of what was at that time called "the crime of the century."

Why do people confess to crimes they have not committed? Vrij³⁷ has suggested six possible explanations: (1) a pathological need for attention, or to enhance self-esteem by the notoriety; (2) an attempt to relieve guilt or depression about other

matters by inflicting punishment on themselves; (3) a delusional or schizophrenic inability to distinguish fantasy from fact, so that hearing of a crime makes them believe they committed it; (4) an attempt to protect someone else, such as a relative, who they believe is the real criminal; (5) an attempt to obtain a reduced punishment after they conclude that they cannot prove their own innocence, such as when the police claim that the evidence of their guilt is conclusive; and (6) an attempt to hide other facts, whether incriminating or embarrassing. We might add still another motivation: Some voluntary false confessors act out of a misplaced civic responsibility to be of assistance to the police.

Cases of false confessions of crime are well known to law enforcement officials. The danger posed by such confessions is that an innocent person will be sent to prison and perhaps death, while the guilty party remains free to continue to prey on society. Police may be fooled by false confessors, especially when the crime is not a high-visibility affair, the confessor was not otherwise known to police, and manpower was unavailable to thoroughly investigate the crime and the confession. Under these conditions the confession may be perceived as an economically efficient solution of a crime. Overburdened public defenders may contribute to the problem by not discovering the nature of the false confession and the existence of the factitious disorder. Overburdened courts of criminal justice happily accept confessions with only minimal inquiry (to ask the defendant if the confession was true and voluntary) in more than 90% of criminal cases.

Just how serious a problem false confessions are for the legal system is difficult to gage because of the problems inherent in proving ultimate innocence. On the one hand, police interrogators tend to underestimate the number of false confessions. Inbau, Reid & Buckley³⁸ acknowledge that false confessions are a problem, but they believe that such confessions are a product of three impermissible interrogation techniques: (1) inflicting physical force; (2) threatening physical harm;

and (3) promising the suspect that if he confesses he can go free or will receive a light penalty. Noticeably absent from this list are: (1) the use of extended hours of questioning without relief; (2) deprivation of food, water and sanitary facilities; (3) lying and deception as to the purpose of the questioning; (4) lying and deception as to the nature of the evidence against the suspect; and (5) the systematic and extensive manipulation of psychological components of the suspect's thinking and beliefs. Nevertheless Inbau and his associates believe that the use of the techniques detailed in their book will never lead to a false confession. Gudjonsson,³⁹ in the leading text on false confessions, has aptly described this opinion as "naive."

Also on the "naive" side, but more consistent with popular belief, are the remarks of an American police official: "There is a principle in interrogation. A person will not admit to something they haven't done, short of torture or extreme duress. No matter how long you are grilled, no matter how much you are yelled at, you are not going to admit to something you have not done."⁴⁰ The prevalence of this belief provides a justification for the current admission of expert testimony on why innocent people may confess to crimes they never committed and on why innocent people in therapy may report false memories of horrific events, such as being molested by their parents, when those events never happened. Juries are not likely to understand these ideas without such testimony, because these views expressed by experts run contrary to widely held community opinions about confessions and human behavior.

The middle ground on the prevalence of false confessions is stated by Kassin,⁴¹ who estimates that in the United States 35 to 600 confessions a year are false.

Commentators at the other extreme assume that false confessions are very frequent, and indeed, as Ofshe and Leo state, "they happen all the time."⁴² The reason given for the over-

whelming occurrence of false confessions is the adoption by police departments of social psychological techniques of influence and persuasion that are virtually irresistible.⁴³ This assumption has been extended to the therapy room, where, it is asserted, therapists, using the same or similar techniques of influence as those used by the police, implant false memories that appear as a form of a false confession of facts that never actually occurred. Furthermore, it is asserted that the number of therapist-implanted false memories has reached "epidemic" proportions, which would make therapists more negatively productive than police departments, since the term "epidemic" has not been applied to police interrogation problems.

Whatever the actual numbers, false confessions remain a problem for courts of law. England and Wales have adopted legislation to protect the subjects of police interrogation by regulating the nature of the questioning.⁴⁴

Two other types of falsity, apart from intentional perjury, have been occupying the courts' attention in recent years. The first involves the perplexing situations in which there are false confessions of physical or mental illness, and the second category includes the hundreds of cases involving the report and recantation of false memories.

3. Factitious disorders and false confessions of illness

The Court of Appeals in *United States v. Shay*⁴⁵ explained the role of factitious disorders in legal cases as follows:

Pseudologia fantastica is categorized as a factitious disorder in the Diagnostic and Statistical Manual of Mental Disorders (3d ed. 1987) ["DSM-III-R"] and is sometimes referred to as Munchausen's Disease, named after Baron von Munchausen, who was a German storyteller who wandered the countryside spinning tall tales. Pseudologia fantastica is a variant of lying, often characterized as an extreme form of pathological lying. R. Sharrock and M. Cresswell, *Pseudologia Fantastica: A Case Study of a Man Charged with Murder*, 29 Med.Sci.Law 323, 323 (1989). Unlike "con-men," whose lying is for the purpose of some material gain, victims of this condition present falsifications that are "disproportionate to

any discernible end.” Id. Pseudologues represent fantasies as real occurrences. “These fantasies often involve dramatic, grandiose, and exaggerated events consciously acknowledged as false by the patient, yet presented as truth.” Charles W. Dithrich, *Pseudologia Fantastica, Dissociation, and Potential Space*, in *Child Treatment*, 72 *Int.J.Psycho.Anal.* 657, 657 (1991). “External reality is negated by an enthralling, seductive and exciting inner world in which anything is possible.” Id. at 658. The gain for the pseudologue could be ego enhancement or the attention received as a result of the story. . . . Many lie for no apparent reason, in circumstances where they have nothing to gain from not telling the truth. Anne Vaughan, “Believe me—I cannot tell the truth,” *The Independent*, July 9, 1991, at 13. Pseudologues are also often highly compliant and suggestible to misleading information. . . .” They are often histrionic or suggestible types who thrive on attention and lie for a quick high * * * and don’t worry about the consequences.” Vaughan, *supra*. Furthermore, even when they are confronted with their lies, many pseudologues are unable to control their lies. . . . As noted by one doctor, “[i]t is quite common for people suffering from pseudologia fantastica to turn up at a police station confessing to a crime they did not commit. Usually these have been high-profile, well-publicized cases such as bank robberies. “This group of pseudologues loves the excitement and power that helping the police brings. It makes them feel important and they relish all the attention and fame that they receive from the case * * *.” Id.

A new kind of false confession is beginning to occupy the attention of courts of law. In the first category of these cases, adults present themselves for medical treatment without revealing that their wounds were self-inflicted. False stories are told about how the physical harm occurred, or if it occurred at all. Adults intentionally present themselves to medical facilities with, in the words of DSM-IV,⁴⁶

fabrication of subjective complaints (e.g., complaints of acute abdominal pain in the absence of any such pain), self-inflicted conditions (e.g., the production of abscesses by injection of saliva into the skin), exaggeration or exacerbation of preexisting general medical conditions (e.g., feigning of grand mal seizure by an individual with a previous history of seizure disorder), or any combination or variation of these. (p. 471)

The DSM-IV refers to these situations as “factitious disorders,” which are clearly recognized as a mental disturbance. A significant difficulty for the legal system, and the experts who testify on these issues, is determining which individuals are malingering,⁴⁷ which is not a mental disorder, from which individuals may be mentally disturbed. As one commentator⁴⁸ has noted:

The charge that a claimant is malingering is damning when applied properly. “Malingering” is not a mental disorder, but a pattern of behavior in which a person “fake[s] or exaggerat[es] injury or illness in order to get money or various other payoffs. . . . In common parlance it’s called goldbricking or shamming.” This is to be distinguished both from somatoform or conversion disorders, in which emotional instability presents itself as a specific, limited loss of physical function, and from factitious disorders, in which an individual intentionally mimics physical or psychological symptoms in order to gain relief from emotional conflict. (Internal citations omitted)

Another commentator⁴⁹ has also addressed the complexity of arriving at an accurate diagnosis in cases where primary and secondary gains may induce deceptive conduct:

The malingerer should be distinguished from those with genuine psychopathology, such as those who have various personality disorders. These personality disorders include: (1) the uncooperative patient; (2) the person with factitious disorder; and (3) the person with mixed malingering and factitious disorder. While malingerers consciously and volitionally feign illness for some personal gain, by contrast, “uncooperative patients” have no clear motive for behaving in such a manner. Uncooperative patients might behave as they do because they distrust the physicians evaluating them or they enjoy the power it appears to provide them. Persons with factitious disorder may have voluntary control over their behavior. Such a disorder, however, is caused by a psychological problem in which the individual needs to obtain relief from emotional conflict and does so by mimicking physical or psychological illness or injury. This mimicry, therefore, is in a sense without blameworthiness.

The DSM-IV⁵⁰ describes the difference between malingering and factitious disorder in the following manner:

In malingering, the individual also produces the symptoms intentionally, but has a goal that is obviously recognizable when the environmental circumstances are known. For example, the intentional production of symptoms to avoid jury duty, standing trial, or conscription into the military would be classified as malingering. . . . In contrast, in Factitious Disorder, the motivation is a psychological need to assume the sick role. (p. 471)

The difficulty of making an accurate diagnosis—with more than a touch of sarcasm directed at the legal system—was uttered by an expert in a case where, in response to the attorney's question as to whether a claimant was a malingerer, Dr. Unsworth, the expert, responded: "I wouldn't be testifying if I didn't think so, unless I was on the other side; then it would be a post traumatic condition."⁵¹

Friedland⁵² singles out cases of workers' compensation and cases where plaintiffs claim to have been injured by defective products, as legal situations where determinations of truth vs. intentional lying arise most frequently.

A second category of intentional deception, where again people would naturally assume that a person is speaking the truth, occurs in the factitious by proxy situations. In these cases the sufferer of a factitious disorder is harmful and deceptive not to himself, but rather to others. In its most usual appearance, mothers injure their children and then intentionally lie as to how the child got sick.⁵³

These cases of factitious disorder by proxy might not raise more than an academic debate in the medical literature, but the incursion of the diagnosis into courts of law has created great controversy. In the first-category cases, the claimant seeks money or attention or the avoidance of an unpleasant task. The second-category cases, however, raise more significant possibilities of criminal conviction.⁵⁴

It is relatively clear that in the legal context, factitious disorder by proxy cases involve three distinct elements. First, it

must be proved with facts that the physical and/or mental harm to the child (or other) was caused by the defendant.⁵⁵ Second, medical testimony is needed as to whether the defendant was suffering from factitious disorder by proxy. Third, assuming that the defendant did cause the harm and is suffering from the disorder, what should the law do about it?

On this third point, should the fact that the defendant suffers from the disorder be used to excuse punishment? To reduce the sentence? To assist in the proof that the defendant caused the harm (from the fact that the defendant has the disorder, we infer that the defendant caused the harm)?

Once a medical judgment becomes the basis for a legal excuse, justification, or defense, controversy will follow. Mart⁵⁶ has argued that the disorder is overdiagnosed, especially because of fuzzy criteria. Allison and Roberts⁵⁷ go further and state that because "the construction of Munchausen by Proxy Syndrome follows a pattern we have seen develop in both witchcraft and hysteria," its very existence as a medical or psychiatric condition is questionable. This controversy in the medical arena has opened the door to lawsuits against medical and mental health professionals, who now are being sued for failing to properly diagnose the disorder or for having improperly diagnosed the disorder.⁵⁸ Some law firms have been advertising that they will sue any professional who uses a factitious disorder diagnosis. In general, the law remains hopelessly far from a uniform and cohesive analysis concerning whether to recognize, and what to do about, factitious disorder by proxy.⁵⁹

There is little doubt that the factitious disorders will be the next major battleground for massive adversarial battles involving lawsuits against medical and mental health professionals.

II. False plaintiffs

1. Manufacturing plaintiffs: "You believed me so now you should be liable"
- Lawsuits against therapists for talking cures were relatively unheard of until the late 1980s.⁶⁰ Now hundreds of therapists have been brought into the courtroom, and lawsuits against mental health professionals continue to be filed on an increasing variety of theories.⁶¹ One major source of litigation involves a patient who sues his or her former therapist claiming that the diagnosis and treatment were negligent. At the core of these cases is the claim that the memories expressed by the patient in therapy were actually implanted by the therapist, and that the dissociative disorder the patient was diagnosed as having was actually iatrogenically created. Plaintiffs claim that they spent years of time and countless funds receiving treatments for disorders caused by the therapist. They further claim that they have not been able to get better until they completely left the therapist's treatment and later learned how they had been victimized. In essence, as many experts have written or testified in court, the therapist is being sued for believing the patient.

Recanters, like any other patients, may sue therapists for malpractice. If the treatment by the therapist has been legally substandard, liability should ensue. Just as people generally assume that confessors must be telling the truth because why else would they say what they said, people also assume that recanters must now be telling the truth because why else would they say what they said? The concept of false recanting seems quite alien to common understanding. Therapists are at grave legal risk because of this popular misconception.

One explanation for false recanting in therapist cases may be found in the social influence literature.⁶² Accusers who are placed into groups of recanters, or who are heavily influenced by people who do not believe in repressed memory, may be persuaded to disavow "memories" that are actually real. Just as social influences may create false memories, so too may they create false recanters.⁶³ As Beahrs, Cannell and Gutheil⁶⁴

noted, "false memories are more likely to arise from social influence, either inside or outside of hypnosis or psychotherapy; intrinsic suggestibility (especially interrogative) and dissociative potential; and less so, simply from being hypnotized" (p. 50). The mere fact that a patient disavows formerly held beliefs does not automatically mean that the recantation is the truth. Social influence theory makes it clear that if it is possible to believe that something happened when it never did, then it is also possible to believe that nothing happened when something did. It is not clear whether these principles are symmetrical. In other words, more work must be done to determine whether it is easier (or harder) to believe the former (false memories) than the latter (false recanting). That both are possible, however, is quite clear.

Of course, it is unfair and unwise to argue that from the mere fact that false memories occur in therapy, the therapist should automatically be liable. It will still be necessary to show that the false memories are a product of negligent conduct by the therapist. To meet this burden of proof, the medical records must clearly show a repetitive and sustained scheme of indoctrination coupled with a personality trait making the patient susceptible to this social influence. Elsewhere we have articulated the appropriate legal test for recantor cases involving claims of social influence.⁶⁵

2. Litigation as a mental disorder

It has been alleged and generally assumed that in the retractor cases filed against therapists, the plaintiff-retractors did not get better. This failure to improve is one of the reasons leading to the filing of the lawsuits. In fact, however, this assumption is not correct.⁶⁶ In general, retractors do get better with regard to their dissociative symptoms. Ironically, it is the fact that they do improve that increases the likelihood of lawsuits being brought against them. Once the debilitating dissociative features of the diagnosis recede sufficiently in treatment to allow the patient to be fully functional, the borderline or factitious components of the diagnosis exert more authority and become paramount motivating factors. The

elimination of the more pressing and traumatic dissociative problems creates the need for, and exposes the borderline and factitious problems to, post-treatment suggestive manipulation. As noted by Peter Barach, president of the International Society for the Study of Dissociation:⁶⁷

I do think that there are certain styles of treatment (heavily abreactive, focusing on alters one at a time, relative avoidance of examining negative transference) that do not get the patient dealing with the borderline pathology until relatively late in the game, if at all. . . . If the borderline pathology is dealt with earlier rather than later, then the patient “quickly” starts to express hatred toward the therapist and will drop out of treatment rather than face the extreme disparity between her negative and positive views of the therapist and of herself (Kernberg described this surpassingly well). In that situation, the patient probably hasn’t been in treatment long enough to make a good case that she has been damaged by treatment, and it’s unlikely that a suit would go forward. However, if the borderline pathology is *Not* dealt with until later if at all, then the patient wants to return to her “loving” family and will shift all of the negative feelings from the family to the therapist to make it possible for her to return to the bosom of her family. I have referred to this scenario as “False Mammary Syndrome.”

The appearance of recanting in some legal cases, especially where sexual conduct is involved, did not begin with the current round of false memory lawsuits. Recanting is not a new phenomenon in psychiatry. Our modern concern about repressed memories and recanting in forensic settings was anticipated by Erickson as early as in 1938. His article “Negation or Reversal of Legal Testimony”⁶⁸ is a fascinating account of two different instances of provable, fully documented physical and/or sexual abuse that was later denied (recanted) by the victims.

In the first reported case described by Erickson, two young girls, 9 and 11 years of age, were found in a brothel run by their parents when it was raided by the police. The girls freely gave detailed and explicit descriptions of what had happened to them in the brothel. Their accounts were corroborated by available evidence. After the passage of some

months their memories began to fade, and ultimately they claimed they had no memories of ever being in a brothel. They became annoyed at people who suggested that they had been in such an awful place, or who suggested that their loving parents would ever do such a hideous thing to them.

According to Erickson, during the first interview the girls were interested in having a sympathetic listener. By the second interview, two months later, they no longer had a need to tell their story, and the details became vague and contradictory. The "repugnance" associated with the first interview was replaced by the girls with "resentment" about their current physical condition, which included venereal disease. By the third interview the girls' medical problems had been cured, they had adjusted to their surroundings, and they were focused on immediate matters. Consequently they denied much of the story and had only vague statements about their past. The final interview, conducted six months after the initial interview, was the most difficult, because the girls resented talking about the past and trivialized the whole experience ("some bad men came to the house, but nothing bad happened"). The girls expressed warmth for their parents and disgust that the state authorities had invaded their lives.

Erickson found that once their confidence had been obtained, with careful questioning the girls could provide much of the initial detail, only they now claimed the information they first gave was untruthful. However, Erickson noted that "they seemed to have no real recollection of the whole experience as an actual happening in their own lives."

The second case described by Erickson involved a woman who was spending a racy evening with a criminal when they had a serious automobile accident. The criminal made no effort to rescue the young woman, and she was severely burned before rescuers were able to save her. At the trial of the criminal, the young woman testified "with much bitterness and hatred," and her story was corroborated by the res-

cuers and by the criminal himself. Eight months after the conviction, the young woman attempted to have the case reversed on the grounds that she had lied. The criminal claimed that she had in fact told the truth and that he did not want his relatively short sentence reversed for a new trial that could produce a longer sentence, especially because he had already admitted his guilt. The young woman now sincerely believed the criminal had exerted every effort to save her, efforts she described in full, though they had never occurred.

Erickson wrote that cases of recanting forensic witnesses were not unknown to psychiatry in 1938. They represent

the not unusual legal situation in which a female, after sexual usage, testifies first against the offending male and then, after a period of suffering, reverses her beliefs and attitudes to testify sincerely in his behalf. This identity is manifest primarily in: (1) the highly pleasurable, exciting initial development of the experience; (2) the sudden complete transformation of this pleasurable situation into one of extreme terror, physical helplessness, and pain; and (3) the final evolution into a situation of long-continued suffering and general helplessness.

According to Erickson, these cases have a fundamental relationship to everyday repression of unpleasant or disagreeable experiences. He concluded that "in all probability the initial psychic dynamism in these cases, as in instances occurring in daily life, was the primary repression of the unpleasant affects arising not only from the traumatic aspects of the experience but from the girls' own guilty pleasurable participation."

Erickson's article suggests that psychodynamic forces might account for recanting where the underlying facts are true. Although the mental mechanisms underlying the recanting were not well known or understood at the time, Erickson's insight that recanting may be the outgrowth of unconscious mental motivations is now finding support among mental health forensic specialists studying the modern recanting cases, as several articles in this issue suggest.

If the plaintiff-patient can overcome these two significant hurdles—evidence that the recanting is itself psychodynamically influenced or socially influenced—then the third possibility is present, that the recanting is true and the “memories” were indeed false. This possibility must be taken seriously, because recanting often follows undue influence, as the brainwashing literature has shown.⁶⁹ Thus, in recanting cases, the defense must have the opportunity, with expert opinion in support when available, that the plaintiff’s recanting is more likely than not unreliable because (1) there is a clear pattern of post-therapy suggestive influences leading to the recanting or (2) the borderline or factitious aspects of the plaintiff’s personality were triggered when the dissociative disorders were improved or cured.

3. A study of recanters in 30 high-visibility therapist lawsuits
- In the past five years one of us (DB) has served as defense expert witnesses in 30 malpractice cases in which the plaintiff alleged that the defendant therapist(s) negligently implanted false abuse memories and/or a false dissociative identity disorder. These 30 cases constitute a substantial database. Previous studies of false memory retractors have suffered from being limited to plaintiff self-reports given after association with pro-false-memory advocacy groups.⁷⁰ In contrast, our study used considerable evidence collected as part of a lawsuit, i.e., deposition and trial testimony of plaintiff and defense lay and expert witnesses, extensive medical records, and collateral family history evidence. There is an obvious sampling bias in that this material was collected in serving as an expert witness for the defense. Nevertheless, this study, we believe, is the first attempt to look at the actual data of a large sample of retractor cases, and despite its limitations, we think the results are useful.

Diagnoses One of the most striking findings in our sample was that the great majority of the retractors had been given multiple, co-morbid psychiatric diagnoses. Only one case (6.7%) had been given a single psychiatric diagnosis. A total of 80% had been given four or more major psychiatric diagnoses, and

60% met the criteria for six or more co-morbid psychiatric diagnoses, made and confirmed by two or more therapists over the course of the treatment. Over the entire course of treatment(s), the multiple diagnoses given to each retractor typically included a major affective diagnosis, an anxiety disorder, posttraumatic stress disorder, a major dissociative disorder diagnosis (dissociative identity disorder (DID) or dissociative disorder not otherwise specified (DDNOS)), at least one Axis II personality disorder diagnosis, most commonly borderline or mixed personality disorder, one or more major addiction (e.g., chemical dependency and/or an eating disorder), sometimes somatization disorder, and/or a sexual desire disorder.

A diagnosis of DID had been made in 37% of the cases and of DDNOS in another 53% of the cases. It is perhaps no accident that the majority of retractors had been given a diagnosis of DDNOS instead of DID. They presented with some symptoms of a dissociative identity disorder, notably alter behavior, at some point in the overall course of their illness, but presented in a way that fell short of definitively meeting the DID diagnostic criteria. Thus the question as to the legitimacy of the alter behavior or of a full DID diagnosis had been considered at some point in the overall treatment.

Through a post-hoc chart review, clinically significant factitious behavior was found in 33% of the cases, although defendant clinicians had not always detected the pattern of deception. Factitious behavior typically overlapped with the dissociative disorder diagnosis. Given the high prevalence rate of factitious behavior in the overall retractor sample, factitious behavior may be a more important alternative explanation for retractor behavior than iatrogenesis (High, this issue). Claiming false memories simply may be another manifestation of factitious, attention-seeking behavior from the courts and pro-false-memory advocacy groups.

Overall it was common to find five to seven co-morbid psychiatric diagnoses existing in the same patient. Since many of these patients represented the extreme of psychiatric severity, a poor prognosis would be expected regardless of the treatment rendered, including treatment well within the standard of care.

*Possible flaws
in the treatment*

We began this analysis with the assumption that such malpractice cases usually result from “bad therapies.” This was not at all the case for the great majority of the 30 retractor cases. Several cases involved minor boundary transgressions (but typically not allegations of sexual misconduct). Two of the 30 cases involved (non-sexual) touch, and another an alleged sexualized form of touch, but not sexual misconduct. Two cases involved extratherapeutic contact. For example, in one case a suicidal patient had been prematurely dismissed from the hospital. The therapist let the patient stay at the therapist’s house for several days, where soothing physical contact was given.

Some of the cases (13.3%) involved complications over termination, but only one involved allegations of patient abandonment (by a therapist hospitalized for psychiatric reasons). Seven percent of the cases involved billing disputes, typically involving a borderline patient alleging some dissatisfaction with treatment and refusing to pay an outstanding debt to the therapist. Three of the cases (10%) had involved flawed collateral patient involvements: exorcism of alter personalities by ministers or deprogrammers.

Contrary to the bad-therapy hypothesis, the main finding was that the great majority of the cases adhered to a generally accepted model of phase-oriented trauma treatment, with reasonable care given to treatment frame issues. While memory processing, not always memory recovery, was a component of such treatment, the typical treatment plan was complex and multimodal, with a variety of broad-based treatment goals at each stage of treatment. Treatment goals tended to

shift flexibly as the patient material shifted over the course of treatment. Contrary to the position taken by plaintiff experts, *none* of the 30 cases could be classified narrowly as “memory recovery therapy,”⁷¹ and none had a single-minded focus on recovering abuse memories. When new abuse memories were reported, the medical record often made it clear that the memory had been self-reported by the patient and not suggested by the therapist. Later, after encounters with pro-false-memory (mis)information, the patient came to misattribute the source of his/her abuse memory to the defendant therapist and forgot that it had been self-reported, sometimes being recovered outside the context of therapy.

The most surprising finding was that the great majority of therapists being sued for allegedly implanting memories were following widely available models for trauma treatment well within the standard of care. A total of 83% had adhered to some version of a phase-oriented trauma treatment model,⁷² and another 7% had followed conventional psychodynamic treatment without a trauma focus.

*Pre-therapy
influences*

In nearly half (43%) of the 30 cases a defendant therapist was sued for allegedly implanting false memories of abuse and/or a false dissociative disorder even where the fact pattern clearly showed that the abuse memories and/or the dissociative condition was well established *prior to* the onset of the treatment by the defendant. Two high-profile cases illustrate this fact.

In *Carl v. Peterson et al.*⁷³ the plaintiff sued some of the inpatient staff at Spring Shadows Glen Hospital for allegedly implanting false memories of abuse and ritual abuse and a false dissociative identity disorder. Only the inpatient psychologist, Judith Peterson, and the third inpatient psychiatrist, Gloria Keraga, but not the first two inpatient psychiatrists, also were sued. The fact pattern showed that Lynn Carl first began reporting recovered memories of childhood abuse and later ritual abuse concurrent with her five-year outpatient

psychiatric treatment. She also developed progressive dissociative symptoms, including alter behavior, during that interval, as was observed by both the outpatient psychiatrist and the family therapist and confirmed by an independent consultant. She was referred to the inpatient unit for major dissociative disorders at Spring Shadows Glen Hospital because she had already met the diagnostic criteria for dissociative identity disorder, as determined by an independent consultant. It defies logic that the plaintiff sued specifically Peterson and Keraga for allegedly implanting false abuse memories and a false dissociative disorder when the medical record of both the outpatient psychotherapy and the family therapy consistently documented the abuse memories and major dissociative symptoms clearly *prior to* any treatment rendered by the defendants. Yet neither the prior treating outpatient psychiatrist nor the family therapist—or, for that matter, the first two inpatient psychiatrists—was sued. The jury decided against the defendants for implanting these pre-existing memories and the dissociative disorder and awarded nearly \$5 million.

Similarly, in *Burgess v. Rush-Presbyterian-St. Luke's Medical Center et al.*,⁷⁴ the plaintiff sued her treating psychiatrist, Bennett Braun, and the Rush-Presbyterian Hospital for allegedly implanting false memories of childhood abuse and false dissociative identity disorder diagnoses. The medical record clearly documented that the plaintiff had reported progressively more complex abuse memories and had manifested many of the clinical features of dissociative identity disorder, including alter behavior, in her outpatient psychotherapy in Iowa. Because her abuse memories and multiple personality features were already well developed, she was referred by her outpatient therapist to the specialty inpatient unit for dissociative disorders at Rush-Presbyterian Hospital in Chicago and to Dr. Braun, a well-known authority on multiple personality disorder. How could Dr. Braun have created, through iatrogenic therapeutic suggestion, false memories and a false DID diagnosis if they were already present before his

involvement in the case? Yet despite this absurd fact pattern, the insurance carrier settled against the defendants for close to \$11 million.

Post-therapeutic suggestive influences

There is a certain hypocrisy in the retractor claim that defendant therapists have allegedly implanted false memories. The plaintiff would like the court to believe that s/he was especially vulnerable to suggestive influences in the treatment rendered by the defendants that caused the development of false memories of abuse that never happened and/or a false dissociative disorder diagnosis that s/he never had. Yet in all 30 cases the plaintiff failed to report his or her vulnerability to post-therapeutic suggestive influences that might have been operative in the shaping of the retraction belief itself.

The most striking finding from our analysis was that significant post-therapeutic suggestive influences associated with the development of the retraction belief could be identified in every one of the 30 cases. Given that the medical record failed to document any pattern of allegedly therapeutic suggestive influences causing false abuse memories in the great majority of these cases, an interesting hypothesis arising from these data is that post-therapeutic suggestive influences are at least strong, and often are more compelling in their influence in shaping the retraction belief than any therapeutic practices might have been in allegedly contributing to false beliefs about abuse that allegedly never happened. The overwhelming conclusion from these data is that most retraction beliefs are *not* a function of the person correcting a previously distorted or mistaken recollection of personal history, but rather are the result of a complex pattern of systematic post-therapeutic suggestive influences.

In analyzing these 30 cases we were able to identify a number of often overlapping post-therapeutic suggestive influences, including exposure to pro-false-memory information; patient networks; family influences; treatment influences occurring

after treatment by the defendant therapists; and legal influences.

A major source of shaping retraction beliefs was exposure to false-memory information. Some false-memory proponents have argued that exposure to *The Courage to Heal* and other self-help books can contribute to the development of false memories about abuse that never happened.⁷⁵ But pro-false-memory books, such as *The Myth of Repressed Memories*, *Making Monsters*, *Confabulations*, and *Victims of Memory*⁷⁶ are equally suggestive, unless we believe that suggestive influences are limited exclusively to what the therapist does in therapy.

In our analysis of these 30 cases, significant exposure to false-memory (mis)information occurred in the great majority of the cases and had a significant impact on the progressive shaping of retraction beliefs. Media exposure was a significant factor in 33% of the retractors. For example, at least two plaintiffs testified that a 1993 pro-false-memory article in the *Houston Chronicle* contributed to their developing significant doubts about their previous treatment (*Roome v. Memorial City*; *Romoser v. Memorial City*), as did an article in *Vanity Fair* for another plaintiff (*Shanley v. Peterson et al.*).⁷⁷

In at least two cases consultations provided by pro-false-memory experts were critical in causing plaintiffs to change their minds. In *Christianson v. Strom* and *Trones v. Strom*⁷⁸ two cousins brought a complaint to the church following recovery of abuse memories of their uncle, a church minister, who had allegedly taken down their pants in a locked bathroom and possibly molested them as children. During an exhaustive church mediation process, the uncle never denied the acts, but simply said he failed to remember them. Nevertheless he considered offering a partial apology, which might have settled the matter. However, the uncle was then interviewed by a known false-memory expert for a single consultation session. In the very brief single-session interview the

“expert” determined that the uncle was “not a sexual offender,” that he had never abused his nephews, and that the recovered memories were “false.” He offered the opinion that the uncle should sue the therapists for allegedly implanting false memories, which the uncle subsequently did. In *Strom v. Christianson et al.*,⁷⁹ based on the idea “implanted” by the false-memory consultant, the uncle sued both of his nephews along with their respective therapists. The third-party suit against the therapists was eventually dismissed by the court, and the respective suits by the uncle and nephews were settled.

In *Carl v. Peterson et al.*⁸⁰ plaintiff Lynn Carl terminated her nearly two-year inpatient treatment at a specialty unit for dissociative disorders having achieved at least partial integration of her alter personalities. During her subsequent half-way house treatment in another part of the country, she eventually had a consultation with a noted false-memory expert, Paul McHugh, at the recommendation of her then therapist. According to the documentation in the medical record, in a brief interview the consultant determined that she never was abused and never had DID. He further advised “before she considered legal action against her former hospital that she first establish a mode of life that could be evaluated favorably by the court system.”⁸¹ There is no evidence that these so-called pro-false-memory experts ever sought independent corroboration that the previously reported abuse memories were indeed false, and it is doubtful that they ever made a chart review of all previous treatment before rendering these impressively quick opinions.

Influence by other patients and disaffected parties also played a significant role in the development of retraction beliefs in 20% of these cases. Mary Shanley’s deposition testimony (*Shanley v. Peterson et al.*),⁸² for example, revealed that she had developed contact with other high-profile retractors who had also sued their therapists—Lynn Carl, Lucy Abney, Patricia Burgus, and Laura Pasley. According to testimony,

one of these retractors helped her prepare the “chronology” of her treatment history for the law firm representing her. In *Burgess v. Burgoyne*⁸³ three college students who had all participated in both individual and group treatment for abuse with the same therapist met independently, on more than one occasion, sometime after termination. The result was a decision to jointly sue their former therapist as a team. At least one of these girls had been given false-memory books to read by her attorney, following which she met other former patients seeing the same therapist and convinced them to join her suit. Lynn Carl’s initial negative reappraisal of her former inpatient DID treatment began after a disaffected nurse formerly employed at Spring Shadows Glen, not working on her unit, contacted her unsolicitedly about a complaint she wished to make against the hospital. This former employee became the star surprise witness at the civil trial wherein the jury awarded Carl nearly \$5 million. However, cross-examination of this same witness during the criminal trial against Peterson revealed that the former employee had misstated some of the facts.

What do these data tell us? That sometimes litigious patients, plaintiff attorneys, and other individuals intentionally solicit other former patients in order to influence them. In some of the Houston and Wisconsin cases, expanding networks of plaintiffs have emerged, each of whom influences and reinforces the others’ retraction beliefs to provide support and justification to follow through with lawsuits against the same therapist or small group of therapists.

Unfortunately a fair portion of retraction beliefs were also influenced by therapists who had seen the patients *after* the treatment had been rendered by the defendants. Often these subsequent therapists accepted the patient’s complaints about former therapists at face value, even where it was clear that a borderline patient might have developed an unrealistically negative perspective about that treatment based on borderline splitting. The medical record of at least some of these thera-

pists showed a clear pro-false-memory bias, or at least a negative bias about the former treatment. Yet in nearly every one of these cases, the subsequent therapists developed these beliefs without having either talked with the former therapist or reviewed the previous medical records. Rarely did we find evidence of a “neutral stance” as recommended in the 1993 APA Task Force on Memory.⁸⁴

In *Hess v. Fernandez*⁸⁵ the patient initially began to question her former treatment after her insurance carrier recommended a treatment review in order to continue coverage. The consultant, a noted expert on factitious behavior, opined that the focus on memory work had resulted in a deterioration in functioning, not because the patient lacked a dissociative diagnosis, but because her pattern of factitious behavior and need to adopt the sick role had complicated the treatment course. In *Downing v. McDonough*⁸⁶ a subsequent therapist took the borderline patient’s complaints about her former therapist at face value and accepted the patient’s refusal to let her contact the former therapist to gain his perspective on the treatment, thereby dangerously reinforcing the borderline splitting and transference distortions of the patient. In several other cases negative reappraisals of former treatments by defendants were directly attributed to reviewing that treatment with a subsequent therapist who reinforced the negative appraisal based on the patient’s self-report alone, without seeking any corroboration.

Family influences were also a main contributor to the development of false-memory retraction beliefs. In *Abney v. Metro National*⁸⁷ the patient had been subjected to pressure by her husband to relinquish her abuse belief after their child alleged abuse by him and a mandated CPS report had been filed. In *Hess v. Fernandez*⁸⁸ the patient’s husband, the mayor of the local town, had disclosed at a Sexual Awareness Rally that his wife had an abuse background and multiple personality disorder. Later, after a potentially embarrassing incident in which the police were called to his home for an alleged

domestic violence incident, the husband contacted a lawyer and pressed for a malpractice suit against the therapist for implanting the abuse memories and dissociative disorder. The possibility that these acts might have served to clear his name and his political career cannot be ruled out.

Persistent family-of-origin pressure played an important role in about one-third of these cases (30%). In *Marietti v. Kluff*⁸⁹ a patient alleging childhood abuse by her currently estranged father was visited by him in the hospital to “talk sense” into her, and her estranged sister also tried to contact her on a regular basis. The patient eventually retracted, reconciled with her family (who bought her a house), and sued the consultant for confirming the diagnosis of DID. In *Cragun & Cragun v. Phillips*⁹⁰ the same therapist saw four sisters who had continuous or recovered memories of abuse allegedly by the father. Although the youngest sister had doubts about her recovered memories, all four sisters sued the parents in a civil suit for damages arising from the alleged childhood abuse. Later the youngest sister retracted after contact with her family. She moved back into the family-of-origin home. Contradicting her previous sworn deposition testimony, she then joined her parents against her three sisters in a suit against the therapist.

Some of these patients with chronically deteriorating courses over a number of years had become estranged from their spouses and children due to frequent hospitalizations, self-harmful and suicidal behaviors, switching to alter personalities in front of the family, reporting bizarre abuse to family members, etc. A powerful motivation contributing to the development of a retraction belief was a custody battle. If a former therapist could be blamed for the long-standing pattern of dysfunction, which disappeared upon retraction, then this strategy might be credible to the courts in justifying visitation or custody of children previously lost in a separation or divorce. For example, Lynn Carl hadn’t seen her children in two and a half years. The development of false-memory beliefs became a catalyst for the reunification of Lynn with

her former husband and her children, all of whom subsequently joined the lawsuit against the defendant therapists. In *Smiley v. Remuda Ranch*⁹¹ the patient, who had consented at one point to making teaching tapes as a classic example of the DID diagnosis and its treatment, eventually retracted her belief that she had DID in the context of an attempt to win custody or visitation of her estranged children. In *Taylor v. Fairbanks*⁹² the husband sued his wife's therapist along with his own therapist for allegedly implanting memories of ritual abuse in both of them, after the estranged wife left the state with the children to live elsewhere.

Outright coaching by attorneys and related legal influences as a significant contributor to the development of retraction beliefs are difficult to assess because of the attorney-client privilege. In *Hess v. Fernandez*⁹³ the plaintiff admitted that her attorney had supplied her with books by Loftus and Ofshe and that these had been important in forming her retraction beliefs. The college girl who met with two other former patients in her group therapy to loop them into her lawsuit also worked with that same attorney in *Burgess v. Burgoyne*.⁹⁴ In *Turner v. Honker*⁹⁵ the plaintiff hoped for a large sum of money from a legal suit she brought against a company after a truck had run into her. In part she hoped this money might pay for her considerable medical expenses arising from her PTSD/DID treatment. The attorneys and expert witnesses for the company subpoenaed her medical records. They testified that her psychiatric treatment was "below the standard of care because it had reconstructed a history of abuse and suggested MPD." They also added that this treatment had nothing to do with damages arising from the accident. Disillusioned that she had not received what she felt was due based on this testimony, she began to negatively reevaluate her former treatment. A subsequent therapist reinforced her developing retraction beliefs by taking her complaints at face value and never reviewing the previous treatment either by means of the medical record or talking with the therapists. In *Jones v. Hutchins*⁹⁶ the patient saw a therapist and recovered memo-

ries of abuse. She filed a civil suit against her parents for the alleged abuse. The first attorney failed to do anything with the suit for over a year. She dismissed that attorney. The second attorney proceeded with the suit through the discovery stage but then dropped the case. She then contacted a third attorney. She was given information that she would never make any money suing her parents for abuse and that she would have a better chance if she sued her therapist for implanting false abuse memories. She did this, even though she had to contradict her previous oath at deposition testimony in the suit against her parents in order to sue her therapist.⁹⁷

Some of these cases may represent patients with an antisocial personality diagnosis who saw profit in suing a former therapist, or factitious patients needing to file a suit in order to get attention as from previous care-givers. In *Romoser v. Memorial City*⁹⁸ the plaintiff had a long history of antisocial behaviors dating back to childhood, including a history of embezzlement at worksites. After suits by other retractors had received considerable press in the local Houston news, the plaintiff filed a similar suit. The question arises as to whether such suits represent another way of being “on the take,” now bolstered by seemingly sophisticated false-memory arguments. In *Rapshaw v. Tendler*⁹⁹ a thorough chart review showed that the plaintiff had a long history of lying about medical and psychiatric symptoms and also of making, then retracting, false abuse allegations.

We could give many more examples, but from this study and other cases we have examined the point is clear. False-memory retraction beliefs, and the lawsuits that arise from them, develop out of a complex set of (1) patient motivations (seeking custody or family reconciliation, antisocial profit-seeking, or factitious attention-seeking) and (2) social influences, including systematic exposure to pro-false-memory (mis)information, family-of-origin and current family pressure to retract, subsequent therapists who naively reinforce

patients' disgruntlement with previous therapists, and outright coaching by pro-false-memory consultants and attorneys. None of the 30 retraction cases fits the profile of a patient being misled in treatment and subsequently correcting the misperceptions, as false-memory proponents have implied. In contrast, these retractors had been subjected to multiple post-therapeutic suggestive influences, not the least of which included systematic exposure to false-memory information, and the combination of which served to radically reshape and reinforce the patient's belief that a former therapist had committed malpractice by implanting false abuse memories and/or a false DID diagnosis.

There is a certain hypocrisy here. Plaintiff expert witnesses, who have testified that defendant therapists have allegedly implanted false memories in patients, seem remarkably oblivious to the suggestive effects of their own writings, public presentations, and testimony. If *therapeutic* malpractice is said to occur whenever a patient develops abuse memories in treatment and later retracts them, is it *scientific* or *legal* malpractice when retraction beliefs are shaped by exposure to pro-false-memory information supplied by false-memory scientists, pro-false-memory expert witnesses, or attorneys?

III. Conclusion

The natural belief that if people say things contrary to their best interests, then those things must be true, is too narrow a perception about human conduct and motivation. Courts of law, especially in the last 25 years, have increasingly considered cases of false confessions and the reasons for them. Expert testimony concerning why people falsely confess is routinely admitted into evidence.

A similar belief, that retractors must be telling the truth, has not been subjected to the same type of correction as has the false-confession cases. It was only until after a sufficient

number of retractor cases had accumulated that patterns in their presentations could be seen. Although many of the cases involving patients suing their therapists have claimed that iatrogenic social influence is the only plausible explanation for the dissociative disorder and the allegedly false beliefs, it has only recently been perceived that the social influence forces at work after the conclusion of the therapy are especially vital in evaluating the claims of the patients that their retracted memory is now in fact true. One major hurdle that has obfuscated the picture, and continues to do so, is the shield of the attorney–client privilege. When the patient sues the therapist, the patient waives the psychotherapist–patient privilege; therefore everything that happened in therapy is discoverable. But the patient does not waive the attorney–client privilege; therefore post-therapy influences by attorneys have been very hard to document fully. It may be that if patients want to sue on the basis of retracted memories, they should be held to waive the attorney–client privilege for any information relevant to post-therapy social influence and indoctrination. The privilege would remain for legal strategies, etc.

Even more recent than the recognition of post-therapeutic social influences, the exact roles played by borderline and factitious disorders have not yet been fully appreciated.

This article has presented the most comprehensive study to date attempting to analyze the complex issues surrounding retraction. As some of the papers in this journal suggest, other researchers are reaching similar conclusions about the importance of isolating and examining psychodynamic and social influences that were present prior to the retraction.

For court cases in which retraction is an issue, we make the following suggestions. First, a thorough examination of the medical records should be made to discover if the therapy was unduly suggestive. Second, a careful review of the treatment should be undertaken to see if borderline and/or facti-

tious disorders were present. Third, a close look at any post-treatment social influences is essential, preferably by an expert in social influence or persuasion. In this regard, the attorney–client privilege should be deemed waived for discovery of facts relating to social influences applied to the patient-client. Fourth, expert testimony on post-treatment social influences should be admissible in court. If a pretrial *Frye* or *Daubert-Kumho* hearing is involved, an expert in social influence should not be permitted to testify about such influences in therapy unless there is also an expert qualified to testify about such influences after treatment. Thus either *no* opinion testimony about social influences is admitted, or opinion testimony about *both* in-therapy and post-therapy influences is admitted.

For centuries people have pondered the question “What is truth?” Perhaps we can now come closer to finding an answer by carefully examining the reverse question, “What is deception?”

Notes

1. *United States v. Shay*, 57 F.3d 126 (1st Cir. 1995).
2. It is worth observing that this evidentiary point serves as the foundation for the anti-hypnosis rulings in the United States. In *People v. Ebanks*, 117 Cal. 652, 49 P. 1049 (1897), a defendant argued that an expert who put him into trance should be able to testify as to what the defendant said in trance, and that the defendant’s statements in trance were truthful. The Supreme Court of California rejected this argument, and rightfully so. See A.W. Schefflin & J.L. Shapiro, *Trance on Trial* (New York: Guilford Press, 1989). If defendant had succeeded in his claim, he could have avoided taking the witness stand and being cross-examined. His exculpatory statements uttered in trance would be introduced by the expert, who would then be telling the jury to believe the defendant. Although the court ruled correctly, it did so with a sweeping generalization that “the law of the United States does not recognize hypnotism.” A concurring opinion urged later courts to read the majority sentence only in the context of the very narrow issue before the court. That warning has not been heeded. A.W. Schefflin, H. Spiegel, and D. Spiegel, “Forensic uses of hypnosis,” in A.K. Hess & I.B. Weiner, eds., *Handbook of Forensic Psychology*, Second Edition, 474-498 (New York: John Wiley & Sons, 1998).

3. E.F. Loftus and J.M. Doyle, *Eyewitness Testimony: Civil and Criminal*, Third Edition (Charlottesville, VA: Lexis Law Publishing, 1997).
4. L.S. Wrightsman and S.M. Kassin, *Confessions in the Courtroom* (Newbury Park, CA: Sage Publications, 1993).
5. J.H. Wigmore, *Evidence in Trials at Common Law* (Rev. by J.H. Chadbourne) (Boston: Little, Brown, 1970).
6. J.H. Langbein, *Torture and the Law of Proof* (Chicago: University of Chicago Press, 1976).
7. H. Kramer and J. Sprenger, *Malleus Maleficarum* ("The Witches' Hammer") (1487), translated and introduced by Rev. M. Summers (New York: Dover Publications, 1971).
8. G. Spence, *Trial By Fire: The True Story of a Woman's Ordeal at the Hands of the Law* (New York: William Morrow & Co., 1986).
9. M.G. Paulsen, "The Fourteenth Amendment and the Third Degree," 6 *Stanford Law Review* 411 (1954).
10. P.G. Zimbardo, "The Psychology of Police Confessions." 1(2) *Psychology Today* 17-20, 25-27 (1967); H. Beckett, "NYU Prof Hits Cops on Arrest Tactics," *The New York Post* (September 3, 1966) (quoting Zimbardo as saying, "The techniques employed by our American police are more highly developed and more psychologically sophisticated and more effective than the Chinese Communist 'brainwashing' techniques which we have denounced."). See E.D. Driver, "Confessions and the Social Psychology of Coercion," 82 *Harvard Law Review* 42 (1968).
11. J.G. Thomas, "Police Use of Trickery as an Interrogation Technique," 32 *Vanderbilt Law Review* 1167-1213 (1979); W.S. White, "Police Trickery in Inducing Confessions," 127 *University of Pennsylvania Law Review* 581-629 (1979); R.A. Leo, "From Coercion to Deception: The Changing Nature of Police Interrogation in America," 18 *Crime, Law, and Social Change*, 35-39 (1992).
12. F.E. Inbau and J.E. Reid, *Criminal Interrogation and Confessions*, Second Edition (Baltimore, MD: Williams & Wilkins, 1967).
13. B.C. Jayne, "Appendix: The Psychological Principles of Criminal Interrogation," in F.E. Inbau, J.E. Reid & J.P. Buckley, *Criminal Interrogation and Confessions*, Third Edition (Baltimore, MD: Williams & Wilkins, 1986).
14. *Miranda v. Arizona*, 384 U.S. 436, 86 S.Ct. 1602, 16 L.Ed.2d 694 (1966).

15. F.E. Inbau, "A Forum on the Interrogation of the Accused," 49 *Cornell Law Quarterly* 382 (1963-64); F.E. Inbau, "Over-Reaction—The Mischief of *Miranda v. Arizona*," 73 *Journal of Criminal Law & Criminology* 797 (1982); F.E. Inbau and J.P. Manak, "Miranda v. Arizona—Is It Worth the Cost? (A Sample Survey, with Commentary, of the Expenditure of Court Time and Effort)," 24 *California Western Law Review* 185 (1988); and F.E. Inbau and Y. Kamisar, "The Importance of Being Guilty," 63 *Journal of Criminal Law & Criminology* 182 (1977).
16. O.J. Rogge, *Why Men Confess* (New York: DaCapo Press, 1959).
17. S.R. Gerber and O. Schroeder (eds.), *Criminal Investigation and Interrogation* (1972 revised reprint) (Cincinnati: W.H. Anderson, 1972), p. 361.
18. *United States v. Hall*, 974 F.Supp. 1198 (C.D.Ill. 1997).
19. *Reilly v. State*, 32 Conn.Supp. 349, 355 A.2d 324 (1976).
20. D.S. Connery, *Guilty Until Proven Innocent* (New York: G.P. Putnam's Sons, 1977). For other, similar cases, see J. Fisher. *Fall Guys: False Confessions and the Politics of Murder* (Carbondale, Ill: Southern Illinois University Press, 1996).
21. R. Ofshe, "Coerced Confessions: The Logic of Seemingly Irrational Action," 6 *Cultic Studies Journal* 1-15 (1989).
22. A.W. Schefflin and E.J. Frischholz, "Significant Dates in the History of Forensic Hypnosis," 41 *American Journal of Clinical Hypnosis* 84-107 (1999).
23. Wrightsman and Kassir, *supra* note 4, at 135.
24. *People v. Page*, 2 Cal. App. 4th 161, 2 Cal. Rptr.2d 898 (1st Dist. 1991).
25. Professor Elliot Aronson, whose testimony was in issue in the *Page* case, is an award-winning social psychologist who is most known for his classic text *The Social Animal*, 8th Edition (New York: Worth Publishers, 1999).
26. A. Vrij, "Interviewing Suspects," in A. Memon, A. Vrij & R. Bull, *Psychology and Law: Truthfulness, Accuracy and Credibility* (New York: McGraw-Hill, 1998), pp. 124-146.
27. Wrightsman and Kassir, *supra* note 4, at 130.
28. R. Ofshe, "Inadvertent Hypnosis During Interrogation: False Confession Due to Dissociative State; Mis-identified Multiple Personality and the Satanic Cult Hypothesis," 40 *International*

- Journal of Clinical and Experimental Hypnosis*, 125-156 (1992). The Ingram case attracted the attention of Lawrence Wright, who wrote a two-part series of poorly researched articles in *The New Yorker* glorifying Ofshe's role in the case. Wright's patently myopic view of the case was then published as a book: L. Wright. *Remembering Satan* (New York: Knopf, 1993).
29. Report of Proceedings, *Washington v. Ingram*, No. 88-1-752-1 (Thurston City, Sup.Ct. 1990), pp. 912-913.
 30. *Supra* note 29. Also, P.G. Cassell, "The Guilty and the 'Innocent': An Examination of Alleged Cases of Wrongful Conviction from False Confessions," 22 *Harvard Journal of Law and Public Policy* 523-603 (1999).
 31. *State v. Ingram*, No. 13613-9-II (Wash.Ct.App., Jan. 22, 1992).
 32. *Ingram v. Riveland*, No. C93-599WD (W.D. Wash., May 5, 1994), and *Ingram v. Riveland*, No. 94-35627 (9th Cir., June 26, 1995).
 33. Washington Board of Clemency and Pardons, Transcript of Hearing on Paul Ingram (June 7, 1996).
 34. Ofshe, *supra* note 28, at 151.
 35. *Supra* note 33. See also R. Zimmerman, "Son of Deputy Says He Was Sexually Abused: Dramatic Report in Testimony to Clemency Board," *Seattle Post-Intelligencer* (June 8, 1996), p. B1.
 36. Cassell, *supra* note 30; K.A. Olio and W.F. Cornell, "Making Meaning Not Monsters: Reflections on the Delayed Memory Controversy," 3 *Journal of Child Sexual Abuse*, 77-94 (1994); R.M. Reece, "Making Meaning—A Pediatrician's View," 3 *Journal of Child Sexual Abuse*, 119-122 (1994); and K.A. Olio and W.F. Cornell, "The Facade of Scientific Documentation: A Case Study of Richard Ofshe's Analysis of the Paul Ingram Case," *Journal of Psychology, Public Policy and Law* (in press).
 37. Vrij, *supra* note 26, at 139. See J.M. Schneck, "Hypnoanalytic Study of a False Confession," 15 *International Journal of Clinical and Experimental Hypnosis* 11-18 (1967).
 38. Inbau, Reid & Buckley, *supra* note 13.
 39. G.H. Gudjonsson, *The Psychology of Interrogations, Confessions and Testimony* (Chichester, England: John Wiley & Sons, 1992). See A.W. Schefflin, "Book Review of Gudjonsson, *The Psychology of Interrogations, Confessions, and Testimony*," 36 *American Journal of Clinical Hypnosis* 226-228 (1994).

40. R. Perske, "Johnny Lee Wilson Did Not Kill Anybody," 32 *Mental Retardation* 157-159, at 159 (1994).
41. S.M. Kassir, "The Psychology of Confession Evidence," 52 *American Psychologist* 221-233 (1997).
42. Quoted in Cassell, *supra* note 30.
43. R.A. Leo and R.J. Ofshe, "The Consequences of False Confessions: Deprivations of Liberty and Miscarriages of Justice in the Age of Psychological Interrogation," 88 *Journal of Criminal Law & Criminology* 429-496 (1998).
44. I. Bryan, *Interrogation and Confession: A Study of Progress, Process and Practice* (Aldershot, Hampshire, England: Ashgate, 1997); R.W. Shuy, *The Language of Confession, Interrogation, and Deception* (Thousand Oaks, CA: Sage Publications, 1998).
45. *United States v. Shay*, 57 F.3d 126 (1st Cir. 1995).
46. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*. (Washington, DC: American Psychiatric Press, 1994).
47. H.V. Hall and D.A. Pritchard, *Detecting Malingering and Deception: Forensic Distortion Analysis (FDA)*. (Delray Beach, FL: St. Lucie Press, 1996).
48. T. Zimbalist, "Liar, Liar, Your Back's Not on Fire: A Request for Review of the Admissibility of Expert Testimony on Malingering in Workers' Compensation Cases," 30 *Arizona Attorney* 20-26, p. 20 (1994).
49. S.I. Friedland, "Law, Science and Malingering," 30 *Arizona State Law Journal* 337-395 (1998).
50. *Supra* note 46.
51. *Ladner v. Higgins, Inc.*, 71 So.2d 242, 244 (La.Ct.App. 1954).
52. Friedland, *supra* note 49.
53. M.T. Flannery, "Munchausen Syndrome by Proxy: Broadening the Scope of Child Abuse," 28 *University of Richmond Law Review* 1175-1233 (1994).
54. L.H. Goldman and B.C. Yorker, "Mommie Dearest? Prosecuting Cases of Munchausen Syndrome by Proxy," 13 *Criminal Justice* 26-33 (1999).

55. Short of actual eyewitness observation of the defendant causing harm to another to make that person ill, hidden cameras have been used to catch defendants in the act. The legal issues surrounding the use of covert video are explored in B.C. Yorker, "Covert Video Surveillance of Munchausen Syndrome by Proxy: The Exigent Circumstances Exception," 5 *Health Matrix: Journal of Law-Medicine*, 325-346 (1995).
56. E.G. Mart, "Problems with the Diagnosis of Factitious Disorder by Proxy in Forensic Settings," 17 *American Journal of Forensic Psychology* 69-82 (1999).
57. D.B. Allison and M.S. Roberts, *Disordered Mother or Disordered Diagnosis?: Munchausen By Proxy Syndrome* (Hillsdale, NJ: The Analytic Press, 1998), p. 72.
58. C.M. Perman, "Diagnosing the Truth: Determining Physician Liability in Cases Involving Munchausen Syndrome by Proxy," 54 *Washington University Journal of Urban and Contemporary Law* 267-290 (1998).
59. M.M. Brady, "Munchausen Syndrome by Proxy: How Should We Weigh Our Options?" 18 *Law & Psychology Review* 361-375 (1994); T. Vollaro, "Munchausen Syndrome by Proxy and Its Evidentiary Problems," 22 *Hofstra Law Review* 495-520 (1993).
60. D. Brown, A.W. Schefflin and D.C. Hammond, *Memory, Trauma Treatment, and the Law* (New York: W.W. Norton, 1998).
61. A.W. Schefflin, "Memory in Litigation: Those Who Repress The Past . . . ," in R.I. Simon and D.W. Shuman (eds.), *Predicting the Past: The Retrospective Assessment of Mental States in Civil and Criminal Litigation* (Washington, DC: The American Psychiatric Press, in press).
62. P.G. Zimbardo and M.R. Leippe, *The Psychology of Attitude Change and Social Influence* (New York: McGraw-Hill, 1991).
63. *Supra* note 60.
64. J.O. Beahrs, J.J. Cannell and T.G. Gutheil, "Delayed Traumatic Recall in Adults: A Synthesis with Legal, Clinical, and Forensic Recommendations," 24 *Bulletin of the American Academy of Psychiatry and Law* 45-55 (1996).
65. D. Brown, A.W. Schefflin and C.L. Whitfield, "Recovered Memories: The Current Weight of the Evidence in Science and in the Courts," 27 *Journal of Psychiatry & Law* 5-156 (1999).

66. D. Brown, A.W. Schefflin and D.C. Hammond, "False Memory Lawsuits: The Weight of the Scientific and Legal Evidence," 1999 Manfred S. Guttmacher address to the American Psychiatric Association annual meeting, Washington, DC, May 16, 1999.
67. P. Barach. Personal communication by electronic mail to Alan W. Schefflin, October 1999.
68. M.H. Erickson, "Negation or Reversal of Legal Testimony," 40 *Archives of Neurology and Psychiatry*, 548-553 (1938).
69. A.W. Schefflin and E.M. Opton, Jr., *The Mind Manipulators* (New York: Paddington Press, 1978).
70. H.I. Lief and J.M. Fetkewicz, "Retractors of false memories: The evolution of pseudomemories," *Journal of Psychiatry & Law*, 23:411-435, 1995.
71. R. Ofshe and E. Watters, *Making Monsters: False Memories, Psychotherapy, and Sexual Hysteria* (New York: Charles Scribner's Sons, 1994).
72. D. Brown, A.W. Schefflin and D.C. Hammond, *Memory, Trauma Treatment and the Law* (New York: Norton, 1999) (see chapter 13 on phase-oriented trauma treatment); F.W. Putnam and R.J. Loewenstein, "Treatment of Multiple Personality Disorder: A Survey of Current Practices," 150 *American Journal of Psychiatry* 1048-1052 (1993).
73. *Carl v. Peterson et al.* U.S. District Court, Southern District, Houston Case No. H-95-661.
74. *Burgess et al. v. Rush-Presbyterian-St. Luke's Medical Center.* State of Illinois, Cook County Circuit Court Case No. 91 L 8493.
75. E. Bass & L. Davies, *The Courage to Heal: A Guide for Women Survivors of Child Abuse* (New York: Harper & Row, 1988).
76. E. Goldstein, *Confabulations: Creating False Memories, Destroying Families* (Boca Raton, FL: SIRS Books, 1992); E.F. Loftus and K. Ketcham. *The Myth of Repressed Memories: False Memories and Allegations of Sexual Abuse* (New York: St. Martin's Press, 1994); Ofshe & Watters, *supra* note 71; M. Pendergrast. *Victims of Memory* (Hinesburg, VT: Upper Access Books, 1995).
77. *Roome v. Memorial City General Hospital Corp. et al.*, Harris County, TX, District Court, Case No. 94-011-879; *Romoser v. Memorial City General Hospital Corp. et al.*, Harris County, TX, District Court, Case No. 95-043243; *Shanley v. Peterson et al.*, Harris County, TX, District Court, Case No. 94-4162.

78. *Christianson v. Strom*, Otter Tail County, MN, District Court, Case No. C3-95-44; *Trones v. Strom*, Otter Tail County, MN, District Court, Case No. C4-95-151.
79. *Strom v. Christianson et al.*, Otter Tail County, MN, District Court, Case No. C2-94- 2079.
80. *Carl*, *supra* note 73.
81. *Carl*, *supra* note 73 (Dr. Quaytman psychiatric treatment note 9/2/94, documenting a consultation by Paul McHugh).
82. *Shanley*, *supra* note 77.
83. *Burgess et al. v. Burgoyne et al.*, Pierce County, WI, Circuit Court, Case No. 97-CV-202.
84. American Psychiatric Association, *APA Board of Trustee's Statement on Memories of Sexual Abuse* (American Psychiatric Association, 1993).
85. *Hess et al. v. Fernandez*, Marathon County, WI, Circuit Court, Case No. 95-CV-138.
86. *Downing v. McDonough*, Essex County, Commonwealth of Massachusetts, Superior Court, Case No. 940579.
87. *Abney v. Metro National Corp. et al.*, Harris County, TX, District Court, Case No. 93-054106.
88. *Hess*, *supra* note 85.
89. *Marietti v. Kluft et al.*, Philadelphia County Court of Common Pleas, PA, Case No. 9509-02260.
90. *Cragun & Cragun v. Phillips*, King County, WA, Superior Court, Case No. 95-2-20701-4.
91. *Smiley v. Remuda Ranch et al.*, Maricopa County, AZ, Superior Court, Case No. CV-94-176-73.
92. *Taylor et al. v. Fairbanks, et al.*, Salt Lake County, UT, District Court, Case No. 970907633MP.
93. *Hess*, *supra* note 85.
94. *Burgess v. Burgoyne*, *supra* note 83.
95. *Turner & Turner v. Honker et al.*, Collin County, TX, District Court, Case No. 199-773-91.

96. *Jones v. Hutchins et al.*, Harris County, TX, District Court, Case No. 95-39005.
97. *Jones v. Hutchins et al.*, *supra* note 96. “[Attorney] recommended that instead of suing her parents she sue the providers that had treated her in the past, alleging False Memory Syndrome” (vol. 1, p. 196, plaintiff deposition).
98. *Romoser v. Memorial City*, *supra* note 77.
99. *Rapshaw v. Tandler*, Philadelphia County Court of Common Pleas, PA, Case No. 002091.