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Hypnotic Memories and Civil Sexual Abuse Trials

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I. INTRODUCTION

In the next few paragraphs, the reader will eavesdrop on a psychotherapy session. During this session, the therapist uses hypnosis, a common technique in clinical practice today. In the past, the legal system has paid little attention to the memory retrieval techniques used in psychotherapy because statutes of limitations have prevented patients from using memories of childhood wrongs uncovered in adult psychotherapies to bring suit. However, recent changes will force the legal system to examine whether the memory restoring techniques used in psychotherapy can produce memory that is trustworthy enough for the legal system to accept. What follows is a tragically common case history, a successful treatment, and a policy-loaded legal issue.

Mary Smith began psychotherapy with Dr. Frank Jones, a licensed clinical psychologist, at the age of twenty-nine.[1] She had been troubled during most of her adult life with difficulties in forming relationships. She suffered from impaired self-esteem and complained of hopelessness about the future.[2] When she entered therapy, Mary recalled little of her childhood.[3]

After ten months of therapy with no progress in accessing early childhood memories, Dr. Jones began to suspect that Mary had been sexually abused as a child. Specially trained in hypnosis, Dr. Jones had often used hypnosis to overcome therapy stalemates.[4] In an effort to prepare Mary for hypnosis, Dr. Jones told her that he believed that something very traumatic had happened to her during her childhood, the discovery of which was important for the success of her therapy.[5]

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1. The depiction of the therapist as a male and the patient as a female was selected for this hypothetical because it conforms to the most common pattern found in treatment relationships.

2. For a discussion of the range of emotional problems associated with childhood sexual abuse, see notes 31, 34-42 and accompanying text.

3. Adults who were sexually abused as children often lack memory of these childhood sexual experiences when they enter treatment. Repression and dissociation are two ego defenses that operate to keep traumatic memories beyond conscious access. For a discussion of repression and dissociation, see Part III.

4. Hypnosis is widely used by therapists who specialize in sexual abuse disorders. See sources cited in notes 91, 107, 167 and accompanying text. For the many advantages that hypnosis brings into abuse survivor psychotherapies, see Part IV.C.

5. The hypnotic interview Dr. Jones conducted with Mary Smith, while clinically correct,

He then suggested using hypnosis and attempted to explain it to Mary. He said that her unconscious memory contained stored recollections of everything that had happened to her and that hypnosis would "cause her to recall the traumatic childhood event that she was blocking from memory."[6] Mary was reluctant at first, saying that it might be better if she did not remember. She consented, however, when Dr. Jones assured her that she would be in a safe place during her hypnotic session where no one could harm her and that he would bring her out of the trance whenever she indicated.

Dr. Jones then explained to Mary what would happen during the session. He told her that he would use progressive relaxation suggestions to assist her in reaching a state of deep relaxation extending throughout her mind and body. Once she achieved full relaxation, he would count backward from ten to one, and by the time he reached one, Mary would be in a deep trance.[7] At this point, her unconscious mind would take control, and she would do whatever he suggested.[8] Dr. Jones would then ask Mary to project a documentary film of her childhood onto an imaginary television screen. Mary would watch the filmed account she projected from the secure environment of Dr. Jones's office. The television story she would produce, however, would not be an ordinary television program. She could control the projector's speed. She

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suffers from forensic shortcomings. Forensic problems with this interview are discussed in notes 6, 9, 12, 132, 143-45 and accompanying text.

6. Forensic hypnosis experts would disagree with Dr. Jones's representation that a person's memory contains an accurate record of everything that happens during one's life. Dr. Jones subscribes to the "tape recorder" tbeory of human memory. This theory lacks scientific foundation but is often promoted by police hypnotists. See, for example, Roy Udolf, *Forensic Hypnosis: Psychological and Legal Aspects* 29-30 (Lexington, 1983). It is forensically objectionable to give "tape recorder" guarantees to subjects about to undergo hypnosis because it puts pressure on the subjects to produce information tbat may not exist in their memory. A subject who falsely believes that her memory contains complete information has a greater risk of confabulating missing information during hypnosis. Moreover, guarantees create a false confidence in memory accuracy and make witnesses harder to cross-examine. See, for example, Martin T. Orne, et al., *Hypnotically Induced Testimony*, in Gary L. Wells and Elizabeth F. Loftus, eds., *Eyewitness Testimony: A Psychological Perspective* 171 (Cambridge, 1984).

7. Hypnotic induction usually begins with relaxation techniques. There are a wide variety of induction strategies. Unlike the procedures and techniques used during the hypnotic interview, trance induction and deepening techniques do not influence the accuracy of the memory materials recovered. See, for example, Udolf, *Forensic Hypnosis* at 40 (cited in note 6).

8. While scientists do not understand the exact nature of hypnosis, most believe that hypnosis causes distinctive alterations in cognition and mental functioning. Among the characteristic alterations that occur during trance are heightened suggestibility, reduction of critical judgment, increased behavioral compliance, and heightened imaginative capacity. See, for example, Ernest R. Hilgard, *The Experience of Hypnosis* 6-10 (Harcourt, Brace & World, 1968). Mental alterations do not occur to the same extent in all subjects. The most important factor affecting the amount of change is the subject's hypnotic susceptibility. Highly hypnotizable subjects are more extensively influenced by hypnosis. For a discussion of hypnotizability and its effect on memory, see notes 10, 214-27 and accompanying text.

would accelerate backwards in time until she reached the frightening childhood experience that was troubling her. At this point, Mary would slow down the projector so that she could see and hear every detail of this experience.[9]

Dr. Jones then hypnotized Mary and used age regression[10] to take her back to when she was eight years old. He then told Mary to project her documentary onto the imaginary television screen. Mary was a particularly good hypnotic subject. After hypnotic regression, Mary began to fidget and assumed the posture and speaking manner of an eight-year-old.[11] Dr. Jones then asked Mary whether she saw anything on the television screen that they needed to discuss. Mary said no. Dr. Jones then took Mary back to the age of seven and asked her the same question.

At this point, Mary began to tremble and cry hysterically. Dr. Jones told Mary that the time had come to slow down the projector and

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9. The method proposed by Dr. Jones is called "television technique." Clinical handbooks recommend this technique because it gives the patient emotional distance from traumatic memories. See, for example, Frank W. Putnam, *Diagnosis and Treatment of Multiple Personality Disorder* 231 (Guilford, 1989); David Spiegel, *Hypnosis*, in John A. Talbott, Robert E. Hales, and Stuart C. Yodofsky, eds., *Textbook of Psychiatry* 907, 915 (Am. Psychiatric, 1988); see also notes 131-32 and accompanying text. Forensic experts, however, hold television technique in low regard because they believe it encourages hypnotized subjects to believe that everything they see, hear, and experience in the documentary projected onto the imaginary television screen comes from an infallible memory source and is authentic. See Alan W. Sheflin and Jerrold L. Sbapiro, *Trance on Trial* 68-69 (Guilford, 1989); Udolf, *Forensic Hypnosis* at 40-41 (cited in note 6); American Medical Association Council on Scientific Affairs, *Scientific Status of Refreshing Recollection by the Use of Hypnosis*, 34 Int'l J. Clinical & Experimental Hypnosis 1, 4-5 (1986); Orne, *Hypnotically Induced Testimony*, in *Eyewitness Testimony* (cited in note 6); Campbell W. Perry, et al., *Hypnotic Age Regression Techniques in the Elicitation of Memories: Applied Uses and Abuses*, in Helen M. Pettinati, ed., *Hypnosis and Memory* 128, 136-37 (Guilford, 1988).

10. Age regression is a technique frequently used by both clinical and forensic hypnotists. Highly hypnotizable subjects often assume age-appropriate affects and behaviors when they undergo hypnotic age regression. They are capable of experiencing the events they remember in life-like detail. Some highly hypnotizable subjects report losing their sense of personal identity in the present. They experience the past as if it were the present. Whether age regression stimulates an actual return to an earlier state and the literal reliving of past events, nevertheless, remains a subject of lively debate. Compare Perry, *Hypnotic Age Regression*, in *Hypnosis and Memory* at 134-35 (cited in note 9) (warning clinicians not to be deceived by imagery and emotion into unconditionally accepting memories reported during age regression as historically accurate) and Udolf, *Forensic Hypnosis* at 32-33 (cited in note 6) (questioning whether the reliving is literal) with Robert Reiff and Martin Sheerer, *Memory and Hypnotic Age Regression* 64-81 (Int'l Univ., 1959) (taking the position that age regression leads to a genuine re-experiencing of childhood memories). Many experts believe that the personality changes seen during hypnotic age regression result from hypnotically suggested role-playing rather than an actual return to an earlier state. Orne, *Hypnotically Induced Testimony*, in *Eyewitness Testimony* at 179-82 (cited in note 6).

11. The behavioral changes Mary Smith exhibits at this point suggest that she is highly hypnotizable. For a discussion of the characteristics of highly hypnotizable subjects and the increased memory risks that are associated with high hypnotizability, see notes 214-27 and accompanying text.

that he wanted her to tell him, in as much detail as she could, everything she heard and saw on the television screen. Mary said that she was in a dark room, her bedroom. She described the wallpaper as dirty. The window was partially open and a storm was going on outside. At this point, Mary became pale and began shaking with terror. She grew silent. Dr. Jones, sensing that Mary needed to feel his presence, began actively assisting Mary in bringing forth her memories. "Did someone come into your room?" Mary nodded. "Was it your mother?" Mary shook her head, "no." "Who came?" Silence. "Was it your father?" Mary again shook her head, "no." "Was it your Uncle Ned? Did he come into your room?" Crying hysterically and shaking, Mary this time nodded, "yes." "What happened next?" Silence. "Did he touch you?" Mary again nodded, "yes." "Where did he touch you?" Silence. "Did he touch you in your pee-pee?" Mary again nodded, "yes." "What did your Uncle Ned touch you with—his hands or with something else?" Silence. "Did your Uncle Ned get on top of you?" Mary uttered a high-pitched scream, "Oh my God! Uncle Ned stop! I can't breathe! You are hurting me! Stop!"[12] After the hypnotic session, Mary recalled more details about the night of the storm. During several later hypnotic sessions, Mary recalled five other occasions, taking place between the time she was three[13] and seven, when her Uncle Ned had entered her bedroom

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12. The questions Dr. Jones asked are leading questions. While leading questions are generally objectionable in courtroom proceedings, they are even more so during hypnotic interviews. Hypnosis is accompanied by heightened receptiveness to suggestion, which renders hypnotized subjects more susceptible to leading questions and misleading input than subjects in normal waking states. See, for example, William H. Putnam, *Hypnosis and Distortions in Eyewitness Memory*, 27 Int'l J. Clinical & Experimental Hypnosis 437 (1979)(finding that hypnotized subjects are more responsive to leading questions); Peter W. Sheehan and Jan Tilden, *The Consistency of Occurrences of Memory Distortion Following Hypnotic Induction*, 34 Int'l J. Clinical & Experimental Hypnosis 122 (1986)(finding that subjects have a greater tendency to incorporate misleading input when false information is introduced after induction). Many experts believe that hypnosis increases the risk of memory contamination even when the interviewing technique is flawless. See, for example, Udolf, *Forensic Hypnosis* at 43-48 (cited in note 6). Flawed hypnotic technique aggravates the risk that details which are not clearly fixed in memory may be changed. See, for example, Orne, *Hypnotically Induced Testimony*, in *Eyewitness Testimony* at 195 (cited in note 6); Martin T. Orne, et al., *Reconstructing Memory Through Hypnosis: Forensic and Clinical Implications*, in Helen M. Pettinati, ed., *Hypnosis and Memory* 21, 23-25 (Guilford, 1988). Part V.C. of this Article, nevertheless, takes the position that memories of emotionally-charged personal experiences are less malleable under hypnosis than memories of the details of eyewitnessed events. For a forensic critique of Dr. Jones's interview with Mary Smith, see notes 6, 9, 143-45 and accompanying text.

13. On the ability of very young children to form and retain memories, compare Katherine Nelson, *The Ontogeny of Memory for Real Events*, in Ulric Neisser and Eugene Winograd, eds., *Remembering Reconsidered* 244, 244-65 (Cambridge, 1988)(asserting that adult memory rarely exists for childhood events occurring before the age of 3 or 4) with Lenore Terr, *Too Scared to Cry* 181-82 (Harper & Row, 1990) (agreeing that preverbal children lack verbal memory of traumatic events, but maintaining that even infants have behavioral memories of traumatic experiences that are reenacted in play behaviors and fears).

and molested her. With the assistance of Dr. Jones, Mary worked through her traumatic memories in therapy, and within one year, she had improved so much that she was able to leave treatment and proceed with a normal life. At this point, it was too late to bring criminal charges.

Mary, however, consulted an attorney. She and her attorney decided to bring a tort action against Uncle Ned. Even though the sexual assaults had taken place more than twenty years earlier, a newly enacted statute of limitations in Mary's jurisdiction postponed the accrual of claims based on childhood sexual abuse until memories of childhood wrongs are rediscovered by the plaintiff in adulthood.

Uncle Ned's attorney used pretrial discovery to inquire into the circumstances behind Mary's belated recall. When he learned that she had been hypnotized during her psychotherapy and that she had reported no memories of childhood sexual abuse before the hypnotic session, Ned's attorney moved to disqualify Mary from testifying. He based his request on a case in which the police had used hypnosis to refresh the memory of a crime witness. After hypnosis, the witness was able to identify a suspect that he previously had failed to recognize. The state supreme court gave the following reasons for rejecting the witness's testimony:

> Numerous scientific research studies have concluded that hypnosis has the power to distort memory and to make testimony unreliable. During hypnosis, subjects are highly suggestible and become preoccupied with pleasing the hypnotist. The hypnotist's suggestion can be entirely unintended. Subjects can pick up subtle cues about the hypnotist's wishes from the hypnotist's body language, tone of voice, and approving or disapproving expressions. Hypnosis also causes a reduction of critical judgment. Loss of critical judgment and eagerness to please the hypnotist may prompt subjects to treat as memories vague and fragmentary impressions that they would not regard as trustworthy in a normal waking state. Moreover, hypnosis intensifies the subject's powers of imagination. The vividness of hypnotic imagery makes it difficult for hypnotized subjects to distinguish imagined events from things they have seen and experienced. Consequently, hypnotic memories can represent a mixture of original perceptions, facts suggested by the hypnotist, and details supplied by the imagination to compensate for gaps in memory. There is no way for the hypnotist or the subject to determine the origin of hypnotic memories based on their content. Moreover, after hypnosis, subjects are incapable of separating their new memory impressions from their original ones. As a result, the subject's memory can change during hypnosis without the subject's awareness.
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> The most serious problem, however, is that hypnosis bolsters the subject's confidence while reducing his memory accuracy. When subjects awake from hypnosis, they are often convinced that everything they recalled during the session was accurate. Hypnosis hardens memory, makes subjects resistent to cross-examination, and augments their credibility. The tendency of hypnosis to obstruct the adversarial process poses a serious threat to justice.
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> All of these memory hazards are well-documented in scientific literature. Because hypnosis lacks general acceptance in the scientific community as a reliable method for restoring memory, the foundation required for admitting scientific evi-

dence has not heen satisfied. We hold, therefore, that a witness may not testify about matters recalled during hypnosis.[14]

Mary Smith's attorney acknowledged that eyewitness memory has shortcomings that hypnosis exaggerates. He nevertheless argued as follows:

> The circumstances surrounding Mary Smith's hypnotic recovery of memory bear no resemblance to the case relied upon by Uncle Ned's attorney. Mary Smith was not an eyewitness to a passing crime involving a stranger whom she barely saw. She remembered being sexually assaulted on numerous occasions by a member of her own family whom she knew and recognized. The trauma Mary Smith suffered in childhood was so deeply imprinted on her memory that she developed amnesic barriers to wall off the terrible truth from her consciousness. The purpose of Mary Smith's hypnosis was therapeutic. She underwent hypnosis to free her memory from the grips of repression so that she could regain memory contact with her childhood. Psychotherapists have been using hypnosis in this manner for more than a century.[15]

After reading the supreme court's opinion and listening to the argument of Mary Smith's attorney, should the judge allow Mary Smith to testify?

In 1991, an Illinois appellate court, relying on forensic hypnosis precedents, ruled that a plaintiff who recalled being sexually molested during a hypnotic psychotherapy session was incompetent to testify about the experiences she remembered.[16] Because psychotheray delves

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14. The state supreme court's opinion was written by this author and is fictitious. However, it restates concerns about hypnosis that a majority of state courts today hold. See sources cited in notes 291 and 303. Some of the concerns stated in the hypothetical opinion are legitimate; others overstate what research studies generally show. For critical commentary on pretrial hypnosis, see generally, Orne, *Hypnotically Induced Testimony*, in *Eyewitness Testimony* at 173-204 (cited in note 6); Orne, *Reconstructing Memory Through Hypnosis*, in *Hypnosis and Memory* at 22-25 (cited in note 12); Udolf, *Forensic Hypnosis* at 72-90 (cited in note 6); Bernard L. Diamond, *Inherent Problems in the Use of Pretrial Hypnosis on a Prospective Witness*, 68 Cal. L. Rev. 313, 332-42 (1980).

15. For a discussion of historical and contemporary uses of hypnosis in psychotherapy, see sections A to C of Part IV.

16. The case referred to in the text is *Tardi v. Henry*, 212 Ill. App.3d 1027, 571 N.E.2d 1020 (1991). The *Tardi* plaintiff resembled Mary Smith in only one sense. She recalled being sexually abused during a hypnotic therapy session. The *Tardi* plaintiff had a lengthy psychiatric history and a diagnosis (borderline personality disorder) that carried a prognosis of instability and deceitfulness. While in treatment for these disorders, she underwent hypnosis. During the session, she remembered being raped in her home on one occasion and sexually touched during hospital and office treatments on several other occasions by a neurosurgeon to whom she had been referred for care. The *Tardi* plaintiff was not a credible witness. Her hypnotic and prehypnotic recollections, as well as her testimony on the witness stand, were riddled with inconsistencies. The jury, nevertheless, believed her and awarded her a judgment. The Illinois appellate court ruled that the defendant should have been granted a judgment notwithstanding the verdict because hypnosis had made the plaintiff incompetent to testify about her memories, even in a civil case. *Tardi*, 571 N.E.2d at 1026. The court relied on precedents concerning forensic hypnosis testimony and did not consider whether memory restored by clinical hypnosis is equally unreliable.

While the *Tardi* court's clinical hypnosis analysis was slipshod, its overall result was correct. The plaintiff's uncorroborated testimony was the only testimony offered in support of her claim,

into the distant past, courts have rarely been called upon to address clinical uses of hypnosis.[17] Statutes of limitations have spared courts the need to examine whether hypnosis can restore accurate childhood memories. Indeed, courts have never taken a careful look at whether any of the other memory reviving techniques used in psychotherapy can

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and was full of contradictions. Regardless of how the plaintiff came to remember the things she alleged, her testimony was insufficient to support the jury's verdict. Consequently, the court could have reversed the plaintiff's judgment on the ground that the verdict was against the weight of evidence, without deciding whether her testimony should have been excluded because it related to things she remembered during a hypnotherapy session. Whether patients who have undergone clinical hypnosis should be allowed to testify is a very serious and policy-laden issue. The *Tardi* court should have saved this question for a proper case when it would not be overshadowed by concerns about the witness's overall lack of credibility.

17. There have been a few other cases where clinical hypnosis testimony has been challenged. These cases, however, differed from the Mary Smith case. Hypnosis was used in these cases to treat witnesses for traumatic amnesias precipitated by recent violent experiences rather than to restore memory for experiences that had happened in childhood. See, for example, *State v. Moreno*, 709 P.2d 103 (Hawaii 1985); *Landry v. Bill Garrett Chevrolet, Inc.*, 430 So.2d 1051 (La. Ct. App. 1983); *People v. Reese*, 149 Mich. App. 53, 385 N.W.2d 722 (1986); *State v. Grimmett*, 459 N.W.2d 515 (Minn. Ct. App. 1990); *State v. Varela*, 817 P.2d 731 (N.M. Ct. App. 1991); *West v. Howard*, No. L-90-290, 1991 WL 254208 (Ohio App. Ct. Sept, 13, 1991); *State v. Biskup*, 460 N.W. 502 (Wis. Ct. App. 1990). Courts deciding the admissibility of clinical hypnosis testimony have, with few exceptions, relied on forensic hypnosis precedents. Consequently, most have excluded the testimony. See, for example, sources cited in note 16 and above. Reliance on forensic hypnosis precedents to decide clinical hypnosis cases has resulted because courts and parties have failed to recognize the differences between these uses of hypnosis. Everyone has simply assumed that all hypnosis is the same. See, for example, sources cited in note 16 and above. In *People v. Reese*, the prosecutor appeared to be aware of potential differences, but made such a feehle attempt to distinguish clinical hypnosis testimony from forensic hypnosis testimony that the court rejected the distinction. 385 N.W.2d at 722. In *Landry v. Bill Garrett Chevrolet, Inc.* and *State v. Varela*, however, the courts were persuaded not to follow forensic hypnosis precedents but not on the grounds that memory restored through clinical hypnosis is potentially more reliable. See 430 So.2d at 1051; 817 P.2d at 731. In *Landry*, an automobile crash plaintiff undertook hypnotic treatment for traumatic amnesia and, while in trance, remembered details of the accident. The court ruled that memory restored through hypnosis was reliable enough for use in civil cases. 430 So.2d at 1051. *Varela* was a criminal case. 817 P.2d at 731. During a hypnotic therapy session a child prosecuting witness recalled being sexually abused. Id. The court admitted the testimony even though the therapist had failed to comply with the jurisdiction's procedural standards requiring videotaping of hypnotic interviews because the sexual abuse disclosure had been unexpected and the therapist was unprepared. Id. Consequently, despite occasional litigation, no court has given serious and thoughtful consideration to the question of whether memory restored by clinical hypnosis is more trustworthy than memory restored in a forensic context.

This Article takes no position on whether courts should admit the testimony of parties who receive clinical hypnosis for traumatic amnesias precipitated by catastrophic events and violent acts involving strangers. The memories these patients recover may be less reliable than those recovered by patients like Mary Smith. Events like automobile crashes and attacks by strangers often occur under adverse conditions that may interfere with the patient's ability to correctly perceive important details of the event. Hypnosis cannot retrieve information if it was never stored in memory. See notes 172-87 and accompanying text. Lack of memory for details exaggerates the tendency of hypnotized subjects to incorporate suggestions and confabulate missing information. See notes 193-213 and accompanying text. Consequently, hypnosis may be a less reliable memory restoration technique for victims of catastrophic accidents and violent events involving strangers than for victims of sexual abuses perpetrated by members of their own family.

restore memory that is sufficiently trustworthy for courts to accept as the basis for testimony. However, this situation will soon change. Since 1989, seventeen states have enacted laws preserving tort claims of adults who coped with childhood sexual abuse by developing psychological defenses to block the experiences from conscious recall.[18] Many courts are now effecting similar changes.[19] As a result of these changes in limitations law, matters uncovered in psychotherapy are now being retold in courtrooms all over the country. The memory practices used in psychotherapy are destined to become critical issues in these trials.

Therapeutic hypnosis is more popular today than at any time in history. Burgeoning clinical interest in hypnosis has been fueled both by increased evidence of its treatment effectiveness and by pressures from third-party payers to develop speedier and more cost-effective treatment approaches.[20] In a period when health insurance policies often cover no more than twenty-five psychotherapy visits per year, clinicians no longer have the latitude they once had to wait patiently for memories to arise in the normal course of a long-term psychotherapy. Even divorced from economic considerations, many psychotherapists prefer hypnosis to standard psychotherapy techniques.[21]

Adults helped to remember their childhoods by psychotherapy have begun beating a steady path from the couch to the courtroom. In April of 1991, two middle-aged sisters in Orange County, California sued their seventy-six-year-old mother, claiming that she had forced them from infancy to participate in satanic cult rituals consisting of horrors that defied belief.[22] They alleged that vivid memories of these

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18. For a discussion of recent legislative changes in tort statutes of limitations on childhood sexual abuse, see note 52 and accompanying text.

19. For a discussion of recent judicial changes in tort statutes of limitations on childhood sexual abuse, see notes 43-51 and accompanying text.

20. For a discussion of the clinical advantages that hypnosis contributes to psychotherapy, see notes 308-18 and accompanying text. For the special advantages it adds to abuse survivor psychotherapies, see Part IV.C.

21. See note 20 and accompanying text.

22. The Orange County satanic abuse trial received extensive press coverage. See, for example, Henry Chu, *Suit Claiming Satanic Abuse Nearing the Jury*, Los Angeles Times, at B7 (April 11, 1991); Sonni Efron and Henry Chu, *Jury Splits Verdict in Cult Trial*, Los Angeles Times at A1 (April 13, 1991).

As a result of the media's fascination with childhood sexual abuse, growing numbers of Americans are being prompted to remember horrors from their childhood. Roseanne Arnold, Oprah Winfrey, LaToya Jackson, former Miss America Marilyn Van Derbur, and numerous other celebrities have recently broken silence and gone public with tales from their childhood. See, for example, Coates, *Celebrity Tales of Childhood Abuse Jar Similar Memories for Many*, Chicago Times at C3 (Oct. 13, 1991). Childhood sexual abuse suits are now being filed all around the country against parents, siblings, family friends, teachers, ministers, and others. See generally, Malcolm Ritter, *Sudden Recall of Forgotten Crimes Is a Puzzler for Juries, Experts Say*, Los Angeles Times at A10 (June 30, 1991); Tracey Thompson, *Delayed Lawsuits of Sexual Abuse on the Rise*, Washington Post at B1 (Aug. 14, 1991); Irene Wielawski, *Unlocking the Secrets of Memory*, Los Angeles

horrors had returned during their separate treatments with the same therapist for multiple personality disorder. Their therapist acknowledged on cross-examination that he encouraged patients to use "self-hypnotic" techniques to recall traumatic childhood events. The baffled jurors reached a compromise verdict. They found that the defendant had been "negligent" in her child rearing and awarded nominal damanges.

Trials like the Orange County trial are no longer unusual.[23] Often the alleged acts of abuse happened decades before the suit. Abuse survivor suits all share one common issue—whether recent allegations of old misdeeds are credible. Hypnosis weighs heavily on credibility. Should judges and juries listen to testimony about childhood abuses that the plaintiffs remember during hypnotic therapy sessions?

This is not a simple question. Many paths of inquiry need to be explored. Part II of this Article summarizes the measures legislatures and courts are taking to prevent the claims of adults who were sexually abused as children from being time-barred because of delays attributable to psychological problems resulting from the abuse itself.

The remainder of this Article addresses the evidence supporting such claims. The central issue is whether hypnotic therapy techniques can restore trustworthy memory. The legal system's knowledge about hypnosis has come from cases concerning forensic uses of hypnosis to refresh the memories of eyewitnesses and victims for forgotten details of recent crimes and accidents. As a result of expert testimony in these cases, a majority of courts today believe that hypnosis cannot provide testimony that satisfies courtroom standards of reliability. Courts may fail to appreciate that the hypnotic testimony offered in childhood sexual abuse cases differs from the hypnotic testimony with which courts are familiar. This Article seeks to establish that the new hypnotic testimony differs from the old and can be more reliable.

This Article maintains that hypnosis works best, and perhaps may only work, when information is kept out of conscious awareness by ego-defenses that protect the psyche from trauma. Part III of this Article explains how two ego-defenses, repression and dissociation, operate to prevent voluntary conscious recall of traumatic experiences.

Part IV examines hypnotic methods and techniques used in clinical practice. It discusses the treatment advantages that hypnosis offers in sexual abuse psychotherapies.

Times at A1 (Oct. 3, 1991). While memory flashbacks occasionally provide the vehicle for rediscovery of childhood sexual victimizations, the most common route is through psychotherapy.

23. See sources cited in note 22 and accompanying text.

Against this backdrop, Part V explores the paradoxical positions espoused by the clinical world and the hypnosis research community on whether hypnosis can restore memory without changing it. Hypnosis scientists, based on experiments conducted in memory laboratories, have testified for more than a decade that hypnosis is a dangerous technique that makes memory unsafe for courtroom testimony. Clinicians, on the other hand, who listen daily to the wrenching hypnotic memories of patients and who compare these memories with their patients' psychological symptoms and waking behaviors, have a different impression about the capabilities of hypnosis. Contrary to experimental research findings, clinicians who practice hypnosis believe that the memories their patients recall under hypnosis are reasonably accurate accounts of sexual victimizations they suffered in childhood.

Part V attempts to sort through these opposing positions and to determine which position is valid when memory problems result from psychological factors. Part V concludes that courts will commit a serious error if they rely on hypnosis laboratory research findings to answer this question. Hypnosis research designs adhere to eyewitness memory models and do not test the workings of hypnosis on pathological memory problems. Part V identifies many reasons why hypnosis may perform more accurately in clinical situations than laboratory experiments have shown. Part V also identifies several safety devices that will filter out most false claims and that will permit defendants to defend effectively against the others.

The legal system's decision to disqualify as witnesses persons who have undergone clinical hypnosis may reshape the practice of psychotherapy. Part VI argues that, before taking this step, courts should inquire whether the memory-restoring techniques used in "talking" psychotherapies possess an accuracy superior to that of hypnosis for patients who enter treatment with no memories of childhood sexual abuse and who leave with memories of childhood horrors. Part VI concludes that the risk of memory distortion from hypnotic and talking psychotherapies is about the same. Psychotherapy is not blessed with refined instruments that allow the therapist to look inside the patient's mind to locate the historical roots of the patient's problem. Sometimes patients experience lightning flashes of memory that cause the past to come back into sharp focus. Flashbacks are uncommon, however, and when they do not occur, the patient and therapist must weave the past from the material of dreams, slips of the tongue, clues provided by relatives, and the therapist's interpretations. If the picture of the past that emerges during the therapy accounts for the patient's clinical symptoms; if it provides a satisfactory explanation for the patient's previously inexplicable feelings and behaviors; if it seems real enough to the

patient and is confirmed by the therapist; then the patient will accept this picture as true and will incorporate it into his or her revised memory. After psychotherapy, the patient's memory will never be the same.[24]

There are numerous ways in which slippage leading to a false uncovering can transpire during psychotherapy. Slippage can occur between what happened and what the patient remembers as happening; between the patient's vague images of the past and the patient's attempts to put these images into words of coherent description; between what the patient says and what the therapist understands the patient as saying; and between what the therapist understands the patient as saying and how the therapist interprets the patient's communications back to the patient. Serious slippage at any of these points can lead away from the truth. Hypnosis offers a more direct route into the patient's unconscious. The patient can access the past directly. The memories are revelational, and the patient does not need the therapist's interpretations to piece the past together.

Part VII considers the probable impact that a refusal to admit hypnotherapy recall testimony will have on good patient care. If psychotherapists respond by subordinating the patient's clinical interest to the patient's legal rights, psychotherapy treatment for sexually abused patients will lose a valuable treatment technique. No corresponding gain to the legal system will offset this loss. Testimony offered at civil sexual abuse trials will not necessarily improve by driving therapeutic hypnosis out of existence. "Talking" therapies cannot insure that patients who enter treatment with little memory of childhood will discover a more accurate picture of the past. This Article concludes that because the clinical community accepts hypnosis as a reliable technique for restoring memory and because the scientific community has never shown that hypnosis is dangerous in clinical settings, a court would have no basis for excluding Mary Smith's testimony. What happened to Mary Smith twenty years ago is something that no one but her Uncle Ned can ever know for certain; nevertheless, the triers of fact, if permitted to hear Mary Smith's account, should be able to evaluate her credibility and to give her testimony the weight it deserves.

II. Contemporary Reforms in Tort Statutes of Limitations

During the past decade, sexual abuse of children has emerged as one of the nation's most critical social problems. Although exact figures on the prevalence of childhood sexual abuse remain unavailable, con-

24. See, for example, Donald P. Spence, *Narrative Truth and Historical Truth: Meaning and Interpretation in Psychoanalysis* 161-214 (W.W. Norton & Co., 1982).

temporary estimates exceed even the most radical projections of former times.[25] Studies of general population samples show an incidence of childhood sexual abuse of females that ranges between nineteen and thirty-one percent.[26] Studies of patient populations run even higher.[27] The secret nature of the crime, the dynamics of family relationships, the difficulties of using children as witnesses, and the unavoidable strain that adversarial proceedings place on children have combined to make child abuse cases nightmares for the legal system.[28] The problems intensify when the sexual abuser is a close family member.[29]

During the past decade, legislatures have toughened criminal statutes on childhood sexual abuse and have implemented numerous procedural changes designed to make criminal courtrooms less threatening for child witnesses.[30] Reforms facilitating civil suit, however, have oc-

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25. Phillip M. Coons, et al., *Post-Traumatic Aspects of the Treatment of Victims of Sexual Abuse and Incest*, 12 Psychiatric Clinics of N. America 325, 325 (1989). The use of different criteria for determining when acts not involving sexual penetration amount to sexual abuse probably accounts for part of the variation in statistical findings. For reported findings based on statistical surveys taken from general population samples, see John Briere, *Therapy for Adults Molested as Children: Beyond Survival* 1 (Springer, 1989); David Finkelhor, *A Sourcebook on Child Sexual Abuse* 17-18 (Sage, 1986); Ruth S. Kempe and C. Henry Kempe, *The Common Secret: Sexual Abuse of Children and Adolescents* 13 (W. H. Freeman, 1984). As would be expected, studies show a higher incidence of childhood sexual abuse in surveys taken of patient populations than in general population surveys. See, for example, Briere, *Therapy for Adults* at 1; Coons, et al., 12 Psychiatric Clinics of N. America at 325-26; Colin A. Ross, et al., *Abuse Histories in 102 Cases of Multiple Personality Disorder*, 36 Can. J. Psychiatry 97 (1991). Psychiatric inpatient population studies report a prevalence of between 22% and 44%, while outpatient population studies report a prevalence of between 14% to 46%. Coons, et al., 12 Psychiatric Clinics of N. America at 326. Childhood sexual abuse is strongly linked with several adult psychiatric disorders. See, for example, id. at 325-26. Studies have shown that 75% to 90% of patients suffering from multiple personality disorder were sexually abused in childhood. See, for example, id. at 325-26; Ross, et al., 36 Can. J. Psychiatry at 97 (reporting a 90.2% correlation in a study of 102 cases of multiple personality disorder). Childhood sexual abuse has also been linked statistically to borderline personality disorder, see, for example, Michael H. Stone, *Individual Psychotherapy with Victims of Incest*, 12 Psychiatric Clinics of N. America 237, 237-39 (1989), post-traumatic stress disorder, see, for example, id., and various eating disorders, see, for example, Coons, et al., 12 Psychiatric Clinics of N. America at 327. Strong statistical correlations like these have made the diagnosis of childhood sexual abuse more precise. This decreases the likelihood that experienced therapists will validate pseudomemories and stimulate groundless lawsuits.

26. See, for example, Coons, et al., 12 Psychiatric Clinics of N. America at 325. See also Briere, *Therapy for Adults* at 1; Elaine R. Cacciola, Comment, *The Admissibility of Expert Testimony in Intrafamily Child Sexual Abuse Cases*, 34 UCLA L. Rev. 175 (1986).

27. See sources cited in note 25.

28. See, for example, Susan B. Apel, *Custodial Parents, Child Sexual Abuse, and the Legal System: Beyond Contempt*, 38 Am. U. L. Rev. 491, 494-501 (1989); Jocelyn B. Lamm, Note, *Easing Access to the Courts for Incest Victims: Toward an Equitable Application of the Delayed Discovery Rule*, 100 Yale L. J. 2189, 2189-90 (1991); Note, *The Testimony of Child Victims in Sex Abuse Prosecutions: Two Legislative Innovations*, 98 Harv. L. Rev. 806, 806-11 (1985).

29. See Cacciola, 34 UCLA L. Rev. at 175-88 (cited in note 26).

30. Legislatures have removed obstacles to criminal prosecutions by broadening the definition of child sexual abuse, stiffening the penalties for sexual crimes committed against children,

curred more slowly. Victims of childhood sexual abuse have always had an abundance of available tort theories. Theories such as assault, battery, and tortious infliction of emotional distress have existed for centuries. The problem in the past has not been a theory of recovery, but a time-bar upon making the claim. Tort statutes of limitations are short and traditionally run from the time the wrongful act is committed. Because the abuser is usually a parent or someone with authority over the child, sexually victimized children are rarely able to seek damages during childhood.

The child's youthfulness and physical environment are not the only barriers to suit. Sexual abuse affects the child's personality in ways that hinder suit even when the child becomes an adult.[31] Adults who were

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and extending criminal statutes of limitations on child sexual abuse. For a summary of these developments, see Jessica E. Mindlin, Comment, *Child Sexual Abuse and Criminal Statutes of Limitations*, 65 Wash. L. Rev. 189 (1990); Note, 98 Harv. L. Rev. at 808 (cited in note 28). Legislatures have also enacted procedural innovations designed to make criminal trials less threatening and more hospitable for child prosecuting witnesses. Liberal exceptions to hearsay rules, authorizations for videotaped testimony, and electronic innovations allowing child witnesses to testify outside of the perpetrator's physical presence are among the procedural reforms with which legislatures are currently experimenting. For a discussion of contemporary procedural reforms now taking place within the criminal justice system, see Anna Frissell and James M. Vukelic, *Application of the Hearsay Exceptions and Constitutional Challenges to the Admission of a Child's Out-of-Court Statements in the Prosecution of Child Sexual Abuse Cases in North Dakota*, 66 N.D. L. Rev. 599 (1990); Michael H. Graham, *The Confrontation Clause, the Hearsay Rule, and Child Sexual Abuse Prosecutions: The State of the Relationship*, 72 Minn. L. Rev. 523 (1988); Robert P. Mosteller, *Child Sexual Abuse and Statements for the Purpose of Medical Diagnosis or Treatment*, 67 N.C. L. Rev. 257 (1989); Paula E. Hill and Samuel M. Hill, Note, *Videotaping Children's Testimony: An Empirical View*, 85 Mich. L. Rev. 809 (1987). For the Supreme Court's response to some of the new legislative innovations, see *White v. Illinois*, 112 S. Ct. 736 (1992); *Maryland v. Craig*, 110 S. Ct. 3157 (1990); *Idaho v. Wright*, 110 S. Ct. 3139 (1990).

31. Psychotherapy patients who were sexually abused during childhood enter treatment with a variety of symptoms and complaints. The nature and severity of the symptoms varies with (1) the patient's genetic makeup, (2) the age when the abuse began, (3) the frequency, duration and types of the abuse, (4) tbe identity of the abuser, and (5) the availability of other caretakers in the child's environment to soothe the child. See Eliana Gil, *Treatment of Adult Survivors of Childhood Abuse* 35-47 (Launcb, 2d ed., 1990); Bennett G. Braun, *Psychotherapy of the Survivor of Incest With a Dissociative Disorder*, 12 Psychiatric Clinics N. America 307, 310 (1989); Coons, et al., 12 Psycbiatric Clinics of N. America at 444 (cited in note 25); Stone, 12 Psychiatric Clinics of N. America at 238 (cited in note 25); Cornelia B. Wilbur, *The Effect of Child Abuse on the Psyche*, in Richard P. Kluft, ed., *Childhood Antecedents of Multiple Personality* 22, 25-26 (Am. Psychiatric, 1985).

Psychologist John Briere has identified four categories of psychological impairments that can develop from childhood sexual abuse: (1) post-traumatic stress, (2) cognitive, (3) emotional, and (4) interpersonal. Briere, *Therapy for Adults* at 5 (cited in note 25). *Post-traumatic stress symptoms.* Adult survivors frequently complain of intrusive memories, recurrent nightmares and flashbacks, apathy, loss of interest in daily life, avoidant behaviors, feelings of isolation, detachment, depersonalization, sleep disturbances, difficulties in concentrating, memory problems, irrational feelings of guilt, and anxieties over dangers within the environment. Id. at 5-11. *Cognitive changes.* Adult victims often experience lasting cognitive changes in the way they perceives tbemselves, others, and the future. Id. at 11. Victims tend to perceive themselves as ugly, evil, dirty, and had; to feel guilty and to blame themselves for what happened; to experience an overwhelming sense of

sexually abused as children often require years of psychotherapy before they develop insight into the origins of their emotional problems and gather the emotional strength needed to confront their abusers in court.[32] Consequently, even in jurisdictions that toll limitations during a plaintiff's minority, the time period afforded is rarely long enough to bring suit.[33]

Childhood sexual abuse stirs up many emotions. Children are forced to develop coping strategies to deal with the shame, terror, betrayal, anger, guilt, helplessness, confusion, and pain they feel. The abused child's need for emotional escape from an environment in which physical escape is impossible leads to the mobilization of an assortment of ego-defenses that continue into adulthood and that often prevent adults who were abused as children from bringing suit. Memory disturbances frequently occur.[34] The human psyche tends to protect itself against unbearable reality by blunting, blurring, or obliterating the elements of experience. Emotional numbing, denial, repression, and dissociation are commonplace psychological coping mechanisms that sexually abused children use.[35] The first two coping mechanisms deaden the pain without obliterating the memory. Repression and dissociation,

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helplessness and hopelessness; and to distrust others and fear intimacy. Id. at 11-15. *Emotional changes.* Adult victims often complain of anxiety, depression, tension, feelings of impending doom, suicidal thoughts, loss of interest in pleasure, and other mood impairments. Id. at 15-18. *Interpersonal impairments.* Sexual victimization disrupts normal patterns of development and leads to disturbances of interpersonal relations, acting out behaviors, self-destructiveness, chemical dependency, and social isolation. Id. at 18-28. See, for example, Gil, *Treatment of Adult Survivors* at 41-61; Leonore C. Terr, *Childhood Traumas: An Outline and Overview*, 148 Am. J. Psychiatry 10 (1991). Repeated exposure to acute trauma, moreover, can lead to the development of many serious psychiatric disorders. Dr. Lenore Terr reports that chronic childhood trauma has been linked by researchers to conduct disorders, borderline personality disorder, major affective disorders, attention-deficit-hyperactivity disorders, phobic disorders, obsessive-compulsive disorders, panic disorders, and acute dissociative disorders such as multiple personalities. Terr, *Too Scared to Cry* at 148 (cited in note 13).

32. See, for example, Alan Rosenfeld, Recent Development, *The Statute of Limitations Barrier in Childhood Sexual Abuse Cases: The Equitable Estoppel Remedy*, 12 Harv. Women's L. J. 206, 214-15 (1989).

33. See, for example, id.; Ann Marie Hagan, Note, *Tolling the Statute of Limitations for Adult Survivors of Childhood Sexual Abuse*, 76 Iowa L. Rev. 355 (1991); James William Harshaw, III, Comment, *Not Enough Time?: The Constitutionality of Short Statutes of Limitations for Civil Child Sexual Abuse Litigation*, 50 Obio St. L. J. 753 (1989); Lamm, 100 Yale L. J. at 2189 (cited in note 28); Carol W. Napier, Note, *Civil Incest Suits: Getting Beyond the Statute of Limitations*, 68 Wash. U. L. Q. 995 (1990); Melissa G. Salten, Note, *Statutes of Limitations in Civil Incest Suits: Preserving the Victim's Remedy*, 7 Harv. Women's L. J. 189 (1984).

34. For a discussion of how repression and dissociation operate to defend the psyche against painful mental content, see Part III.

35. See, for example, Briere, *Therapy for Adults* at 5-11, 111-18, 121-22 (cited in note 25).

on the other hand, cause memories of childhood sexual abuse to vanish beyond conscious recall.[36]

Memory problems, however, are not the only psychological problems that hinder sexually abused children from suing in adulthood. Sexual abuse by important caretakers is a terrible betrayal that sends a double message to the child. The child develops inner confusions about what is natural, normal, and loving and what is morally reprehensible.[37] When sexual abuse takes place from early childhood onward, the child may fail to recognize that the sexual acts were unnatural and emotionally damaging and, consequently, may be unable to connect her adult psychological problems with these childhood experiences.[38] Even when the abused child's memory and ability to judge reality remain undisturbed, sexual abuse shapes the child's personality in ways that prevent suit. Abused children suffer from low self-esteem, hopelessness, and helplessness.[39] They often blame themselves for what happened between them and their abusers.[40] The emotional strength needed to confront the abuser in court is further sapped by the tendency of childhood sexual abuse to engender feelings of shame, guilt, terror, and pain in the victim.[41] These feelings make adults who were abused as children reluctant to bring legal action leading to public disclosure and private reliving of their agonizing and shame-ridden childhood ordeals. As a result of the emotional baggage they carry into adulthood, many adults who were sexually abused as children remain psychologically unable to confront their abusers in court until they have worked through their emotional problems in adult psychotherapies.[42]

Although the need for amending tort statutes of limitations to afford adult victims of childhood sexual abuse a meaningful opportunity for suit has always existed, it went unrecognized until very recently. Adults seeking tort remedies for childhood sexual abuse initially turned to the courts for relief. Requests for tolling based on the doctrine of

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36. For a discussion of how repression and dissociation operate to dispose of painful mental content, see Part III.

37. See, for example, Briere, *Therapy for Adults* at 18-21 (cited in note 25).

38. See, for example, Harshaw, 50 Ohio St. L. J. at 756-57 (cited in note 33).

39. See, for example, sources cited in note 31.

40. See, for example, sources cited in note 31; Briere, *Therapy for Adults* at 12-15 (cited in note 25); Rosenfeld, 12 Harv. Women's L. J. at 206-10 (cited in note 32).

41. See, for example, sources cited in note 31.

42. Many clinicians believe that confronting the perpetrator in court is therapeutic for abuse victims. Some even encourage their patients to bring civil suits based on the belief that bringing suit constitutes a constructive outlet for aggression, an opportunity for vindication, and a positive step toward the patient's mastering of the trauma and taking charge of her life. See, for example, Diane H. Schetky and Elissa F. Benedek, *The Sexual Abuse Victim in the Courts*, 12 Psychiatric Clinics of N. America 471, 479 (1989). The tremendous cost of long-term psychotherapy that abuse victims often need affords another incentive for suit.

delayed discovery[43] began surfacing in abuse survivor civil pleadings about a decade ago.[44] Sexual abuse plaintiffs have commonly asserted one of two grounds for applying this doctrine. Plaintiffs who have developed psychological defenses against remembering rely on memory problems as grounds for tolling.[45] Plaintiffs who have never forgotten the terrifying events of their childhoods claim that the abuse caused psychological problems that prevented them from recognizing that the acts perpetrated against them in childhood were responsible for the emotional turmoil they suffered as adults.[46]

Courts initially hesitated to accept either argument for extending limitations.[47] Memory loss arguments, however, gradually won favor

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43. When the doctrine of delayed discovery applies, accrual of the cause of action is postponed until the plaintiff discovers, or by the exercise of reasonable diligence could have discovered, the claim. Because of the psychological consequences associated with childhood sexual abuse, discovery of the cause of action in a manner that is sufficient to facilitate suit often does not occur until the sexually abused child is well into her adult years. In many cases, years of psychotherapy are required before adults abused in childhood gain the awareness, insight, and emotional strength needed to confront their abusers in court. See, for example, sources cited in note 33.

44. Most cases dating before 1986 are unreported. See, for example, Salten, 7 Harv. Women's L. J. at 204 n.96 (cited in note 33).

45. See, for example, *Johnson v. Johnson*, 701 F. Supp. 1363 (N.D. Ill. 1988) (applying Illinois law and finding that Illinois courts would toll limitations in favor of plaintiffs who suppressed memories of the abuse); *Mary D. v. John D.*, 216 Cal. App.3d 171, 264 Cal. Rptr. 633 (1990) (holding that the discovery rule applies to plaintiffs who can establish that memory of the abuse was obstructed until shortly before filing suit); *Meiers-Post v. Schafer*, 170 Mich. App. 174, 427 N.W.2d 606 (1988) (holding that the discovery rule applies if the plaintiff repressed memory of the abuse and the abusive acts are corroborated by other evidence); *Peterson v. Bruen*, 792 P.2d 18 (Nev. 1990) (holding that the discovery rule applies, irrespective of knowledge and delay, when allegations of childhood sexual abuse are clearly and convincingly corroborated; without corroborative evidence, normal accrual rules apply); *Osland v. Osland*, 442 N.W.2d 907 (N.D. 1989) (holding that the discovery rule applies where severe emotional trauma renders the plaintiff psychologically incapable of discovering her cause of action within the applicable limitations period); *Tyson v. Tyson*, 727 P.2d 226 (Wash. 1986) (refusing to apply the discovery rule to childhood sexual abuse claims on the ground that evidence about what happened years before in private is stale and unreliable) (superseded by statute). For a more detailed account of the changes now taking place in the applications of statutes of limitations to abuse survivor civil claims, see sources cited in notes 32 and 33.

46. See, for example, *Daly v. Derrick*, 230 Cal. App.3d 1321, 281 Cal. Rptr. 709 (1991) (holding that accrual is postponed until the plaintiff discovers all facts essential to the cause of action); *E.W. v. D.C.H.*, 754 P.2d 817 (Mont. 1988) (refusing to apply the discovery rule to plaintiffs who retain memory for the acts but fail to appreciate the psychological consequences) (superseded by statute); *Hammer v. Hammer*, 418 N.W.2d 23 (Wis. Ct. App. 1987) (finding the discovery rule applicable when childhood sexual abuse prevents the plaintiff from appreciating the abusive nature of the sexual acts and their causal relationship to her adult psychological problems). For a more detailed account of legal developments now taking place in applying statutes of limitations to abuse survivor civil claims, see sources cited in notes 32 and 33.

47. See, for example, *DeRose v. Carswell*, 196 Cal. App.3d 1011, 242 Cal. Rptr. 368 (1987) (refusing to toll statute of limitations for plaintiffs who maintain memory contact with childhood) (superseded by statute); *Tyson*, 727 P.2d at 226 (refusing to apply the discovery rule to either type of childhood sexual abuse claim)(superseded by statute).

with courts.[48] Currently, courts in at least nine jurisdictions will toll limitations for plaintiffs who coped with childhood abuse by blocking the incidents from their memory.[49] Courts in several jurisdictions, however, have refused to give comparable protection to plaintiffs who acknowledge remembering what happened but claim that psychological problems delayed them from discovering that sexual abuse caused them serious emotional harm.[50] The rigid distinction between plaintiffs who have lost memory and plaintiffs who have lost insight into the cause of their psychological problems may be softening. Several recent cases have adopted tolling exceptions broad enough to encompass both classes of plaintiffs.[51]

Adult victims of childhood sexual abuse have recently joined forces and have concentrated their efforts on state legislatures. Success through the legislative route has been rapid. Since 1989, seventeen states have adopted special statutes of limitations with broad tolling exceptions for childhood sexual abuse tort actions.[52] All seventeen statutes postpone the operation of limitations until both the wrongful acts

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48. See, for example, *Johnson*, 701 F. Supp. at 1363 (applying Illinois law and holding that Illinois courts would apply the discovery rule to plaintiffs suffering from psychological memory blocks) (broadened by statute); *Meiers-Post*, 427 N.W.2d at 69 (holding that the discovery rule applies to plaintiffs who repress memories of the abuse only when there is objective evidence corroborating the plaintiffs' testimony); *E.W.*, 754 P.2d at 817 (dismissing the complaint of a plaintiff who admitted continuing awareness of the abuse but who claimed psychological confusion about the cause of her adult emotional problems; dicta suggesting that if the plaintiff had sustained an abuse-caused memory loss, the doctrine of delayed discovery might apply) (superseded by statute).

49. *Johnson*, 701 F. Supp. at 1363; *Daly*, 281 Cal. Rptr. at 709; *Callahan v. State*, 464 N.W.2d 268 (Iowa 1990); *Meiers-Post*, 427 N.W.2d at 606; *Peterson*, 792 P.2d at 18; *Jones v. Jones*, 242 N. J. Super. 195, 576 A.2d 316 (1990); *E.W.*, 754 P.2d at 817 (dicta); *Osland*, 442 N.W.2d at 907; *Showalter v. Oberlin*, 1991 Ohio App. Lexis 2382 (Ohio App. May 24, 1991) (holding implied from affirming of damage judgment); *Hammer*, 418 N.W.2d at 23.

50. See, for example, *DeRose*, 242 Cal. Rptr. at 368 (superseded by statute); *E.W. v. D.C.H.*, 427 N.W.2d at 606 (superseded by statute). Several courts have rejected the discovery doctrine for both types of plaintiffs. See, for example, *Lindabury v. Lindabury*, 552 So.2d 1117 (Fla. Ct. App. 1989); *Bassile v. Convent House*, 575 N.Y.S.2d 233 (N.Y. Sup. Ct. 1991); *Whatcott v. Whatcott*, 790 P.2d 578 (Utah Ct. App. 1990); *Tyson*, 727 P.2d at 226 (superseded by statute).

51. See, for example, *Daly*, 281 Cal. Rptr. at 709; *Peterson*, 792 P.2d at 18 (holding that the statute of limitations is tolled, regardless of the length of the delay or the plaintiff's knowledge, where there is clear and convincing evidence of the abusive acts); *Osland*, 442 N.W.2d at 907; *Jones*, 576 A.2d at 316; *Hammer*, 418 N.W.2d at 23.

52. Jurisdictions with special statutes of limitations on actions for childhood sexual abuse include: Alaska Stat. § 9.10.140(b)(1)-(2) (1991); Cal. Civ. Pro. Code § 340.1 (West. Supp. 1992); Ill. Ann. Stat. ch. 110, § 13-292.2 (Smith-Hurd 1991); Iowa Code Ann. § 614.8A (West Supp. 1991); 1992 Kan. Sess. Laws Ch. 307 (S.B. 662); 14 Me. Rev. Stat. Ann. § 752-C (West Supp. 1991); Minn. Stat. Ann. § 541.073 (West Supp. 1992); Mo. Rev. Stat. § 537.046 (Supp. 1991); Mont. Code Ann. § 27-2-216 (1991); Nev. Rev. Stat. § 11.215 (1991); 1992 Okla. Sess. Law Serv. Ch. 344 (H.B. 1914) (West); 1991 Or. Laws Ch. 392, § 1, amending Or. Rev. Stat. § 12.117(1); 1992 R.I. Pub. Law 92-84 (92-H 7478); S.D. Cod. Laws § 26-10-25 (Supp. 1991); Utah Code Ann. § 78-12-25.1 (Supp. 1992); 12 Vt. Stat. Ann. §§ 522, 560 (Equity Supp. 1991); Va. Code § 9.01-249(6) (Michie 1991); Wash. Rev. Code § 4.16.340 (Supp. 1992).

and the resulting psychological damage are discovered. When adjustments are made for the impact of statutes on antecedent cases, at least twenty-two jurisdictions today will toll limitations for plaintiffs who maintained sanity by blocking childhood traumas from memory.[53]

III. Two Psychological Explanations for the Disappearance of Traumatic Memories: Repression and Dissociation

When middle-aged plaintiffs make allegations of childhood sexual abuse, jurors are likely to be puzzled over the delay in filing suit. Many will question how the plaintiff could have "forgotten" being sexually victimized as a child. The answer is that it is often easier for victims to forget than to remember.[54] Exposure to intense shocks and horrors activates internal coping mechanisms that are designed to protect the integrity of the psyche. One way the psyche preserves its equilibrium is by placing unbearable memories beyond conscious recall.[55] Repression and dissociation both perform this function, but they perform it in different ways.[56] These ego-defenses were discovered in the late nine-

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53. These 22 jurisdictions are comprised of the 17 jurisdictions with statutes, see sources cited in note 52, and the following jurisdictions, which have favorable case law: *Meiers-Post*, 427 N.W.2d at 606 (Mich.); *Jones*, 576 A.2d at 316 (N.J.); *Osland*, 442 N.W.2d at 907 (N.D.); *Showalter*, 1991 Ohio App. Lexis at 2382 (Ohio) (by implication); *Hammer*, 418 N.W.2d at 23 (Wis.).

54. In one study, 60% of adult victims of childhood sexual abuse in the survey reported that they had "forgotten" the incidents before reaching age 19. Malcolm Ritter, *Sudden Recall of Forgotten Crimes Is a Puzzler for Juries, Experts Say*, Los Angeles Times § A10 (June 30, 1991). Children who suffer repeated acts of abuse are more likely than others to banish the memories from conscious awareness. See, for example, Briere, *Therapy for Adults* at 124 (cited in note 25).

55. For a more comprehensive discussion of repression and dissociation, see generally, Harry Guntrip, *Psychoanalytic Theory, Therapy, and the Self* 3-9 (Basic, 1973); H. P. Laughlin, *The Ego and Its Defenses* 357-86 (Aronson, 2d ed. 1979); William W. Meissner, *Theories of Personality and Psychopathology: Classical Psychoanalysis*, in Harold I. Kaplan and Benjamin J. Sadock, eds., 1 *Comprehensive Textbook of Psychiatry* 337, 382-89 (Williams & Wilkins, 4th ed., 1985); John C. Nemiah, *Dissociative Disorders (Hysterical Neurosis, Dissociative Type)*, in Harold I. Kaplan and Benjamin J. Sadock, eds., 1 *Comprehensive Textbook of Psychiatry* 942, 944-47 (Williams & Wilkins, 4th ed., 1985).

56. The American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (Am. Psychiatric, Rev. 3rd ed., 1987) ("*DSM-III-R*"), includes a section on dissociation but makes no reference to repression. The omission of repression reflects the decision to describe mental disorders according to observable clinical features, without addressing their origins or causes. Id. at xxiii-xxiv. Repression is omitted because repression is not clinically observable. Its existence is inferred. Dissociation, on the other hand, is a clinically observable characteristic found in a group of disorders that *DSM-III-R* labels "Dissociative Disorders." Id. at 269-77. Dissociative disorders are characterized by an absence of normal integration of thoughts, feelings, and experiences into mainstream consciousness and memory. Id. at 269. The dissociative disorders group includes multiple personality disorder, psychogenic fugue, psychogenic amnesia, and depersonalization disorder. Id. at 269-77. For a description of these four disorders, see Putnam, *Multiple Personality Disorder* at 13-23 (cited in note 9).

teenth century—repression by Sigmund Freud[57] and dissociation by a group of his contemporaries who were engaged in clinical work with patients suffering from multiple personality disorder.[58]

A. Repression

Repression is a universal ego-defense that plays a central role in regulating psychological equilibrium.[59] The function of repression is to keep painful or unacceptable ideas, impulses, and feelings out of conscious awareness.[60] Repression performs this function in an automatic, unconscious, and involuntary way. Matters that are repressed from conscious awareness are assigned to a deeper level of the psyche, known as the unconscious, where information is no longer accessible to voluntary recall. Anxiety is the stimulus that regulates repression. Anxiety sends a signal to the ego to activate or intensify repression in order to maintain psychological equilibrium.[61]

Repression has two different functions. One is to block unconscious psychic materials—such as instinctual drives, primordial conflicts, and infantile wishes and fantasies—that have never reached a conscious level, from breaking through and entering into consciousness.[62] This function is termed primary or primal repression.[63] The second function is to exclude from conscious awareness anxiety-provoking experiences that have entered into conscious awareness from without.[64] The expulsion of unacceptable mental content that has entered from without is

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57. See, for example, Meissner, *Classical Psychoanalysis*, in 1 *Comprehensive Textbook of Psychiatry* at 382-89 (cited in note 55).

58. Discovery of dissociation and discovery of the therapeutic uses of hypnosis share a common history. See, for example, Eugene L. Bliss, *Multiple Personality, Allied Disorders and Hypnosis* 36-58 (Oxford, 1986); Ernest R. Hilgard, *Divided Consciousness: Multiple Controls in Human Thought and Action* 1-16 (John Wiley & Sons, 1977); Putnam, *Multiple Personality Disorder* at 26-31 (cited in note 9); Richard Kluft, *The Dissociative Disorders*, in John A. Talbott, Robert E. Hales, and Stuart C. Yudofsky, eds., *Textbook of Psychiatry* 557, 558-59 (Am. Psychiatric, 1988).

59. For a comprehensive discussion of repression and its role in mental functioning, see Laughlin, *The Ego and Its Defenses* at 357-85 (cited in note 55).

60. See, for example, id. at 358-59. Repression differs from suppression. Suppression involves an active, deliberate, and conscious attempt to forget acutely painful or unacceptable thoughts and wishes by diverting attention to other matters. Id. at 361. Repression, on the other hand, operates automatically, outside of conscious awareness and control. Id.

61. On the relationship between anxiety and repression, see, for example, id. at 372; S. Marmer, *Theories of the Mind and Psychopathology*, in John A. Talbott, Robert E. Hales, and Stuart C. Yudofsky, eds., *Textbook of Psychiatry* 123, 131-32 (Am. Psychiatric, 1988); Meissner, *Classical Psychoanalysis*, in 1 *Comprehensive Textbook of Psychiatry* at 380-83 (cited in note 55); Nemiah, *Dissociative Disorders*, in 1 *Comprehensive Textbook of Psychiatry* at 884-85 (cited in note 55).

62. See, for example, Laughlin, *The Ego and Its Defenses* at 363-66 (cited in note 55).

63. See, for example, id. at 363.

64. See, for example, id. at 363-64.

called secondary repression.[65] The banishing of painful memories beyond voluntary conscious recall is an illustration of secondary repression.[66] The experience is registered in mainstream conscious awareness, although sometimes only fleetingly, and is afterwards expelled from conscious mental life and assigned to the unconscious part of the mind.[67] The discarding process can occur gradually over time or almost instantaneously.[68] The ego responds to anxiety-provoking mental content by mobilizing mechanisms of repression.[69] The anxieties that lead to repression can result from fright, rage, shame, or other anxiety-provoking emotions.

Although repressed memories are blocked from consciousness, they are not stripped of energy. Repressed memories remain emotionally charged and active in the unconscious where they can cause emotional problems later in life if ego-defenses later break down.[70] The weakening of these defenses is usually heralded by an attack of acute anxiety.[71]

B. Dissociation

Dissociation is an ego-defense that activates when the psyche suffers an overwhelming blow.[72] Exposure to abrupt trauma that trans-

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65. See, for example, id.
66. See, for example, id. at 364-66.
67. See, for example, id. at 364.
68. See, for example, id.
69. See, for example, sources cited in note 61.
70. See, for example, Laughlin, *The Ego and Its Defenses* at 375-78 (cited in note 55).
71. See, for example, id. at 375-76.
72. Dissociation is a defense that is activated by exposure to extreme trauma. Dissociative symptoms often continue for brief periods afterwards but usually go away. However, for children who are forced to take repeated refuge in dissociative defenses in early years, chronic and severe dissociative disorders can result. David Spiegel, *Keynote Address at the Eighth International Conference on Multiple Personality/Dissociative States* (Nov. 15, 1991) (audiotape transcript availahle through Audio Transcripts, Ltd.).

Recent research findings reveal that dissociation is a very common response to trauma. Id. Trauma victims often report one or more of the following dissociative sensations during or shortly after a traumatic episode: stuporous lack of responsiveness to surroundings; emotional detachment; feelings of bodily estrangement; feelings that the experience was unreal or had a dream-like quality; emotional and physical numbing; the experience of floating above one's body and feeling sorry for tbe victim below; time distortions; memory blackouts; and alterations of attention. Id.

Posttraumatic stress disorder and dissociation are allied concepts. Id. In fact, many researchers have begun to conceptualize multiple personality disorder, the most disabling of all dissociative disorders, as a chronic posttraumatic stress disorder. See, for example, Branscomb, *Dissociation in Combat-Related Post-Traumatic Stress Disorder*, 4(1) Dissociation 13 (1991); Coons, et al., 12 Psychiatric Clinics of N. America at 332 (cited in note 25). Based on recent research advances, the American Psychiatry Association Task Force, engaged in working on the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, is considering the adoption of a new diagnostic category called "Brief Reactive Dissociative Disorder." American Psychiatric Association Task Force on DSM IV, *DSM-IV Options Book: Work in Progress* K:5-K:3 (September 1, 1991).

For an in-depth understanding of how dissociation works to defend the psyche against trauma,

forms a person into a helpless victim can cause the experiencing of reality to shatter and break apart.[73] During dissociative episodes, the four components of experience—behavior, emotion, physical sensation, and knowledge—which are normally associated and processed as a single unit in awareness and memory, become separated and disorganized.[74] As a result, the components of experience are no longer processed in conscious awareness and stored in memory in their normal manner.[75] Some of the components become split off; the dissociated parts are processed outside of mainstream consciousness and become compartmentalized in mind spaces where they are inaccessible to conscious recall.[76] By disorganizing the elements of reality, dissociation offers a mechanism of psychological escape from the constraints of unbearable reality.[77]

The precise subjective alterations that occur during dissociative episodes depend upon the particular components of experience that are dissociated or split off.[78] If the emotional component is dissociated, the traumatic event will be accompanied by feelings of detachment, psychological numbing, and estrangement from body and surroundings.[79] The

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see Bliss, *Multiple Personality* at 164-92 (cited in note 58); Putnam, *Multiple Personality Disorder* at 6-23 (cited in note 9); Frank W. Putnam, Jr., *Dissociation as a Response to Extreme Trauma*, in Richard P. Kluft, ed., *Childhood Antecedents of Multiple Personality* 66 (Am. Psychiatric, 1985); David Spiegel, *Dissociation, Double Binds, and Posttraumatic Stress in Multiple Personality Disorder*, in Bennett G. Braun, ed., *Treatment of Multiple Personality Disorder* 61 (Am. Psychiatric, 1986).

73. See, for example, David Spiegel, *Hypnosis in the Treatment of Victims of Sexual Abuse*, 12 Psychiatric Clinics of N. America 295 (1989); Spiegel, *Keynote Address* (cited in note 72).

74. See, for example, James P. Block, *Assessment and Treatment of Multiple Personality and Dissociative Disorders* 1-11 (Professional Resource, 1991); Hilgard, *Divided Consciousness* at 216-24, 242-56 (cited in note 58); Putnam, *Multiple Personality Disorders* at 12-23 (cited in note 9); Braun, *BASK Model of Dissociation* (pts. 1 & 2), I(1) Dissociation 4 (1988), I(2) Dissociation 16 (1988) ("*BASK*"); Braun, 12 Psychiatric Clinics of N. America at 307-12 (cited in note 31); Kluft, *Dissociative Disorders*, in *Textbook of Psychiatry* at 558-59 (cited in note 58). For a description of the range of dissociative reactions seen in trauma victims, see notes 72, 74-88 and accompanying text.

75. See, for example, Block, *Assessment and Treatment* at 1-11 (cited in note 74); Hilgard, *Divided Consciousness* at 185-256 (cited in note 58); *BASK* (cited in note 74).

76. See, for example, Hilgard, *Divided Consciousness* at 259-62; sources cited in note 74.

77. Dissociation buffers the psyche against trauma in two ways. First, it allows the victim to blunt or obliterate the reality of the traumatic experience while it is in progress. And second, it isolates the memory of the experience and maintains it beyond conscious recall so that the victim will not be tormented by later mental replays of the experience. Kluft, *Dissociation & Subsequent Vulnerability: A Preliminary Study*, 3 Dissociation 160, 168 (1990).

78. For a description of the range of dissociative reactions that victims often experience during and in the immediate aftermath of severe psychic traumas, see notes 72, 78-88 and accompanying text.

79. See, for example, Laughlin, *The Ego and Its Defenses* at 97-103 (cited in note 55). For a description of the broad range of dissociative responses that can occur during and after traumatic episodes, see sources cited in note 72.

experience may seem unreal and dreamlike. Victims of sudden trauma often report feeling as if the experience were happening to someone else or as if they were floating above their bodies witnessing the traumatic event below.[80] If physical sensation is dissociated, the victim may experience a sense of bodily paralysis, numbness, and deadness.[81]

Highly-dissociative individuals have the ability to make all vestiges of the traumatic experience magicly disappear.[82] When the psyche perceives an experience as too overwhelmingly threatening to accept its reality, the psyche spontaneously retreats into an altered state of consciousness. The traumatic experience is registered, processed, and stored outside of mainstream conscious awareness and memory.[83] The result is instantaneous amnesia. When normal conscious awareness returns, the intervening period is experienced as a black-out. The victim will have no waking recall of the incident.[84]

Dissociation, at least over the short term, provides a life-saving, pain-sparing, and creative solution for the sexually abused child.[85] However, while dissociation buys peace of mind in the present, this peace comes at a tremendous price. Because dissociation walls off the traumatic experience, it prevents the child from coming to terms with the trauma at a later date. Dissociation, consequently, has been characterized as a loan from the future to pay for the present.[86] Moreover, for children who live in abusive settings, repeated use of dissociative de-

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80. See, for example, Spiegel, 12 Psychiatric Clinics of N. America at 295-96 (cited in note 73); Spiegel, *Keynote Address* (cited in note 72).

81. See sources cited in note 72 and accompanying text.

82. See, for example, Putnam, *Dissociation*, in *Childhood Antecedents of Multiple Personality* at 66 (cited in note 72); Spiegel, *Dissociation*, in *Treatment of Multiple Personality Disorder* at 64-66 (cited in note 72). Dissociation is the mechanism that accounts for the traumatic amnesia that rape victims, soldiers after battle, and victims of other acutely traumatic episodes often experience. See, for example, Putnam, *Dissociation*, in *Childhood Antecedents of Multiple Personality* at 72-74. For the lucky, the memory loss is only temporary and resolves spontaneously within a few weeks. For others, memory problems may continue, and acute psychiatric disorders may result. See id. Disorders brought on by dissociative reactions to acute trauma can include psychogenic amnesia, psychogenic fugue, depersonalization disorder, and in extreme cases, multiple personality disorder. See, for example, sources cited in note 56; Putnam, *Multiple Personality Disorder* at 12-23 (cited in note 9). Multiple personality disorder, which develops during early childhood, is a disorder in which memories of traumatic experiences are parcelled out among separate personality states. The memories remain inaccessible to the main personality. See, for example, id. at 40-71. Experts today believe that this disorder is far more common than was previously believed. See, for example, id. at 54-55.

Dissociative barriers sometimes develop leaks. When this happens, memories can return in the form of flashbacks in which the person relives the traumatic experience as if it were happening in the present. See, for example, sources cited in note 72.

83. See, for example, sources cited in notes 72 and 74.

84. See, for example, Bliss, *Multiple Personality* at 107-12 (cited in note 58).

85. See, for example, Gil, *Adult Survivors* at 148-49 (cited in note 31).

86. Speigel, *Keynote Address* (cited in note 72).

fenses becomes an addictive style of coping and can lead to mental fragmentation and lasting psychological damage.[87] If sexual victimization occurs often enough and at an early enough age, a child who can easily dissociate in the face of trauma stands a risk of developing multiple personality disorder.[88]

Dissociative disorders experts believe that spontaneous self-hypnosis is the mechanism responsible for dissociative alterations of conscious experience and accompanying memory loss.[89] Researchers have established interesting correlations between dissociative capacity, hypnotizability, and the severity of early childhood punishment.[90] Because dissociative memory barriers result from the processing of experience in a self-hypnotic state, many dissociative disorders specialists believe that dissociated memories can be recovered and reintegrated only by re-

87. See, for example, sources cited in notes 82 and 88.

88. The development of multiple personality disorder is believed to require at least two separate ingredients: (1) severe physical, sexual, or emotional abuse in early childhood; and (2) an inborn biological capacity to dissociate. See, for example, Bennett G. Braun and Roberta G. Sachs, *The Development of Multiple Personality Disorder: Predisposing, Precipitating, and Perpetuating Factors*, in Richard P. Kluft, ed., *Childhood Antecedents of Multiple Personality* 37 (Am. Psychiatric, 1985). One theoretical explanation of the development of multiple personalities postulates that the abused child, while in a self-hypnotic state, imagines that the experience is happening to someone else and uses fantasy to endow the "other" with physical attributes and a life history. See, for example, Bliss, *Multiple Personality* at 150-57 (cited in note 58).

89. See, for example, Bliss, *Multiple Personality* at 64-116 (cited in note 58); Hilgard, *Divided Consciousness* at 216-56 (cited in note 58); Spiegel, *Hypnosis*, in *Textbook of Psychiatry* at 910-12 (cited in note 9). The postulated connection between dissociation and spontaneous self-hypnosis explains why many dissociative disorders experts regard hypnosis as an indispensable treatment technique in recovering and integrating dissociated memories. See, for example, notes 91, 119-24 and accompanying text; Bliss, *Multiple Personality* at 914-16; Putnam, *Multiple Personality Disorder* at 222-52 (cited in note 9). See also notes 231-36 and accompanying text.

90. See, for example, Josephine R. Hilgard, *Personality and Hypnosis: A Study of Imaginative Involvement* 207-24, 242-47, 283-85 (Univ. of Chicago, 2d ed. 1979) (linking hypnotizability with severity of childhood punishment); Putnam, *Dissociation*, in *Childhood Antecedents of Multiple Personality* at 65-66 (cited in note 72) (linking dissociation and hypnotizability). But see Fred H. Frankel, *Hypnotizability and Dissociation*, 147 Am. J. Psychiatry 823 (1990) (cautioning that attempts to link dissociative capacity with hypnotizability are unproven and premature). Dr. Josephine R. Hilgard was the first researcher to identify the correlation between hypnotic susceptibility and the severity of childhood punishment. She speculates that this relationship arises from the abused child's use of fantasy formation to block painful experiences from conscious awareness. Hilgard, *Personality and Hypnosis* at 283-87. Since Dr. Hilgard's discovery, many other researchers have reported findings consistent with this connection. See, for example, Carlson and Putnam, *Integrating Research on Dissociation and Hypnotizability: Are There Two Pathways to Hypnotizability?*, 2 Dissociation 32 (1989); James A. Chu and Dianna L. Dill, *Dissociative Symptoms in Relation to Childhood Physical and Sexual Abuse*, 147 Am. J. Psychiatry 887 (1990); Edward J. Frischolz, *The Relationship Among Dissociation, Hypnosis, and Child Abuse in the Development of Multiple Personality Disorder*, in Richard P. Kluft, ed., *Childhood Antecedents of Multiple Personality* 100 (Am. Psychiatric., 1985); Barbara Sanders and Marina H. Giolas, *Dissociation and Childhood Trauma in Psychologically Disturbed Adolescents*, 148 Am. J. Psychiatry 50 (1991); Randall K. Stutman and Eugene L. Bliss, *Post-Traumatic Stress Disorder, Hypnotizability, and Imagery*, 142 Am. J. Psychiatry 741 (1985).

turning the patient to the same hypnotic state. Consequently, hypnosis has become a standard treatment technique in dissociative disorders therapies.[91]

IV. Uses of Hypnosis in Psychotherapy

A. *The Historical Bond Between Hypnosis and Psychiatry*

Modern dynamic psychiatry owes its birth to late eighteenth and nineteenth century physicians who used hypnosis in their clinical and scientific practices.[92] In 1784, the Marquis de Puysegur, a physician, discovered that during hypnosis patients had access to important secrets unavailable to them in waking states. Based on this insight, he postulated that the mind had two memory states, one conscious and the other unconscious.[93] A century later, Jean-Martin Charcot, another clinical hypnotist, noted that when patients under hypnosis recalled traumatic childhood events, clinical improvement followed. From this, Charcot postulated that neurosis was caused by traumatic memories festering in the unconscious.[94] This discovery so impressed Sigmund Freud that in 1885 he left his practice in Vienna to study under Charcot in Paris.[95] This was a major turning point in Freud's career. After returning from Paris, Freud introduced hypnosis into his clinical practice and used it for the next five years (1887-1892), the period when he

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91. See, for example, William N. Friedrich, *Hypnotherapy With Traumatized Children*, 39 Int'l J. Clinical & Experimental Hypnosis 67 (1991); Miller, *Hypnotherapy in a Case of Dissociated Incest*, 34 Int'l J. Clinical & Experimental Hypnosis 13 (1986). On the importance of hypnosis in dissociative disorders psychotherapies, see also notes 119-24, 310-11 and accompanying text.

92. All histories trace the origins of modern dynamic psychiatry to a prominent circle of late 18th and 19th century physicians and psychiatrists who used hypnosis to explore the unconscious. See, for example, Bliss, *Multiple Personality* at 3-63 (cited in note 58); Leon Chertok and Raymond de Saussure, *Therapeutic Revolution: From Mesmer to Freud* (Brunner-Mazel, 1979); Henri F. Ellenberger, *The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry* (Basic, 1970). Franz Anton Mesmer, a late 18th century physician, planted the seeds of modern psychiatry when he discovered a hypnotic treatment that he called animal magnetism. See, for example, Bliss, *Multiple Personality* at 9-14; Ellenberger, *Discovery of the Unconscious* at 53-192. Mesmer's assertions that animal magnetism could cure patients sparked such controversy within scientific circles that King Louis XVI appointed a panel of France's leading scientists to investigate whether Mesmer's mysterious cure had any scientific foundation. See, for example, Chertok and de Saussure, *Therapeutic Revolution* at 9. Scientist Benjamin Franklin, chemist Lavoisier, and professor of anatomy Dr. Guillotin served on this panel. See, for example id. The panel found Mesmer's magnetic cures to be unscientific and branded Mesmer a quack. See, for example, id. Scientists lost interest in hypnosis until a group of mid-19th century psychiatrists, engaged in the investigation of dissociative phenomena and the treatment of patients suffering from multiple personality disorder, rediscovered hypnosis and used it as their main treatment approach. See, for example, Ellenberger, *Discovery of the Unconscious* at 53-102.

93. See, for example, Chertok and de Saussure, *Therapeutic Revolution* at 158-65 (cited in note 92).

94. See, for example, id. at 80.

95. See, for example, id. at 65.

made two of his most important psychoanalytic discoveries—the influence of the unconscious and the existence of transference.[96] In 1892, however, Freud abandoned hypnosis[97] in favor of free association.[98]

B. *The Modern Revolution of Hypnosis in Psychotherapy*

When Freud abandoned hypnosis, he took mainstream psychiatry with him. Clinical interest virtually disappeared until the end of World War II when veterans hospitals discovered that soldiers suffering from war stress disorders responded favorably to hypnosis.[99] The veterans hospitals experience lead to the official recognition of hypnosis as a legitimate treatment modality by the Council on Mental Health of the American Medical Association in 1958 and by the American Psychological Association two years later.[100]

Hypnosis is used today in psychiatry, psychology, medicine, and dentistry.[101] A 1982 survey of 600 randomly selected members of the

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96. See, for example, id. at 78-117.

97. There has been much speculation why Freud abandoned hypnosis. See, for example, id. at 117-52. There were probably many different reasons. By that time, the medical community was losing interest in hypnosis. See, for example, id. at 117. Erotic complications that hypnosis appeared to cause in some patients and the inability to use hypnosis with patients who were not hypnotizable also concerned Freud. See, for example, id. at 117-25. The most important reason, however, was Freud's discovery of a mind-exploring technique, known as free association, that fit better with his psychoanalytic theories and methods. Freud had come to believe that dreams, fanatasies, and slips of the tongue revealed the unconscious in disguised form. See, for example, Meissner, *Classical Psychoanalysis*, in 1 *Comprehensive Textbook of Psychiatry* at 337-63 (cited in note 55). Moreover, hypnosis did not lend itself to the interpretation of dreams, transference, or resistance, central features of Freud's psychoanalytic methods. See, for example, id. at 409-18. There even may have been an element of professional rivalry in Freud's abandonment of hypnosis. He viewed repression as the chief mechanism responsible for psychological forgetting. See, for example, id. at 355-58. A rival school of 19th century psychiatrists who were devotees of hypnosis assigned primacy to dissociation. See sources cited in note 92. This, too, may have contributed to Freud's decision to abandon hypnosis.

98. Free association is a technique whose ground rules require the patient to provide an unedited stream of consciousness containing all thoughts, images, ideas, and fantasies that arise during the therapeutic hour. The therapist uncritically listens for clues outside of the patient's awareness and makes interpretations that seek to link the patient's childhood past with the patient's present problems and symptoms. See, for example, Robert J. Ursano, Stephen M. Sonnenberg, and Susan G. Lazar, *Psychodynamic Psychotherapy* 20-22 (Am. Psychiatric, 1991). This technique is used in psychoanalysis and, in modified form, in psychoanalytic psychotherapies. Part VI of this Article takes the position that the risk of unwitting memory contamination is prohably not significantly different in "talking" psychotherapies than in hypnotic ones.

99. See, for example, Spiegel, *Hypnosis*, in *Textbook of Psychiatry* at 907-08 (cited in note 9).

100. See, for example, Scheflin and Shapiro, *Trance on Trial* at 57-58 (cited in note 9).

101. See, for example, D. Corydon Hammond, *Handbook of Hypnotic Suggestions and Metaphors* (N.W. Norton, 1990); Fred H. Frankel, *Significant Developments in Medical Hypnosis During the Past 25 Years*, 35 Int'l J. Clinical & Experimental Hypnosis 231 (1987); Erika Fromm, *Significant Developments in Clinical Hypnosis During the Past 25 Years*, 35 Int'l J. Clinical & Experimental Hypnosis 215 (1987). Standard uses of hypnosis in medicine, dentistry, and the

American Psychological Association engaged in psychotherapy and counseling practices revealed that of those surveyed forty-seven percent had training in hypnosis; thirty-five percent had used hypnosis in their clinical practice for more than a year; and twenty-seven percent regularly used hypnosis on an average of one or more times per month.[102] Since the 1982 survey, economic pressures to develop briefer and more cost-effective approaches to psychotherapy and increasing evidence that hypnosis is an effective treatment for a broad range of problems have combined to heighten professional interest in hypnosis. Psychiatrists and psychologists are now attending hypnosis training programs in record numbers.[103] The growing professional excitement over hypnosis has spread to nurses, social workers, marital and family counselors, habit control specialists, and others within the mental health field.[104] New clinical applications are constantly being tried on an ever-expanding patient population.[105] Moreover, hypnosis has spread beyond treatment rooms. Many therapists now teach self-hypnotic techniques to their patients so that the patients can continue therapy between sessions.[106]

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mental health field include the following: pain management; preparation for surgery; ego-strengthening and enhancement of self-esteem; stress reduction; treatment of anxiety and phobic disorders; treatment of migraine headaches; cancer treatments; treatment of dermatological disorders; healing of psychosomatic conditions; treatment of posttraumatic stress disorder, multiple personality disorder, and other disorders etiologically linked to trauma; reduction of guilt; treatment of sleep disorders, sexual dysfunctions, and eating disorders; and addictions, weight loss, and other habit control problems. See, for example, Hammond, *Handbook of Hypnotic Suggestions* at 1. New uses for hypnosis are constantly being discovered.

Most medical and dental applications of hypnosis and many mental health applications do not entail hypnotic memory work. Applications of hypnosis that rely on the power of hypnotic suggestion to deaden pain or to induce patients to make beneficial changes in their lives will rarely become concerns for the legal system. Only when hypnosis is used to explore memory may the goals of law and treatment potentially collide.

102. William A. Kraft and Emil R. Rodolfa, *The Use of Hypnosis Among Psychologists*, 24 Am. J. Clinical Hypnosis 249 (1982). There is a vast and growing literature on clinical hypnosis, including at least two journals devoted exclusively to research advances, the *International Journal of Clinical & Experimental Hypnosis* and the *American Journal of Clinical Hypnosis*. For general information about the techniques used in clinical hypnosis, see Graham D. Burroughs and Lorraine Dennerstein, eds., *Handbook of Hypnosis and Psychosomatic Medicine* (Elseuner-North-Holland Biomedical, 1980); M. Gerald Edelstein, *Trauma, Trance, and Transformation* (Brunner-Mazel, 1981); Hammond, *Handbook of Hypnotic Suggestions* at 1 (cited in note 101); Benjamin Wallace, *Applied Hypnosis: An Overview* (Nelson-Hall, 1979).

103. See, for example, Elgan L. Baker, *The State of the Art of Clinical Hypnosis*, 35 Int'l. J. Clinical & Experimental Hypnosis 203, 203-04 (1987).

104. See, for example, id. at 203-04; Scheflin and Sbapiro, *Trance on Trial* at 6 (cited in note 9).

105. See, for example, Baker, 35 Int'l. J. Clinical & Experimental Hypnosis at 208 (cited in note 103).

106. See, for example, id. at 206-07; Yvonne M. Dolan, *Resolving Sexual Abuse* 116-19 (W.W. Norton, 1991); Putnam, *Multiple Personality Disorder* at 224 (cited in note 9).

C. *Advantages of Hypnosis in the Treatment of Sexually Abused Patients*

Hypnosis is widely used by childhood sexual abuse specialists.[107] Practitioners claim that hypnosis achieves the same results as traditional psychotherapies by a quicker and more cost-effective route.[108] They further claim that hypnosis strengthens the therapeutic relationship.[109] The patient perceives the therapist's orchestration of powerful changes in her mental state as evidence of great competence. This causes the patient to develop a positive transference toward the therapist, which increases the chances that the therapy will be effective.[110]

Memory work is one of the most important therapeutic applications of hypnosis. Since the nineteenth century, clinicians have used hypnosis to penetrate amnesic barriers and restore lost traumatic memories. The clinical community's confidence in the power of hypnosis to restore lost traumatic memories is not shared by the hypnosis research community. Many members of the hypnosis research community believe that hypnosis is incapable of producing genuine memory improvement.[111] The contrasting positions taken by the clinical and research

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107. See, for example, Bliss, *Multiple Personality* at 193-220 (cited in note 58); Edelstein, *Trauma* at vi-viii (cited in note 102); Putnam, *Multiple Personality Disorder* at 219-52; Udolf, *Forensic Hypnosis* at 196-99 (cited in note 6); Friedrich, 39 Int'l. J. Clinical & Experimental Hypnosis at 67 (cited in note 91); Miller, 34 Int'l. J. Clinical & Experimental Hypnosis at 13 (cited in note 91); Thurman Mott, Jr., *The Role of Hypnosis in Psychotherapy*, 24 Am. J. Clinical Hypnosis 241, 242-46 (1982); Spiegel, *Hypnosis*, in *Textbook of Psychiatry* at 914-16 (cited in note 9); Spiegel, 12 Psychiatric Clinics of N. America at 299-302 (cited in note 73); Richard P. Kluft, *Using Hypnotic Inquiry Protocols to Monitor Treatment Progress and Stability in Multiple Personality Disorder*, 28 Am. J. Clinical Hypnosis 63, 65 (1985); Richard P. Kluft, *Varieties of Hypnotic Interventions in the Treatment of Multiple Personality*, 24 Am. J. Clinical Hypnosis 230 (1982). See also sources cited in note 315.

108. See, for example, Edelstein, *Trauma* at xv (cited in note 102); Spiegel, 12 Psychiatric Clinics of N. America (cited in note 73).

109. See, for example, Mott, 24 Am. J. Clinical Hypnosis at 244-46 (cited in note 107).

110. See, for example, id.

111. The phrase "hypnosis research community," as used in this Article, collectively refers to experimental memory psychologists engaged in the laboratory study of hypnosis, rather than to a cohesive and organized body. Because the findings from research into the effects of hypnosis on memory have not been uniform, the description of researchers as being part of a "community" suggests a greater consensus than exists. Some patterns of findings, however, are more common than others. When this Article discusses the "position" taken by the "research community," it refers to the research findings that are most common.

Experimental research findings, while generally showing an increase in memory productivity, rarely show improvement in memory accuracy. Subjects tend to give more answers, both correct and incorrect. This has led to the speculation that hypnosis reduces critical judgment and causes guessing rather than genuine memory enhancement. See, for example, American Medical Association, 34 Int'l J. Clinical & Experimental Hypnosis at 1 (cited in note 9); Mathew H. Erdelyi, *Hypermnesia: The Effect of Hypnosis, Fantasy, and Concentration*, in Helen M. Pettinati, ed., *Hypnosis and Memory* 64 (Guilford, 1988); Orne, *Reconstructing Memory Through Hypnosis*, in *Hypnosis and Memory* at 21 (cited in note 12); Sheehan and Tilden, 34 Int'l J. Clinical & Experi-

communities, however, can be explained by the fact that they are observing different phenomena. The hypnosis research community's inability to reproduce clinical memory successes in laboratory experiments results from the fact that researchers are testing hypnosis on a different population and are asking hypnosis to perform altogether different memory tasks.[112] Hypnosis research experiments use subjects who have normal memory function.[113] Laboratory experiments attempt to learn whether hypnosis can expand memory beyond the boundaries of waking recall.[114] Transcending the normal powers of memory is an ambitious task and one that hypnosis may be incapable of performing. The clinical community, on the other hand, asks much less from hypnosis. Clinical memory work is carried on with patients who are suffering from traumatic disturbances of memory. Clinicians use hypnosis to dislodge psychological defense mechanisms that are intruding upon the patient's normal recall ability.

Explanations exist that can account for the power of hypnosis to perform the more limited task that clinical situations require. These explanations relate to assumptions about the origins and workings of repression and dissociation. Because repression and dissociation use different mechanisms to block traumatic memories from awareness, hypnosis may operate on each in different ways.

Anxiety supplies the psychological stimulus responsible for activating repression.[115] The psyche defends itself against anxiety-provoking information by excluding it from conscious awareness.[116] Repression, consequently, is in essence an anxiety inhibition against remembering. Several characteristics associated with hypnosis may coalesce to overcome anxiety barriers against remembering. Hypnosis produces a state of profound relaxation and calmness. In addition, it intensifies powers of concentration and focuses attention inward so that the subject becomes absorbed in the internal affairs of the mind.[117] Powerful relaxation, when combined with intense, undivided concentration, may free the patient from the anxieties which cause repression and may enable

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mental Hypnosis at 122 (cited in note 12). See also Udolf, *Forensic Hypnosis* at 33 (cited in note 6).

112. For a discussion of the influence of hypnosis laboratory research designs on the interpretation and application of research findings, see Part V.A.

113. For a description of paradigm research designs used in hypnosis laboratory investigations, see id.

114. Id.

115. See, for example, notes 61, 64-69 and accompanying text.

116. Id.

117. See, for example, Bliss, *Multiple Personality* at 105-08 (cited in note 58).

the patient to recall experiences that she was previously unable to remember.[118]

A different theory may explain the effectiveness of hypnosis on dissociation. Many dissociative disorders experts believe that dissociation results from spontaneous self-hypnosis.[119] In the face of overwhelming trauma, the psyche retreats from reality through spontaneous self-hypnosis. The traumatic episode is registered in a hypnotic state of consciousness disconnected from mainstream conscious awareness.[120] Induction of hypnosis reinstates a similar consciousness state. Contemporary memory theorists believe that memory is state-dependent in the sense that information acquired in a particular consciousness state is best remembered when the subject is again in the same state.[121] Pleasant memories, for example, elude people who are depressed, but return when the depression goes away.[122] Hypnosis may facilitate recovery of dissociated memories by returning the subject to a hypnotic state of consciousness comparable to the state that existed when the information was encoded.[123] The reestablishment of a similar consciousness

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118. One commentator gives the following explanation of the effectiveness of hypnosis in overcoming repression:

> Most experts agree that hypnosis minimizes the defenses of the patient, especially the defense of repression. . . . People in hypnosis . . . lose some of the ability to be reflectively aware, and self-reactions of embarrassment, guilt, and anxiety are reduced. The attention of the patient is turned inward and there is accessibility to deep, emotional material of which the individual is not normally aware. In this stage primary modes of tbought predominate and there is the emergence of visual imagery, symbolism, a kind of timelessness, and the absence of the usual logic. . . . The hypnotic relationship becomes a relatively safe place to experience tbe anxiety surrounding his neurotic conflicts.

C. Scott Moss, *Dreams, Images, and Fantasy: A Semantic Differential Casebook* 280 (Univ. of Illinois, 1970). For related accounts, see Udolf, *Forensic Hypnosis* at 197 (cited in note 6); Orne, *Reconstructing Memory*, in *Hypnosis and Memory* at 38-39 (cited in note 12).

119. See, for example, notes 89-91 and accompanying text.

120. For a description of how dissociation operates, see notes 72-91 and accompanying text.

121. See, for example, James M. Swanson and Marcel Kinsbourne, *State-Dependent Learning and Retrieval: Methodological Cautions and Theoretical Considerations*, in John F. Kihlstrom and Frederick J. Evans, eds., *Functional Disorders of Memory* 275 (Lawrence Erlbaum, 1979); Spiegel, 12 Psychiatric Clinics of N. America at 299 (cited in note 73). The following passage summarizes contemporary assumptions about the conditions necessary to stimulate the retrieval mechanisms of memory:

> Today, most theorists assume that how well something is remembered depends not only on what that something is, or how it was encoded, but also on the circumstances that surround its retrieval. Accordingly, remembering is now conceptualized as a joint product or interaction between information that has been stored in the past and information tbat is present in the cognitive environment of the rememberer. . . . Studies showing that memory performance depends on tbe similarity or match between drug or mood states at encoding and retrieval thus square with this interactive view of remembering, and thereby strengthen its appeal.

Eich, *Theoretical Issues in State Dependent Memory*, in Endel Tulvig and Wayne Donaldson, eds., *Organization of Memory* 331, 334 (Academic, 1972).

122. See sources cited in note 121.

123. See, for example, Bliss, *Multiple Personality* at 112-14 (cited in note 58); Hilgard, *Di-*

state may provide the proper associative network and retrieval cues needed to activate dissociated memories. This explanation has been captured by the observation of a well-known dissociative disorders expert that "[t]he path into the cave is the path leading out."[124] Theories accounting for the facility of hypnosis in recovering repressed and dissociated memories can also explain why the clinical and research communities have reached different conclusions about the effectiveness of hypnosis.[125]

Hypnosis performs clinical tasks aside from memory retrieval that are important in psychotherapy. Memory and insight alone rarely suffice to bring relief from psychological distress. The patient must make contact with emotions that have been stifled and discharge these emotions in order to put the past behind and move on.[126] Hypnosis brings the past into sharper focus and intensifies the patient's emotional discharge.[127] For patients who are highly hypnotizable, hypnosis can trigger an "abreaction" during which the patient emotionally relives the past with all of its original sounds, smells, anguishes, and terrors.[128] By causing a more powerful emotional discharge, hypnosis brings the patient quick relief from psychological distress and leads to a more durable recovery.[129]

Hypnosis also provides the therapist with better control over the therapy. The crumbling of memory barriers exposes the patient to risks of being flooded and overwhelmed. When traumatic memories are recovered in a hypnotic state, the therapist can regulate the pace at which

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vided Consciousness at 244-45 (cited in note 58); Spiegel, 12 Psychiatric Clinics of N. America at 300 (cited in note 73).

124. Bliss, *Multiple Personality* at 112.

125. Part V discusses additional factors accounting for the variant positions taken by the clinical and research communities about the efficacy of hypnosis in restoring memory.

126. See, for example, Briere, *Therapy for Adults* at 85-88 (cited in note 25). Psychologist John Briere stresses the importance of catharsis in sexual abuse psychotherapies. Adults who were sexually abused as children tend to suppress their emotions and to avoid going places and doing things tbat might cause them to remember childhood traumas. The consumption of mental energies needed to keep from feeling and remembering cripples them in daily living. ld. at 85. These patterns continue until stifled emotions from childhood are released. Id. at 85-86.

127. See, for example, Bliss, *Multiple Personality* at 78-82 (cited in note 58); Spiegel, 12 Psychiatric Clinics of N. America (cited in note 73). Hypnosis intensifies the patient's emotional response by imparting a vivid and lifelike quality to memories. See, for example, Bliss, *Multiple Personality* at 79-91. Patients who are highly hypnotizable experience the past as if it were happening in the present. The hypnotic reliving of a memory experience, called "abreaction," can be more traumatic than the original experience. See, for example, Putnam, *Multiple Personality Disorder* at 230 (cited in note 9). Mary Smith, the hypothetical plaintiff in Part I, experienced a hypnotic abreaction. See notes 10-11 and accompanying text.

128. See sources cited in note 127.

129. See, for example, Putnam, *Multiple Personality Disorder* at 235-52; Spiegel, 12 Psychiatric Clinics of N. America at 300-02.

they reenter consciousness.[130] When the limits of the patient's endurance are reached, the therapist can bring the patient out of hypnosis with permission to remember only as much of the session as can be tolerated. Hypnosis, moreover, allows the therapist to modulate the intensity of remembering. The therapist can cushion the emotional impact of unbearable memories by directing the patient to project them onto an imaginary television screen where they can be re-experienced from an emotionally safe distance.[131] Dr. Jones used this technique with Mary Smith to provide the emotional distance that he believed she needed to look at the past.[132]

D. Comparison of Clinical and Forensic Hypnotic Interviewing Techniques

Memory alteration occurs, at least to some degree, in all psychotherapies. This is inevitable because of the distance in time from the events remembered, the patient's unconscious defenses and resistances, and the influence of transference and countertransference.[133] Sigmund Freud postulated that most incest memories were the product of Oedipal fantasies.[134] In modern times, it has become clear that the Oedipal

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130. See, for example, Spiegel, *Hypnosis*, in *Textbook of Psychiatry* at 914-16 (cited in note 9); Spiegel, 12 Psychiatric Clinics of N. America at 300-02.

131. For a more detailed description of this technique, see, for example, Putnam, *Multiple Personality Disorder* at 231 (cited in note 9); Spiegel, *Hypnosis*, in *Textbook of Psychiatry* at 914-16 (cited in note 9). Other hypnotic maneuvers can be combined with television technique to reduce the terrifying sense of helplessness that accompanies being a victim. For example, tbe patient can be told to divide the imaginary television screen in half and to imagine herself on one half as the helpless child who lived through the experience and on the other half as an adult confronting the perpetrator. Id. Hypnosis affords opportunities for personalizing treatments that are unavailable in talking psychotherapies.

132. While recommended use of television technique pervades the clinical hypnosis literature, forensic experts object to this technique on the ground that it stimulates imagination and instills false confidence in memory accuracy. See sources cited in note 9.

133. See note 256 for an explanation of "transference" and note 288 for an explanation of "countertransference."

134. Freud initially accepted his patients' accounts of incestuous abuse as historically accurate memories of traumas experienced in childhood. See, for example, Marmer, *Theories of the Mind*, in *Textbook of Psychiatry* at 124-25 (cited in note 61). However, when incest memories recurred more frequently than Freud believed possible, he revised his views and sought other explanations. His search resulted in the theory of the "Oedipal complex." This theory explains sexual abuse memories as unconscious infantile fantasies that are mistaken for actual experiences. According to Freud's theory, infantile children have sexual strivings that are directed toward the parent of the opposite sex. See, for example, Briere, *Therapy for Adults* at 34-35 (cited in note 25). The male child's fear of castration and the female child's penis envy cause these longings to be banished from conscious awareness and replaced by unconscious fantasies of having seduced the desired parent. See, for example, id.

Freud's theory of the Oedipal complex gained mainstream acceptance within the psychiatric community and was widely accepted until fairly recently. See, for example, id. As a result, therapists gave incest memories Oedipal interpretations and dismissed them as fantasies. See, for ex-

fantasy theory explains many fewer incest memories than Freud once believed. Nevertheless, false memories of childhood sexual abuse can be awakened during psychotherapy. This is true both in hypnotic and in "talking" psychotherapies. However, different factors are likely to contribute to false remembering in hypnotic and "talking" psychotherapies.[135] In hypnotic therapies, the potential for false remembering arises because people in trance, while not deprived of free will, suspend their usual conscious editing functions, have heightened imaginative capacities, and become more responsive to suggestion.[136] This increases their vulnerability to therapeutic interventions and places them at a higher risk of self-distortions of memory.[137] As a result, courts are likely to pay special attention to the dialogue that takes place during hypnotic therapy sessions.

Although clinical and forensic hypnotists use many of the same memory retrieval techniques, the dialogues that take place during the session are probably quite different.[138] This is because forensic and clinical hypnotists use hypnosis to achieve different goals. Had Dr. Jones been a forensic hypnotist interviewing Mary Smith with a view to future litigation, his undivided focus would have been on retrieving Mary's memories in their pristine original form so that the past

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ample, id. During the past decade, however, it has become abundantly clear that Freud erred in believing that incest is rare. As a result, the mental healtb community has now begun to take sexual abuse memories seriously. See, for example, id. For criticism of Freud's abandonment of the seduction tbeory, see Jeffrey M. Masson, *The Assault on Truth: Freud's Suppression of the Seduction Theory* (Farrar, Straus & Giroux, 1984).

135. See Part VI for how false memories can be created in "talking" psychotherapies.

136. See, for example, Spiegel, *Hypnosis*, in *Textbook of Psychiatry* at 908 (cited in note 9).

137. Though people tend to become more vulnerable to suggestion during hypnotic interviews than in waking state interviews, psychotherapy settings are unique and the treatment modality may not greatly affect the patient's level of vulnerability. Memory psychology studies have shown that the identity of the interviewer bas a significant impact on the subject's suggestibility level. The subject's perception of the interviewer as a person of higher status and greater knowledge automatically leads to exaggerated susceptibility. See, for example, Elizabeth F. Loftus, *Eyewitness Testimony* 97-99 (Harvard, 1979). In view of the patient's transference attachment to and eagerness to please the therapist, the net result may be that the patient's level of suggestibility may not be significantly less in "talking" psychotherapies than in hypnotic ones. See, for example, sources cited in note 280 and accompanying text; Spence, *Narrative Truth* at 86-99 (cited in note 24) (discussing how transference can influence the patient's recall).

138. Numerous textbooks have been written on hypnotic techniques recommended for clinical memory work. See, for example, Edelstein, *Trauma* (cited in note 102). Standard hypnotic techniques used in clinical memory work include the following: hypnotic regression (in which the therapist regresses the subject back in time to the age or period when the event to be remembered took place); affect bridge (in which the therapist regresses the patient back in time to the period when the patient first felt the emotions or symptoms that are now troubling the patient); automatic writing (in which the patient engages in writing her unconscious thoughts while performing some other activity); and television technique (in which tbe patient projects the memory experience onto an imaginary television screen). Id. at 49-64. For a survey of hypnotic techniques recommended for forensic use, see Udolf, *Forensic Hypnosis* at 39-58 (cited in note 6).

event could be reconstructed in court exactly as it happened. To accomplish this, he would have scrupulously avoided giving any cues that might have been interpreted as directing Mary's memories.[139] As a clinician, Dr. Jones was concerned with Mary's treatment interests. The past that is important in therapy is not the same past that is the focus of legal proceedings. Clinicians care less about obtaining a perfect picture of the actual events that happened to their patients than about understanding their patients' subjective impressions of the past. Childhood experiences can never be recaptured in their pure original form decades later in adult psychotherapies. Clinicians are concerned with their patients' internal perceptions of childhood, not whether past events happened exactly as their patients remember.[140] Because the past has a different meaning in therapy, clinicians are often less guarded about the dialogue that takes place during hypnotic therapy sessions.[141]

The intensity of the empathic bond between the hypnotist and subject is a second characteristic that distinguishes forensic and clinical hypnotists. Forensic interviewers maintain a safe emotional distance from the subject, which permits them to lead with their heads rather than their hearts. Clinicians, on the other hand, usually find detachment more difficult and, consequently, run a greater risk of overstepping the boundaries of interviewing neutrality. Clinicians may become so involved in resonating to the patient's inner needs that their inter-

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139. For a discussion of forensically approved interviewing technique, see Udolf, *Forensic Hypnosis* at 35-58; Orne, *Hypnotically Induced Testimony*, in *Eyewitness Testimony* at 204-10 (cited in note 6).

140. See, for example, Spence, *Narrative Truth* at 21-33, 175-214 (cited in note 24); Udolf, *Forensic Hypnosis* at 33-34 (cited in note 6); Diamond, 68 Cal. L. Rev. at 328 (cited in note 14); Orne, *Reconstructing Memory Through Hypnosis*, in *Hypnosis and Memory* at 52-54 (cited in note 12).

141. Psychotherapists who do not engage in forensic work rarely have special training in forensic technique. Ignorance of the potential of hypnosis to change memory may also be a factor in the more relaxed clinical style. However, clinical literature is beginning to caution hypnotherapists about the legal ramifications of hypnosis and to recommend integrating specified forensic procedural safeguards into hypnotic therapy sessions. See, for example, Shefiin and Sbapiro, *Trance on Trial* at 12-18 (cited in note 9); Spiegel, 12 Psychiatric Clinics of N. America at 303 (cited in note 73). Psychiatrist Dr. David Spiegel, a recognized leader in both clinical and forensic hypnosis, warns that "it is almost inevitable that attorneys will raise the possibility" of hypnotic contamination resulting from the practices of psychotherapy. Id. While he laments that "certain legal precedents have come to essentially interfere with hypnosis in treating victims of sexual abuse," and maintains that courts have exaggerated the dangers from hypnosis, Spiegel grudgingly recommends that hypnotherapists videotape all contacts with sexual abuse patients and conduct their interviews in a neutral fashion, without introducing or intruding information. Id. Part VII of this Article disagrees with Dr. Spiegel's recommendation to videotape psychotherapy sessions. Many patients will find it difficult to discuss their most intimate thoughts while being videotaped. Taping may cause preoccupation and worries about privacy and confidentiality. See notes 325-26 and accompanying text.

ventions become automatic rather than carefully planned.[142] As a result, leading questions and suggestions can readily slip into a hypnotic therapy session without the clinician's conscious awareness.

Had a forensic hypnotist interviewed Mary Smith, he would not have: (1) revealed his expectations before the session about the information he expected to uncover; (2) told Mary that her mind had stored memories of everything that happened to her;[143] (3) asked leading questions;[144] or (4) suggested that Mary Smith use her imagination and pretend that her memories were a documentary that she was watching on a television screen.[145] Rarely is anyone besides the psychotherapist and the patient present during hypnotherapy sessions. However, because clinicians engaged in patient practice rarely have forensic training, therapy sessions like that conducted by Dr. Jones may be fairly common.[146]

The fact that Dr. Jones's interviewing techniques may have been slack by forensic standards does not mean courts should disqualify Mary Smith from testifying. This article will offer five separate reasons why Mary should be allowed to testify even if courts disapprove of Dr. Jones's interviewing style. One reason is that Mary's memories related to an intensely traumatic personal experience that she had a lengthy opportunity to observe, and to observe accurately, before her memory impressions were stored. The line that the legal system has drawn between waking state and hypnotic interviews is a crude method for safeguarding memory integrity. Some memories are made of durable materials and are more resistant to change under hypnosis than others are in waking state interviews.[147] Memories of traumatic autobiographi-

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142. See, for example, Spiegel, *Hypnosis*, in *Textbook of Psychiatry* at 908 (cited in note 9).

143. For forensic objections to the use of metaphors suggesting that the mind works like a tape recorder with subjects who are about to undergo hypnosis, see sources cited in note 6.

144. For a discussion of the hazards of leading questions during hypnotic interviews, see sources cited in note 12.

145. For forensic objections to this technique, see sources cited in note 9 and accompanying text.

146. See, for example, Michael D. Yapko, *Trancework: Introduction to the Practice of Clinical Hypnosis* 256 (2d ed. 1989). The hazards of memory alteration during psychotherapy, however, are not unique to hypnotic therapies. Psychotherapists have no perfect ways to restore memory. The techniques available in talking psychotherapies for recovering repressed and dissociated memories are less exact than hypnosis. Moreover, the risks of memory transformation during the course of psychotherapy are equally present. Parts VI and VII argue that disqualifying plaintiffs who have undergone hypnosis will impoverish psychotherapy without improving the quality of the testimony that plaintiffs who have suffered pathological memory blocks will be able to provide in support of their claims.

147. Experimental memory psychologists have proven that eyewitness perception and memory are highly unreliable. Eyewitness testimony can suffer from shortcomings resulting from incorrect perception at the input stage, internal revisions during the storage phase, and contamination during the retrieval stage. See, for example, notes 188-98 and accompanying text. Both the legal and experimental memory psychology literatures have commented extensively on this problem. See, for example, Loftus, *Eyewitness Testimony* (cited in note 137); Elizabeth F. Loftus and

cal events are different from other memories. Horror creates a picture that stands out in memory. Though repression and dissociation can maintain this picture beyond conscious viewing, the picture is securely anchored. When impressions are securely anchored, hypnotic interviewing techniques have much less influence on memory.[148] If Mary Smith was, in fact, molested by her uncle, nothing Dr. Jones said or did is likely to have changed her memory.

The much more important question for courts to ask is whether hypnosis can create sexual abuse memories in subjects who have never experienced abuse. Research experiments have shown that the vast majority of subjects who experience hypnosis lack imaginative capacities that are rich enough to accept memory transplants during hypnosis and to carry them as memories into waking state.[149] Experimental attempts to engraft false autobiographical memories have succeeded only with a small and readily identifiable segment of the population—the highly hypnotizable.[150]

Hypnotizability is a stable trait that can be measured. Because persons who are at risk of confabulating sexual abuse under hypnosis are readily identifiable, the legal system has alternatives for managing this risk short of excluding the testimony.[151]

James F. Doyle, *Eyewitness Testimony: Civil and Criminal* (Kluwer, 1987); Gary L. Wells and Elizabeth F. Loftus, eds., *Eyewitness Testimony: Psychological Perspectives* (Cambridge, 1984); Michael W. Mullane, *The Truthsayer and the Court: Expert Testimony on Credibility*, 43 Me. L.R. (1991); Christopher M. Walters, Comment, *Admission of Expert Testimony on Eyewitness Identification*, 73 Cal. L. Rev. 1402 (1985); Fredrick A. Woocher, Note, *Did Your Eyes Deceive You? Expert Psychological Testimony on the Unreliability of Eyewitness Identification*, 29 Stan. L. Rev. 969 (1977). The testimony of an eyewitness about the details of events observed quickly under adverse event conditions is much less reliable than Mary Smith's testimony about her traumatic childhood experiences. The line that courts have drawn between hypnotic and waking state interviews ignores memory durability. Courts should consider this factor because some memories can withstand hypnosis better than others can endure waking state interview. See Part V.C.

Despite the known shortcomings of eyewitness memory, courts have never hesitated to admit the testimony of eyewitnesses, even after attorneys have tried, and perbaps even succeeded, in corrupting their memories. See Stephen Landsman, *Reforming Adversary Procedure: A Proposal Concerning the Psychology of Memory and the Testimony of Disinterested Witnesses*, 45 U. Pitt. L. Rev. 547 (1984) (proposing adversary system reforms designed to protect disinterested eyewitnesses from memory contaminating pretrial contacts with attorneys). Courts have been content to rely on cross-examination, occasionally reinforced through cautionary instructions, see, for example, *People v. Guzman*, 47 Cal. App. 3d 380, 121 Cal. Rptr. 69 (1975), and on expert testimony educating jurors about the unreliability of eyewitness memory, see, for example, *People v. McDonald*, 690 P.2d 709 (Cal. 1984). Part V.E. argues that defendants in sexual abuse civil trials have greater resources for defending against false hypnotic memories than defendants who are falsely accused by eyewitnesses, and that, consequently, there is no need to exclude Mary Smith's testimony. See Part V.E.

148. See notes 193-210 and accompanying text.

149. See sources cited in note 219.

150. See notes 214-26 and accompanying text.

151. These alternatives are discussed in Part V.E.

V. Is Hypnotic Memory Reliable?: Conflicting Views of the Research and Clinical Communities

A. *The Relationship Between Laboratory Research Designs and the Interpretation of Hypnosis Research Findings*

The hypnosis research community has been engaged in conducting laboratory experiments testing the impact of hypnosis on memory for more than a half century.[152] In the paradigm laboratory research study, normal subjects with normal recall ability are exposed to pictures, films, and staged reenactments of violent events and accidents and are later questioned under hypnosis to test their memories. Often control groups of waking state subjects are used to make comparisons. In some studies, interviewers deliberately attempt to falsify the subjects' memories to determine whether false information will be accepted more readily under hypnosis than in waking state interviews.[153] Hypnosis laboratory researchers have never experimented with subjects suffering from pathological memory blocks; nor have they used memory information that even remotely resembles the wrenching autobiographical experiences that patients recall during hypnotherapy. The reason why hypnosis scientists have failed to investigate whether hypnosis is effective in clinical situations is that they are incapable of developing laboratory research designs that would make this type of study possible.[154]

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152. Even though research has been ongoing for many decades, there are fewer published scientific studies about the effects of hypnosis on memory than the legal system probably appreciates. According to one count, there have been no more than three dozen published scientific studies conducted during the past 50 years. Erdelyi, *Hypermnesia*, in *Hypnosis and Memory* at 66-67 (cited in note 111). While research findings have occasionally shown memory improvement, the results, on the whole, have tended to be unfavorable. See, for example, sources cited in notes 164 and 165. Given such a small pool of studies and occasional inconsistencies, the influence of hypnosis on memory may not be as clearly established as many courts presently believe.

153. See, for example, Orne, *Hypnotically Induced Testimony*, in *Eyewitness Testimony* at 183-89 (cited in note 6).

154. The need for scientific validity and reliability in memory psychology research limits what can be studied. See, for example, Eugene Winograd, *Continuities between Ecological and Laboratory Approaches to Memory*, in Ulric Neisser and Eugene Winograd, eds., *Remembering Reconsidered* 11, 11-15 (Cambridge, 1988). To determine whether the subject's memory is accurate, the experimenter must be able to verify the subject's responses. Scientific control is purchased at a premium in laboratory research. In order to control for response accuracy, laboratory experimenters are forced to test recall for materials designed in research laboratories rather than taken from the experimental subject's life memories. Id. Even experimentalists admit that laboratory research techniques have very limited ability to yield reliable information about long-term memory retention, the operation of memory in real life settings, and particularly the effects of trauma on memory. See, for example, Harry P. Bahrick, *Broader Methods and Narrower Theories for Memory Research: Comments on the Papers by Eseneck and Chermak*, in Laird S. Cermak and Fergus I. M. Craik, eds., *Levels in Processing in Human Memory* 141, 142 (Lawrence Erlbaum, 1979); William F. Battig, *The Flexibility of Human Memory*, in Laird S. Cermak and Fergus I. M. Craik, eds., *Levels in Processing in Human Memory* 23, 23-24 (Lawrence Erlbaum, 1979). To study these three matters in their relationship to each other, memory psychologists

In order to obtain scientifically reliable results, memory researchers are forced to use controlled research designs structured in ways that enable the researcher to verify whether the reported memories are accurate.[155] The need for corroborating the subject's response accuracy prevents laboratory investigators from studying whether hypnosis can reverse repression and dissociation. Researchers cannot perform experiments using patients who are suffering from traumatic memory disturbances because researchers have no way to document whether the memories retrieved under hypnosis are accurate reproductions of the original experience.

Nor can researchers solve this methodological dilemma by selecting ordinary research subjects and supplying them with the memory information on which they will be tested. Ethical constraints preclude researchers from delivering the tremendous psychological blow needed to induce research subjects to develop psychological defenses against remembering.[156] Traumatic disturbances of memory can be precipitated only by exposing subjects to extreme trauma.[157] Consequently, hypnosis investigators have been unable to study whether hypnosis is effective in clinical situations.[158] Methodological constraints have forced laboratory investigators to confine hypnosis research studies to subjects with normal recall ability and to test them for their recall of materials prepared in laboratories rather than for emotionally charged information taken from the subjects' own life experiences.[159]

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would have to abandon laboratory research methods. This would expose investigators to charges by others within their field that their findings are "unscientific." See, for example, William F. Brewer, *Memory for Randomly Sampled Autobiographical Events*, in Ulric Neisser and Eugeme Winograd, eds., *Remembering Reconsidered* 21, 23-24 (Cambridge, 1988) (criticizing the Crovitz technique for studying autobiographical memory as "unscientific"). Consequently, despite decades of laboratory investigations studying the workings of human memory, experimental knowledge about long-term memory retention, autobiographical memory operation, and the impact of trauma on memory remains relatively primitive.

155. See sources cited in note 154. See also Endel Tulving, *Episodic and Semantic Memory*, in Endel Tulvig and Wayne Donaldson, eds., *Organization of Memory* 381 (Academic, 1972) (commenting on the methodological shortcomings of contemporary research designs in yielding reliable information about long-term memory and memory in real life).

156. See, for example, Loftus and Doyle, *Eyewitness Testimony: Civil and Criminal* at 50 (cited in note 147).

157. For a discussion of repression and dissociation, see Part III.

158. The clinical community is handicapped in similar ways from demonstrating that hypnotic therapy techniques reinstate accurate patient memory. Except in rare cases in which the perpetrator confesses or other members of the family come forward, the therapist must rely on clinical "fit" to evaluate the accuracy of patient memories. For clinical means of evaluating whether sexual abuse memories "fit" and, consequently, are likely to be accurate, see notes 240-46 and accompanying text.

159. Experimental designs used in hypnosis laboratory research vary in their degree of sophistication. See generally, Erdelyi, *Hypermnesia*, in *Hypnosis and Memory* at 66-67 (cited in note 111) (summarizing research designs used in all published studies); Orne, *Hypnotically In-*

There have been numerous published research studies about the impact of hypnosis on memory.[160] Although these studies provide a wealth of information about hypnosis, the relevance of this information to issues within the legal system is circumscribed by research design. Scientific inferences about the workings of hypnosis on memory are permissible only if the research designs used in the experiment approximate the real-life situations to which the research findings are applied. Research studies in which experimental subjects are questioned under hypnosis about filmed and staged accidents and violent events replicate eyewitness situations. Standard research designs offer worthwhile insights into the influence of hypnosis on the memory of eyewitnesses for the details of passing events. The hypnosis research community's scientific literature served the legal system well when courts were faced with forensic uses of hypnosis to refresh eyewitness testimony. However, current laboratory research designs do not allow for meaningful generalization about the workings of hypnosis in clinical situations.

This Article is not the first to reach this conclusion. In 1986, the American Medical Association Council on Scientific Affairs appointed a panel to review the scientific literature and to evaluate the use of hypnosis to refresh memory. This panel was chaired by Dr. Martin Orne, who is probably the nation's foremost critic of hypnosis. After studying this matter, the panel concluded that "the current literature does not support the use of hypnosis on casual or moderately involved witnesses."[161] The panel report, nevertheless, incorporated a note of caution. The report stated that existing laboratory research findings do not provide definitive answers about the workings of hypnosis in clinical situations.[162]

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duced Testimony, in *Eyewitness Testimony* at 183-89 (cited in note 6) (describing typical designs). Some research designs, such as those that test memory for word-pairs, nonsense syllables, and number sequences, are irrelevant to the workings of hypnosis in any real life situations. Experiments using stimulus materials devoid of inherent or contextual meaning uniformly show that hypnosis is incapable of improving memory. See, for example, Erdelyi, *Hypermnesia*, in *Hypnosis and Memory* at 64-68; Orne, *Reconstructing Memory Through Hypnosis*, in *Hypnosis and Memory* at 34-36 (cited in note 12). Experiments testing the effects of hypnosis in meaningful stimulus information, such as poems, pictures, stories, and films, have produced more varied findings. See, for example, Erdelyi, *Hypermnesia*, in *Hypnosis and Memory* at 64-69. Nevertheless, even for meaningful stimuli, research findings, on the whole, have not been favorable. See notes 163-66 and accompanying text.

160. See Erdelyi, *Hypermnesia*, in *Hypnosis and Memory* at 66-67 (summarizing findings from all published studies).

161. American Medical Association, 34 Int'l J. Clinical & Experimental Hyponosis at 6 (cited in note 9).

162. Id. at 6. The panel emphasized that "generalization from the laboratory to the real world depends on the degree to which the laboratory situation accurately represents the field situation." Id. After recognizing the shortfalls in experimental research designs, the panel concluded: "With respect to cases where there is a preexisting psychopathology and/or extreme emotional

B. Can Hypnosis Improve Memory Functioning?

There is little evidence that hypnosis increases memory functioning for subjects with normal recall ability.[163] While laboratory experiments have not conclusively disproven the existence of memory enhancing powers,[164] the general picture that emerges from laboratory research

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trauma, the current experimental literature is not definitive." Id.

Professor Alan Scheflin and psychologist Dr. Jerrold Shapiro have voiced similar misgivings about the relevance of experimental literature to clinical situations. They express the following view:

> [L]aboratory studies . . . are not . . . indicative of how memory or hypnosis works in the clinical setting. The laboratory cannot duplicate the real emotional anguish of victims, nor can it duplicate the motivational factors leading a person to recall vital fact. . . . [T]he global amnesia following traumatic events, and the clinical treatment of this amnesia with hypnosis, cannot be replicated in experimental settings in university laboratories.

Scheflin and Shapiro, *Trance on Trial* at 96 (cited in note 9).

163. Although some studies have shown that hypnosis is capable of improving memory, see, for example, Gordon L. Stager and Richard M. Lundy, *Hypnosis and the Learning and Recall of Visually Presented Materials*, 33 Int'l J. Clinical & Experimental Hypnosis 27 (1985), the most common finding is that hypnosis increases the subject's memory productivity at the expense of a decline in memory accuracy. See, for example, Orne, *Reconstructing Memory Through Hypnosis*, in *Hypnosis and Memory* at 34-44 (cited in note 12) (summarizing research findings). The inverse relationship between memory productivity and memory accuracy that numerous studies have shown has convinced many hypnosis researchers that hypnosis lacks memory enhancing powers. Hypnosis merely *appears* to improve memory because it increases memory output. In reality, however, hypnosis increases output by reducing critical judgment and causes subjects to guess more often about uncertain memories than they would in a normal waking state. See, for example, Erdelyi, *Hypermnesia*, in *Hypnosis and Memory* at 64-83 (cited in note 111); Orne, *Reconstructing Memory Through Hypnosis*, in *Hypnosis and Memory* at 21-44 (speculating on possible mechanisms of hypnotic memory enhancement but concluding tbat research findings fail to confirm that hypnosis improves memory).

164. While experimental findings on the ability of hypnosis to improve memory are mixed, the overall picture is pessimistic. For a sampling of research findings, see Erdelyi, *Hypermnesia*, in *Hypnosis and Memory* (cited in note 111) (finding that hypnosis increases memory response productivity by reducing the subject's critical judgment and making the subject more willing to guess; concluding that waking concentration is superior to hypnosis); Griffin, *Hypnosis: Toward a Logical Approach in Using Hypnosis in Law Enforcement Agencies*, 8 J. Pol. Sci. & Admin. 385 (1985) (finding that hypnosis significantly enhances memory and that hypnotized subjects do not confabulate more than nonhypnotized subjects); Putnam, 27 Int'l J. Clinical & Experimental Hypnosis at 437 (cited in note 12) (finding that hypnotized subjects are more vulnerable to leading questions than waking-state subjects); Peter W. Sheehan, *Confidence, Memory, and Hypnosis*, in Helen M. Pettinati, ed., *Hypnosis and Memory* 95 (Guilford, 1988) (finding that hypnosis causes subjects to experience higher levels of confidence in memory accuracy); Howard W. Timm, *An Examination of the Effects of Forensic Hypnosis*, in David Waxman, et al., eds., *Modern Trends in Hypnosis* 327 (Plenum, 1985) (finding that hypnosis offers neither substantial advantages nor disadvantages over standard guided memory assistance procedures); Graham F. Wagstaff, *Hypnosis and the Law: The Role of Induction in Witness Recall*, in David Waxman, et al., eds., *Modern Trends in Hypnosis* 345, 346 (Plenum, 1985) (finding that hypnosis lacks any special advantage in enhancing memory when there are no psychological factors responsible for forgetting; concluding that for normal subjects, hypnosis works no better than motivated waking-state concentration); Mark Zelig and William B. Beidleman, *The Investigative Use of Hypnosis: A Word of Caution*, 29 Int'l J. Clinical & Experimental Hypnosis 401 (1981) (finding that hypnotized subjects are more likely to capitulate to leading questions). For summarizing articles, see American Medical Association, 34

studies is that hypnosis cannot assist normal subjects in transcending powers of waking-state memory.[165] Actually, many hypnosis researchers believe that hypnosis increases memory productivity, at the expense of memory accuracy, by inducing hypnotic subjects to place confidence in vague images that they would regard as too uncertain to treat as memories in normal waking states.[166]

The clinical literature paints a different picture of hypnosis. Clinical journals and textbooks abound with case histories of spectacular memory successes.[167] Even though patient self-reports about their childhoods are rarely subject to outside corroboration, clinicians have their own methods for validating memories. If the patient's memories are vivid, detailed, and intensely real to the patient and if the experiences remembered match the patient's clinical profile and explain the patient's symptoms and behaviors, the patient's experiences are treated as clinically validated.[168] Some memories fit like tailor-made gloves and provide meaning and explanation for a whole cluster of symptoms, atti-

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Int'l J. Clinical & Experimental Hypnosis at 1 (cited in note 9); Orne, *Hypnotically Induced Testimony*, in *Eyewitness Testimony* at 171 (cited in note 6); Orne, *Reconstructing Memory Through Hypnosis*, in *Hypnosis and Memory* at 21 (cited in note 12).

165. The following quotation summarizes the prevailing view of hypnosis researchers concerning the ability of hypnosis to improve the memory of normal subjects:

> It seems most unlikely . . . that hypnosis revives traces of the original perception and typically facilitates vivid access to the original stimulus material, or routinely allows [subjects] to pay selective attention to the material to be remembered, thereby increasing the probability of accurate recall. But it is possible, at least as far as recall is concerned, that memories retrieved in hypnosis are more inaccurate because they are constructive products of hypnotized [subjects'] imaginative capacities at work.

Sheehan and Tilden, 34 Int'l J. Clinical & Experimental Hypnosis at 132 (cited in note 12). For summarizing articles, see *American Medical Association*, 34 Int'l J. Clinical & Experimental Hypnosis at 1; Orne, *Hypnotically Induced Testimony*, in *Eyewitness Testimony* at 171 (cited in note 6); Orne, *Reconstructing Memory Through Hypnosis*, in *Hypnosis and Memory* at 21.

166. See sources cited in note 163.

167. See, for example, Joel O. Brende and Bryce S. Benedict, *The Vietnam Combat Delayed Stress Response Syndrome: Hypnotherapy of "Dissociative Symptoms"*, 23 Am. J. Clinical Hypnosis 34 (1980); Friederich, 39 Int'l. J. Clinical & Experimental Hypnosis at 67 (cited in note 91); Miller, 34 Int'l. J. Clinical & Experimental Hypnosis at 13 (cited in note 91); Spiegel, 12 Psychiatric Clinics of N. America at 295 (cited in note 73). See also sources cited in note 107.

168. The following passage illustrates the clinical approach used to evaluate the authenticity of a patient's hypnotic memories of childhood sexual abuse. Referring to several previously discussed case reports, one clinical observer writes:

> It is difficult to conceive that they made it all up, that it was an exercise of their creative imaginations which came about because they were "hypersuggestible." Through the employment of hypnosis the patients were able to present convincing causal connections between their various symptoms and earlier, traumatic experiences, often taken from early childhood. The connections revealed a precise, detailed, and convincing set of circumstances, and the symptoms have specific meaning which becomes transparently clear when the etiology is known.

Moss, *Dreams, Images, and Fantasy* at 287 (cited in note 118). See also notes 240-46 and accompanying text.

tudes, moods, and behaviors that are otherwise perplexing.

If the courts demand stronger proof that the memories recovered by patients during hypnotherapy are the same memories that they lost in childhood, this proof will rarely be forthcoming.[169] The same methodological problems that have prevented laboratory researchers from studying the workings of hypnosis in clinical situations have hindered the clinical community from establishing, other than by happenstance, that the memories which patients recover under hypnosis are faithful reproductions of childhood experiences. However, clinicians who watch the genuine suffering and anguish their patients experience when recounting wrenching childhood memories, memories that make logical sense out of many aspects of their troubled lives, cannot fathom that these memories could be generated by the patients' imaginations or by their own technical errors.

Though the scientific and clinical literature report different experiences with hypnosis, their accounts are not in conflict. Both communities may be drawing accurate conclusions based on what they are seeing; they simply may be observing different occurrences. The reasons

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169. While memory research psychologists and clinicians both study memory, they investigate distinct aspects of memory, use different investigative techniques, and speak entirely different languages. Clinicians focus on psychological causes of memory pathology and have acquired their knowledge about these matters through studying and reporting individual cases arising in clinical practice. Memory research psychologists, on the other hand, have acquired their knowledge about memory through controlled research studies conducted in university memory laboratories. See notes 152-59 and accompanying text. Because experimental researchers cannot reproduce repression and dissociation in research laboratories, experimental investigators have almost exclusively studied normal memory. Repression and dissociation are not part of an experimentalist's lexicon.

There has been virtually no cross-fertilization or mutual sbaring of ideas between these two scientific fields. See, for example, Daniel L. Schacter and Endel Tulving, *Amnesia and Memory Reserarch*, in Laird S. Cermak, ed., *Human Memory and Amnesia* 1, 1-2 (Lawrence Erlbaum, 1982). Clinicians and experimental researchers neither read each other's literature nor accept each other's theories. Id. Experimental researcbers tend to discount claimed clinical successes in restoring lost traumatic memories as anecdotal, unproven, and based on "unscientific" clinical investigative techniques. See, for example, Orne, *Hypnotically Induced Testimony*, in *Eyewitness Testimony* at 180 (cited in note 6); Orne, *Reconstructing Memory Through Hypnosis*, in *Hypnosis and Memory* at 48 (cited in note 12). Clinicians, in turn, tend to dismiss experimental findings that memory is reconstructive rather than reproductive as inconsistent with their own clinical observations in patient treatment. See, for example, Schacter and Tulving, *Amnesia*, in *Human Memory and Amnesia* at 2. Scientists from these two memory fields have never debated their opposing views in tbe courtroom. However, childhood sexual abuse claims will pit experts from these two fields against each other. Because the research community has not studied the impact of childhood sexual abuse or any other major trauma on memory or the impact of hypnosis on subjects who have been traumatized, experimentalist testimony about the unreliability of memory may bear little relevance to the trustworthiness of memories restored in psychotherapy. See sources cited in notes 154, 161-62. Tbe clinical community, on the other hand, has practical experience with these problems but lacks hard proof that memories restored through therapeutic hypnosis are accurate. Consequently, the "ideal" expert witness who possesses both experience with psycbological memory problems and hard proof to validate an expert opinion does not exist.

why a subject lacks recall of an experienced event may hold the answer to whether hypnosis can aid memory. When no pathological obstructions exist, normal memory retrieval processes probably work at maximum efficiency under conditions of intense waking concentration.[170] Hypnosis may be incapable of improving normal memory functioning. However, when trauma obstructs memory functioning, hypnotic relaxation, alterations of mood, intensification of concentration, and reinstatement of a mental context similar to the one existing when the information was encoded may be able to break down psychological defenses that hinder the normal retrieval mechanisms of memory.[171] As a result, hypnosis may work in clinical situations in ways that hypnosis laboratory researchers have been unable to observe.

Knowledge of how the mind processes information sheds added light on why hypnosis researchers have been unable to replicate clinical memory successes. There are three phases of memory informational processing: (1) the input phase, when information is registered and stored in short-term memory, (2) the long-term storage phase, and (3) the retrieval phase, when information is brought back into conscious awareness.[172] Malfunctioning during any of these three phases can make information unavailable for later recall.

The failure to attend to, register, and store stimulus information during the initial phase of memory is probably the most common cause for recall failure.[173] No matter how sharp one's powers of observation are, it is impossible for any observer to register and absorb all the sensory information that is part of human experience. Memory registration is selective; only bits and pieces of experience are actively recorded.[174] The rest of experience is filtered out and never becomes a part of memory. After sensory registration takes place, memory information is stored briefly in short-term (conscious) memory before it is later transferred to long-term (permanent) memory. Most sensory input registered in short-term memory never makes it into long-term memory. It is discarded within a few seconds in order to make room for new input.[175] Hypnosis has no power to restore nonexistent memories about matters that the person had an opportunity to observe but never registered or memories momentarily registered and immediately discarded as insuffi-

170. See, for example, Udolf, *Forensic Hypnosis* at 33 (cited in note 6).

171. For theories explaining the power of hypnosis to penetrate pathological memory barriers, see notes 115-124 and accompanying text.

172. See, for example, Loftus, *Eyewitness Testimony* at 22 (cited in note 137); Elizabeth F. Loftus, *Memory* 13-33 (1988); Udolf, *Forensic Hypnosis* at 27.

173. See, for example, Loftus, *Memory* at 74-76.

174. See, for example, Loftus, *Eyewitness Testimony* at 21-51; Udolf, *Forensic Hypnosis* at 23.

175. See, for example, Udolf, *Forensic Hypnosis* at 23-26.

ciently meaningful to warrant transferring to permanent memory.[176] Only if needed information has entered long-term memory storage does hypnosis hold forth any possibility of reviving memory. As time passes, however, memory traces tend to weaken and decay.[177] The rate of decay, nevertheless, varies with the distinctiveness of the memory traces and the depth at which the information has been processed in the memory.[178] This explains why memory for intensely significant, distinctive life events tends to decay less rapidly than memory for other information.[179]

Memory retrieval mechanisms are activated when stimulus information and contextual cues received in the present correspond to, match, or evoke attributes of the information previously stored in memory.[180] In order for successful remembering to occur (*i.e.*, for past information to be brought back into conscious awareness), the mind must register the stimulus materials and then locate and access the appropriate memory traces.[181] Hypnosis researchers have speculated about, but

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176. See, for example, id. at 27.

177. See, for example, Larry L. Jacoby and Fergus I. M. Craik, *Effects of Elaboration of Processing at Encoding and Retrieval: Trace Distinctiveness and Recovery of Initial Context*, in Laird S. Cermak and Fergus I. M. Craik, eds., *Levels in Processing in Human Memory* 1 (Lawrence Erlbaum, 1979).

178. Many memory theorists rely on the "levels-of-processing theory" to explain differences in memory retention for different information. See, for example, Jacoby and Craik, *Effects of Elaboration*, in *Levels in Processing in Human Memory* (cited in note 177); Endel Tulving, *Relation Between Encoding Specificity and Levels of Processing*, in Laird S. Cermak and Fergus I. M. Craik, eds., *Levels in Processing in Human Memory* (Lawrence Erlbaum, 1979). According to levels-of-processing theorists, memory retention is a function of the depth and distinctiveness with which the information has been processed in memory. See, for example, id. at 1, 5-7. Meaningful, distinctive memory events are more deeply processed in memory and leave more lasting and durable memory traces. These traces are less likely to decay over time and, being more distinctive, are more accessible to the retrieval mechanisms of memory. See, for example, Jacoby and Craik, *Effects of Elaboration*, in *Levels in Processing in Human Memory* at 5-7; Tulving, *Relation*, in *Levels in Processing in Human Memory*. Consequently, distinctive and meaningful events are easier to remember. Few events are more profoundly meaningful than childhood sexual abuse. See, for example, notes 203-10 and accompanying text. As a result, it seems unlikely that childhood sexual abuse experiences can ever be permanently forgotten. While repression and dissociation may suppress retrieval mechanisms of memory, the underlying memory traces are likely to remain relatively intact and accessible through hypnosis.

179. See sources cited in note 178.

180. See, for example, Norman E. Spear, *The Processing of Memories: Forgetting and Retention* 50-51 (Lawarence Erlbaum, 1978).

181. If hypnosis influences memory, it does so by acting on retrieval mechanisms. When retrieval mechanisms are obstructed by psychological influences, the ability of hypnosis to influence memory is explainable. See, for example, notes 115-25 and accompanying text. When retrieval mechanisms are unobstructed and waking concentration attempts at remembering have proven ineffective, theories to explain the influence of hypnosis on retrieval mechanisms are harder to identify. For speculation about the possible interaction between hypnosis and the retrieval mechanisms of memory, see Orne, *Reconstructing Memory Through Hypnosis*, in *Hypnosis and Memory* at 25-31 (cited in note 12).

have been unable to pinpoint, properties associated with hypnosis that would cause it to amplify the normal retrieval mechanisms of memory.[182] When memory information remains unavailable after concentrated efforts at waking recall and psychological reasons cannot account for the recall failure, it is likely that the information was never registered or, if it was registered, that it no longer exists in long-term memory storage.[183] Negative research findings on the ability of hypnosis to improve memory may reflect little more than the absence of information about the matters tested upon.

Examination of standard research designs used in hypnosis laboratory investigations suggests that input and storage failures may be largely responsible for the lack of success in improving memory functioning in hypnosis experiments.[184] In the paradigm study, research subjects with normal recall ability are tested under hypnosis about memory for the peripheral details of complex events they have observed fleetingly.[185] The information that hypnotic research subjects are questioned about is the type of information that is least likely to have been clearly fixed in memory and most likely to deteriorate rapidly.[186] Lack of memory for matters questioned about may be a major contributor both to the retrieval failures and the reconstructive errors reported in the hypnosis experimental literature.[187] The use of hypnosis to improve eyewitness memory for details that were not attended may be like drilling in an empty oil well. All that can be recovered is rocks and salt water. When wells are full, however, the same explorations have the potential for yielding oil.

C. Can Hypnosis Change Memory?

Incorporation of suggestion and intrusions of fantasy on memory do not occur only when people are hypnotized. They are normal aspects of human memory.[188] When events are photographed with a camera, the

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182. See discussion in note 181.

183. See notes 172-82 and accompanying text.

184. For a description of the standard research designs used in hypnosis laboratory experiments and the relevance of research design to the interpretation of research findings, see notes 152-162 and accompanying text.

185. See notes 152-62 and accompanying text.

186. See notes 172-83, 188-98 and accompanying text.

187. See notes 188-98 and accompanying text.

188. Dr. Elizabeth Loftus is known for her research on the imperfections of eyewitness perception and memory. Her research findings have highlighted the numerous predictable ways in which eyewitness memory can become distorted, even during waking states, through the incorporation of new information from without and through spontaneous reconstructions from within. Dr. Loftus has published numerous articles and books discussing her research findings. For information about her research findings and those of other investigators in this field, see Loftus, *Eyewitness Testimony* (cited in note 137); Loftus, *Memory* (cited in note 172); Loftus and Doyle,

images are permanently fixed, and even though pictures may fade with time, the images do not change. Human memory does not work this way. Memory pictures can undergo active change through processes that operate outside of conscious awareness.[189] Problems of memory instability exist both under hypnosis and in normal waking states.[190] However, hypnosis aggravates the normal reconstructive tendencies of memory.[191] During hypnosis, subjects tend to be more suggestible and

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Eyewitness Testimony: Civil and Criminal (cited in note 147); Wells and Loftus, eds., *Eyewitness Testimony: Psychological Perspectives* (cited in note 147); Elizabeth F. Loftus, *Remembering Recent Experiences*, in Laird S. Cermak, ed., *Human Memory and Anmesia* 230 (Lawrence Erlbaum, 1982).

189. For a description of the numerous ways memory transformations can occur during storage and retrieval phases of memory, see Loftus, *Eyewitness Testimony* at 53-133 (cited in note 137); Loftus, *Memory*, at 35-50 (cited in note 172); Loftus and Doyle, *Eyewitness Testimony: Civil and Criminal* at 67-94 (cited in note 147).

190. The influences that cause memory distortions and revisions can come from sources inside or outside the rememberer's mind. New information acquired after an event can radically change a person's original perception so that subsequent memory bears little resemblance to the past experience. See, for example, Loftus, *Eyewitness Testimony* at 54-87 (cited in note 137); Loftus, *Memory* at 38-45 (cited in note 172); Loftus and Doyle, *Eyewitness Testimony: Civil and Criminal* at 75-82 (cited in note 147). The perception of an event that was originally stored in memory can be unconsciously altered through the assimilation of new information from watching television, reading newspaper accounts, overhearing conversations, and discussing the events with others. See, for example, Loftus, *Eyewitness Testimony* at 54-55. Memory, moreover, is extremely sensitive to influences that occur during the retrieval phase. See, for example, id. at 88-109; Loftus and Doyle, *Eyewitness Testimony: Civil and Criminal* at 75-78. Factors as subtle as the wording of questions or the identity of the questioner can alter the content of memory. See, for example, Loftus, *Eyewitness Testimony* at 55-62, 90-99; Loftus and Doyle, *Eyewitness Testimony: Civil and Criminal* at 75-78. Dr. Elizabeth Loftus demonstrated in one of her experiments how the word "smash" could create memories of a much more serious automobile accident than the word "hit" when used in questioning experimental subjects about a film they had seen. "Smash" produced higher estimates of speed and vivid memories of nonexistent glass at the accident scene. Loftus, *Eyewitness Testimony* at 77-78, 95-97; Loftus and Doyle, *Eyewitness Testimony: Civil and Criminal* at 75-78.

Internal influences can also cause memory slippage. See, for example, Loftus, *Memory* at 134-47; Loftus, *Eyewitness Testimony* at 78-86; Loftus and Doyle, *Eyewitness Testimony: Civil and Criminal* at 83-85. Human memory has a natural tendency to account for missing information by supplying the missing details from the subject's general store of life experiences or from logical deductions about what the missing information ought to be. See, for example, Loftus, *Eyewitness Testimony* at 78-87. The process of internal self-elaboration on memory is called "confabulation" and is a normal part of all human mental behavior. Id. Unconscious psychological influences can also cause internal self-distortions of memory. Even in waking states, unconscious drives, wishes, fantasies, and thoughts can intrude upon and color memory. See, for example, Loftus and Doyle, *Eyewitness Testimony: Civil and Criminal* at 83-84. A common example of internal self-distortion of memory is the tendency of most people to slant the past with wishful thinking by remembering themselves in a better light and recalling their contributions to past events as more important than they actually were. Id. Moreover, people in waking states can sometimes mistake things they have imagined for things that have happened to them. See, for example, Kenneth S. Bowers and Ernest R. Hilgard, *Some Complexities in Understanding Memory*, in Helen M. Petinatti, ed., *Hypnosis and Memory* 3, 5-12 (Guilford, 1988).

191. See, for example, Perry, *Hypnotic Age Regression*, in *Hypnosis and Memory* at 128 (cited in note 9) (finding that hypnotic age regression increases tendencies to confabulate); Put-

more imaginative. Thus, they are more willing to adjust their memory pictures by adding or substituting details suggested by the hypnotist or by touching up the picture through internal self-elaboration on memory.[192]

While memory pictures are never completely anchored, some are shot with finer lenses and are more securely anchored than others.[193] Memory restructuring occurs most often, both inside and outside of hypnosis, when a person's original impressions about an event are vague.[194] Memory psychology research suggests numerous reasons why memory for childhood sexual abuse should hold up better under hypnosis than memory for the information that subjects are tested about in hypnosis laboratory experiments. The complexity of an event and the conditions under which the event is experienced have a direct influence on the accuracy and permanence of the picture originally stored in memory.[195] Standard hypnosis experiments test hypnosis under eyewitness event conditions in which memory, even in waking states, functions very poorly.[196] The receipt of too much sensory information in a brief interval causes stimulus overload with the result that details may be misperceived or not attended.[197] Because eyewitness memory pictures are usually shot in haste, the images tend to be blurry. Informa-

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nam, 27 Int'l. J. Clinical & Experimental Hypnosis at 437 (cited in note 12) (finding that hypnotic subjects respond less accurately to leading questions than subjects in normal waking states). But see, for example, Sheehan, *Confidence*, in *Hypnosis and Memory* at 99 (cited in note 164) ("Evidence on the whole has been against, rather than in support of, the hypothesis that hypnosis generally creates inherent distortion in memory.") For the views of Dr. Martin Orne and the late Dr. Bernard Diamond, two of the most outspoken critics of forensic hypnosis, see Diamond, 68 Cal. L. Rev. at 333-37 (cited in note 14); Orne, *Hypnotically Induced Testimony*, in *Eyewitness Testimony* at 173-92 (cited in note 6); Orne, *Reconstructing Memory Through Hypnosis*, in *Hypnosis and Memory* at 23-25, 44-46 (cited in note 12).

192. See, for example, sources cited in note 191.

193. Studies show that when people's memory images are sharp and clear, they tend to resist attempts to change their memories. See, for example, Loftus, *Eyewitness Testimony* at 124-28 (cited in note 137). Memory is invariably sharper for the main themes of events than for the peripheral details. See sources cited in notes 194 and 198. The most durable of all memories, however, are those relating to emotionally charged personal experiences. See notes 203-10 and accompanying text.

194. See, for example, Loftus, *Eyewitness Testimony* (cited in note 137); Loftus, *Remembering Recent Events*, in *Human Memory and Amnesia* at 249-54 (cited in note 188) (finding that waking state subjects with vague recollections about an event are more susceptible to suggestion); Sheehan and Tilden, 34 Int'l J. Clinical & Experimental Hypnosis at 123 (cited in note 12) (finding that highly hypnotizable subjects err more often than others on questions relating to peripheral details but not on questions relating to main themes).

195. For a discussion of event factors that influence the accuracy, clarity, and sharpness of stored memory images, see Loftus, *Eyewitness Testimony* at 23-25, 63-67 (cited in note 137); Loftus and Doyle, *Eyewitness Testimony: Civil and Criminal* at 32-43 (cited in note 147).

196. See notes 147, 197-98 and accompanying text.

197. See, for example, Loftus and Doyle, *Eyewitness Testimony: Civil and Criminal* at 45 (cited in note 147); Loftus, *Eyewitness Testimony* 247-49, 240-52, 329 (cited in note 137).

tion that has not been securely anchored in memory yields more readily to reworking during hypnosis.[198] Abused children have prolonged and often repeated opportunities to observe the events they later remember. They usually know the perpetrator. The abusive acts do not entail complex, ambiguous, or high-risk information that people tend to confuse. A child need not estimate spatial distances,[199] judge colors,[200] or catalog the facial features of strangers[201] to form a correct memory picture of sexual abuse. The event conditions under which childhood sexual abuse takes place increase the chances that the child's original memory picture was accurate.[202] A clear original picture is less likely to change over time or be influenced by hypnotic retrieval methods.

Moreover, yet another factor endows childhood sexual abuse memories with a sharpness and clarity shared by few other memories. Sexual abuse is terrifying for children. Emotional trauma has a peculiar effect on memory. It improves memory both for the fact that the event happened and for the event's central theme.[203] Fear causes a selective narrowing of attention and a fixation on the threatening features.[204] People tend to remember shocking and horrifying experiences because they are

198. Memory psychology experiments with waking state subjects show that when people have clear memory pictures, they are more resistant to memory changes. See, for example, Loftus, *Eyewitness Testimony* at 23-31, 52-54, 63-70, 124-28 (cited in note 137); Loftus and Doyle, *Eyewitness Testimony: Civil and Criminal* at 32-46 (cited in note 147). Because hypnosis merely exaggerates tendencies that exist in human memory, memory clarity should reduce vulnerability to suggestion and tendencies to confabulate during hypnosis as well. Experiments with hypnotic subjects have shown that they are more resistant to misinformation that relates to central objects and central event themes than that which relates to peripheral details. See, for example, Sheehan and Tilden, 34 Int'l. J. Clinical & Experimental Hypnosis at 128 (cited in note 12). The only explanation for this phenomena is that people tend to have clearer and sharper memory pictures of the central themes of events than of their details and that the clarity of the memory picture reduces the elasticity of their memories during hypnosis.

199. People naturally tend to remember some types of details more poorly than others. See, for example, Loftus and Doyle, *Eyewitness Testimony: Civil and Criminal* at 39-43, 95-111 (cited in note 147). People often confuse speeds, distances, and durations of events; id. at 39-41, colors of objects; id. at 41-43, and facial characteristics of strangers; id. at 95-111. See also Loftus, *Eyewitness Testimony* at 27-31 (cited in note 137). Recall of events involving high-risk memory information tends to be less reliable.

200. See sources and discussion in note 199.

201. See id.

202. For a discussion of how event conditions, such as exposure times, event frequencies, and event facts, can influence the accuracy and permanency of memory, see Loftus, *Eyewitness Testimony* at 23-31; Loftus and Doyle, *Eyewitness Testimony: Civil and Criminal* at 32-43.

203. For thorough treatment of the influence of stress and fear on memory, see Terr, *Too Scared to Cry* (cited in note 13); Loftus, *Eyewitness Testimony* at 31-36, 153-56; Loftus and Doyle, *Eyewitness Testimony: Civil and Criminal* at 43-53.

204. See, for example, Loftus, *Eyewitness Testimony* at 33-36 (cited in note 147); Loftus and Doyle, *Eyewitness Testimony: Civil and Criminal* at 50-51 (cited in note 147) ("In a highly stressful state people concentrate more on just a few features from their environment, and they consequently pay less attention to others. This selectivity of attention can be seen when people experience crimes involving weapons.").

distinctive.[205] They stand out from other life experiences. People never forget the day that their house burned down or seeing their child struck by an automobile. Even though trauma reduces memory of details,[206] memory accuracy for details will not make or break childhood sexual abuse civil cases. For children whose memory capacities have matured, trauma has the same effect.[207] Childhood horrors leave a lasting impression on children,[208] so lasting that many develop amnesic barriers to wall the terrible truths from conscious awareness.[209] If Mary Smith was

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205. See, for example, Loftus and Doyle, *Eyewitness Testimony: Civil and Criminal* at 45 (cited in note 147) ("When people try to remember personal episodes from their past, they seem to be able to recall that a highly emotional event occurred, and to recall some details that surround the event."); Craig R. Barclay and Peggy A. DeCook, *Ordinary Everyday Memories: Some of the Things of which Selves Are Made*, in Ulric Neisser and Eugene Winograd, eds., *Remembering Reconsidered* 91, 121 (Cambridge, 1988) (finding that memory for traumatic autobiographical experiences tends to be better than for less significant memory events); Brewer, *Memory for Autobiographical Events*, in *Remembering Reconsidered* at 21 (cited in note 154) (finding that autobiographical memory tends to be reasonably accurate, particularly for distinctive memories).

206. For the effect of trauma on memory for event details, see sources and discussion in notes 203-05.

207. Dr. Lenore Terr, a noted authority on the effects of trauma and sexual abuse on the psychological development of children, maintains that trauma effects the memory of children even more profoundly than the memory of adults. Terr, *Too Scared to Cry* at 7, 8, 170-71 (cited in note 13). Concerning the memory of children for traumatic experiences, Dr. Terr observes:

> The memory of trauma is shot with higher intensity light than is ordinary memory. And the film doesn't seem to disintegrate with the usual half-life of ordinary film. Only the best lenses are used, lenses that will pick up every last detail, every line, every wrinkle, and every fleck. There is more detail picked up during traumatic events than one would expect from the naked eye under ordinary circumstances.

Id. at 170.

208. See, for example, Terr, *Too Scared to Cry* at 35-37, 128-29, 171-76 (cited in note 13); Lenore C. Terr, *Childhood Traumas: An Outline and Overview*, 149 Am. J. Psychiatry 10, 12, 14 (1991). Dr. Terr believes that psychic trauma leaves an indelible mark on a child's mind, no matter how young she is when the trauma occurs. Terr, *Too Scared to Cry* at 182. She notes, however, that memory differences exist between victims of unexpected, single-incident traumas and victims of repeated and long-standing traumas. Id. at 182-83; Terr, 149 Am. J. Psychiatry at 14-18. Child victims of single traumas, in her opinion, have almost picture-perfect recall of those traumatic experiences. Terr, *Too Scared to Cry* at 171-72. "Traumatic fright is unique. And it is remembered." Id. at 37. Child victims of repeated and sustained abuse tend to have more blurred and fragmentary memories about the details of abuse incidents but not about the identity of the abusers or the acts themselves. Id. at 134-38, 182-85. Dr. Terr acknowledges, however, that memories about the details of traumatic events may change over time. Id. at 140. When buried memories are recovered years later during adult psychotherapies, the recovered memories may not be in their original form. Id. at 4. While the experiences remembered are true, the details may no longer be accurate. Adult memories of particular incidents of childhood sexual abuse sometimes represent condensations of abuse experiences that happened over an extended period of time rather than an historically correct account of the particular incident remembered. Id. Consequently, adult memories of childhood sexual abuse may be false as to the particular incident but true about what happened in childhood. Id. See also sources and discussion in note 210.

209. While repression and dissociation block traumatic memories from conscious awareness, they do not destroy the underlying memory traces. For a discussion of repression and dissociation, see Part III.

in fact molested in childhood and repressed or dissociated the memories, the risk of memory alteration during hypnosis is slight.[210] The only question for courts to ponder is whether hypnosis might implant false memories of childhood sexual abuse.

D. *Can Hypnosis Implant False Memories of Childhood Sexual Abuse?*

The memory errors that hypnotized subjects make with greater frequency in paradigm hypnosis laboratory experiments are mistakes about the details of events they *have* experienced.[211] Such mistakes could cause serious injustices when the guilt or innocence of an accused turns on the accuracy of eyewitness memory. In childhood sexual abuse civil suits, however, such errors are unlikely to compromise justice. In these suits, the trier of fact must determine the truth of the whole experience rather than the accuracy of the details. Contrary to the impression that appears to exist within the legal system, hypnosis laboratory studies have not proven that hypnosis causes massive distortion of memory.[212] Research subjects do not report rapes and muggings when shown films of automobile accidents. They make the same eyewitness memory errors that subjects make in waking state experiments,

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210. This Article does not contend that memories recovered in hypnotic (or nonhypnotic) psychotherapies reproduce childhood experiences exactly as they happened. Childhood memories recovered in adult psychotherapy are often no longer in their original form. Over time, separate memories of similar incidents may be batched together as "screen memories." Screen memories capture, combine, and condense fragmentary recollections of many similar experiences with an important childhood figure and symbolically depict these experiences in the form of a specially remembered event that may or may not have happened. See, for example, Spence, *Narrative Truth* at 57-58, 87-91 (cited in note 24); discussion in note 208. Consequently, screen memories may be true, while at the same time inaccurate. Rather than an accurate picture of some actual incident that happened in the past, screen memories represent a condensed picture of many similar incidents that the mind has merged into one composite.

211. See discussion in notes 194, 198, and 199.

212. Dr. Martin Orne and the late Dr. Bernard Diamond have played high visibility roles in shaping the attitude of the courts toward hypnosis. In their writings and court appearances, both have tended to emphasize negative research findings and to downplay positive or neutral ones. See generally, Diamond, 68 Cal. L. Rev. at 313 (cited in note 14); Orne, *Hypnotically Induced Testimony*, in *Eyewitness Testimony* at 171 (cited note 6); Orne, *Reconstructing Memory Through Hypnosis*, in *Hypnosis and Memory* at 21 (cited in note 12). As a result, a majority of state courts today take a dim view of hypnosis. See sources cited in note 303.

During the 1980s, hypnosis became a popular subject of commentary in legal literature. For a listing of some of the numerous articles that have been written about hypnotic memory refreshment, see sources cited in note 291. Each time the hypnosis story was told, the dangers seemed to grow larger. As a result of these embellishments, many courts today have the impression that hypnosis causes massive distortions of memory. Nevertheless, scientific research findings have never demonstrated that hypnosis affects most subjects this way. See, for example, Sheehan, *Confidence*, in *Hypnosis and Memory* at 99 (cited in note 164) ("Evidence on the whole has been against, rather than in support of, the hypothesis that hypnosis generally creates inherent distortion in memory reports"), and at 100 ("There is no general, pervasive distortion effect for hypnosis").

though often with greater frequency. However, research shows that hypnotized subjects remember the main themes of events no less accurately than do other subjects.[213]

The only evidence that hypnosis can implant false autobiographical memories comes from experiments with subjects who are hand-picked for their high hypnotizability. The hypnotically talented, who comprise ten to fifteen percent of the population, have spirited imaginations, vivid powers of imagery, and the capacity to set aside reality.[214] Experiments with hypnotically talented subjects prove that hypnotists can plant false autobiographical memories that will carry over into waking state.[215]

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213. See discussion in notes 194 and 198.

214. Increased memory elasticity during hypnosis results from cognitive changes that occur when people are hypnotized. See, for example, Bliss, *Multiple Personality* at 98-99 (cited in note 58); Hilgard, *Divided Consciousness* at 163-65 (cited in note 58); American Medical Association, 34 Int'l J. Clinical & Experimental Hypnosis at 3 (cited in note 9); Ganaway, *Historical Versus Narrative Truth: Clarifying the Role of Exogenous Trauma in the Etiology of MPD and its Variants*, 2 Dissociation 205, 208-09 (1989). The following cognitive changes are associated with hypnosis: (1) increased responsiveness to suggestion; (2) reduced critical judgment; (3) increased capacity for fantasy formation; and (4) diminished reality testing. Bliss, *Multiple Personality* at 98-99; Hilgard, *Divided Consciousness* at 163-65; Ganaway, 2 Dissociation at 208-09.

These cognitive alterations, nevertheless, do not occur in all subjects to the same extent. The degree of mental change experienced during hypnosis varies with individual levels of hypnotizability. See, for example, Hilgard, *Divided Consciousness* at 167-71; Hilgard, *Personality and Hypnosis* at 88, 219-24, 270-74, 285-87 (cited in note 90). No more than 10% to 15% of the population are highly hypnotizable. See, for example, Hilgard, *Divided Consciousness* at 155-62; Perry, et al., *Hypnotic Age Regression* in *Hypnosis and Memory* at 192 (cited in note 9). Only the highly hypnotizable are capable of experiencing trances at levels that are deep enough to confuse events taking place in their own minds with things that have happened. See generally, Hilgard, *Divided Consciousness* at 91-100; Ganaway, 2 Dissociation at 208-14; Laurence, et al., *Duality, Dissociation, and Memory Creation in Highly Hypnotizable Subjects*, 34 Int'l. J. Clinical & Experimental Hypnosis 295 (1986). See also Ernest R. Hilgard, *Research Advances in Hypnosis: Issues and Methods*, 35 Int'l. J. Clinical & Experimental Hypnosis 248, 249-55 (1987).

The traits of the highly hypnotizable that facilitate confusion of internal fantasy and external reality during hypnosis are part of their own personalities and do not necessarily materialize only upon a formal induction. See, for example, Bliss, *Multiple Personality* at 70, 77-81, 94-95; Hilgard, *Divided Consciousness* at 88; Powers, *Fantasy Proneness and the UFO Abduction Phenomenon*, 4 Dissociation 46, 46-48 (1991). The hypnotically talented have spirited imaginations and tend to fantasize a large part of the time. They are able to see, smell, and touch the things they fantasize. See, for example, Bliss, *Multiple Personality* 73-81; Hilgard, *Personality and Hypnosis* at 88 (cited in note 90). They have such intense powers of imagination and absorption that they are capable of assimilating fantasy memories from books, television stories, and movies, and often mistake what they have read, seen, or heard for their own experiences. See, for example, Ganaway, 2 Dissociation at 208-09. Moreover, the ability of the hypnotically talented to slip into spontaneous self-hypnotic states, without effort or awareness, makes reality testing difficult for them. See, for example, Bliss, *Multiple Personality* 78-81. Being unaware that they have slipped into a different state, they may recall experiences imagined during self-hypnotic states as genuine memories. Persons who are highly hypnotizable also tend to be impressed easily by things people tell them and are abnormally suggestible. See, for example, id. at 94-95; Hilgard, *Divided Consciousness* at 220, 224, 285-87.

215. See notes 216-18 and accompanying text.

However, even with highly hypnotizable subjects, the success rate in creating memories of events that subjects have never experienced is far from overwhelming. In the well-known Laurence, Nadon, Nogrady, and Perry experiment, which critics of forensic hypnosis often cite as evidence that hypnotic memory is dangerous, only twenty-two percent of experimental subjects selected for their high hypnotic capacities would accept a hypnotic memory transplant that they had been awakened on a particular night of the previous week by a loud bang.[216] An additional twenty-seven percent, who had previously been certain that they had slept through this night, were confused after the experiment about how well they had slept. The remaining fifty-one percent flatly rejected the attempt to alter their memory and stood by their original sleep recollections.[217] This experiment proves, at most, that it is sometimes possible to implant false autobiographical memories in subjects who are extremely hypnotizable.[218] Attempts to reproduce results like these with subjects of normal hypnotizability have not been successful.[219]

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216. Laurence, et al., 34 Int'l. J. Experimental & Clinical Hypnosis at 302-03 (cited in note 214).

217. Id.

218. In the following passage, Dr. Ernest Hilgard depicts the experience of hypnosis as seen through the eyes of the highly hypnotizable:

> When they age regress, they believe they are actually children again; they describe what happens in the present tense and do not identify the hypnotist as such. When they hallucinate, they have difficulty in distinguishing the real from the hallucinated, even when told that one of the percepts is hallucinated. They can readily add content to the suggestions of the hypnotist, as in elaborating a fantasy or describing the scenes in a hallucinated motion picture. They can perform automatic writing, composing messages or solving problems without awareness of what the dissociated hand is doing. They can carry out posthypnotic suggestions, even rather bizarre ones, without being ill at ease over what is happening.

Hilgard, *Divided Consciousness* at 160 (cited in note 58).

219. In a recent experiment conducted by Labelle, Laurence, Nadon, and Perry, attempts to implant hypnotic pseudomemories failed with all subjects who scored in the lower ranges of hypnotizability. The authors concluded that hypnotic susceptibility strongly predicts whether pseudomemories can be created by hypnosis. Louise Labelle, et al., *Hypnotizablity, Preference for an Imagic Cognitive Style, and Memory Creation in Hypnosis*, 99 J. Abnormal Psychol. 222 (1990). Stanford University professor Dr. Earnest Hilgard reports similar findings. After discussing a well-known experiment in which a hypnotic subject was induced through suggestion to continue visualizing the person seated beside him after the person had moved and to tolerate the incongruity of simultaneously visualizing the same person in two places at one time, Dr. Hilgard makes the following observation:

> This experiment works, of course, only with very highly hypnotizable subjects who cannot tell tbe hallucinated person from the real person. These hypnotic virtuosos are very rare, and experimenters who try to refute this kind of experiment by a careless selection of subjects are bound to fail. Even a very hypnotizable person may proceed with the experiment to the point of seeing the two people, carrying on conversations with both, and describing both in the same terms. But when questioned about which is real, he may very well have no difficulty in deciding, because one of the persons is diaphanous, and the back of the chair is visible "through" him.

Short of experiments with subjects selected for their hypnotic talent and occasional anecdotes about bizarre memory incidents during hypnosis,[220] there is no evidence that subjects mistake fantasized experiences for events that have happened to them. For most people, hypnosis causes only a marginal exaggeration of the normal human propensity to confabulate. The elaborations that subjects supply in hypnosis laboratory experiments are poorly remembered details of events they have actually seen. The human mind naturally tends to complete pictures by inserting what ought to be there.[221]

For the vast majority, however, elasticity of human memory has limits, even under hypnosis. It takes a luxurious imagination to endow a suggested or fantasized molestation experience with the sensory vividness and detail needed to mistake it for an actual memory.[222] Only those who can add lifelike qualities to the things they imagine are at risk of making this mistake.[223] The ability under hypnosis to experience fantasized events as real is a capacity found only among those who are highly hypnotizable.[224] The hypnotically talented have remarkable pow-

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Hilgard, *Divided Consciousness* at 99-100 (cited in note 58). The hypnotic virtuosos that Dr. Hilgard refers to in the above passage are those at the top end of the high hypnotizability range and who comprise at most five percent of the population and probably less than one percent. Id. at 158.

220. Bizarre memory experiences occasionally occur during hypnosis. Accounts exist of hypnotized subjects remembering birth, reincarnate, and future life experiences. Hypnotic experiences like these are manifestations of the subject's high hypnotizability rather than normal consequences of hypnosis. See, for example, Hilgard, *Divided Consciousness* at 49-51 (cited in note 58); Ganaway, 2 Dissociation at 208-10 (cited in note 214). People who have not undergone formal induction occasionally report identical supernatural experiences. Accounts of U.F.O. sightings, attacks by monsters from the sea, and death and rebirth experiences, probably have a similar explanation. See, for example, Ganaway, 2 Dissociation; Powers, 4 Dissociation (cited in note 214). The hypnotically talented are able, without effort or awareness, to slip into self-hypnotic states. They later remember hypnotically fantasized experiences as real events. See sources cited in note 214. However, hypnosis does not cause the imagination to run wild in subjects who are within normal ranges of hypnotizability. See sources and discussion in notes 219 and 224.

221. See discussion in note 190.

222. People usually have fairly sharp, clear, and accurate memories of the personal traumas they have suffered. See notes 203-09 and accompanying text. Thus it is hard for people to mistake imagined traumatic events for real life occurrences. In order for the mind to make this mistake, the imagined event must be sufficiently lifelike to create a subjective sense of "remembering." Only an extravagant imagination can accomplish this feat. The sensory vividness needed to transform an imagined experience into a memory is beyond the imaginative powers of most people. The highly hypnotizable alone have imaginative powers that are rich enough to experience their fantasies as real. See discussion in notes 214, 218-20, and sources cited in note 224.

223. See discussion in notes 214, 218, 222, and 224.

224. See, for example, Stephen P. Kahn, et al., *The Relation of Self-Reports of Hypnotic Depth in Self-Hypnosis to Hypnotizability and Imagery Production*, 37 Int'l. J. Clinical & Experimental Hypnosis 290 (1989) (finding a strong correlation between the ability to produce realistic imagery during hypnosis and hypnotizability); Robert Nadon, et al., *Multiple Predictors of Hypnotic Susceptibility*, 53 J. Personality & Social Psychol. 948 (1987) (finding strong correlations between imagic thinking and hypnotic capacity). See also, Elgan L. Baker and Eugene E. Levitt,

ers of imagination.[225] During hypnosis, they are able to see, touch, and smell the things they imagine.[226] The sensory richness of their hypnotic fantasies hinders them from separating internal events and external reality. Consequently, while it is possible for hypnosis to instill false memories of childhood sexual abuse, this danger exists only with subjects who are highly hypnotizable.

E. Can the Legal System Provide Adequate Protection Against Confabulated Sexual Abuse Claims Without Excluding Testimony?

Hypnotizability is a stable trait that can be measured with a high degree of accuracy by scientifically validated tests.[227] As a result, those who are at risk of confabulating sexual abuse memories during hypnosis can be identified. Virtually all jurisdictions have discovery rules patterned after Rule 35 of the Federal Rules of Civil Procedure.[228] These rules empower trial courts to order parties to submit to mental examinations when mental condition is in controversy. Hypnotizability is a mental condition that is relevant to the confabulation risk. The ability of experts to determine whether a plaintiff is highly hypnotizable and presents a confabulation risk will enable the legal system to reach an equitable solution in cases such as Mary Smith's.[229] Courts could ap-

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The Hypnotic Relationship: An Investigation of Compliance and Resistance, 37 Int'l. J. Clinical & Experimental Hypnosis 145 (1989) (finding a strong correlation between hypnotizability and responsiveness to hypnotic suggestion); Stephen J. Lynn, et al., *Goal-Directed Fantasy, Hypnotic Susceptibility, and Expectancies*, 53 J. Personality & Social Psychol. 933 (1987) (reporting similar findings). See also sources cited in note 219.

225. For a discussion of the cognitive traits of the highly hypnotizable, see notes 214, 218, and 224.

226. See sources cited in notes 214, 218, and 224.

227. A number of different scales and tests have been developed for measuring hypnotizability. See, for example, Hilgard, *Divided Consciousness* at 257-66 (cited in note 58); Irving Kirsch, James R. Council, and Cynthia Wickless, *Subjective Scoring for the Harvard Group Scale of Hypnotic Susceptibility, Form A*, 38 Int'l. J. Clinical & Experimental Hypnosis 112 (1990); Spiegel, *Hypnosis* in *Textbook of Psychiatry* at 909 (cited in note 9). Some have been scientifically validated and provide highly accurate measurements. See, for example, Carlo Piccione, Ernest R. Hilgard, and Phillip G. Zimbardo, *On the Degree of Stability of Measured Hypnotizability Over a 25-year Period*, 56 J. Personality & Social Psychol. 289 (1989) (finding that the Stanford Hypnotic Susceptibility Scale yields a high degree of stability in hypnotic responsiveness based on numerous retestings of the same subjects over a 25-year period). Many are simple and take only a few minutes to administer. See, for example, Spiegel, *Hypnosis*, in *Textbook of Psychiatry* at 909 (cited in note 9).

228. Rule 35 of the Federal Rules of Civil Procedure empowers trial courts to order physical or mental examinations of a party when her physical or mental condition is in controversy. Virtually all states have similar discovery rules. See, for example, Charles A. Wright and Arthur Miller, *Federal Practice and Procedure* § 2231, at 665-66 (1970).

229. The proposal that the legal system rely on hypnotic susceptibility testing to separate plaintiffs who are capable of confabulating sexual abuse memories from those who are not is offered only as a solution for the problem this Article poses. Hypnotic susceptibility testing cannot determine whether the testimony of an eyewitness who has undergone hypnosis is likely to be

proach this problem in one of two ways.

First, courts could treat high hypnotizability as a factor bearing on admissibility. Under this approach, the judge would invoke Rule 35 to require Mary Smith to undergo hypnotizability testing and would use the test results in deciding whether to allow her to testify. Mary Smith could testify if she scored within low or moderate ranges of hypnotizability but not if she scored in the high ranges and, therefore, presented a confabulation risk.

Second, courts could treat hypnotic capacity as a factor relating to Mary Smith's credibility, admit her testimony, and let the trier of fact decide whether her sexual abuse memories represent fact or hypnotic fantasy. Under the credibility approach, her Uncle Ned could secure a compulsory hypnotizability examination. If the test results reveal high hypnotizability, he would have a powerful adversarial weapon for exposing a hypnotically manufactured claim. His expert witnesses could inform the jury that Mary Smith is highly hypnotizable, that highly hypnotizable people have luxurious imaginations, and that when put under hypnosis, as Mary Smith was, highly hypnotizable people can confabulate sexual abuse memories and mistake their hypnotic fantasies as real.[230]

If the trait of high hypnotic capacity were randomly distributed throughout the population, the first approach would be preferable because it would spare defendants the terrible damage to their reputation that unfounded allegations of child molestation would cause. However,

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unreliable. Less extensive alterations of critical judgment, alterations that are possible even in subjects of moderate hypnotizability, can stimulate confabulatory recall of poorly remembered event details. Because accuracy of memory for small details can make the difference between the life and death of the accused, and because it is impossible to determine on the basis of a subject's hypnotizability whether hypnosis has diminished detail accuracy, hypnotic susceptibility testing is not a feasible solution for this problem. However, hypnotic susceptibility testing can identify those who have the capacity to confuse fantasized events for real experiences. See notes 214-26 and accompanying text.

230. Rarely will a formerly hypnotized sexual abuse plaintiff be able to overcome damaging expert testimony that she is highly hypnotizable and a confabulation risk. Jurors have a natural inclination to mistrust sexual abuse allegations and to believe that plaintiffs who make these allegations are either fantasizing or lying. See, for example, Morrison T. Forrey, *When Will We Be Believed? Rape Myths and the Idea of a Fair Trial in Rape Prosecutions*, 24 U.C. Davis L. Rev. 1013 (1991); Toni M. Massaro, *Experts, Psychology, Credibility, and Rape: The Rape Trauma Syndrome Issue and Its Implications for Expert Psychological Testimony*, 69 Minn. L. Rev. 395, 404-10 (1985); Schetky and Benedek, 12 Psychiatric Clinics of N. America at 474 (cited in note 42). A plaintiff's long delay in asserting a sexual abuse claim will compound these credibility problems. When expert testimony is presented identifying the plaintiff as highly hypnotizable and explaining the confabulation risk associated with this trait, a formerly hypnotized sexual abuse plaintiff will rarely be able to overcome these hurdles and win. Those who do will need powerful proof corroborating their memories. Consequently, treating hypnotizability as a matter of weight rather than admissibility is unlikely to result in findings of liability based on hypnotically manufactured claims.

the trait of high hypnotizability is not randomly distributed. There are two developmental pathways that can lead to high hypnotic capacity.[231] One pathway is benign and is nothing more than a continuation into adulthood of the imaginative capacity and intense powers of concentration found in children.[232] The other pathway is not benign; it results from childhood trauma.[233] Scientific studies have shown that childhood trauma is a strong predictor of hypnotic capacity.[234] Clinical studies confirm that severe abuse in early childhood and high hypnotizability often go hand-in-hand.[235] The abused child's need for psychological escape can lead to overreliance on fantasy formation and to the development of hypnotic talent.[236] Consequently, Mary Smith's high hypnotic capacity, if she is highly hypnotizable, may reflect a pathological response to the abuse that she has alleged.

While testing can measure Mary Smith's hypnotic responsiveness, it cannot determine the cause. Causation can be determined only by knowing what happened in Mary Smith's childhood or, in other words, by trying the case in full. Consequently, the first approach, which treats high hypnotizability as a bar to testimony, may exclude too much testimony and too often protect defendants at the cost of eliminating meritorious claims.[237] Jurors are qualified to decide questions of causation

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231. See sources cited in notes 90 and 214.

232. See, for example, Hilgard, *Personality and Hypnosis* (cited in note 90); Carlson and Putnam, 2 Dissociation (cited in note 90).

233. See sources cited in note 90.

234. See, for example, Hilgard, *Personality and Hypnosis* at 207-24, 242-47, 283-87 (cited in note 90).

235. The correlation between hypnotizability and childhood trauma is particularly high in subjects suffering from dissociative disorders. See, for example, Bliss, *Multiple Personality* at 150-52 (cited in note 58); Spiegel and Cardena, *New Uses of Hypnosis in the Treatment of Posttraumatic Stress Disorder*, 51 J. Clinical Psychiatry 39, 40 (1991). Persons with multiple personality (dissociative) disorder, for example, uniformly test in the upper ranges of hypnotizability. See, for example, Bliss, *Multiple Personality*. However, studies also show that between 75% and 90.2% of persons with this disorder were sexually abused as children. See sources cited in note 25. For discussion of tbe origins of dissociative disorders, see sources cited in notes 88 and 90, and text accompanying notes 82-90.

236. See, for example, Hilgard, *Personality and Hypnosis* at 220-24, 283-85.

237. Another advantage of the credibility approach over the admissibility approach is that it avoids the need for arbitrary line-drawing. Hypnotizability runs along a continuum without bright numerical lines between high, medium, and low capacity. Scoring in the 85th or 84th percentile on scales for measuring hypnotizability probably carries no significant difference in confabulation risks. However, if hypnotizability scores were used to determine whether plaintiffs would be allowed to testify, courts would have to establish a cut-off point which would endow small test differences with enormous legal importance. If, for example, the court were to adopt the 85th percentile and above as indicative of high hypnotizability, plaintiffs scoring in the 84th percentile would be permitted to testify while those slightly above would not. The predictive value of hypnotizability scores on confabulation risk is not this precise. Consequently, line-drawing would result in treating similarly situated plaintiffs unequally.

and of credibility.[238] The cause of high hypnotizability, the likelihood of confabulation, and the strength of Mary Smith's proof that her uncle abused her in childhood are intimately related matters that should be decided by triers of fact rather than disposed of at the admissibility stage.

The risk that jurors will believe hypnotically manufactured claims, if the plaintiff's testimony is admitted, is slight.[239] First, for the case to reach the courts, the plaintiff's therapist must be fooled. The clinical community will weed out most patently groundless claims.[240] Clinicians seldom place primary, let alone exclusive, reliance on a patient's hypnotic memories in making clinical formulations about a case.[241] What the patient says under hypnosis about the past is evaluated in light of the patient's symptoms, patterns of thoughts and behaviors, object relations, and other clinical characteristics.[242] Within the past few years

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238. One argument often advanced against the admission of hypnotically enhanced testimony is that hypnosis diminishes the effectiveness of cross-examination by creating false confidence and hardening the witness's memory. See, for example, Sheehan, *Confidence*, in *Hypnosis and Memory* (cited in note 164). The Supreme Court, however, has rejected this argument. In *Rock v. Arkansas*, 483 U.S. 44 (1987), a case involving the right of a previously hypnotized criminal defendant to testify at her own trial, the Supreme Court observed that "[Arkansas] has not been shown that hypnotically enhanced testimony is always so untrustworthy and so immune to the traditional means of evaluating credibility that it should disable a defendant from presenting her version of the events for which she is on trial." Id. at 61. The Court pointed out that expert testimony and cautionary instructions could be used to supplement cross-examination and expressed confidence that these measures would provide adequate methods for impeaching a formerly hypnotized witness's testimony. *Rock* amounts to the Supreme Court's assessment that the adversary system is capable of adjusting to hypnotically enhanced testimony when other interests of importance to the legal system are at stake.

239. See sources and discussion in note 230.

240. Many contemporary legal commentators believe that the opinions of psychiatrists and psychologists lack sufficient reliability for legal purposes. See, for example, Lee Coleman, *The Reign of Error: Psychiatry, Authority, and Law* (Beacon, 1984); Bruce J. Ennis and Thomas R. Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 Cal. L. Rev. 693 (1974); Faust and Ziskin, *The Expert Witness in Psychology and Psychiatry*, 242 Science 31 (1988); Marianne Wessen, *Historical Truth, Narrative Truth, and Expert Testimony*, 60 Wash. L. Rev. 332 (1985). Involvement in matters outside their areas of expertise has badly tarnished the reputations of psychiatry and psychology. Psychiatrists and psychologists are not good at predicting future dangerousness or assessing the psychopathology of criminal defendants whom they have interviewed briefly. Clinical practice, however, is what psychiatrists and psychologists are trained to do and what they do best. Longer opportunities to observe patients and increasing diagnostic precision provide a more dependable foundation for clinical assessments than for expert opinions in other settings.

241. See, for example, Charles E. Osgood, *Forward* in Moss, *Dreams, Images, and Fantasy* at 10-11 (cited in note 118).

242. Patient memories are used primarily to test or validate a clinical formulation rather than as a source for diagnosis. See id. at 10. When the patient's memories conflict with the therapist's clinical judgment, therapists tend to place more confidence in their own judgments. See id. at 11. For a discussion of clinical symptoms that are confirmatory of childhood sexual abuse memories, see Stone, 12 Psychiatric Clinics of N. America at 237-39 (cited in note 25) (reviewing research findings on psychological abnormalities commonly found in adults who were sexually

there have been numerous research advances in the clinical detection of childhood sexual abuse.[243] These advances have validated the existence of strong associations between childhood sexual abuse and specified adult psychiatric disorders[244] and have produced other valuable findings that add precision to clinical assessments of childhood sexual abuse.[245] With some psychiatric disorders, childhood sexual abuse memories fit like a tailor-made glove and the clinical impasse becomes when, rather than if, these memories will emerge in the therapy. In the case of multiple personality disorder, for instance, studies reveal that between seventy-five and ninety percent of patients who develop this disorder were sexually victimized in childhood.[246] With modern research advances, well-trained therapists are unlikely to be fooled by hypnotic fantasies when they are inconistent with the patient's clinical profile. When therapists fail to validate sexual abuse memories, the memories tend to die a natural death in therapy. The clinical filtering that takes place before a patient's hypnotic memories are validated, traditional adversarial mechanisms, and the ability of experts, by measuring hypnotizability, to identify plaintiffs who represent confabulaton risks, afford defendants adequate protection against false hypnotic memories of childhood sexual abuse and make exclusion of testimony unnecessary.

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abused as children).

243. Childhood sexual abuse changes the victim's personality. Several recent studies suggest that these personality changes can be detected by Rorschach and M.M.P.I. tests. See, for example, Louise Goldwater and John F. Duffy, *Use of the MMPI to Uncover Histories of Childhood Abuse in Adult Female Psychiatric Patients*, 46 J. Clinical Psychol. 392 (1990); Eleanor A. Saunders, *Rorschach Indicators of Chronic Childhood Sexual Abuse in Female Borderline Inpatients*, 55 Bull. Menninger Clinic 48 (1991). Research has identified numerous other clinical indicators of sexual abuse in childhood. See, for example, Gold, *History of Child Sexual Abuse and Adult Sexual Fantasies*, 6 Violence Victim 75 (Spring 1991) (finding that adult sexual fantasies have different content in the case of patients who were sexually abused in childhood); Donald C. Goff, et al., *Self-Reports of Childhood Sexual Abuse in Chronically Psychotic Patients*, 37 Psychiatry Research 73 (1991) (finding that childhood sexual abuse patients score higher on dissociative experience scales, report more amnesia, and relapse more frequently); Negg, et al., *Object Representation in the Early Memories of Sexually Abused Borderline Patients*, 148 Am. J. Psychiatry 864 (1991) (finding differences in early object relation memories among borderline patients who were sexually abused In childhood and concluding that borderline syndrome may in some cases be related to childhood sexual abuse); Stone, 12 Psychiatric Clinics of N. America at 237-39 (cited in note 25) (identifying patterns of symptoms, object relationship abnormalities, bizarre thoughts, self-defeating behaviors, and other characteristics often seen in incest victims).

244. See sources cited in notes 25, 31, and 243.

245. See sources cited in note 243.

246. See sources cited in note 25. Because of the high correlation between the development of multiple personality disorder and severe abuse in childhood, one commentator has gone so far as to advocate that the diagnosis, standing alone, should be treated as prima facie evidence of child abuse, justifying child protective agency intervention. See Elliott, *State Intervention and Childhood Multiple Personality Disorder*, 10 J. Psychiatry & Law 441 (1982).

VI. Do the Memory Reconstruction Techniques Used in "Talking" Psychotherapies Yield a More Accurate Picture of the Past?

In jurisdictions where statutes of limitations on childhood sexual abuse have been changed, tolling is available only if psychological problems have prevented timely discovery of the claim.[247] As a result, most plaintiffs will need to journey through psychotherapy before they travel to court.[248] A relevant question for courts to consider before disqualifying patients who have undergone hypnotic psychotherapies is whether other psychotherapy approaches lead to more trustworthy memory. When childhood memory has been lost, there are only two ways to restore it—through hypnosis or through processes of psychodynamic (insight-oriented) psychotherapy.[249] Psychodynamic psychotherapies use techniques to uncover the past that are slower than hypnosis and provide no superior guarantee that memories recovered are accurate.

The basic premise underlying psychodynamic theory is that psychological problems originate in childhood relationships and events.[250]

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247. See notes 43-53 and accompanying text.

248. In order to establish grounds for tolling in jurisdictions where tolling is authorized, a sexual abuse tort plaintiff must establish that psychological problems delayed discovery of the cause of action. See sources cited in notes 49, 52, and 53. Without a psychotherapist's testimony, it will be difficult for plaintiffs to do this. Flashbacks of recall are, of course, possible, and sometimes do occur. In the Eileen Franklin case, Eileen Franklin had a flashback memory of watching her father rape and murder her eight-year-old playmate 20 years earlier. The memories flooded back while Franklin was looking at her daughter who was then the same age as her friend at the time of her death. Her father was convicted on the basis of this flashback. Patricia Lerner, *Report of Rape Brings Justice 25 Years Later*, Los Angeles Times at B3 (Dec. 12, 1990). However, claims of recent flashbacks raise credibility problems and probably will not be regarded as sufficient to overcome a statute of limitations time bar to a civil suit.

249. There is a vast assortment of psychotherapy treatment approaches besides hypnosis and psychodynamic psychotherapy. Among the other major approaches are cognitive therapy, behavioral therapy, supportive therapy, and group therapy. The other major approaches, however, do not focus on the patient's past and, consequently, are not concerned with the patient's memories. They attempt to produce clinical improvement by changing cognitions and behaviors in the present. Psychodynamic therapies, in contrast, attempt to restructure the personality through the development of insight into the patient's childhood past. For a discussion of the vast assortment of psychotherapy treatment approaches, see Daniel W. Shuman, *Psychiatric and Psychological Evidence* 76-87 (McGraw-Hill, 1986); Robert J. Ursano and Edward K. Silberman, *Individual Psychotherapies*, in John A. Talbott, Robert E. Hales, and Stuart C. Yodofsky, eds., *Textbook of Psychiatry* 855-(Am. Psychiatric, 1988).

250. Psychodynamic (insight-oriented) psychotherapies focus on the effects of past experiences in molding current perceptions, patterns of behaviors, and object relations. See, for example, Ursano, Sonnenberg, and Lazar, *Psychodynamic Psychotherapy* at 2 (cited in note 98). In psychodynamic therapies, the patient talks about whatever comes to mind during the therapy hour. The therapist listens for recurrent themes and common patterns in the patient's materials and clarifies and interprets these materials for the patient. See id. at 7-8, 21-22. The interpretations usually try to connect the patient's present problems to significant relationships and events from early child-

The treatment techniques used in psychodynamic therapies are built on principles of mental functioning and techniques developed by Sigmund Freud.[251] Psychodynamic therapies use verbal exchanges to develop insight and, consequently, are called "talking cures."[252] Having postulated that the origin of the patient's psychopathology is located in the patient's childhood past, psychodynamic theory encounters the problem that adherents to its tenets lack direct access to the source of the affliction. The psyche has dealt with the patient's stressful childhood by repressing the painful past and forcing the patient's most important memories into the unconscious part of the mind.[253] Because the psychotherapist cannot look inside the patient's mind and see the core of the affliction, access to the information needed for the patient's cure must come through the patient. The patient, however, cannot provide this information directly because the cause of the patient's emotional distress is concealed from the patient as well. Consequently, the information needed to reconstruct the patient's past must be derived indirectly.

Psychodynamic theory postulates that the patient's unconscious mind reveals itself in a symbolic and disguised form in the patient's dreams, thoughts, fantasies, slips of the tongue, interpersonal relations, attitudes, and waking behaviors—in short, in everything the patient thinks, says, and does.[254] The therapist listens to the patient's material for underlying themes, patterns, and cues outside the patient's awareness and interprets these matters for the patient.[255] Transference plays an important role in psychodynamic psychotherapies. Freud maintained that all human beings tend to structure their current relationships by superimposing onto significant persons in the present attributes, feelings, and wishes linked with important childhood caretakers.[256] Freud

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hood. See id. at 31-52.

251. See, for example, id. at 4.

252. See, for example, id. at 3.

253. The unconscious forces that cause the patient's emotional distress and present problems also prevent the patient from recognizing the causes of her maladaptive symptoms and behaviors. See, for example, id. at 31. For a discussion of repression, see notes 59-71 and accompanying text.

254. See, for example, Ursano, Sonnenberg, and Lazar, *Psychodynamic Psychotherapy* at 1-45 (cited in note 98); Marmer, *Theories of the Mind*, in *Textbook of Psychiatry* at 126-29 (cited in note 61).

255. See, for example, Ursano, Sonnenberg, and Lazar, *Psychodynamic Psychotherapy* at 1-45 (cited in note 98); Marmer, *Theories of the Mind*, in *Textbook of Psychiatry* at 124-29 (cited in note 61).

256. "Transference" refers to the unconscious displacement of attitudes, wishes, fantasies, and feelings originally associated with important childhood caretakers onto relationships in the present. See, for example, Ursano, Sonnenberg, and Lazar, *Psychodynamic Psychotherapy* at 52 (cited in note 98); Marmer, *Theories of the Mind*, in *Textbook of Psychiatry* at 130-40 (cited in note 61); Stephen C. Scheiber, *Psychiatric Interview, Psychiatric History, and Mental Status Examination*, in John A. Talbott, Robert E. Hules, and Stuart L. Yudofsky, eds., *Textbook of Psychiatry* 163, 171-72 (Am. Psychiatric, 1988). Transference distortions of present relationships are

called this tendency "transference."[257] Freud believed that a patient's unconscious past is manifested in the patient's transference reactions to the psychotherapist and that through the analysis of the transference the patient could reexperience the past inside the treatment relationship.[258] Dreams are also important in psychodynamic psychotherapies. Freud regarded dreams as the "royal road to the unconscious."[259] He believed that by dissecting the surrealistic, garbled symbolisms of dreams the psychotherapist could discover a deeper meaning and could get a glimpse at the patient's psychodynamic structure and important memories.[260] From thousands of bits and pieces supplied by the patient's transference reactions to the therapist, memory fragments, fantasies, dreams, and reports of current events, the therapist and patient work together in "talking" psychotherapies to reconstruct the patient's forgotten childhood.[261]

Freud often compared the psychoanalytic process to an archeological dig in which the therapist and patient collaboratively excavate fragments from the past and then combine the fragments to reassemble the structure as it originally stood.[262] Psychoanalyst Donald Spence dis-

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common mental occurrences both inside and outside therapeutic relationships and are experienced by the healthy and sick alike. Treatment relationships, however, facilitate the emergence of transference in exaggerated form. See, for example, Ursano, Sonnenberg, and Lazar, *Psychodynamic Psychotherapy* at 20. In psychodynamic psychotherapies, interpretation of the patient's transference reactions to the therapist is employed as a technique to help the patient gain insight into how the past continues to affect her present life. See, for example, id. at 44-45.

257. See sources cited in note 256.

258. For a discussion of how transference interpretations are used in psychodynamic psychotherapies to guide patients toward understanding their unconscious thoughts, feelings, and attitudes, see, for example, Ursano, Sonnenberg, and Lazar, *Psychodynamic Psychotherapy* at 26-28, 42-53.

259. See, for example, id. at 65.

260. For the role of dreams and methods of dream interpretation in psychodynamic psychotherapies, see, for example, id. at 65-74; Marmer, *Theories of the Mind*, in *Textbook of Psychiatry* at 127-29 (cited in note 61).

261. Memories of childhood traumas rarely return in the form of flashbacks. Reconstructing the past during therapy involves a prolonged and tedious process, as the following passage reveals:

> In popular caricatures of psychiatric treatment the patient remembers dramatic childhood events in a melodramatic fashion. In reality this remembering occurs as a result of the detailed effort to dissect the frequently small memories of long-forgotten, sometimes repetitively experienced parts of the past as they present in the transference relationship. Through the transference the patient develops an understanding of what was experienced in the past and how that experience lives on in the here and now.

Ursano, Sonnenberg, and Lazar, *Psychodynamic Psychotherapy* at 44-45.

262. Spence, *Narrative Truth* at 160 (cited in note 24). Freud's use of archeological symbolism to describe the analytic process is captured in the following paragraph:

> But just as the archaeologist builds up the walls of the building from the foundations that have remained standing, determines the number and position of the columns from depressions in the floor and reconstructs the mural decorations and paintings from the remains found in the debris, so does the analyst proceed when he draws his inferences from the fragments of memories, from the associations and from the behavior of the subject of the analysis.

putes this metaphor and argues that the creation of a "narrative truth" that accounts coherently for things the patient has forgotten produces the same therapeutic benefits as making contact with the patient's actual past ("historical truth").[263] He further argues that psychotherapists cannot know which type of truth they have uncovered.[264] By "narrative truth," Spence means a picture of the past that "fits" the clinical picture. The picture weaves together a large number of pieces of the patient's life in a way that makes sense, provides a coherent account for the patient's symptoms, and enables the patient to understand thoughts, patterns of behavior, and other facets of the patient's life that previously made no sense.[265] If the picture of the past that unfolds during psychotherapy reduces the patient's tangled life into "a relatively small number of organizing principles"[266] and seems real enough to the patient to accept, the patient will assume that the picture of the past is true and will adopt this picture as her own genuine memory.[267] As a result of resolving the past, the patient will experience a relieving sense of closure and will be able to use her new insight to see things in new ways and construct new meanings in life.[268] The net result is that the patient's condition will improve. Once the past has been reconstructed, however, the past is effectively changed and the original version is lost both for therapy and for all other purposes.[269] The patient's memory will never be the same.

Although the past can never be reconstructed in its original form, a well-trained therapist and an honest patient can usually create a fairly faithful reproduction of how things were. Nevertheless, a well-intended therapist and an honest patient can also follow the wrong direction and arrive at a portrait of the past that satisfies the requirements of "narrative truth," and that the patient will accept as true, but that in fact is false. "Talking" psychotherapies are as capable of implanting false memories of childhood sexual abuse as hypnotic ones. The therapeutic

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Sigmund Freud, *Constructions in Analysis*, in James Strachey, ed., 23 *The Standard Edition of the Complete Psychological Works of Sigmund Freud* 259 (Hogarth, 1964).

263. Spence, *Narrative Truth* at 287-92 (cited in note 24). Spence rejects Freud's assumption that "every effective interpretation must also contain a piece of historical truth." Id. at 21-22. He takes the position that "the framing of the formulation is just as important as its content," and that "narrative truth by itself" can have a significant clinical impact on the patient. Id. at 22. In Spence's view, "making contact with the actual past" is less important to the patient's recovery than "creating a coherent and consistent account of a particular set of events." Id. at 28.

264. Id. at 21-36, 287-92.

265. Id. at 162-72.

266. Id. at 163.

267. Id. at 166-72.

268. Id. at 169-70.

269. Id. at 91-94

processes that could work to accomplish this result, however, are different.

Spence identifies four pathways through which distortions of the past can enter during insight-oriented psychotherapy. Slippage can occur between what happened and what the patient remembers as having happened;[270] between the patient's vague impressions of the past and the patient's attempts to put these impressions into words;[271] between what the patient says and what the therapist understands the patient as saying;[272] and between what the therapist understands the patient as saying and how the therapist interprets the patient's communications back to the patient.[273] If a serious slippage occurs at any of these points, it can prejudice the way the therapist analyzes and interprets the patient's materials. For patients who do not remember their childhoods, interpretations that seem to fit and give coherent meaning to many pieces of the patient's life are particularly compelling because

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270. Memory psychologists have proven that memory images do not become permanently fixed when the memory picture is shot. Memories can undergo active reconstruction as a result of internal and external reshaping influences that operate outside of a person's awareness. See, for example, sources and discussion in notes 189-90 and accompanying text. Hence, the memories that the patient brings into the therapy may already have been falsified.

271. Psychotherapy dialogues begin with the patient's presentation of memories, dreams, and impressions of experience. The materials that are important in psychotherapy are essentially visual. The patient initially faces the problem of finding words that will convey the essence of her dreams, memories, images, and feelings to the therapist. However, as Spence points out, "[m]uch of what is visual cannot be put into words; certain kinds of stylized images may be captured, but the complex visual scene represented by a dream or an early memory can probably never be completely realized by language." Spence, *Narrative Truth* at 28 (cited in note 24). Consequently, the patient's memory is invariably changed simply by the process of attempting to express it in words. Id. at 37-70, 92. Moreover, because the patient's description can never be complete, the therapist must take an active listening stance and must continually (albeit unconsciously) supply background details and assumptions from his own experience in order to grasp what the patient is attempting to communicate. Id. at 28-29. Because the therapist is constantly engaged in "supply[ing] a wide range of background assumptions and listen[ing] in an active, constructive manner, making assumptions about incomplete sentences, fillling out ambiguous references, and otherwise supplying what the patient leaves out," Id. at 29, what the therapist hears may fail to coincide with the patient's original unspoiled mental impressions.

272. Altbough therapists attempt to see events through the eyes of the patient and to experience the patient's reality, this is, as Spence points out, a superhuman task. Because the patient's explanations are invariably incomplete, the therapist unconsciously compensates by adding meanings and assumptions from his own life. See discussion in note 271. If the patient talks about Aunt Meg, who was "stern," the therapist may visualize the stern Aunt Meg as his mother's stern sister and not the patient's aunt, whom the therapist cannot possibly picture exactly as the patient does. Due to the inevitability of active listening, the patient's materials, when filtered through the therapist's meaning system, may emerge quite differently. Spence, *Narrative Truth* at 102-13 (cited in note 24).

273. The goal of interpretation is to establish links between the patient's present clinical presentation and the patient's past. However, because the patient's dreams, memories, and impressions of daily events are capable of many interpretations, the therapist's choice of interpretations may sometimes depend as much on the therapist as on the patient. Spence, *Narrative Truth* at 109-13, 117-24 (cited in note 24).

they cannot be disproven.[274] If slippage introduces a false theme into the therapy and interpretations incorporating this theme appear often enough and explain enough of the patient's life, narrative truths can result.

Spence points out numerous reasons why plausible accounts of what happened in early childhood have a greater chance of being accepted as true and incorporated into memory in psychotherapy settings than in other settings. First, the materials that are the focus of insight-oriented therapies—dreams, fantasies, vague memories, impressions of events—do not anchor their interpretations and are capable of many different meanings and explanations.[275] If the same interpretation occurs in enough of the patient's materials and recurs often enough, the

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274. In the following passage, Spence explains why interpretations that contain good "narrative fits" are likely to be accepted as historically correct.

> The fact that the infantile experience can never be documented has a further implication. Not only will the explanation never be disconfirmed; its very inaccessibility means that there are very few historical constraints on the form of the presumed triggering event. The final solution need only be plausible, and, in the last analysis, its form will be justified by how much it explains. . . . Once we have constructed a hypothetical event which, no matter how unlikely, seems to account for all the important features in the case, then the success of our invention tends to confirm its existence. Its truth value, we might say, is a hostage to its explanatory success.

Id. at 143.

275. Many besides Spence have observed that the unstructured nature of the materials dealt with in psychotherapy facilitates opportunities for memory creation, as well as for memory uncovering. Hypnotherapist M. Gerald Edelstein asserts that memory reconstruction techniques used in insight-oriented psychotherapies lend themselves as readily to memory restructuring as hypnotic techniques. M. Gerald Edelstein, *Trauma, Trance, and Transformation: A Clinical Guide to Hypotherapy* 17 (Brunner-Mazel, 1981). He argues that an insight-oriented psychotherapist can "almost always 'uncover' what he expects to be there." Id. at 16-21, 91-94. Because the data produced by the patient is always subject to multiple interpretations, the therapist can discover support in the material for his formulations of the case. Thus, the simple statement by a patient, "I was upset when my mother left me with a baby-sitter," could be heard by a therapist who has a proclivity for diagnosing narcissistic character disorders as an expression of narcissistic demandingness, by a therapist concerned with dependency problems as an expression of undue attachment to the mother figure, and by a therapist who is focused on repressed anger as an expression of infantile rage. Id. at 17-18.

Edelstein uses a case report from a session held by another therapist to show that how, when, and over what issue the therapist elects to intervene, places the therapist's imprint on the patient's future memory production and determines the direction of the therapy. Id. at 19-20. When a patient recounts a dream, an impression of a recent event, or a memory from the past, the material is invariably rich, complex, and full of many different themes, around which the therapist might intervene. By emphasizing one aspect of the communication over the others, the therapist's intervention contains an implicit suggestion that the therapeutic dialogue progress along the lines that the therapist, based on his understanding of the case, regards as most significant. When the patient acts on the therapist's indirect suggestion and produces more materials of the type the therapist has indicated an interest in hearing, the therapist, on hearing new information consistent with the same reading, is prone to regard the new information as a confirmation that his interpretation was correct. Id. at 19-21.

explanation will acquire a truth-value based on familiarity.[276] Second, interpretations that have the power to explain a large number of symptoms, attitudes, and behaviors that are bewildering to the patient appear to be accurate.[277] Third, explanations are appealing in and of themselves because they satisfy a human need for closure.[278] Fourth, patients with no recall of childhood lack conflicting evidence to refute the therapist's account.[279] And fifth, the therapist's constructions have added powers of persuasion because they are reinforced by transference.[280]

No therapist ever intentionally sets out to implant false memories of childhood sexual abuse. However, there are several ways in which slippage can occur. One way is through the patient's own materials. Patients can have mistaken impressions about what happened in childhood and the patient's materials can lead the therapist and patient off in the wrong direction. Alternatively, patients can turn to relatives for

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276. Spence, *Narrative Truth* at 166-72 (cited in note 24). Spence points to the normal human tendency to equate familiar matters with established facts. "[I]f . . . we encounter the [same] argument once or twice a day, we have a new sense of it being true hecause frequency is highly correlated with likelihood." Id. at 170.

277. In explaining the process by which a therapist's construction of the past tends to become "true," Spence observes that "it becomes true because it is plausible, because it fits with other parts of the patients past; over time, if repeated sufficiently often, it becomes familiar, which adds a further sense of truth; and its very frequency . . . can be reassuring." Id. at 173. See also id. at 166-71.

278. Spence maintains that interpretations that produce good narrative fits have the added allure of satisfying the patient's need for closure. Id. at 170. The patient experiences a sense of relief in "seeing [her] tangled life reduced to a relatively small number of organizing principles." Id. at 163.

279. Spence notes that the therapist's interpretations gather added force because the patient has no snapshots of the past against which to check them. Id. at 142-143; see also discussion in note 274.

280. Spence, *Narrative Truth* at 171 (cited in note 24). The concept of "transference" is explained in note 256. The perception of the therapist as an idealized parent figure is a transference distortion that commonly occurs in therapy. This distortion makes the patient vulnerable to the therapist's suggestions and can even color how the patient remembers the past. Spence, *Narrative Truth* at 95-99; Jonas Robitscher, *The Powers of Psychiatry* 10-18 (Houghton Mifflin, 1980).

Spence draws from the research of Dr. Elizabeth Loftus to show how, with a little help from transference, memory pictures can be created without underlying memory events. Spence, *Narrative Truth* at 89-93, 170. In the following passage, Spence explains how interpretations that produce good narrative fits can ripen into actual memories.

> [P]utting the formulation into words helps the patient "see" in a new way and gives reality to what was previously unknown or misunderstood. . . . [T]he analyst's construction of a childhood event, can lead the patient to remember it differently if he remembered it at all; and if he had no access to the event, to form a new memory for the first time. Within his private domain, the newly remembered event acts and feels like any other memory; thus it becomes true. Once this kind of memory has been created, its roots in the patient's historical past become almost irrelevant, and even if it were objectively disconfirmed (by, for example, discovering an old letter or hearing from a long-lost neighbor), its subjective truth value would probably continue.

Id. at 166-67.

clues about forgotten parts of childhood and receive misinformation. Moreover, transference wishes can cause a patient to deliberately misrepresent the past.[281] How the patient presents materials in therapy is always colored, in varying degrees, by the response the patient wants to receive from the therapist.[282] A patient who has a strong wish to impress the therapist and be admired may distort the past by exaggerating childhood accomplishments, while another patient who wants tenderness and sympathy may twist the past by exaggerating childhood miseries.[283] The therapist's acceptance of the patient's distorted accounts of the past will cause these distortions to reappear in later interpretations.[284]

The following scenario illustrates how a transference distortion interjected by the patient for short-term gain in the therapy could eventually become accepted by the therapist and patient alike as a correct account of what happened. Ms. A, who was emotionally, but not sexually, abused in childhood, enters treatment with little recall of her early years. Feeling that she is a boring patient and starved for more attention that she is receiving, Ms. A during one session fabricates a childhood memory that contains a veiled hint of sexual abuse. She notices that she has aroused her therapist's interest and that his bored expression has disappeared. Later in the therapy when she is again needy, Ms. A resorts to the same ploy but this time reports an actual abuse incident. Because emotional and sexual abuse can cause similar clinical presentations, her therapist is pleased that she is finally recovering pieces of her childhood. After this session, incest interpretations begin appearing regularly within the therapy. Incest derivitives are continuously found in Ms. A's dreams, interpersonal relationships, and reactions to events of the present. Ms. A, who lacks direct recall of the past, gradually becomes convinced that she was sexually abused. This explanation causes the turmoil in her life to make sense and, most important of all, her therapist sees unconscious derivatives of incest in many of the things she talks about in therapy.

Slippage can also result from the therapist's blind spots. These blind spots can cause the therapist to misunderstand the patient's materials.[285] If the therapist trades his misunderstanding back to the

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281. Id. at 94-99. The concept of "transference" is explained in note 256.

282. Spence, *Narrative Truth* at 94-99 (cited in note 24).

283. Id. at 95.

284. If the therapist's interpretations incorporating this impression are repeated often enough and explain enough of the patient's life, the patient is likely to accept the interpretations as true. As a result, the patient's memory will be changed. See notes 263-69 and accompanying text, and discussion in notes 273-78.

285. Therapists unconsciously clarify ambiguous communications from the patient and elaborate on incomplete ones by supplying whatever they need for understanding from their own back-

patient often enough in the form of interpretations that appear to explain the patient's materials, the patient may accept the therapist's account as accurate.[286] When the patient's disclosures are ambiguous or incomplete, as they often are, the therapist will unconsciously supply the missing details from his own background to form a mental picture of the patient's experience.[287] The therapist's unconscious elaborations may create a distorted picture. Countertransference[288] is a common cause for misreading patient materials. The therapist's own unresolved conflicts can prompt the therapist to attribute parts of himself to the patient. A therapist, for instance, who was sexually abused in childhood may be captured off guard by a patient whose background appears similar. The therapist's countertransference may cause the therapist to read things into this patient's materials that are not there.[289] Consequently, there is as much opportunity for memory alteration to occur in nonhypnotic psychotherapies as in hypnotic ones.[290]

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grounds. See discussion in notes 271 and 272. The therapist then feeds his unconscious elaborations back to the patient in the form of clarifications and interpretations. In the following passage, Spence describes the process by which the patient's memories can be changed through incorporation of the therapist's unconscious elaborations.

> As the elaborated memory is traded back and forth over the course of several hundred hours, it can easily become something quite different from the patient's initial report. . . . For example, a series of unwitting changes in the language used to describe a crucial early memory may change an elephant into a giraffe; accepted as the original memory, the giraffe then becomes the subject of an official interpretation.

Spence, *Narrative Truth* at 121 (cited in note 24).

286. See notes 263-69, 275-80 and accompanying text.

287. See discussion in notes 271 and 272.

288. "Countertransference" is analogous to "transference." See discussion in note 256. Therapists are humans and they, too, have unconscious thoughts, feelings, wishes, and fantasies that can distort present relationships. The unconscious projection by the therapist of his own emotions, thoughts, feelings, and experiences into the patient's material is called "countertransference." See, for example, Scheiber, *Psychiatric Interview*, in *Textbook of Psychiatry* at 172 (cited in note 256). Countertransference creates blind spots and leads to a misreading of the patient's materials. Id.

289. For an explanation of how repeated countertransferential interpretations of the patient's materials might cause the patient to falsely remember incest, see discussion in notes 271-80 and accompanying text.

290. In short-term psychotherapies, memory guiding is often less subtle. Clinical handbooks differ on how actively the therapist should intervene to elicit incest memories once the therapist is relatively certain that such memories exist. Some clinical handbooks discourage trying too hard to recover memories when the patient has strong psychological defenses. See, for example, Gil, *Adult Survivors* at 199-200 (cited in note 31). Others, in contrast, advocate highly suggestive procedures. See, for example, Stone, 12 Psychiatric Clinics of N. America at 240-43 (cited in note 25). The legal system would be shocked by some of the techniques recommended to awaken incest memories. In a recent article on the use of group therapy with incest victims, for example, the authors recommend the following techniques for aiding members of the group in remembering childhood sexual abuse:

> (1) insisting on remembering and narrating the trauma at various scheduled points in the group process; (2) videotaping and playing back disclosure session; (3) using dyads in which the partner relates details of the incest experience; (4) using drawings, psychodrama or other play techniques to elicit concrete details; (5) asking victims to write down memories or flashbacks; (6) modeling disclosure through films or books; and (7) using a marathon format.

VII. How Will Exclusionary Rules of Evidence Affect the Practice of Psychotherapy?

When pretrial hypnosis first became a legal issue twenty-five years ago,[291] courts viewed the use of hypnosis to refresh memory as comparable to the practice sanctioned by evidence law of allowing witnesses to use written memoranda to refresh their memories while testifying on the witness stand.[292] Consequently, courts originally took the position that witnesses who had undergone hypnotic memory refreshment

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Jean M. Goodwin and Nandini Talwar, *Group Psychotherapy for Victims of Incest*, 12 Psychiatric Clinics of N. America 279, 290 (1989).

Unsupervised self-help groups, which many now attend, also have tremendous memory-contaminating potential. Group members who are highly suggestible and who suffer from boundary problems can easily mistake things they hear in the group for things that have happened to them. See, for example, Gil, *Adult Survivors* at 261.

When risks from hypnosis are measured against those from suggestive treatment practices frequently recommended in the nonhypnotic clinical literature and from the memory-contaminating capabilities of self-help groups, which millions of Americans attend, the risks of memory distortion from hypnotherapy pales by comparison.

291. Numerous articles have been written analyzing how courts have responded or should respond to witnesses who have undergone forensic hypnosis. Consequently, this Article will not rehash this subject. See, for example, Diamond, 68 Cal. L. Rev. at 313 (cited in note 14); Ira Mickenberg, *Mesmerizing Justice: The Use of Hypnotically-Induced Testimony in Criminal Trials*, 34 Syracuse L. Rev. 927 (1983); Dennis Ellsworth Seis and William C. Wester, *Judicial Approaches to the Question of the Admissibility of Hypnotically Refreshed Testimony: A History and Analysis*, 35 DePaul L. Rev. 77 (1985); William G. Traynor, Comment, *The Admissibility of Hypnotically Influenced Testimony*, 55 Tenn. L. Rev. 785 (1988); Michael J. Beaudine, Recent Development, *Growing Disenchantment with Hypnotic Means of Refreshing Witness Recall*, 41 Vand. L. Rev. 379 (1988); Andrew C. Callari, Note, *Rock v. Arkansas: Hypnotically 'Refreshed' Testimony or Hypnotically Manufactured Testimony*, 74 Cornell L. Rev. 136 (1988); Kevin R. Casey, Note, *Hypnotically Refreshed Testimony and the Balancing Pendulum*, 1985 U. Ill. L. Rev. 921; Richard G. Montevideo, Comment, *Hypnosis—Should the Courts Snap Out of It?—A Closer Look at the Critical Issues*, 44 Ohio St. L. J. 1053 (1983).

292. Evidence law has long recognized that memory for past experiences can be stimulated by many different types of retrieval cues. The rules of evidence, consequently, allow witnesses to "refresh their recollections" even while on the witness stand by inspecting writings that may help them remember. If the witness, after inspecting the writing, can independently recall the matters the writing contains, the witness is permitted to testify on the basis of present memory refreshed. See John M. Maguire and Charles W. Quick, *Testimony: Memory and Memoranda*, 3 Howard L. J. 1 (1957). Courts in pre-1980s cases often drew on this analogy as the rationale for admitting testimony of witnesses who had undergone pretrial hypnosis. See Montevideo, 44 Ohio St. L. J. at 1058-59 (cited in note 291). *Harding v. State*, 5 Md. App. 250, 246 A.2d 302 (1968), was the first state court case to consider the use of pretrial hypnosis to refresh a witness's memory. The court, while providing little analysis, ruled that pretrial hypnosis was relevant only to the credibility and weight of the witness's testimony. *Harding* remained the dominant position until the 1980s when the legal tides turned. *Harding* was subsequently overruled in *State v. Collins*, 296 Md. 670, 464 A.2d 1028 (Md. 1983). For several leading pre-1980 cases upholding admissibility, see *United States v. Awkard*, 597 F.2d 667 (9th Cir.), cert. denied, 444 U.S. 885 (1979); *Wyller v. Fairchild Hiller Corp.*, 503 F.2d 506 (9th Cir. 1974); *Creamer v. State*, 232 Ga. 136, 205 S.E.2d 240 (1974); *State v. McQueen*, 295 N.C. 96, 244 S.E.2d 414 (1978) *overruled by*, *State v. Peoples*, 319 S.E.2d 177 (1985); *State v. Jorgenson*, 492 P.2d 312 (Or. App. 1971).

should be allowed to testify.[293] The original position was consistent with the modern philosophy that truth and justice are best served when the trier of fact is allowed to hear the testimony of all persons who have knowledge of the facts involved.[294] Courts expressed their faith that the credibility problems introduced by hypnosis were within the understanding of ordinary lay jurors and that with cross-examination, expert testimony, and cautionary instructions, the trier of fact would be able to assess accurately the witness's credibility and to give the testimony whatever weight it deserved.[295]

In 1980, the late Dr. Bernard Diamond published an article in the University of California Law Review that shocked the legal system into changing its former views.[296] Dr. Diamond described the impact of hypnosis on memory in the most unfavorable light that scientific research studies could support. He took a bold stand. Charging that the use of pretrial hypnosis to refresh witness memory was "tantamount to the destruction or fabrication of evidence,"[297] Dr. Diamond argued that "testimony by previously hypnotized witnesses should never be admitted into evidence."[298]

Dr. Diamond's analysis jolted the legal system. Courts responded by going in several directions. Notwithstanding Dr. Diamond's analysis,

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293. See sources cited in note 291.

294. The Federal Rules of Evidence provide that "(e)very person is competent to be a witness." F.R.E. 601. The advisory committee's notes to Rule 601 explain that few are so inherently incapable of testifying in a manner potentially useful to the trier of fact that the judge should deprive the trier of fact of the benefit of their testimony. F.R.E. 601 advisory committee's notes. Consequently, the decision was made to convert former grounds for disqualification into factors bearing on credibility and weight. The policy position taken by the Federal Rules is widely acclaimed by experts in the field of evidence and is now followed in many state jurisdictions as well. See, for example, John H. Wigmore, 2 *Evidence in Trials at Common Law* § 492 (Chadbourn rev., 1979); *McCormick on Evidence* § 61 (E. Clary 3d ed., 1984); Henry Weihoffen, *Testimonial Competence and Credibility*, 34 Geo. Wash. L. Rev. 53 (1956).

295. See, for example, *Chapman v. State*, 638 P.2d 1280, 1282-84 (Wyo. 1982). The Supreme Court in *Rock v. Arkansas*, 483 U.S. 44 (1987), recently expressed its confidence in the ability of jurors to evaluate the credibility of hypnotic recall testimony. The Court stated that "[Arkansas] has not been shown that hypnotically enhanced testimony is always so untrustworthy and so immune to the traditional means of evaluating credibility that it should disable a [previously hypnotized] defendant from presenting her version of the events for which she is on trial." Id. at 61.

296. Diamond, 68 Calif. L. Rev. at 313 (cited in note 14). Dr. Diamond's article interpreted laboratory research findings in the worst possible light. His article succeeded in grabbing the attention of courts and was instrumental in changing the law. After Dr. Diamond's article, the legal tides turned against pretrial hypnosis. Numerous courts have cited Dr. Diamond's article as the basis for rejecting admission of hypnotically refreshed testimony. See, for example, *Stokes v. State*, 548 So.2d 188, 190 (Fla. 1989); *People v. Zayas*, 131 Ill.2d. 194, 546 N.E.2d 513, 516 (1989); *State v. Moreno*, 709 P.2d 103, 104 (Hawaii 1985); *State v. Collins*, 296 Md. 670, 464 A.2d 1028, 1041 (1983) (overruling *Harding v. State*, 246 A.2d at 302); *Comm. v. Nazarovitch*, 436 A.2d 170, 174 (Pa. 1981).

297. Diamond, 68 Cal. L. Rev. at 314 (cited in note 14).

298. Id. at 315.

favorable research findings had occurred often enough to satisfy some courts that the issue of pretrial hypnosis should be treated as one of credibility and weight.[299] These courts stood by the original view. Several courts attempted to salvage hypnosis by devising procedural safeguards designed to cleanse the hypnotic interview process of interviewer taints.[300] The procedural safeguard approach conditioned admissibility on the taping of hypnosis sessions so that trial courts could review the session and determine if the subject's memory had been contami-

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299. See, for example, *Pearson v. State*, 441 N.E.2d 468 (Ind. 1982); *State v. Wren*, 325 So.2d 756 (La. 1983) *State v. Brown*, 337 N.W.2d 138 (N.D. 1983); *Chapman v. State*, 638 P.2d 1280 (Wyo. 1982).

300. The procedural safeguards approach derives from recommendations made by Dr. Martin Orne as part of his expert testimony in *State v. Hurd*, 173 N.J. Super. 333, 414 A.2d 291, 297 (1980), aff'd, 86 N.J. 525, 432 A.2d 86 (1981). Dr. Orne, at this point in his career, believed that hypnotically induced recollections could be made safe enough for use in the courtroom if procedural steps were taken to eliminate the possibility that the testimony was a product of the hypnotist's suggestions. *Hurd*, 414 A.2d at 296. The *Hurd*-Orne procedural safeguards impose the following conditions on admissibility:

1. The hypnotic session must be conducted by a licensed psychiatrist or psychologist who is trained in the use of hypnosis and who is not affiliated with the prosecutor, a law enforcement agency, or the defense. Only the hypnotist and subject are allowed to be present during any phase of the hypnotic session.

2. A written log must be kept of all information imparted to the hypnotist by law enforcement personnel before the session.

3. Prior to induction, the hypnotist must elicit a detailed description of everything the subject remembers about the matters that will be explored under hypnosis. The subject's account must be obtained in the form of an unpressured, free narrative, without prompting or cuing.

4. A permanent record must be made of all contacts between the hypnotist and subject. The record must include the pre-induction interview, the hypnotic session, and post-hypnotic discussions. The preferred technique for making this record is on videotape so that the court can determine if the hypnotist's expressions or body language contain unintended suggestions. *Hurd*, 432 A.2d at 96-97.

Under the *Hurd* approach, the trial judge reviews the record of the session outside the presence of the jury to determine whether the testimony will be admitted. In addition to monitoring for suggestive interviewing technique, courts using this approach also weigh the appropriateness of using hypnosis for the kind of memory loss encountered. Id. at 95-96. Dr. Orne testified, and the New Jersey Supreme Court accepted, that hypnosis is more likely to yield accurate recall when the subject is suffering from a pathological loss of memory than when the subject simply has forgotten aspects of the event. Id. If the judge determines that this case is one in which hypnosis is likely to yield accurate recall, the judge then reviews the record of the session for compliance with the procedural guidelines. Id. at 96. The party seeking admission has the burden of establishing by clear and convincing evidence the absence of any impermissible suggestion by the hypnotist. Id.

Several jurisdictions besides New Jersey have adopted this approach. See, for example, *House v. State*, 445 So.2d 815 (Miss. 1984); *State v. Beachum*, 643 P.2d 246 (N.M. App. 1981); *State v. Weston*, 16 Ohio App.3d 279, 475 N.E.2d 805 (1984). Some have modified the New Jersey approach and consider factors besides compliance with procedural safeguards in determining whether the testimony is reliable. See, for example, *People v. Romero*, 745 P.2d 1003 (Colo. 1987) (holding that determinations of reliability should be based on the totality of circumstances and stating criteria for the trial judge to apply); *State v. Iwakiri*, 682 P.2d 571 (Idaho 1984) (holding that determinations of reliability should be based on the totality of circumstances, with strong emphasis being placed on compliance with procedural safeguards).

nated.[301] A majority of the courts, however, found Dr. Diamond's article so devastating to hypnosis that they took his advice, barred hypnotic memory testimony,[302] and restricted witnesses who had undergone hypnosis to testifying about facts that the witness demonstrably knew before the session began.[303]

Experimental findings that hypnosis can both change and harden eyewitness memory[304] had occurred often enough that courts were justified in taking precautions in admitting the testimony of eyewitnesses who had undergone hypnosis. Although experimental findings do not address the reliability of hypnosis in clinical settings,[305] defense attorneys inevitably will raise this question when they eventually realize how often hypnotic treatment techniques are used in clinical practice today. If courts rigidly follow stare decisis when this issue is raised, the results will cause senseless damage to effective psychotherapy. The decision to exclude this testimony will place therapists who use hypnosis in the terrible dilemma of having to choose between the patient's best treatment interests and the patient's legal rights.[306] Therapists can, of course, and

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301. See sources cited in note 300.

302. Dr. Diamond's article advocated disqualifying witnesses who had undergone pretrial hypnosis from testifying about anything that was discussed during the session, even if the witness recalled the information before being placed under hypnosis. Diamond, 68 Cal. L. Rev. at 335-36 (cited in note 14). California alone has taken Dr. Diamond's advice to the extreme of disqualifying witnesses from testifying about matters of which they demonstrated knowledge before the session began. See *People v. Shirley*, 641 P.2d 775 (Cal. 1982). The remaining jurisdictions that reject hypnotically enhanced testimony differentiate between prehypnotic and hypnotic recall. Witnesses who have been hypnotized are permitted to testify about information recalled before the session, even if the information was explored under hypnosis. However, they will not be allowed to testify about additional matters discovered during the session. See sources cited in note 303.

303. Courts in the following jurisdictions, among others, refuse to permit witnesses to testify about facts recalled for the first time under hypnosis: *Contreras v. State*, 718 P.2d 129 (Alaska 1986); *State v. Mena*, 624 P.2d 1274 (Ariz. 1981); *People v. Zayas*, 131 Ill.2d. 289, 546 N.E.2d 513 (1989); *Stokes v. State*, 548 So.2d 188 (Fla. 1989); *State v. Haislip*, 237 Kan. 461, 701 P.2d 909 (1985); *State v. Collins*, 296 Md. 670, 464 A.2d 1028 (1983) (overruling an earlier decision adopting per se admissibility); *People v. Gonzales*, 329 N.W. 743 (Mich. 1982); *State v. Mack*, 292 N.W.2d 764 (Minn. 1980); *Alsbach v. Bader*, 700 S.W.2d 823 (Mo. 1985); *State v. Palmer*, 210 Neb. 206, 313 N.W.2d 648 (1981); *People v. Hughes*, 59 N.Y.2d 523, 453 N.E.2d 484 (1983); *State v. Peoples*, 319 S.E.2d 177 (N.C. 1984) (overruling an earlier decision adopting per se admissibility); *Comm. v. Nazarovitz*, 436 A.2d 170 (Pa. 1981).

304. See sources cited in notes 164-66 and accompanying text. See also sources cited in note 191.

305. See Part V.A.

306. The therapist's dilemma is discussed by law professor Alan Scheflin and psychologist Jerrold Shapiro in *Trance on Trial*. Scheflin and Shapiro, *Trance on Trial* at 9-12 (cited in note 9). Their book offers advice to the clinical community on how to comply with anticipated legal meddling in the clinical use of hypnosis. Scheflin and Shapiro advise clinicians to maintain complete records of all information provided by patients suffering from traumatic amnesias, from the initial telephone call contact forward. Id. at 15-16. They instruct clinicians to take audiotaped or videotaped histories of what the patient remembers before inducing hypnosis, and to tape both the session and all posthypnotic interactions with the patient. Id. They caution therapists to avoid

most probably will, shift this choice to patients by explaining the legal ramifications of hypnotic treatment and getting the patient's informed consent to the use of hypnosis.[307] Informed consent, however, will not solve the problem. It will simply shift the therapist's dilemma to the patient. If patients give informed consent to hypnotic treatment, they will emerge from psychotherapy with improved memory but with no legal redress.

What will be the loss to patients and to society if patients or their therapists solve this dilemma in favor of legal rights over treatment? The losses will be substantial and will not be limited to patients who seek treatment for psychological problems stemming from childhood sexual abuse.[308] To avoid potential liability, obtaining informed consents will become a standard practice among hypnotherapists. Because

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suggestive comments and advise them to refrain from assuring patients that hypnosis will help them remember. Id. They strongly discourage prompting, asking leading questions, or cueing. Id. Above all, they admonish clinicians to secure informed consents to protect themselves against legal liability in the event that a court finds that hypnosis has contaminated the patient's testimony. Id. at 15.

307. See discussion in note 306.

308. Hypnosis has been demonstrated to be effective with a wide variety of disorders and is extensively used in psychology and psychiatry, as well as in dentistry and medicine. See notes 101-06 and accompanying text. Different users of hypnosis tend to emphasize different treatment benefits. Dr. Lewis W. Wolberg, who recommends hypnosis as an adjunct to conventional talking psychotherapies, explains the benefits from hypnosis as follows:

> Because hypnosis is capable of promoting relaxation, of rendering the individual more susceptible to suggestion, and of facilitating closer contact with the inner self, advantage may be taken of these characteristics in the management of certain emotional problems. Symptomatic disturbances produced or aggravated by anxiety and tension may be relieved, and destructive habit patterns reorganized through hypnorelaxation and hypnosuggestion. When the therapy is short-term and directed toward abbreviated objectives, hypnosis, utilized properly, can expedite treatment by encouraging rapport, stimulating emotional catharsis, catalyzing the placebo effect, and hastening other non-specific elements. In longer-term reconstructive therapy, the periodic induction of hypnosis may be helpful toward dissipating resistance and obstructions to communicating, augmenting dreaming, accelerating the remembering of important developmental incidents, activating transference, and helping working-through. When a patient seems to have reached a stalemate in therapy, hypnosis may open up new dimensions for exploration and understanding. It may propagate the translation of insight into action.

Wolberg, *Forward*, in M. Gerald Edelstein, *Trauma, Trance, and Transformation: A Clinical Guide to Hynotherapy* at vii-viii (Bruner-Mazel, 1981).

Dr. C. Scott Moss finds that hypnosis works well as an adjunct to analytic psychotherapies. Moss, *Dreams, Images, and Fantasy* at 6 (cited in note 118). He writes that:

> Hypnotherapy . . . is an emotionally corrective therapeutic experience. It frees fantasy and imagination, allowing access to preconscious and unconscious content, and it encourages memorial reversion, so that patients can move fiexibly along the time continuum, living and re-experiencing the past and comparing and contrasting past with present perceptions, emotions, and experiences. The intensity of mental imagery solicited through hypnosis encourages a direct reconditioning process. It is also a procedure that largely relieves the therapist of the need for involved interpretations, since hypnotically induced experiences are both revelationary and convincing.

Id. For the special enrichments hypnosis adds to sexual abuse psychotherapies, see Part IV.C.

many patients are apprehensive of hypnosis already, informed consents may cause some patients who could benefit from hypnosis to abandon this form of psychotherapy.

Hypnosis meets a social need because it enables therapists to reach some patients who are otherwise untreatable.[309] The effect of closing courtroom doors to patients who have undergone hypnotherapy will be devastating for patients with dissociative disorders. Many dissociative disorders treatment specialists believe that hypnosis is the only means of gaining access to dissociated memories.[310] Consequently, patients suffering from dissociative disorders will forfeit their legal rights.[311]

Moreover, hypnosis facilitates shorter treatment periods and maximizes the employment of available psychotherapy resources through more efficient application.[312] Because hypnosis allows more rapid access to memories, it is an extremely useful technique for intensive, time-limited therapies.[313] Hypnosis, therefore, permits treatment of economically underprivileged patients who lack financial resources to absorb the cost of long-term psychotherapies and who would otherwise fail to receive mental health care.[314] For victims of recent traumas, there is

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309. Some patients are unsuitable for psychodynamic psychotherapies. To prosper in insight-oriented psychotherapies, the patient needs to be psychologically-minded and capable of observing feelings without acting on them. In addition, the patient must be capable of forming a stable treatment relationship. Ideally, the patient should have a social support network that she can rely on during stormy periods of therapy. Finally, the patient must have a relatively intact and observing ego. See, for example, Ursano, Sonnenberg, and Lazar, *Psychodynamic Psychotherapy* at 16-17 (cited in note 98). See also note 318 and accompanying text.

310. See notes 89, 91, 119-24 and accompanying text. If hypnosis is not indispensable to dissociative disorders treatment, it is certainly vitally important. Virtually all dissociative disorders experts recommend hypnosis as the treatment of choice. See, for example, Putnam, *Multiple Personality Disorder* at 221-22 (cited in note 9). One leading treatment specialist estimates that he uses hypnosis with over 95% of his multiple personality (dissociative) disorder patients. Id. at 227 (commenting on the experience of Dr. Richard Kluft). See also Richard P. Kluft, *Using Hypnotic Inquiry Protocols to Monitor Treatment Progress and Stability in Multiple Personality Disorder*, 28 Am. J. Clinical Hypnosis 63, 65 (1985)(observing that hypnosis can save patients years of morbidity).

311. This will be ironic because dissociative disorders are almost invariably caused by trauma. Childhood sexual abuse histories are found in the overwhelming majority of patients suffering from multiple personality (dissociative) disorder. See sources cited in note 25.

312. See, for example, Moss, *Dreams, Images, and Fantasy* at 10 (cited in note 118).

313. Id. at 4-7.

314. Economic considerations are a primary factor behind the recent upsurge in the popularity of hypnosis. Insurance companies and government purchasers of health care services are currently putting strong pressure on the mental health community to devise newer and more cost-effective treatment approaches. Mounting doubt about whether "talking" therapies yield benefits in proportion to their time-consumption and cost have sparked new interest in the potential of hypnosis to deliver shorter psychotherapies. See, for example, Wolberg, *Forward*, in *Trauma, Trance, and Transformation* at xvi (cited in note 308). Users of hypnosis believe that they can accomplish the same results as talk therapists but by a much quicker and more cost-effective route. Id. at xv.

probably no treatment as effective as hypnosis.[315] Hypnosis facilitates brief, intensive, crisis-oriented psychotherapies that lead to a rapid reestablishment of the victim's emotional stability.[316] Hypnosis also enriches long-term treatments by allowing for changes in technique when treatment stalemates are reached.[317] It is particularly useful with culturally and economically deprived patients who often lack the verbal facility, introspection, and abstract conceptual abilities needed to prosper in "talking" therapies.[318] Hypnosis, in short, enriches the practice of psychotherapy in many irreplaceable ways.

Courts may be tempted to salvage therapeutic hypnosis by making clinicians who practice hypnosis comply with the procedural standards for hypnotic interviewing[319] that were developed by the New Jersey Supreme Court in *State v. Hurd*.[320] The New Jersey procedural safeguards approach was based on a proposal by Dr. Martin Orne[321] and is followed in a minority of states courts.[322] Instead of categorically excluding testimony obtained through pretrial hypnosis, this approach attempts to make the testimony trustworthy by establishing safeguards for the conduct of hypnotic interviews.[323] The requirement that hypnotic sessions be recorded is the centerpiece of this approach. Recording enables trial courts to review the session before reaching a decision on whether to admit the testimony.[324]

The imposition of *Hurd*-procedural safeguards on clinical practice will damage good patient care almost as much as outright exclusion of

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315. See, for example, Bruce W. Elbert, *Hypnosis and Rape Victims*, 31 Am. J. Clinical Hypnosis 50 (1988); William H. Smith, *Antecedents of Posttraumatic Stress Disorder: Wasn't Being Raped Enough?*, 39 Int.l. J. Clinical & Experimental Hypnosis 129 (1991); Speigel, 12 Psychiatric Clinics of N. America 295 (cited in note 73); Edwin V. Valdiserri and Jessie P. Byrns, *Hypnosis as Emergency Treatment for a Teen-age Rape Victim*, 33 Hospital & Community Psychiatry 767 (1982).

316. See, for example, Moss, *Dreams, Images, and Fantasy* at 4-7 (cited in note 118).

317. See, for example, Wolberg, *Forward*, in *Trance, Trauma, and Transformation* at vii-vii.

318. See sources cited in note 309.

319. Some believe that the judicial imposition of *Hurd*-Orne procedural safeguards is inevitable. Warnings to incorporate these procedures into clinical practice are beginning to appear in clinical literature. See, for example, sources cited in notes 141 and 306.

320. 129 N.J. Super. 409, 432 A.2d 525 (N. J. 1981). For a discussion of the procedural safeguards approach, see note 300.

321. See discussion in note 300. Dr. Orne has since disowned this proposal. He now believes that procedural safeguards are inadequate to address some of the dangers that hypnosis poses, such as the dangers of unintentional cueing, confabulation, and false confidence. See, for example, Orne, *Reconstructing Memory Through Hypnosis*, in *Hypnosis and Memory* at 50-55 (cited in note 12). Consequently, Dr. Orne now believes that, no matter how carefully the interview is conducted, once a potential witness has been hypnotized, the witness's testimony is no longer safe for courtroom use. Id.

322. See sources cited in note 300.

323. See sources cited in note 300.

324. See sources cited in note 300.

testimony. The introduction of privacy-threating tape recorders will change the atmosphere of psychotherapy. Tape recorders carry the tacit message that breaches of trust and confidentiality are possible and may even be contemplated.[325] Few things are more important to psychotherapy than the patient's trust that what she discloses will be kept in the utmost confidence.[326] Many patients may have difficulty experiencing this trust with a videotape recorder running. As a result, taping may induce some patients to withhold important information and may make others so self-conscious that they cannot relax enough to undergo hypnotic induction. Moreover, since therapists can never know for certain what a patient will discover under hypnosis, if *Hurd*-safeguards are imposed, therapists may feel pressure to videotape all sessions they hold. This will cause needless privacy concerns for the overwhelming majority of patients whose childhoods were relatively ordinary. Finally, the introduction of videotape recorders into therapy offices will lead to the need for explaining to the patient why the session is being taped. Some patients may understand the therapist's explanation as a statement of expectation that the session will lead to memories that will take the patient to court. Highly suggestible patients may act on this message and produce memories that they believe the therapist wants to hear.

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325. Videotaping or tape recording of sessions is a deviation from the normal frame of therapy. All deviations can be expected to have damaging repercussions within the therapy. See, for example, Robert Langs, *The Therapeutic Environment*, 4, 123, 205-96 (Aronson, 1979). Some experts not only oppose the videotaping and tape recording of sessions, but they even oppose extensive note-taking on the grounds that these practices intrude on the one-to-one therapeutic relationship and imply possible violations of trust and confidence. Id. Videotaping will prompt patient concerns about confidentiality and will cause the session to have an artifical and unnatural atmosphere. Worries about privacy may cause some patients to experience unconscious inhibitions against remembering. Such worries may even color the memories that are produced during the session. Id.

Damage to the therapy could perhaps be minimized if the treating therapist were to refer the patient to another hypnotist once the need for hypnotic memory work became apparent. For a discussion of this proposal, see, for example, Scheflin and Shapiro, *Trance on Trial* at 238 (cited in note 9). However, in times of tight funds for psychotherapy, expecting therapists to take this precaution may be unrealistic. Moreover, there may be therapeutic benefits to the patient from sharing the terrifying and painful memories with her treating therapist.

326. All experts agree that privacy and confidentiality are essential to effective psychotherapy. See, for example, Steven R. Smith and Robert G. Meyer, *Law, Behavior and Mental Health: Policy and Practice* 45-77 (New York Univ., 1987). Even under optimum conditions of confidentiality, patients have difficulty speaking freely and disclosing their innermost shames and fears to another person. See, for example, Abraham S. Goldstein and Jay Katz, *Psychiatrist-Patient Privilege: The GAP Proposal and the Connecticut Statute*, 118 Am. J. Psychiatry 733, 734 (1962). The following frequently quoted passage from Guttmacher and Weihofen summarizes the patient's predicament: "The psychiatric patient confides more utterly than anyone else in the world. He exposes to the therapist not only what his words directly express; he lays bare his entire self, his dreams, his fantasies, his sins, and his shame." Manfred S. Guttmacher and Henry Weihoffen, *Psychiatry and the Law* 272 (Norton, 1952). The presence of a videotape recorder will destroy this sense of confidentiality.

Consequently, the introduction of videotape recorders may agitate the very problem that procedural safeguards are designed to avert. The legal system is accustomed to taking witnesses as it finds them, and it should follow this practice in the case of witnesses who have previously undergone hypnotherapy.

VIII. CONCLUSION

The adult survivor community has fought hard for the right to bring delayed childhood sexual abuse suits that psychological impairments disabled them from bringing on time. They have succeeded in changing the law in at least twenty-two states. This will be a hollow and bitter victory if courts now exclude their testimony because the psychotherapy treatments that helped them remember were legally unacceptable. In jurisdictions that have elected to extend limitations and entertain suits based on long-forgotten memories of acts that took place behind closed doors, legislatures and courts have weighed the risk that some memories will be honest lies and others outright perjury and have determined that gains in individual and social justice make these risks worthwhile.[327] It would be inconsistent for these jurisdictions to find now that the only testimony these plaintiffs can offer is unreliable.

This Article has given five separate reasons why courts should not do this. First, the existence of a memory hazard from the use of hypnosis on subjects with pathological memory disturbances has never been scientifically established. The American Medical Association Council on Scientific Affairs, based on a report prepared by Dr. Martin Orne, has taken the position that the hypnosis experimental literature does not provide definitive answers about the workings of hypnosis in clinical situations. Consequently, courts have no justification for disqualifying witnesses who are otherwise qualified. The clinical world has recognized hypnosis as an effective memory restoring technique for more than a century. Both the Council of Mental Health of the American Medical Association and the American Psychological Association have approved this technique. Hypnosis has more widespread clinical acceptance today than at any other time in history. If the courts require proof of scien-

327. When courts consider whether to toll limitations for sexual abuse tort actions, they perform an implicit balancing process. The court must weigh the harm from unfair deprivation of a remedy against the risk that passage of time will have obscured the facts and will jeopardize the possibility of an accurate and fair resolution of the claim. In some cases, courts have engaged in explicit balancing. See, for example, *Tyson v. Tyson*, 727 P.2d 226 (Wash. 1986) (refusing to toll limitations on actions for childhood sexual abuse on the grounds that the risk of unfairness in forcing defendants to face stale claims for which objective and verifiable evidence is lacking outweighs individual and social gains from allowing plaintiffs to bring delayed sexual abuse civil suits).

tific acceptance as a condition of admissibility, they should note that the relevant scientific community accepts it.

Second, explanations exist that can account for the efficacy of hypnosis in clinics but not in laboratories. Hypnosis has properties that appear capable of freeing memory from constraints of repression and dissociation. The fact that hypnosis has been demonstrated incapable of performing memory miracles on laboratory subjects with normal recall abilities reflects natural limitations of human memory rather than limitations of hypnosis when put to tasks it is capable of performing.

Third, additional reasons exist for believing that hypnosis works better in clinical situations than hypnosis laboratory tests have shown. Paradigm hypnosis laboratory experiments test hypnosis on eyewitness memory, which, as the legal system already knows, is highly impermanent and easily reconstructed. Hypnosis research experiments have yielded only two findings relevant to this Article: first, that hypnosis aggravates problems with eyewitness memory; and second, that hypnosis sometimes induces highly hypnotizable subjects to accept hypnotic memory grafts. Eyewitnesses and victims of childhood sexual abuse are not in the same memory class. Victims of childhood sexual abuse usually have much more opportunity to observe the events they later remember: the perpetrators are known; the acts are unambiguous; and traumatic experiences carve a lasting imprint on memory. For plaintiffs who have actually been abused, the chance that hypnosis can reshape their memories in ways that could cause harm to defendants is slight. While hypnosis has the ability to plant false memories of childhood sexual abuse, it can do this only with patients who are richly imaginative, hypersuggestible, and capable of experiencing their hypnotic fantasies as real—in short, the highly hypnotizable. However, the ability to test hypnotizability, coupled with traditional adversarial mechanisms, provides defendants with adequate resources to defend against hypnotically manufactured claims. Moreover, the therapist's clinical observations, experience, and training will detect and suppress false memories of sexual abuse when they are inconsistent with the patient's clinical symptoms and waking state memory reports. The clinical sifting and weeding that takes place before a patient's hypnotic memories are validated provide additional security against false incest claims.

Fourth, excluding testimony of patients who have experienced hypnosis could wreak havoc in psychotherapy patient care by making psychotherapists extremely cautious in using hypnotic memory techniques. This will lengthen psychotherapy treatments and make care unavailable for patients with inadequate insurance coverage. It will also make psychotherapy bumpier and more strenuous for trauma victims because therapists will no longer have tools for modulating the pace and inten-

sity of remembering. In addition, it may doom patients suffering from dissociative disorders because many believe that hypnosis is the only pathway for recovering dissociative (self-hypnotic) memories.

Finally, and most important of all, treating patients who have undergone hypnotic and nonhypnotic psychotherapies differently will accomplish nothing of value to the legal system because both forms of psychotherapy carry a risk of altering memory. The risks are about the same for gaining access to memories that have been locked by trauma. Psychotherapy has only a limited number of keys for gaining access to memories that have been locked by trauma. Psychotherapy, like all human processes, can sometimes go astray. However, until methods are discovered that can do better, the legal system has little choice other than to accept the fact that witnesses who have undergone psychotherapy may sometimes have imperfect memories.