REPRESSED MEMORIES: A CURRENT PERSPECTIVE

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This is a strange time, Mister. No man may longer doubt the powers of the dark are gathered in monstrous attack upon this village. There is too much evidence now to deny it. You will agree, sir?

Reverend Hale in Arthur Miller's *The Crucible*

Introduction

Allegations of sexual assault polarise people like no other issue. This applies equally to members of the Judiciary and the Legal Profession.

There are those who readily assume that any person against whom an allegation of sexual assault is made must be guilty. There are others who understand the fundamental importance of the presumption of innocence.

The 1980's and 90's heralded an enormous interest and focus in respect of issues of sexual assault. This lead to a number of legislative changes in each of the States of Australia. The essential basis for the plethora of reports and legislative changes have been that the criminal law, does not protect persons from sexual assault and that there is an overriding need to obtain greater protection for victims and to have higher conviction rates.

There is no doubting that in terms of pure politics this approach is one of enormous attraction to Governments. The perception is that there is overriding public support for being seen to be active in protecting alleged victims of sexual assault. Further, it is always good politics to be seen to be being hard in respect of criminals.

These trends have seen a major shift away from a "due-process" model to a "crime control" Criminal Justice System. The latter places particular emphasis upon an almost "therapeutic" approach in cases of this nature.

This paper, though dealing with the issue of repressed memory, nevertheless seeks to alert those who work within the Criminal Justice System of the significant danger that a Child Sexual Abuse Industry is very much in operation within Australia and that there

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needs to be a critical appraisal of whether the momentum has swung too far. The paper will seek to address such issues that may arise involving the trial of persons charged with Sexual Assault. This material will hopefully be of assistance in gaining a greater understanding of human memory and the way in which these types of cases can arise and are investigated.

Ideology

1. A fundamental issue that invariably arises in sexual assault allegations is that an alleged victim of sexual assault never lies about such allegations. Their reliability is regarded in ideological terms as being *sacrosanct*.

2. This premise must involve the notion that any person accused of sexual assault must be guilty. Such is contrary to the presumption of innocence and the common sense of how such allegations can arise in suspicious circumstances.

3. This issue can be, in part, better understood by recognising the fundamental difference between the approach taken by the State and its agencies in investigating and prosecuting alleged offenders and those of us who necessarily on occasions defend persons against whom allegations are made. One cannot seek to emphasise that this is a very important issue, which unfortunately has not received the critical attention of many within the community.

4. The fundamental ideology of the State and agencies in investigating and prosecuting alleged offenders is that complainants *must* be believed *immediately upon the disclosure of the alleged sexual assault*. The complainant *must be protected* from any further assault, the complainant's needs in relation to the assault must be met, the response to the assault must be supportive, and the complainant and the family must be assisted in coping with the assault. This underlying philosophy does not involve in any way *an objective that any inquiry should be conducted as to whether the assault or for that matter abuse had actually occurred*. Alternative possibilities are in an ideological sense wilfully excluded.

5. The Royal Commission into Institutional Responses to Child Sexual Assault (the *'Royal Commission'*) has not been concerned with the fundamental rights of persons accused of sexual assaults. This reflects the *premise* that all persons accused of sexual assault must be guilty.

Memory

When I was a young man I could remember everything, whether it happened or not.

Mark Twain

6. We have all experienced the question: What is your earliest memory? I have cross examined witnesses who maintained that their earliest memories are two years of age. I cross-examined a "therapist" who had assisted a witness recover memories 'in utero' and of a 'former life'.[2]

7. All of us agree that there is a period in which one has no memory, referred to as "childhood amnesia". This generally occurs around three or four years of age. I'm sure you have all experienced someone who has maintained that they can recall memories as young as two years of age. Invariably, the reaction to such a memory is scepticism.

8. Memory is a process whereby a person recalls into consciousness information stored in the brain.

9. Repression involves something more than mere forgetting. In the context of sexual assault, it is the partial or total banishment of the abuse from a person's consciousness.

10. Memory is both a constructive and reconstructive process. It is thus subject to a number of factors which can impact upon the encoding process. There are four stages of memory:

    - Input/Encoding
    - Storage/Retention
    - Retrieval
    - Recounting Stage

11. Explicit memory relates to the capacity to consciously recall facts or events. Implicit memory relates to behavioural knowledge of an event without conscious recall. For example, a Vietnam War Veteran may break into a sweat when hearing the sound of a helicopter, but has no recall of a helicopter crash in which his friend was killed.

12. Modern evidence clearly demonstrates that human memory is very much likely to be influenced and revised from the time of encoding up to the time that the memory is retrieved.[3]

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2 *R v H (JR) Childhood Amnesia* (2006) 1 C r App R 195.

3 Statement on Memories of Sexual Abuse, American Psychiatric Association Board of Trustees, 1993; the Royal Australian & New Zealand College of Psychiatrists, Guidelines for Psychiatrists dealing with Repressed Traumatic Memories, May 1996; British Psychological Society Report of Recovered Memory; Position Paper American Psychiatric Association 2000; Colangelo JJ (2009) Case Study- the Recovered Memory Controversy; A Representative Case Study, *Journal of Child Sexual Abuse*, Research, Treatment & Program Innovations for Victims, Survivors and Offenders 18(1), 103-121.

13. Recovered memories theorists believe that sexual trauma is repressed so as to cause either a complete or partial unawareness. In order for these memories to be retrieved various techniques are used. The victim's symptoms are related to the repressed memories.

14. Controversy about recovered memory has its origins with Sigmund Freud. Freud's theory was that repression is the basic means by which unconscious memories are repressed to protect the individual from the emotional sequalae of the threat.[4]

15. Pierre Janet (a contemporary of Freud) treated Leonie a 20 year old woman who suffered from memory difficulties due to her mother's long illness and death. He reported her case to Freud who believed that emotions can repress memory.

16. Elizabeth Von R was a famous patient of Freud. She experienced terrible pain whenever she expressed an unconscious desire that her sister would die so she could marry her brother-in-law. Freud commented that Elizabeth R's repressed ideas were *"stratified concentrically around the pathogenic nucleus… the deeper we go the more difficult it becomes for the emerging memories to be recognised, til near the nucleus we come upon memories which the patient disavows even in reproducing them"*.

17. Another famous patient of Freud, the Wolfman recovered a memory of being seduced by his sister after some dreams.

18. The interesting point about Freudian theory is that Freud believed that it was the wilful intentional effort to repress the memory that caused the hysterical symptoms to occur. In the case of Lucy R, Freud said that *"an idea must be intentionally repressed from consciousness"* for the hysterical symptoms to occur.

19. Thus, the original hypothesis of Freud needs to be contrasted with the modern *evolution* of repression involving a complete or partial *unconscious mechanism*, beyond mere forgetting.

Repression and Disassociation

20. There is no scientific basis for the existence of a process whereby memory can be stored intact and later recalled to consciousness. How then does the theory exist? It does so, by the controversial Freudian theory of repression and the later day concept of disassociation.

21. Up to the 1800's patients with Dissociative Identity Disorder (Multiple Personality Disorder) were often considered to be possessed by evil spirits.

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[4] 1915 Strachy J (ed), *Standing Edition of the Complete Psychology Works of Sigmund Freud*, Vol 14, London; Hogarth Press 1957.

22. Jean-Martin Charchot and Pierre Janet derived the concept of disassociation. This involves a traumatic event or series of events being *split off* from each other. A traumatic event is not integrated with non traumatic memory. This theory has lead to the diagnosis of multiple personality disorder (Dissociative Identity Disorder).

23. Freud, as has been commented upon, explained the concept on the basis of an intentional repression of the '*idea'*.

24. As many would be aware, modern portrayals of multiple personality disorder such as '*The Three Phases of Eve'* and *'Sybil'* lead to an increased awareness of the concept and in 1980 Multiple Personality Disorder was included in the 3rd Edition of DSM(III). This has in turn led to the renaming of the disorder to Dissociative Identity Disorder in 2000. [5]

25. A person with Dissociative Identity Disorder has two or more distinct personalities, each of which determines behaviour during any period in which it is dominant. These are referred to as *alters*. It must be kept in mind that Dissociative Identity Disorder is a chronic dissociative disorder. In diagnostic and clinical terms it requires an *amnestic component*. It also requires *the presence of at least two distinct personalities.*

26. It is important to understand that research reports in the United States of America reveal relatively low incidents of Dissociative Identity Disorder.[6]

27. Dissociative theorists believe there is a difference in the way traumatic memories are stored in the explicit and implicit memory. As a result of the trauma, the sensory and visual experiences are encoded with the implicit memory.

28. How then are the repressed memories brought back into consciousness?

29. Such memories are recovered by the triggering of sensual experiences and visual images similar to that which lead to the repression or disassociation.

30. Thus repression of memory and its therapeutic retrieval is the corner stone for the controversial theory explaining Anorexia Nervosa; Bulima; Post Traumatic Stress Disorder; Depression; Anxiety state and so on. Proponents advocate that only by *unblocking* such memories can a person be healed.

Modern Day Gurus

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5 American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)

6 Studies report that 0.5 to 3% of general psychiatric hospital admissions meet the diagnostic criteria for the Disassociative Identity Disorders, Kaplan & Sadock's Synopsis of Psychiatry, 9th Edition, p 681

31. Proponents of recovered memory are increasingly reluctant to disclose their acceptance of the validity of its theorem. It is the author's experience that this is a deliberate stratagem aimed at preventing defence lawyers and the courts from being able to critically examine evidence of complainants who have recovered memories of sexual assault. It also promotes the notion that every person accused of sexual assault must be guilty.

32. There is nevertheless an extensive network of psychiatrists, psychologists, counsellors and therapists who implacably believe in the process of recovered memory. This is despite the fact that there is no scientific validity in support of the theory and the fact that there have been so many grave injustices perpetrated by reliance upon it as a valid theorem. The Director of the New South Wales Institute of Psychiatry, Louise Newman, as long ago as 2005, said:[7]

> *Of most concern are those practitioners with no or unaccredited qualifications who, because of the unregulated nature of the psychotherapy industry, advertise themselves as experienced clinicians trained to treat an array of issues from stress to the damaging long-term effects of child abuse and maltreatment.*
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> *Some seeking help have complex problems and are vulnerable to inept or inappropriate therapies. As the recent Herald series on the possibility for problems emerging in this area are highlighted, risks from unqualified therapy are significant, particularly for those struggling with the effects of abuse and past trauma. Focusing on early adversity and traumatic memories can be a distressing, needing experienced and qualified support. It is not uncommon for someone going through this to become depressed and even self-harming if the process is not managed correctly.*
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> *An underqualified therapist may not be able to judge when to focus on present issues as opposed to the past or when to refer for more specialist support. The effects of an inappropriate therapy can be long lasting and affect relationships, family and working capacity.*

33. Any analysis of recovered memory cannot fail to acknowledge the role of modern day gurus such as Ellen Bass and Laura Davis, the authors of *The Courage to Heal*; *A Guide for Women Survivors of Child Sexual Abuse*. In this book the authors stated:[8]

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7 Stricter therapy rules needed, for the sake of community Health, Sydney Morning Herald, 21 September 2005.

8 E Bass and L Davis, *The Courage to Heal; A Guide for Women Survivor's of Child Sexual Abuse*, Harper & Row, New York, 1988, pp 21 & 22

> *If you are unable to remember any specific instances like the ones mentioned above but still have a feeling that something abusive happened to you, it probably did…*
>
> *To say, 'I was abused' you don't need the kind of recall that would stand up in a court of law. Often the knowledge that you were abused starts with a tiny feeling, an intuition… Assume your feelings are valid. So far, no one we have talked to thought she might have been abused, and then later discovered that she hadn't been. The progression always goes the other way, from suspicious to confirmation. If you think you were abused and your life shows the symptoms, then you were.*

34. The authors also state:[9]

> *If you have unfamiliar or uncomfortable feelings as you read this book, don't be alarmed. Strong feelings are part of the healing process. On the other hand, if you breeze through these chapters, you probably aren't feeling safe enough to confront these issues. Or you may be coping with the book the same way you coped with the abuse – by separating your intellect from your feelings.*

35. A fundamental tenant of Bass and Davis is the *premise* that it is the person's subjective physical, emotional or spiritual experience that is determinative of whether sexual abuse occurred. The authors state:[10]

> *"Some abuse is not even physical. Your father may have stood in the bathroom doorway, making suggestive remarks or simply leering when you entered to use the toilet Your uncle may have walked around naked, calling attention to his penis, talking about his sexual exploits, questioning you about your body… They are many ways to be violated sexually. There is also abuse on the psychological level. You had the feeling your stepfather was aware of your physical presence every minute of the day, no matter how quiet and unobtrusive you were. Your neighbour watched your changing body with an intrusive interest. You father took you out on romantic dates and wrote you love letters."*

36. Bass and Davis thus actively encourage women to believe that they have been sexually abused despite alleged victims having no memories of the abuse. Further, a victim's physical, emotional and spiritual experience is the essential criterion for determining whether abuse has in fact taken place.

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9 Ibid, p 23

10 *The Courage to Heal: A Guide for Women Survivors of Child Sexual Abuse*, NY: Harper Perennial (originally published by Harper in 1983)

37. Psychiatrist, Judith Lewis Herman has stated that incest is a "*common and central female experience".*[11] Copywriter E Sue Blume and her book *Secret Survivors* state that "*incest is so common as to be epidemic….".*[12]

38. Blume in her book states:

> *It is my experience that fewer than half of the women who experience this trauma later remember or identify it as abuse. Therefore, it is not unlikely that more than half of all women are survivors of childhood sexual trauma….Literally tens of millions of 'secret survivors' carry the weight of his hidden history of abuse.*

39. The popular incest-survivor authors set out to debunk scientific research on memory and protocols of professional organisations. E Sue Blume stated that incest research *"has been used to hide truth and support lies…"*.

40. Those who practice in the area of sexual assault and in particular having represented persons accused, ought be concerned of the exposure of many complainants to popular writings by authors such as Bass and Davis, Herman and Blume. The overriding message conveyed by these authors is that even if a person does not have a memory of abuse that does not mean that abuse has not occurred. In other words, what these popular authors have done is to encourage many thousands of people to believe that they were abused even if they have no memories of such abuse. Furthermore, that an explanation for a person's presenting symptoms are explicable on the basis of repressed memories of abuse. But one example of this is that of the author *Farmer* who has readers undertake one exercise:

- "*whether or not you have any conscious recollection of the abuse you have suffered*"
- *You sit down, relax and mentally return to childhood;*
- *Choose a particular memory, whether fuzzy or clear, and "bring that memory to your full attention";*
- *You, just like "Danielle" think about how verbally abusive her father had been, and "Hazel", who remembered anger and her mother treating her like a rag doll;*
- *This "lifts the lid of repression" and unburies the "Hurting Child";*

41. Bradshaw (1990, 1992) invites readers to consult his "*index of suspicion; do you have trouble knowing what you want? Are you afraid to try new experiences? If someone gives you a suggestion, do you feel you ought to follow it? If you answered even one of these questions "yes" then you "can count of some damage*

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11 Herman, JL (1982) *Trauma and Recovery* NY Basic Books

12 Blume, ES (1990) *Secret Survivors; Uncovering Incest and its After Effects in Women.* NY Ballantine Books

having been done to you… between the 9th and 18th months of your life". (1992 p.49)

42. The real risk with popular authors is the creation of memories which are false.

43. Professor Elizabeth F Loftus in her research as to how False Memories can be created, referred to this when she said *"Spend time imagining that you were sexually abused, without worrying about the accuracy of proving anything or having your ideas make sense… ask yourself these questions: What time of day is it? Where are you? Indoors or outdoors? What kind of things are happening? Is there one or more persons with you?"*[13]

A Closed Approach

44. One of the most pressing problems in this area is that relating to the ideological approach of therapists. As has already been commented upon, there are many persons who describe themselves as *"therapists*" who in fact have no accredited qualifications whatsoever. Even many psychologists and psychiatrists approach the treatment of their patients with an alarming degree of ideological zeal.

45. A critical problem with unqualified therapists is that they are not subject to any rules or protocols such as those in place by Professional Associations such as the Royal Australian and New Zealand Psychiatric College of Psychiatrists/ Psychological Society. Furthermore, such persons are not subject to any professional sanction in the event that their inappropriate techniques are brought to light.

46. As is evident from the writings of popular authors such as Bass and Davis, Blume and Herman, many people enter therapy without any memory of abuse but acquire memories in the course of therapy. There are many therapists who believe that notwithstanding that a patient has no memory of alleged abuse that does not mean that they in fact were not sexually abused. The methodology adopted, is one whereby the patient is made the subject of a symptom check list, and the early diagnosis that such "symptoms" are related to a history of abuse.[14]

47. In a study in 1988 (Forward and Buck) a therapist who had treated 1500 incest victims, discussed her method of diagnosing clients:

"You know, in my experience, a lot of people who are struggling with many of the same problems you are, have often had some kind of really painful things happen to them as kids – maybe they were beaten or molested. And I wonder if anything like that ever happened to you?" (p.161)

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13 Loftus, Elizabeth F (Sep 1997) 'Creating False Memories', Scientific American, vol 277, no 3, pp.70-75.

14 See The Reality of Repressed Memories, Elizabeth F Loftus, American Psychologist May 1993

48. Others adopt similar leading approaches such as "*your symptoms sound like you have been abused when you were a child. What can you tell me about that?*" or "*You sound to me like the sort of person who must have been sexually abused. Tell me what that bastard did to you*".

49. The raising of the alleged history of sexual abuse conveys to the patient that here is a therapist who believes whatever the client is going to tell them. In particular, any alleged memories of a history of sexual abuse.

50. A frequent methodology adopted by therapists in assisting patients recover memories of abuse is that of dreams. Frederickson (1992) uses a methodology "*to expand on or explore images that have broken through to the conscious mind, allowing related images of the abuse to surface. The process lets the survivor complete the picture of what happened, using a current image or flash as a jumping-off point*". This also involved assisting the patient to expand on the images and sensations arising from the dreams "*to shed light on or to recover our repressed memories*". In particular she encourages the use of hypnosis to "*retrieve buried memories*" and for patients "*jot down suspected memories of abuse you would like to explore. Include your own felt sense of how you think you were abused*".

51. An important issue that frequently arises is that complainants are invariably referred to support groups to undertake therapy. One such group in New South Wales is Advocates for Survivors of Child Abuse which conducts its workshops at Mayumarri. The group was commenced by the well known victims advocate Liz Mulliner. This group, like other survivor of incest groups, publish an extensive list of reading materials. A focus of many of the materials and treatment regimes advocated are those based on recovered memory.

52. A problem that can arise with such groups is that of "proto-extension". This is a process that encourages a person to remember details from other victims stories.

Confirmatory Bias

53. We have all experienced the tendency for one to look for evidence that confirms one's suspicions. It is a common enough human trait. This concept known as "*confirmatory bias*" can and often does affect therapists.

54. Therapists often use techniques that *confirm* their biased theory about a patient's presenting symptoms. Check lists are invariably used that have closed questions or leading cues to alert the patient to the direction that the therapist wants the patient to take. In particular these check lists will often seek to elicit a *history* of symptoms that can be categorised as those commonly experienced by persons who have suffered sexual abuse. Often, the therapist has the best of intentions, namely to do their best to help the particular client. However, these *closed*

techniques can and often do lead to a patient forming a belief about a memory that is false.[15]

55. Laura Davis in The Courage to Heal Workbook says this about locating an appropriate therapist:

"There are certain basic things that are necessary in a counsellor. You should make sure your prospective counsellor:

- *Believes that you were abused*
- *Never minimizes your experience or the pain it's caused you*
- *Has information (or is wiling to get information) about the healing process for adult survivors of child sexual abuse*
- *Is willing to hear and believe the worst experiences you have to talk about*
- *Keeps the focus on you, not on your abuser*
- *Doesn't push reconciliation or forgiveness*
- *Doesn't want to have a friendship with you outside of counselling.*
- *Doesn't talk about his or her personal problems*
- *Doesn't want to have a sexual relationship with you, now or ever in the future*
- *Fully respects your feelings (grief, anger, rage, sadness, despair, joy)*
- *Doesn't force you to do anything you don't want to do*
- *Encourages you to build a support system outside of therapy*
- *Encourages your contact with other survivors of child sexual abuse*
- *Teaches you skills to take care of yourself*
- *Is willing to discuss problems that occur in the therapy relationship"*

56. The differences in the approach between legal and psychotherapeutic requirements are summarised as follows:[16]

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15 The Reality of Repressed Memories, Elizabeth Loftus, American Psychologist May 1993 p.530; Courage to Heal Workbook for Women and Men Survivors of Child Sexual Abuse, Laura Davis.

Investigative Role	Therapeutic Role
Historical truth	Narrative truth
Emotionally Neutral	Emotionally orientated
Goal – no change	Goal – is change
Suggestions undesirable	Suggestions desirable
Leading questions avoided	Leading questions required
Video taping required	Recording considered intrusive
Establish guidelines	No Guidelines

False Memories

57. Loftus and Ketcham describe how memories can be implanted into a person's real-life autobiography. Piaget held a memory for over a decade of his attempted kidnapping when he was an infant. His nanny confessed that she had made up the story. Piaget assumed "I therefore, must have heard as a child the account of this story, which my parents believed and projected into the past in the form of a visual memory".

58. Laurence and Perry asked twenty-seven (27) highly hypnotisable individuals during hypnosis to chose a night from the previous week and to describe their activities during the half hour before going to sleep. A suggestion was implanted that they had heard some loud noises and had awakened. Thirteen of the twenty-seven subjects stated after hypnosis that the suggested event had actually taken place. Of the thirteen, six were unequivocal in their certainty. The remainder came to the conclusion on the basis of reconstruction. The subjects were told that the noises had been suggested to them during hypnosis. They still maintained that they had heard them. (Laurence and Perry, 1983, p.524).

59. In a study conducted in 1991 by Haugaard, Reppucci, Laurd and Nauful, children aged 4 to 7 were induced to believe they saw a man hit a girl, when he had not. The study showed that not only did they recall the non-existent hitting, but added their own details.

60. In a study conducted by Pynoos and Nader (1989) children were asked to recall a sniper attack at a school playground. A number of the children were not at the school during the shooting. A number of these persons had memories of the shooting when they were not even at the school and provided details of what they had so called observed.

61. Loftus undertook research as to implanted memory involving a 14 year old boy named Chris. He had been convinced by his older brother, Jim, that he had been lost in a shopping mall when he was 5. He was told it occurred in 1981 and 1982.

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[16] GW Byrnes "Memories of Abuse" 1995 1(3) Psychotherapy in Australia 5 and 6

He told Chris that he was found being led down the mall by a tall, older man wearing a flannel shirt. Chris was crying and holding the man's hand.

62. Two days after the older sibling had convinced his younger brother of this incident, Chris recounted his feelings about being lost:-

"*That day I was so scared that I would never see my family again. I knew that I was in trouble*".

63. As the days went on he recovered further memories including being told not to get lost again by his mother and then the old man's flannel shirt. As time when on, Chris recounted even more specific memories including that the elderly man was bald and he could recall the type of glasses worn by the man who rescued him.

64. A famous case involving a false memory of abuse is that of Paul Ingrim. He was the Chair of the County Republican Committee and was arrested for child sexual abuse in 1988. He denied to Detectives all of the allegations. The police repeatedly interrogated him over some five months including having him interviewed by a psychologist. He then commenced to admit to sexual assaults involving rape and being involved in a Satanic Worshipping Cult which had murdered 25 babies. The Detectives and/or Psychologist used coercive techniques in suggesting to him that particular types of abuse had occurred. One such leading technique was to repeatedly suggest to him that he and several other men had raped his daughter.

65. A psychologist was retained by the prosecution to interview Ingrim, namely Richard Ofshe. As Elizabeth Loftus observes, Ofshe made up a completely fabricated scenario. He informed Ingrim that two of his children had reported that he had forced them to have sex in front of him. Ingrim could not remember this. At Ofshe's urging, Ingrim recovered the memory of the scene. As the interrogation went on, he recovered more and more memories and eventually wrote a confession that the psychologist had invented.

66. As Elizabeth Loftus observed:-

"*These examples provide further insights into the malleable nature of memory. They suggest that memories for personally experienced traumatic events can be altered by new experiences. Moreover, they reveal that entire events that never happened can be injected into memory. The false memories range from the relatively trivial to the bizarre. These false memories, with more or less detail, of course do not prove that repressed memories of abuse that return are false. They do demonstrate a mechanism by which false memories can be created by a small suggestion from a trusted family member, or by hearing someone lie, by suggestion from a psychologist or by incorporation of the experience of others into one's own autobiography.*"

A Thoroughly Debunked Theory

67. In 1996 Hope & Hudson, two eminent researchers published a paper as to the scientific validity of the theory of repressed memory. The authors found that: [17]

> *Laboratory studies over the past sixty years have failed to demonstrate that individuals can 'repress' memories. Clinical studies which extrapolate from the laboratory to the study of real-like traumas must consequently start with the null hypothesis; that repression does not occur…. In summary, present evidence is insufficient to permit the conclusion that individuals can 'repress' memories of childhood sexual abuse. This finding is surprising, since many writers have suggested that there is a high prevalence of repression in the population.*

68. Proponents of recovered memory are loathe to accept that Freud, who was the originator of repressed memory, changed his theory from trauma to children's fantasies of being seduced as the cause of repressed memory. Freud debated whether repression was a conscious or unconscious process.

69. Modern studies of human memory have demonstrated the need to distinguish between repression, suppression and forgetting.

70. Repression involves memory being laid down into the unconscious mind so as the individual *is unaware of it.* Suppression involves a person being conscious of past traumatic events such as sexual abuse but failing to divulge the memory because of shame or guilt, in other words a conscious decision to suppress the memory. Non forgetting as we know is a common enough experience.[18]

71. It is the therapeutic context which needs to be critically examined for one to understand how a person's recall can be influenced by a variety of means, in particular, therapists. In a therapeutic context there are a number of factors which are apparent which can influence a person's so-called memory of sexual abuse, such as;

- The biased approach of therapists and their use of unreliable techniques including leading questions; imagistic work, dream work, journal writing, body work, hypnosis, art therapy, feelings work, group therapy and confrontations.

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17 Can Memories of Childhood Sexual Abuse be Repressed? Harris & G Pope Jr and James I Hudson, Psychological Medicine, 1995, Cambridge University Press; Rivers v Father Flanagans Boys Home (2005) District Court of Douglas County Nebraska

18 "Suppression" is defined as a common act of controlling and inhibiting an unacceptable impulse, emotion or idea; differentiated from repression in that repression is an unconscious process; Comprehensive Text Book of Psychiatry by Kaplan & Saddock 8th Ed.

- The influence of popular authors, the media and proponents who continue to portray a standard or normal modality of being a victim of sexual abuse. The influence that a therapist has over the patient and especially those therapists represents a particular expertise such as hypnosis, EMDR, neurolinguistic programming, satanic ritual abuse and so forth.

- That a patient is often referred to a particular therapist through a network and the propensity of the patient to undergo therapy advanced by the therapist as a means of getting better.

ILLUSTRATIVE CASES

72. Repressed memory is a phenomenon that has developed at a remarkable rate in the United States of America and certainly is now firmly entrenched in Australia. There is a very strong likelihood that there will be an increasing number of cases in which this issue will be extremely important. A number of celebrities, especially those in the United States of America have become firm advocates of this so called 'syndrome'. The most famous to date is Roseanne Arnold who has been only too happy to "disclose" her experiences to her adoring public. Roseanne has alleged that her mother had placed soap in her vagina, her father played with his penis, and also chased after her in their home whilst he was wearing dirty underclothes. She was reported as saying, *"I say what I say because my fans want to hear it"*. Roseanne alleged that her sister, Stephanie was also abused. She asserted that she and her sister would talk about the abuse for days on end. Her sister Stephanie denies that she was ever abused and she has never had any knowledge that her sister had been abused.

73. It is important to understand, as to what is meant by repressed memory. Research indicates that our brains do not necessarily contain a complete record of past experience. Once theory suggests that misleading information may **replace** the original memory. Another suggests that misinformation may only make original memory more difficult to retrieve. In this latter case a person with the right sort of prompting or leading will be able to recover the original memory and thus be able to put to one side the misleading information.

74. A number of authors have observed that memory repression in this context (that is child sexual assault) involves the total banishment from consciousness of the memory.[19]

75. It is important to recognise that children who have been sexually abused may have difficulty with their memory. A number of studies have shown that victims of sexual assault do have such difficulties. In one study thirty eight percent of

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[19] See *R J Ofshe and NT Singh (1993) Recovered memory therapies and robust repression, A collective area (1993). University of California Berkeley.*

women who had apparently been abused when they were aged between three and twelve could not remember the abuse some seventeens years later.[20]

76. If a child's memory is weak they are likely to be more suggestible. They are also subject to **substitution of memory** and in a study conducted by Pynoos and Nader[21] it was found that children who had heard stories of an actual sniper attack at their school later recalled having seen parts of the attack. In a study conducted by Ceci[22] he was able to convince children that they had their hands caught in a mouse trap and had to go to hospital to get the trap removed. This was done by inducing the child to repeatedly think about the event. In a study conducted by Loftus,[23] she was able to convince a number of adults that they had been lost in a shopping mall for some considerable time at about the age of five years. This was done by convincing the adults to believe that these were the memories of a close family member. In this way the false memories were implanted in the context of a relatively short time period and under little pressure. In a study conducted by Spanos[24] hypnotic regression suggestions were given to a number of adults and they were convinced to develop past life identities. Some of these "remembered" that they had been abused as children. These and other studies tend to indicate that memory may well be **reconstructive** and certainly that false recollections can be induced by suggestive procedures.

77. An extremely controversial illustration of some of the issues that can arise are illustrated by the case of **George Franklin**. In 1969 an eight year old Susan Nason was murdered. Franklin's daughter Eileen Franklin Lipsker was herself aged eight at the time of the murder. Miss Lipsker at the age of twenty eight years, recovered a memory of her father killing her best friend. That is her memory had been repressed for over twenty years. The circumstances in which she asserted her first flashback occurred in January 19899 when she was playing with her young children. Her five year old daughter, Jessica looked up and asked her mother a question, "Isn't that right mummy?" With that question Miss Lipsker recalled seeing her friend's eyes before she was murdered. She then recovered other memories and eventually recalled that she had seen her father with his hands raised above his head with a rock in them. She remembered seeing her friend covered in blood and the silver ring on her finger smashed.

78. Eileen's memory was accepted by her therapist and her father was charged with murder. On 30 November 1990 he was found guilty of murder in the first degree.

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20 M Williams, Adult memories of child abuse, Preliminary findings from a longitudinal study, The Advise (1992) at 5 19-20

21 Pynoos R S and Nader K, Children's memory and proximity to violence. **Journal of American Academy of Child and Adolescent Psychiatry (1988) at 28,** 236-241

22 S J Ceci, Cognitive and social factors in children's memory

23 Loftus, Therapeutic recollection of childhood abuse when a memory may not be a memory. Champion March 1994

24 N P Spanos et al, Secondary identity enactments during hypnotic past-life regression, Journal of personality and social psychology (1991) at 61

79. The prosecution relied upon expert testimony that repressed memory was a valid psychological diagnosis despite no scientific evidence that could demonstrate the authenticity of it. In the Franklin trial the jury were obviously more impressed with the expert retained by the prosecution who boldly asserted its legitimacy.

80. In examining the evidence of Miss Lipsker one is confronted with the issue of whether her memory was authentic or not. If it was not authentic then from what source did she obtain the information upon which her so called "memory" was based. The facts of the murder were extensively reported upon in 1969. The media reports contained graphic details as to the way in which the young girl was murdered. Such details included the fracturing of the girl's skull, the wearing of a silver Indian ring, the crushing of that ring. The other remarkable feature of the case was the way in which Miss Lipsker's "memory" varied. In the first statement to police she told the police her father was driving her and her sister Janice to school when they first saw Susie and he made Janice get out of the van and Susie got in it. At the preliminary hearing she had no memory of Janice being in the van. In her first statement to police the trip happened on the way to school in the morning. At the preliminary hearing after it was apparent that Susie had not been missing until after school was out, she "recalled" that it was in the later afternoon.

81. In 1983 one of the most controversial cases involving allegations of sexual assault arose in California and became known as the Martin Pre-School Case. The case originated when a mother of the kindergarten observed that her son's anus was red and that the child had informed her that a pre-school teacher had taken his temperature.

82. The case quickly developed into the most bizarre of allegations including the children had observed animals being slaughtered; that they had been forced to eat cake faeces; they had been taken to churches, to devil land and into underground tunnels beneath the pre-school.

83. The Los Angeles District Attorney asserted that the pre-school had been established for the purpose of child abuse and for the production of pornography. It was claimed that it was part of a paedophile network of other day care centres and investigators concluded that 150 children at the pre-school had been abused. Those arrested included the pre-school teacher who had allegedly taken the temperature of the child; his sister, his mother, his grandmother and three other teachers at the school who were charged with 321 counts of sexual assault involving a number of children.

84. The key expert relied upon by the prosecution was one Dr Roland Summit, Psychiatrist. Dr Summit gave evidence that children are not capable of fabricating stories of sexual assault. He advanced his theory of *"The Child Sexual Abuse Accommodation Syndrome"*. It was arrived at as result of Summit's work with adult survivors of sexual abuse and from discussions with social workers,

psychologists, journalists, police, nurses and persons such as Kay McFarland, a social worker who had pioneered the technique of using anatomically record dolls to encourage children to disclose sexual abuse.

85. The case eventually collapsed and became one of the most expensive debarkle in US criminal history.

86. A key feature of the case was the controversial opinions expressed by Dr Summit and his maintenance of the aforementioned syndrome.

87. In the course of the case Dr Summit attended various conferences including a Child Abuse Conference in Washington when he spoke of a new type of abuse in which children were forced to faeces, participated in blood sacrifices and engaged in sexual ceremonies with grove figures.

88. According to Summit a child who has been exposed to sexual abuse may development accommodation mechanisms including *"domestic martyrdom"*, *"splitting of reality"*, *"altered states of consciousness"*, *"self mutilation"*, *"promiscuity"*, *"projection of rage"*, *"substance abuse"* and a range of other destructive behaviours.

89. Summit in 1992 conceded that his that conceded that CSAAS originated not as a *"laboratory hypothesis or as a designated study of a defined population. It emerged as a summary of diverse clinical consulting experience defined at the interface with paradoxical forensic reaction. It should be understood that without apology that the CSAAS is a clinical opinion, not a scientific instrument"*.

90. Summit further conceded that:

"Syndrome seems to mean a diagnosis which an expert contrives to prove an injury. Syndrome evidence has become a generic term for diagnostic medical or psychological testimony which must be closely scrutinised for scientific reliability, less the intrinsic authority of the expert witness improperly prejudice a jury through contrived or eccentric opinion"

91. The well known author Freckelton has observed:

"The fact is that by cloaking the entity in the language of medical diagnosis, which is the inevitable connotation of the word 'syndrome' Summit originally invested it with a resonance of legitimacy (and no doubt did so advisedly) which it would not otherwise have commanded. The difficulty is that the description is inappropriate from at least two points of view – it is not an entity susceptible of classification in terms of being a constellation of signs or symptoms whose medical aetiology may be unknown; nor is it a pathological condition of any demonstrated kind."

92. Significantly, Summit conceded that the behavioural patterns that he identifies are not pathological; rather they are descriptive of normal children making normal adjustments to an abnormal environment.

93. Summit, himself, stated:

"There has been some tendency to use the CSAAS as an offer of proof that a child has been abused. A child may be said to be suffering from or displaying the CSAAS as it if is a malady that proves the alleged abuse. Or a child's conspicuous helplessness or silence might be said to be consisted with the CSAAS, as if not complaining proves the complaint. Some have contended that a child who retracts is a more believable victim than one who has maintained a consistent complaint. Such absurd distortions fuel the fire against the CSAAS."

94. There is a need for significant caution where expert evidence is relied upon by prosecutors to establish that symptoms allegedly experienced by complainants in sexual assault cases may be typical of persons who have been in fact sexual abused. This has particular relevance in jurisdictions such as Tasmania and in New Zealand where such evidence has been sought to be relied upon.[25]

95. A number of experts have expressed concerns about the opinion of Summit.[26].

96. Beitchman Etal (199, p 546) stated:

"Victims of sexual abuse were characteristic of clinical samples in general. Specifically, children from disadvantaged or disturbed families often displayed behavioural problems, difficulties at school, and low self-esteem. Internalizing behaviours such as sleep disturbance, somatic complaints, fearfulness and withdrawal were also common symptoms in child psychiatric populations and so cannot be automatically conceptualized as sequelae specific to sexual abuse."

97. Another controversial case was that in New South Wales that came to be known by the name of the *"Mr Bubbles Case"*. This was also a case involving allegations of abuse emanating from one person. That person had a psychiatric history and went to the police with her theory that children at the subject kindergarten had been sexually assaulted in a bizarre manner. Police who were poorly trained together with social workers repeatedly interviewed the children and allegations involving drug use; being assaulted with knives; sexual abuse; being filmed for pornographic movies; animal sacrifices and satanic rituals was made.

98. One expert who gave evidence in the case was Professor Oates. His gave evidence based upon examinations of the hymen of female children. The criteria which he based his opinion on was that involving the width of the hymen and of

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25 See s.79A of *Evidence Act, (Tas)*

26 McCord (1987); Gardener (1992, p 297); Beitchman Etal (1991, p 546)

the hymen having an irregular edge. If the hymen was wider than 4 mms or had an irregular edge that this must have occurred as a result of trauma. It was shown in cross-examination that his opinion was fundamentally flawed since such irregularities were commonly reported in non-abused prepubescent girls and he conceded that the test was thus unreliable.

99. Professor Oates relied in part upon the views of an Australian author, namely; Cathy-Ann Mathews in her book *"No Longer a Victim".*

100. Mathews described in her book her recovered memories of being sexually assaulted by her father from the age of 18 months until she was 15 years. Those memories included that her father had set her on fire; threw her down a flight of stairs; tried to kill her by putting her finger into an electric socket; attempted to smother her to death; terrorised her with threats and pushed pins down her fingernails.

101. Such memories had all arisen as a result of therapy and were in fact recovered memories.

102. The recent case in **Bunbury** Western Australia has catapulted the issue of childhood memories to the forefront of the plethora of issues involving child sexual abuse. The case, which resulted in the acquittal of the accused of the majority of counts against him and the resultant decision of the Director of Public Prosecutions not to proceed are of great interest. The principle complainant, being the accused's daughter "P" alleged that between the ages of three and twenty five she was sexually assaulted by her father who used, amongst other things, crucifixes, screw drivers and a drill to assault her. She was forced to undergo abortions and she was forced to participate in ritualistic ceremonies. She alleged that her father forced her to have sex when he held a knife to the throat of her pet cat.

103. The case was all the more remarkable as "P's" sister, "T" also gave evidence corroborating her. She also alleged that her father had attacked her with an axe, a hammer and even a soldering iron. In one stark piece of evidence she recounted that she was in a garage and was tied up by her father whilst he made a snake descend from above her whilst he laughed.

104. "T" first had "flashbacks" of the alleged assaults when she was being treated in 1989 for chronic depression. She had attended upon a Perth psychologist for almost a year. She recounted that something that happened at a family gathering was the trigger for her "recall". She observed a young niece to be bleeding from a vaginal injury which had occurred whilst she was playing with other children. It was some weeks later that she had "flashbacks" of being sexually assaulted by her father.

105. In early 1991 "T's" sister "P" visited a hypnotherapist who confirmed that she was suffering from being sexually assaulted. She had been encouraged to read a book titled "The Courage to Heal". This was a very popular book for incest survivors.

106. In time the allegations were expanded upon to include their mother, grandfather, brothers, uncles and various other persons. "P" alleged that she was raped in 1989 by her father, being at a time when she was pregnant. This occurred again in 1990 and she could not recall such memories until she began her therapy in 1991.

107. Another case that highlights the way in which false memories can be implanted is that of *AW & Ors v State of New South Wales* [2005] NSWSC 543. The Supreme Court considered a case brought by three Plaintiffs, AW, LW, and JS. The actions were for wrongful arrest, false imprisonment and malicious prosecution.

108. AW and LW were the parents and JS was the grandmother of four children SW, JW, EW, and JW.

109. In 1993/94 the eldest child SW had attended upon a psychologist DK who believed in recovered memories. She had consulted the psychologist because of difficulties in a relationship with her boyfriend, MD. She attended upon DK on over 40 occasions. She initially had no memory of any allegations against AW, LW or JS.

110. By her 40th visit SW had recovered memories of fantastic and bizarre allegations against AW and then LW and JS. Such memories included the use of animals in the acts allegedly perpetrated against her; incidents and rituals involving the extraction of blood and menstrual fluid; horrific abortions; adults in black garments involved in some form of ritual abuse.

111. The psychologist DK who at the time of giving therapy to SW had only recently arrived from Canada and gave evidence at the committal hearing of the criminal charges against AW, LW and JS that human memory was like an 'onion ring' and that in time 'one peels away the layers of memory until the 'core' is revealed. All of the charges against AW, LW and JS were dismissed, except one charge involving AW which was discontinued by the DPP.

112. An interesting aspect of this case was that so-called 'memories' of the siblings were influenced by SW. For instance SW had EW read passages from a book titled "Flowers in the Attic". She had underlined passages in the book involving the extraction of blood from the body of the boy's sister referred to in the book. EW took up that suggestion andt told police blood had been extracted from her breast. Evidence from an expert was that it was not possible extract blood from breast tissue. Likewise allegations involving the extraction of large quantities of menstrual material were shown to be impossible.

113. In the action against the State of New South Wales, the children JW and LW gave evidence. They each agreed that their allegations were untrue. EW who had asserted that she had undergone a forced abortion on a kitchen table had at that stage not even commenced to menstruate.

114. The case highlights the dangers of reliance upon recovered memories in the way a witness can come to assert allegations which are false. Though these issues were not canvassed in the hearing before Bell J., nevertheless they were significant issues in the care proceedings which extended over 107 hearing days and in the committal proceedings which extended over some approximate 60 days. A further disturbing aspect of the case was that of the relationship between SW and MD, the Detective who investigated the case. The Plaintiff's case was that MD was having a relationship with SW during the care and committal proceedings. EW gave evidence to support this. MD gave evidence that he formed a relationship with SW shortly after the committal hearing had concluded and that they subsequently lived together for some years.

115. The District Court of Douglas County Nebraska recently considered a case in which the issue of repressed memory was the fundamental issue. Rivers sued Father Flanagan's Boys Home and James E Kelly for assault and battery and alleged that he had suffered from a repressed memory of that abuse which had only been discovered by him on or about March 27, 2002. Boys Town and Kelly denied the allegations and filed a Motion contending that the relevant statute of limitations applied.

116. Dr Pope and Dr Elizabeth Loftus gave evidence. Judge Sandra L Dougherty heard evidence from Dr Pope relating to a study done by Dr Femina who had undertaken study of sexual abuse victims who had initially denied that abuse. Femina found eight (8) of the eighteen (18) subjects who had originally denied the abuse had conceded that they had always remembered the abuse but had chosen not to disclose it at the time of the original study.

117. Dr Pope gave evidence that there was no scientific basis for what is referred to as repressed memory and that the American Medical Association had provided position papers in 1994 and 2000 cautioning acceptable of it as a valid condition. Dr Pope testified that even if there was such a thing as repressed or recovered memory, one cannot evaluate the accuracy of retrieved memories without corroborating evidence. Even if Rivers experienced what is referred to as repressed memory, there would be no way to determine at what point the Plaintiff would have repressed the memory. It was Dr Pope's opinion that the Plaintiff was trying to find some explanation as to why he had suffered for so many years from unexplained "miserable" symptoms. He further was of the opinion that repressed memory should be included as a conversion symptom which is how it is classified in the World Health Organisation Classification of Disorders. In conclusion it was his opinion that none of the studies sought to be relied upon by

the Plaintiff met the established scientific criteria for establishing the existence of repressed memories.

118. Dr Elizabeth Loftus, Ph.d also gave evidence for the Plaintiff. She is a distinguished professor of psychology at the University of California – Irvine and a specialist in memories. She has co-authored 20 books and 400 articles on the subject. She was elected to the National Academy of Sciences in 2004 and the Royal Society of Edinburgh in 2005 and received the Grawemeyer Award in 2005.

119. Dr Loftus gave evidence that the concept of repressed memories is so controversial that one could not possibly be accepted within the scientific community of psychologists and cognitive psychologists.

120. Dr Loftus after evaluating all of the evidence, was of the opinion that there was a large body of external suggestion in the Plaintiff's environment including extensive discussion with his brother about his brother's claims; discussion with the investigator; discussions with his attorney; his dream; family pressure to bring a law suit; and the re-enforcement by Dr Gutnik of her repressed memory.

121. In over 30 years of research Dr Loftus had never found anything to prove the existence of repressed memory. She was further of the opinion that there was no evidence that Rivers had a repressed memory.

122. An issue that arose was whether the Plaintiff had ever been the subject of hypnosis or therapy that had caused him to recover his memory. The evidence was that he had not been exposed to any such therapy. However, Dr Loftus was of the opinion that there were a number of co-contaminants that may have led to the beliefs that the Plaintiff had.

123. Her Honour referred to the statement of the American Psychiatric Association in 1994 in which it was stated:-

"*It is not known how to distinguish, with complete accuracy, memories based on true events from those derived from other sources*".

124. The only way to prove the accuracy of a recovered memory is to produce corroborating evidence. The Association goes on to state:-

"It is not known what portion of adults who report memories of sexual abuse were actually abused. Many individuals who recover memories of abuse have been able to find corroborating information about their memories. However, no such information can be found, or is it possible to obtain, in some situations. While aspects of the alleged abuse situation as well as the context in which the memories emerge, can contribute to the assessment, there is no completely

accurate way of determining the validity of reports in the absence of corroborating evidence".

125. Her Honour also noted that the Association cautioned its members not to contribute to the unreliability of memory reports by re-enforcing false memories. "*Psychiatrists should maintain an emphatic, non-judgemental, neutral stance towards reported members of sexual abuse. As in the treatment of all patients, care must be taken to avoid pre-judging the cause of the patient's difficulties, or the veracity of the patient's reports. A strong prior belief by the psychiatrist that sexual abuse or other factors are or are not the cause of the patients problems is likely to interfere with appropriate assessment and treatment."*

126. Judge Dougherty also made reference to DSM-IV. She stated.[27]

"*The DSM-IV, which is a manual published by the American psychiatric Association, includes dissociative amnesia as one of its recognised diagnoses. In the DSM-IV it states "In recent years, there has been an increase in reported cases of dissociative amnesia that involves previously forgotten early childhood traumas. This increase has been subject to very different interpretations. Some believe that the greater awareness of the diagnosis among mental health professionals has resulted in the identification of ceases that were previously undiagnosed. In contrast, others believe that the syndrome has been over-diagnosed in individuals who are highly suggestible". (Ex. 79, pg.2) The DSM-IV also states as follows "Care must be exercised in evaluating the accuracy of retrieved memories. There has been considerable controversy concerning amnesia related to reported physical or sexual abuse, particularly when abuse is alleged to have occurred during early childhood. Some clinicians believe that there has been an under reporting of such events, especially because victims are often children and perpetrators are included to deny or distort their actions. However, other clinicians are concerned that there may be over reporting, particularly given the unreliability of childhood memories. There is currently no method for establishing with certainty the accuracy of such retrieved memories in the absence of corroborative evidence."*

127. The Plaintiff's mother and brother suffered from bi-polar disorder and episodes of major depression. His brother also experienced psychotic symptoms.

128. In March 2002, a month after attending his father's funeral, Rivers recalled waking up from a dream. In the dream Rivers was in the confessional with Kelly, a catholic priest at Boys Town when he was 13 years of age. Within an hour after waking from the dream, Rivers gave evidence that he recalled that Kelly had told him to pull down his pants during confession "to show him how I masturbated" and then had him pull his pants back up. Rivers asserted that Kelly did not touch his body while his pants were down but that he briefly touched Rivers groin area

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[27] Rivers v Flanagan's Boys Home & Anor Supra p.6 para 3.

during prayer after his pants were back up. Rivers recalled being very frightened that Kelly would tell the supervisor that Rivers had been masturbating.

129. Approximately two weeks after the dream in 2002, Rivers stated that he was alone recalling his times at Boys Town and he recalled a trip to Colorado when he was sleeping in a cabin with his brother Lance and the supervisor Mike Wolf. He had always remembered the trip to Colorado but now he recovered a new memory that someone had "massaged his groin in the darkness". He could not see the individual but believed that it must have been Wolf because there was only Wolfe and his brother Lance in the cabin and he could not accept that Lance could ever have done such a thing. It was thus the confession incident and the cabin incident that formed the basis of the claim by Rivers.

130. In mid April 2002, Rivers was contacted by an investigator working for an attorney representing another individual, James Duffy who claimed in February 2002 to have recovered memories of being sexually abused whilst at Boys Town. Shortly after that call, Rivers told his wife that he had recalled the two incidents. After that Rivers had several conversations with an investigator and a lawyer representing his brother Lance in a case against Boys Town alleging sexual abuse.

131. Dr Pope was of the opinion that Rivers did not meet the criteria for post-traumatic stress disorder because neither of the two incidents described would have been an event that involved actual threat and death or serious injury or threat to the physical integrity of ones self or others. Dr Pope was of the opinion that Rivers did not "repressed" and subsequent "recover" genuine and accurate memories because there is no methodological sound scientific evidence that people can "repress" a memory of an event.

132. Another expert called in the case was Dr Gutnik. Dr Gutnik testified that repression is a Freudian defence mechanism, that is, a theory, an educated guess. The symptoms suffered by the Plaintiff namely flashbacks, feeling estranged from people, being withdrawn, avoiding going back to churches, avoiding going back to Boys Town, difficulty recalling aspects of the confession, difficulty with concentration, irritability, low energy, fatigue, difficulty with sleeping, did not prove that he was the victim of physical or sexual abuse. The only evidence of Rivers recovered memory or its accuracy was what Rivers said himself. Dr Gutnik gave evidence that there were no symptoms or cluster of symptoms or any psychological test that can be used to determine whether a person was sexually abused.

133. The Court found that it could not accept the theory of repressed memory and recovered memory and that there was any scientific support for the theory. It concluded that Rivers had not met his burden of establishing that repressed and recovered memory was reliable and admissible as scientific evidence or properly applicable in the case.

Modern Protocols

134. The American Psychiatric Association in 1993 published a statement on recovered memories of sexual abuse. In summary the statement noted:[28]

- It is not known how to distinguish, with complete accuracy, memories based on true events from those derived from other sources;
- It is not known what proportion of adults who report recovered memories of sexual abuse were actually abused;
- There is no completely accurate way of determining the validity of the claims of remembered abuse in the absence of corroborating information; and
- Clinicians who have not had the training necessary to evaluate and treat patients with a broad range of psychiatric disorders, are at risk of causing harm by providing inadequate care for the patient's psychiatric problems and by increasing the patient's resistance to obtaining and responding to appropriate treatment in the future.

135. In May 1996 the Royal Australian and New Zealand College of Psychiatrists published guidelines for psychiatrists dealing with repressed traumatic memories and the following was noted:[29]

- Memory is highly susceptible to influence and revisions;
- The psychiatrist can facilitate and maximise the therapeutic potential of any memory recovery and respect the right of patients to secure their own uncontaminated memories, but should maintain clinical neutrality in the consulting room and should support patients rather than advocate for them as victims;
- Scientific studies and publications on this topic have burgeoned, but include controversial and extremist works, and this has led to a disturbing increase in 'repressed memory' versus 'false memory' court cases and sensationalist popular press;
- In this climate psychologically positive outcomes are largely made impossible but psychiatrists should maintain 'the hope of a clinical haven' for those who need to explore their own issues in a neutral, supportive environment; and

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28 American Psychiatric Association Board of Trustees', Statement on memories of sexual abuse, American Psychiatric Association, 1993, reprinted in *International Journal of Clinical and Experimental Hypnosis*, Vol XLII, no. 4 October 1994, pp 261-64

29 Australian Psychological Guidelines relating to the reporting of recovered memories, 1995

- It is impossible to know what has occurred privately between two individuals, especially if one of them is a child.

136. An eminent expert, namely; Professor K M McConkey has summarised the modern day position as:[30]

- The mechanisms used in memory recovery therapies tap into the same mechanism as those underlying hypnosis, may lower critical judgment, and increase fantasy;

- Traumatic events are more likely to lead to the occurrence of recurrent and intrusive memories than to repression or disassociation'

- Even if repression is recognised as a concept, it does not necessarily follow that a recovered memory is historically accurate, or free of the distortions and constructive features of memory generally; and that

- The situation in therapy may be complicated by the tendency of therapists to accept and confirm the validity of abuse memories at face value for fear of rejecting the patient and causing secondary abuse through disbelief, a response which provides 'the essential approval for the patient to assume the validity of memories that may not be accurate'.

Techniques

Hypnosis

137. *Hypnosis* is a state in which a person can respond to appropriate suggestions by experiencing altered perceptions, memory or mood.

138. It is typified by a feeling of involuntary movements which seem automatic, and suggested perceptions can alter or replace ordinary ones. It has been described as an altered state of consciousness, a dissociative state, and a state of regression.

139. Hypnosis was discovered by the Austrian Physician Fridrich Anton Mesmer (1734-1815). He described the process as *mesmerism*. The Scottish Physician James Braid (1795-1860) was the first to use the term *hypnosis* (from *hypnos*, the Greek word for *sleep*) in the 1840's. Sigmund Freud used hypnosis early in his career to assist patients to recover repressed memory. Freud observed that patients relived traumatic events while under hypnosis, a process he referred to as *abreaction*.

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30 K M McConkey, *Memory, Repression and Abuse, Recovered Memory and Confident Reporting of the personal past*; American Psychiatric Press Review of Psychiatry, Vol 16, American Psychiatric Press, Washington DC, 1997

140. Adherents of disassociation maintain that a person placed in a hypnotic state functions similarly to that of a person experiencing sleep. A person who is asleep will exhibit typical encephalographic (EEG) changes. A person in a hypnotic state exhibits an EEG that is similar to a person who is fully awake.

141. A person who is placed under hypnosis is in a trance like state. These can be light, medium or heavy. A light trance will induce changes in a person's motor activities such as a person's muscles feeling relaxed and extremities light. In a medium trance a person will experience partial or complete amnesia. A deep trance involves visual or auditory experiences and deep anaesthesia. Frequently time distortion exists especially in a deep trance.

142. Hypnosis is most frequently used to assist persons in refraining from a particular type of behaviour such as cigarette smoking or eating foods. Post hypnotically the therapist instructs the person to either do a particular act or experience a particular sensation upon awaking from the trance state. For example, experiencing the bad taste of cigarettes.

143. Hypnotherapy has become a popular technique in treating persons who have an alleged history of a traumatic event or events such as sexual abuse.

144. Therapists maintain that a patient subjected to a hypnotic trance can recall memories that are unavailable to consciousness in a non-hypnotic state. Thus, as the theory goes such memories confirm the particular hypothesis about a patient's symptoms. Frequently, hypnotherapy is used in combination with *age regression* so as to enable a patient to re-experience events that have occurred earlier in life. Thus, patients in such a state may describe an event with associated emotion and intensity similar to its original occurrence *(abreaction)*.

145. Invariably patients discuss with the therapist in the post hypnotic session such *so-called memories* which are extremely unreliable and frequently have the effect of *confirming* in the patient's mind a belief that a particular traumatic event or events has occurred.

146. The risk of memory distortion whilst under hypnosis has been the subject of investigation and reports for well over a century. Albert Moll, a well known hypnosis researcher stated "retro-active hallucinations are of great importance in law. They can be used to falsify testimony. People can be made to believe that they have witnessed certain scenes, or even crimes".[31]

147. The search of Bernheim noted "I have shown how a false memory can cause false memory given in *good faith,* and how examining Magistrate's can unwittingly cause false testimony by suggestion".[32]

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[31] Moll, A (1958. The Study of Hypnosis. New York; Julian Press) (original work published 1889)

[32] Bernheim, H (1973 Hypnosis and Suggestion in Psychotherapy, New York, Jason Aronson) (original work published 1886).

148. In making the point, Bernheim told a patient in trance that he had been awaken from sleep the night before by a neighbour who coughed, sang and made a racket opening windows. The patient was also told that other neighbours had been aroused from slumber by the noise. When the patient was brought out of trance and asked about the previous night, he reported being awaken by a loud neighbour just as Bernheim falsely suggested in trance. The patient when pressed for further details, readily supplied same. During the waking state, the patient fantasised and confabulated details which had not been suggested by Bernheim.

149. In 1982 a documentary was filmed for the BBC. A hypnotised subject, who had a good night's sleep, was placed in a trance and then told that she had been awaken by loud noises that sounded like gun shots. She was told the time of which the incident had occurred. The patient in her waking state reported the noises and the time that she had heard them. Orne played a tape for her of the pre-hypnosis state that she had slept peaceful throughout the night. Though she was puzzled she was insistent that she had been awaken by loud noises. Thus, she had had "*confirmed*" her hypnotically induced *false* memories than of her tape-recorded pre-hypnotic *true* memories.[33]

150. A team of Canadian researchers in 1986 demonstrated the possibility of creating pseudo-memories with hypnosis.[34]

151. In the author's experience, many therapists who use hypnotherapy have had little or any training in relation to the technique. In many cases in which the author has been involved, therapists have had virtually no training whatsoever in respect of the technique but nevertheless implacably believe that any memory recovered during its process are valid true memories.

152. As one can readily appreciate a patient is totally dependent upon the therapist in the hypnotised state. The patient frequently develops a strong transference of positive attachment to the therapist.

153. If ever a patient was at risk of biased ideation on the part of the therapist, it most frequently occurs where such a therapist uses techniques including hypnotherapy.

Eye Movement Desensitisation and Reprogramming (EMDR)

154. In May 1987 Francine Shapiro whilst walking through a park noticed that some disturbing thoughts she was having suddenly disappeared. She noticed that when she brought the thoughts back to her mind they were not as upsetting or as valid as before. Her previous experience had taught her that disturbing thoughts had a

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33 Barnes, M (1982 Hypnosis on Trial, London, British Broadcasting Corporation)

34 Laurence JR, Nadon R, Nogrady H and Perry C (1986) Duality Disassociation, in Memory Creation in Highly Hypnotisible Subjects. International Journal of Clinical and Experimental Hypnosis, 34, 295-310)

certain "*loop"* to them, in that they tend to play themselves over and over until one consciously does something to stop the changes. She was fascinated that her disturbing thoughts were disappearing and changing without any conscious effort. She noticed that when disturbing thoughts came into her mind her eyes spontaneously started moving very rapidly back and forth and upward and diagonal. The thoughts disappeared and when she brought them back to mind their negative charge was greatly reduced. She started making the eye movements deliberately whilst concentrating on a variety of disturbing thoughts and memories and found that these thoughts also disappeared and lost their charge.[35]

155. In Winter of 1987 Shapiro conducted a study which she regarded as her *"first official study"*. It involved a controlled study with 22 victims of rape, molestation or Vietnam combat who were suffering from traumatic memory. The amount of time since the traumatic event ranged from 1 to 47 years with an average of 23 years. The amount of previous therapy ranged from 2 months to 25 years with an average of 6 years of treatment. The criteria for an inclusion in the study was a self-reported traumatic memory and one or more pronounced symptoms such as an intrusive thought, flashbacks involving vivid recollections that included the feeling that the event is actually occurring.

156. Shapiro found that the treatment group demonstrated two significant changes; anxiety levels decreased, showing a pronounced desensitisation effect, and there was a marked increase in subjects perceptions of how true their positive beliefs were, showing a strong cognitive restructuring.[36]

157. In time, Shapiro developed a model which she described as *Accelerated Information Processing*. At the cornerstone of the theory is that EMDR focuses on the memory itself. According to Shapiro the resulting transmutation of the information and the target of memory appear to occur spontaneously, leading a change in client reaction.

158. Shapiro acknowledges that EMDR produces shifts in the memory itself and the way it is stored. For example, before EMDR treatment a traumatic target memory is manifested by a picture, cognition affect and physical sensations that are in the state – specific and disturbing forms in which they are required. Shapiro believes that such traumatic memory is held in non-declarative memory. After EMDR treatment, however, the memories are stored by the less disturbing picture, a positive cognition and the appropriate effect. In addition, there are no attended disturbing physical sensations. According to Shapiro, the rapid processing of the information allows its appropriate storage and declarative memory, development which means freedom for pathological reactions.[37]

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35 Eye Movement Desensitisation and Reprocessing – basic principles, protocols, procedures, Francine Shapiro – 1995, The Gilbert Press, New York, p 2

36 Ibid, p 3

37 Shapiro Ibid, p 15

Disassociation

159. Shapiro recognised that a patient may present themselves as highly symptomatic but with no memory of a traumatic event. In such cases there should be no *presumption* as to the nature of factual accuracy of the touchstone events. *Clinicians* should take greater care not to lead or interpret for the client.

The Eight Phases of EMDR

Phase 1 – Client History

160. Shapiro emphasises the fundamental importance of obtaining a detailed client history to assess suitability of clients for EMDR treatment.[38]

161. Patients with significant psychiatric backgrounds including those who have suffered severe emotional, physical or sexual abuse need to be very carefully assessed before the treatment is initiated.[39]

162. The EMDR sessions involve high levels of emotional upset and therefore the client's history is of fundamental importance.

163. Shapiro recognises that during EMDR treatment the targeted memory may *"fade, blur or completely disappear"*. In other words, in other cases the client may experience being able to provide a more "detailed description" and "may actually "see the picture more clearly after EMDR treatment".[40]

164. Therefore, according to Shapiro and as a matter of proper professional protocol informed consent should be used with all patients.

165. A clinician or therapist using EMDR should explain to the patient that:

- After EMDR treatment the patient might be unable to access a vivid picture of the traumatic event.
- The patient may no longer recount the incident with extreme emotion.
- EMDR is similar to hypnosis.

166. In the author's experience many therapists using EMDR fail to obtain a proper client history. In particular, patients who have history of dissociative or psychotic states have quite inappropriately been subjected to EMDR treatment. Invariably, therapists do not obtain informed consent and do not explain the true nature and

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38 Shapiro Ibid, p 89
39 Shapiro Ibid, p 90-92
40 Shapiro Ibid, p 96

effect of the treatment to the patient despite the training techniques of Shapiro herself.

167. A patient who has a history of Dissociative Identity Disorder is at particular risk of the treatment as that person is likely to remain focused in the activated or targeted memory. Shapiro herself recognises the dangers of treating persons who have suffered from dissociative disorders with this procedure yet many therapists who use the procedure refuse to accept her warnings. It is thus essential for the therapist to undertake a thorough clinical assessment with every client. As many therapists who use this procedure lack any clinical training they are unable to undertake the proper clinical assessment of a patient.

168. Shapiro provides abundant caution in the use of the procedure. She states;[41]

> *EMDR is a highly interactive therapeutic approach that demands clinician sensitivity and flexibility. It is essential that client selection be conducted properly because of the nature of the unresolved dissociated material that may spontaneously emerge during treatment and the intensity of the emotional experience that may be generated. Therefore, clinicians should use EMDR only with clients who have sufficient stability and appropriate like conditions to handle possible abreactive response and the distressing processing that may continue between therapeutic sessions.*
>
> *EMDR is never implemented in the absence of an adequate client history, a clinical relationship that includes rapport and client comfort and a treatment plan. The treatment plan should identify specific targets, including aspects of secondary gain, which should be sequentially addressed. Essentially, the clinician should ascertain the past memories that set the pathology in motion, the present people and situations that stimulate the dysfunction and the components necessary for an adaptive, desirable template for appropriate future action.*

Phases 2- 3 – Preparation and Assessment

169. The theory of EMDR is explained to the patient. As the theory goes, when trauma has occurred in a person's life it gets locked up in the nervous system. This locked up trauma is triggered by reminders and is the cause of the patient's feelings of hopelessness, fear and so on.

170. The therapist tells the client that the eye movements allow the information to be unlocked and processed in a way similar to that which occurs in Rapid Eye Movement sleep. This permits the negative information to be discharged from the nervous system in a more focused way.[42]

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41 Shapiro Ibid, pp 116-117

42 Shapiro Ibid, p 120

171. In her training, Shapiro encourages clinicians/therapists to use with the client the analogy of the client being on the train and their experiences merely being like the scenery passing by.

172. During the assessment phase the therapist has the patient target the traumatic memory. The patient is asked to select the image that represents that memory. Shapiro suggests that the patient be asked *"What picture represents the entire incident?"* Naturally, many patients would become confused and therefore the therapist is encouraged to ask *"What picture represents the most traumatic part of the incident?"* Invariably, patients cannot conjure a picture. In other words, a picture is not manifested by the memory process. The therapist is then trained to ask the patient *"Think of the incident"*.[43]

173. According to Shapiro the thinking of the incident causes the accessing and stimulation of the targeted information. However, when the patient is asked to think of the incident that patient stimulates their own subjective connections.

174. The next step in the process is to have the patient identify the negative cognition. The therapist asked the patient, *"What words best go with the picture that expresses your negative belief about yourself or experience?"* Invariably, the patient cannot specify a negative self-statement. The therapist then is trained to offer a list of suggestions such as *"I am worthless/powerless/not loved."* The therapist is then trained to encourage the patient by the use of verbal and non-verbal cues to have the client without reservation choose or reject suggestions made by the therapist. Often a therapist will write out a list of negative cognitions and hand it to the patient. The therapist invariably will ask the patient to "*Hold the memory in mind"* and say "*What thoughts do you have about yourself?"*[44]

175. The therapist then develops a positive cognition, for instance, *"What would you like to believe about the event or yourself?"* The positive cognition is a verbalisation of the desired state. According to Shapiro *"It is an empowering self-assessment incorporating the same theme or personal issues of the negative cognition."* [45]

176. Once the patient has developed the positive cognition the patient is asked *"When you think of the incident and repeat the words (clinician states a positive cognition) how true do they feel from one (completely false) to seven (completely true)".* The therapist is encouraged to ask the patient, *"Remember sometimes we know something with our head but it feels differently in our gut. In this case, what is the gut-level feeling of the truth of (clinician states a positive cognition) from one (completely false) to seven (completely true)"*.[46]

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43 Shapiro Ibid, p 130
44 Shapiro Ibid, p 131
45 Shapiro Ibid, p 133
46 Shapiro Ibid, pp 134-135

177. The patient is then asked to name the emotion that he is feeling and the SUD scale (Subjective Units of Disturbance) should be determined. The patient is asked from Zero (neutral or current) to ten (the worst you can think of) *"How does it feel?"*

178. Once this has occurred the patient is then asked *"Where do you feel in your body?"* According to Shapiro the response of the body to a trauma is an important aspect of the treatment.

179. In the author's experience, many clinicians/therapists seek to disavow the leading nature of EMDR therapy. This is because, they, like the complainant, are alert to the legal implications of having undergone this particular type of therapy.

180. According to Shapiro:

> *A client who has difficulty assessing location of the body sensation should be coached. One of the benefits of the client identifying the location of the body sensations is that it provides the client with an alternative of the reliance and verbalisation inherent in most traditional therapies. That is, focusing on the body sensations stimulated during successive sets frees the client from the need to concentrate on painful thoughts or gory pictures. Identifying the location of body sensations during successive sets is often necessary in order to assess the effects of EMDR processing and also lays the ground work for the next phase of the procedure."*

Phases 4-7 – Desensitisation, Installation, Body Scan and Closure

181. Once the final step in the assessment phase has been completed (identifying the location of the body sensation connected to the traumatic event) the clinician/therapist once again explains to the patient how EMDR works and emphasises the importance of not discarding any information.[47]

182. The therapist is trained to ask the patient to keep the image <u>in mind</u> along with the negative cognition and the awareness of the body sensations. For example, *"I want you to now bring up the picture and the words, you feel powerless and concentrate your lower abdomen, now follow my fingers with your eyes"*.

183. <u>Shapiro uses the analogy that this is as if three laser beams are directed at the dysfunctionally stored material</u>.

184. After the material is accessed the therapists initiates the sets of eye movements. The first set should number about 24 and are done horizontally. At the end of each set the therapists asks *"rest/let it go/blank it out and take a deep breath"*. <u>To blank it out patients are coached to simply draw a curtain over the material.</u>

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[47] Shapiro Ibid, p 141

While doing this they are not coached to close their eyes because this could contribute to a dissociation to a trance like state.[48]

185. In the fourth phase, involving desensitisation, the patient's disturbance is reduced (when possible to 0-1) on the SUD scale. The dysfunction material is processed so that it is stored in all of the channels associated with the target event. According to Shapiro's theory, when the traumatic event is reprocessed, a variety of channels of dissociation may be revealed into consciousness.

186. Between each set the clinician should listen carefully to the patient to identify the next focii for processing.

187. Patients invariably report their memories in terms of disturbing imagery, sounds, sensations, emotions, taste or smell. These are targeted immediately by the use of successive sets.

188. A particular issue that arises from EMDR is the new memories that emerge during this treatment. It is not uncommon that new memories do emerge into consciousness and therefore that new memory becomes the focus in the next set. If there are several new memories the patient is instructed to concentrate on the one that he/she finds most disturbing.

Phase 5 - Installation

189. Once desensitisation has been achieved with the SUD scale rating of 0 or 1 the installation phase begins. This involves the installation of a positive cognition. For example, the patient may have had a negative cognition of *"I am useless… I am powerless"*. The installation phase involves the positive cognition being say *"I am in control… I am powerful…"*. The technique involves linking the positive cognition to the memory of the traumatic event. The therapist plays a very significant role in framing the positive cognition and installing it.

Phase 6 – Body Scan

190. After the positive cognition has been installed the patient is asked to hold that memory including the traumatic event and the positive cognition and to scan his/her body mentally from top to bottom and identify any tension in the form of body sensation.

Phase 7 - Closure

191. Shapiro emphasises that if at the end of the session the patient is experiencing any signs of emotional disturbance the therapist should utilise hypnosis or guided visualisation to return him/her to a position of comfort. In the author's experience, invariably many clinicians/therapists utilise hypnosis and/or guided

[48] Shapiro Ibid, p 143

visualisation techniques having not undertaken any formal training in these types of techniques.

192. The therapist is required to properly debrief the patient and to emphasise the important use of the log and the visualisation techniques.[49]

193. Shapiro emphasises that if the patient is not properly debriefed there is a great likelihood that the client will continue processing between sessions at a higher level of disturbance.

Further Specific Techniques

194. Bass and Davis, the authors of *The Courage to Heal* make it very clear that:

> *When you work with someone you think may have been abused, ask out right, 'Were you sexually abused as a child?' This is a simple and straight forward way to find out what you are dealing with. It is also a clear message to your clients that you are available to work with the issue of sexual abuse.*

195. Invariably therapists will represent to their clients that presenting symptoms are consistent with having a past history of abuse. Clients are in a vulnerable position and therapists readily take advantage of that position. If the patient has no memories of abuse that presents no difficulties to the therapist. The quick answer is that of repression. As Bass and Davis state:

> *So far, no one we've talked to thought she might have been abused, and then later discovered that she hadn't been. The progression always goes the other way, from suspicion to confirmation. If you think you are abused and your life shows the symptoms, then you were*

Imagistic Work

196. Bass and Davis in *The Courage to Heal* refer to *imaginative reconstruction*. The authors state:

> *Take an event in your family history that you can never actually find out about. It could be your father's childhood or the circumstance in your mother's life that kept her from protecting you. Using all the details you do know, create your own story. Ground the experience or event in as much knowledge as you have and then let yourself imagine what actually might have happened.*

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[49] Shapiro Ibid, p 162

197. As a matter of common sense, when human beings engage in imagination there are real problems between on the one hand what is reality and what is imagination.

198. In the author's experience and indeed that of psychiatrists and psychologists the use of guided imagery is similar to a person being in a hypnotic state.

199. In people who have subjective difficulties in the first place, the use of imagination is one that can lead to false beliefs.

200. It is of particular concern that imagistic work is often undertaken in combination with a number of other therapies. For example, such in the author's experience is used in combination with hypnosis and EMDR which can lead to a most unsatisfactory situation in which a person can come to believe that information derived by way of imagination is in fact true.

201. The added concern is that therapists make representations to their patients that images including flashbacks are but fragments of a traumatic memory. In other words, a part of the trauma has come through into the person's consciousness. Thus the patient believes readily that such memories are fact.

Dream Work

202. There is an extensive network of therapists who believe that dreams are a means of tapping into the unconscious mind. Dreams occur as a *channel* to the unconscious mind.

203. Therapists encourage patients to believe that dreams of that symbols which are in fact fragments or pieces of memory. For example, any therapists believe that a patient who suffers from nightmares will have been abused. They encourage the patient to look for symbols including dreams involving a bedroom, bathroom, basement, penises, breasts, buttocks and son on.

204. If a patient has sexual content in their dreams this, according to many therapists, is a clear indication that the person has been subjected to sexual abuse.

205. Therapists encourage patients to believe that dreams are in fact factual recollections. The symbols are *fragments* of memory that confirm to both the therapist and the patient a previous history of being abused.

206. Scientific research indicates that there is no clinical evidence to establish that a traumatic experience predictably passes untransformed into dream content. In other words, one simply cannot say that recollections arising from a dream may be identical to or completely different or but a metaphorical betrayal of a traumatic experience.

207. Once again, therapists will interpret dreams as amounting to factual recollections.

Journal Writing

208. Therapists who are proponents of repressed memory and indeed many who may not invariable use a technique known as journal writing.

209. There are a variety of techniques used by therapists. One involves the use of free association in which a patient may write down an image or body sensation that comes to their mind. This technique inevitably leads to concentrating on a traumatic incident and writing a story about it. One of the frequent techniques used by therapist is to convey to the patient the necessity to write down such recollections as quickly as possible.

210. Another technique that is often used is to have the patient respond in writing to a suggested topic or recollection as made by the therapist. The therapist invariably is not concerned with accuracy and once again the technique involves the patient basically being encouraged to write down thoughts as quickly as possible as the subject matter is raised by the therapist.

211. Eminent psychiatrists and psychologists are concerned about the use of journal writing especially in possibly creating in patient's minds false memories.

Body Work

212. According to the theory the body remembers what the mind unconsciously forgets. In other words, if a patient has been sexually abused that patient may repress or suppress his or her memory of the abuse. However, as the theory goes the body will always remember the feeling of being abused.

213. Therapists encourage patients to recall memories of abuse by body work. For example, the smell of toothpaste or the smell of alcohol, the sound of a bed creaking are but some body memories that can arise by this type of therapy.

214. According to E Sue Blume *"the body stores the memories of incest and I have heard of dramatic uncovering and recovery feelings and experienced through body work ...this therapy has been around for a long time but never taken seriously by talk therapists. It should be. It can release memories and feelings that talk therapy cannot touch."*

Art Therapy

215. Therapists often use art therapy to assist their patients in addressing memories about being sexually abused.

216. For example, if a patient has an alleged history of being sexually abused in her bedroom, a therapist may have that patient draw or paint a bedroom so as to enable suppressed emotions to come to the surface. Such therapy often involves repeated leading questions by the therapist to assist the patient in having the suppressed feelings come to the surface.

217. Many therapists will be encouraged to paint or draw to assist their recollections in making the memory of the abuse even more detailed or specific. The therapist will often encourage the patient in adding details to assist the patient's recovery of the specific details of the abusive incident.

218. The patient is also encouraged to look at the particular painting or drawing and identify subject matters or themes within it so as to discuss with the therapist those themes to help come to terms with previous memories of the abusive incident or incidents repressed or otherwise.

Feelings Work

219. This involves the patient being encouraged to link into an emotional response to a traumatic event. In this way the patient is encouraged to believe that a ***feeling*** is in fact a ***feeling memory***.

220. The patient is encouraged to believe that with the emergence of feelings memories associated with those feelings will come out also.

221. For example, a patient or patients may be encouraged to lie down on the floor and to feel sorrow or sadness. They are encouraged to ***feel*** their sadness and as they do they are encouraged to play out or sob and in doing so the memories are said to begin to occur.

222. A very frequent therapy technique is that involving concentrating upon a particular person who is alleged to be the perpetrator and to focus one's anger towards that person. This may involve placing metaphorically the perpetrator in a chair and screaming at that person or hitting the floor or some other object such as a towel or a newspaper or a soft baseball bat. The author has been involved in cases which the complainants have been encouraged to jump on hands, to use phone books, tennis balls and a variety of other techniques.

223. There are a number of concerns with this type of therapy. Whilst the ultimate goal of therapy is to assist the patient, actively encouraging patients to display hostility and anger towards an alleged perpetrator can be very counter productive. There is also the associated risk that memories emerging during such therapy are to say the least unreliable.

Confrontation

224. A very frequent technique used by therapists is to encourage a patient to confront the perpetrator.

225. The confrontation generally occurs at the end of therapy when the therapist has spent some time encouraging the patient to have sufficient confidence in confronting not only the perpetrator but taking the responsible decision to make a complaint about the perpetrator to the police and/or to sue the perpetrator.

226. The key representation made by a therapist to the patient is that by confrontation the patient obtains *emotional strength*.

227. Therapists invariably use techniques associated with a careful preparation of the confrontation phase. Patients are encouraged to obtain support from other persons and this involves telling the patient's version to other persons including friends and relatives and especially those who know the perpetrator. It is not uncommon for letters to be written to the perpetrator and his or her family as a precursor for the confrontation.

228. The patient is encouraged never to be negative when recounting the abuse to the perpetrator or his family. Bass and Davis in *The Courage to Heal* gives some telling examples:

> *Twenty years ago, a woman went to her grandfather's funeral and told each person at the grave site what he had done to her. In Santa Cruz, California, volunteers from Women Against Rape go with rape survivors to confront the rapist in his workplace. There they are, ten or twenty women surrounding a man, giving tangible support to the survivor, as she names what he has done to her… One survivor told us the story of a woman who exposed her brother on his wedding day. She wrote down exactly what he'd done to her and made copies. Standing in the receiving line, she handed everyone a sealed envelope, saying "These are some of my feelings about the wedding. Please read it when you get home."*

Duty of Disclosure

229. It is readily apparent that it has become increasingly difficult for defence lawyers and for that matter, the court itself to be availed of evidence which may be relevant to the reliability and admissibility of the testimony of a witness.

230. There has been an ongoing trend led by abuse advocates and ill-informed social commentators that legal procedures do not adequately protect alleged victims of sexual assault. This trend has been to regard persons accused of sexual assault like those of witchcraft as *Crimen Exceptum*. In prosecuting a charge of witchcraft, the law permitted the admissibility of *spectral evidence* such as dreams, visions and hallucinations of persons said to be bewitched. In 1692 The Salem Witch Trials, in which 19 people were executed, were stopped when the

Governor declared 'spectral evidence' inadmissible. Bishop Frances Hutchinson in his *Historical Essays Concerning Witchcraft (1718)* observed:-

"*In other cases, when wicked or mistaken people charge us with crimes of which we are not guilty, we clear ourselves by showing that at the time we were at home, or in some other place, about our honest business. But in prosecutions for witchcraft, the most natural and just defence is mere jest. For if any wicked person affirms, or any crack-brained girl imagines, or any lying spirit makes her believe, that she sees an old woman, or other person, pursuing her inner vision…such fantastic notions…. Leave the lives of innocent men naked without defence against them*".

231. The real concern, is that the rights of an accused have been so trammelled that the prospects of obtaining a fair trial are fast disappearing.

232. Section 297 of the *Criminal Procedure Act, 1986* is in the following terms:

> *(1) A person cannot be required (whether by subpoena or any other procedure) to produce a document recording a protected confidence, in, or in connection with, any preliminary criminal proceedings.*
>
> *(2) Evidence is not to be adduced in any preliminary criminal proceedings if it would disclose:*
>
> *(a) a protected confidence, or*
> *(b) the contents of a document recording a protected confidence.*

233. Section 297 was amended to overcome the decision of the New South Wales Court of Criminal Appeal in *R v Young* (1999) 46 NSWLR 681.

234. Section 70 of the *Criminal Procedure Act, 1986* provides that a magistrate in committal proceedings may not exclude evidence on any of the grounds set out in s.90 (discretionary excluded admissions) or part 3.11 (discretions to exclude evidence) of the *Evidence Act, 1995.*

235. Section 298 *Criminal Procedure Act* 1986 provides specific circumstances in which evidence of a sexual assault communication may be required to be produced in, or in connection with criminal proceedings or adduced with leave.

236. The fundamental issue that arises is whether there is any obligation on the part of the Director of Public Prosecutions and/or police to disclose to the defence any evidence that may be relevant to the reliability of a witness.

DPP Guidelines

237. The DPP has published guidelines for evidence obtained by hypnosis or EMDR. These guidelines are as follows:

> *"These guidelines apply to evidence obtained either by hypnosis or EMDR (eye movement desensitisation and reprocessing) and should be read accordingly. Failure to comply with them will give rise to a high probability that the court will decline to admit such evidence whether proffered by the Crown or from a witness for the defence.*
>
> *Officers will have regard to these guidelines when determining whether or not such evidence should be tendered on behalf of the Crown.*
>
> *(1) The hypnotically induced evidence must be limited to matters which the witness has recalled and related prior to the hypnosis – referred to as "the original recollection". In other words, evidence will not be tendered by the Crown where its subject matter was recalled for the first time under hypnosis or thereafter. The effect of that restriction is that only detail recalled for the first time under hypnosis or thereafter will be advanced as evidence in support of the original recollection.*
>
> *(2) The substance of the original recollection must have been preserved in written, audio or video recorded form.*
>
> *(3) The hypnosis must have been conducted with the following procedures:-*
>
> *(a) the witness gave consent to the hypnosis;*
> *(b) the hypnosis was performed by a person who is experienced in its use and who is independent of the police, the prosecution and the accused;*
> *(c) the original recollection and other information supplied to the hypnotists concerning the subject matter of the hypnosis was recorded in writing in advance of the hypnosis; and*
> *(d) the hypnosis was performed in the absence of police, the prosecution and the accused, but was video recorded". (emphasis added).*

238. Apart from the guidelines the DPP has a positive obligation to disclose to the defence any material that might have some bearing on the offence charged and the surrounding circumstances of the case including that relating to counselling or treatment which may impact upon the reliability of a witnesses recollection or memory. See *R v Maguire & Ors* (1992) 1 QB 936; *R v CPK* (unrep) CCA 21 June 1995; *R v Murre* (2001) NSWCCA 286; The People (DPP) and Nora Wall [2005] IECCA 140.

239. The English Court of Appeal in ***Regina v Maguire & Ors*** considered the appeals of seven appellants including Patrick Joseph Conlan who had been convicted of offences following bomb explosions at public houses in Guildford and Woollich. In searching the house of the Maguire family no trace of explosives were found in the house. The appellants were arrested and swabs were taken from their hands. An analysis of the swabs by a method known as Thin Layer Chromatography, [TLC] revealed positive traces of nitroglycerine under the nails of all of the male appellant's hands. Mrs Maguire's test was negative. The police found a number of pairs of plastic gloves in the house which, following a TLC test were found to be positive for nitroglycerine.

240. The key issue in the appeal was whether the Crown had an obligation to disclose evidence which was material to the credibility of expert witnesses from the Royal Armament Research and Development Establishment (RADE).

241. The court found that the opinion, from a forensic scientist, who was an advisor to the prosecuting authorities, was, under a duty to disclose material of which he knows and which may have some bearing on the offence charged and the surrounding circumstances of the case. The duty of disclosure is on the authority which retains that expert and which must in turn disclose the information to the defence. The Court of Appeal saw no case for distinguishing between members of the prosecuting authority and those advising in the capacity of a forensic scientist. The test conducted by the experts including that for nitrotoluols and the 'nail test' ought to have been disclosed to the defence and a miscarriage of justice occurred and the convictions were quashed including that of Giuseppe Conlan who died prior to the hearing of the appeal.

242. The New South Wales Court of Criminal Appeal in ***Regina v CPK*** considered an appeal arising from a trial conducted in the District Court in which the appellant was charged with a number of counts of sexual assault involving his daughter.

243. There was evidence that the complainant had first recalled the incident the subject of the first charge approximately ten years after it was said to have taken place. These recollections arose in the course of treatment for attention and stress by a Kinesiologist. In the course of that treatment an incident occurred when, as a result of the therapist laying a hand upon the complainant's head in a certain manner and her relaxing she came to remember what her father had done to her in or about 1980 or 1981. About this she said:

> *I had a memory but it wasn't a memory that I could put in a statement.*

244. And further:

> *I haven't felt safe for the memory to come.*

245. The appellant was convicted of the first, third and fourth counts and during the sentencing proceeding a psychiatrists' report was tendered. In the course of that report the psychiatrist stated:

> *S... described the realisation of the alleged sexual assault by her father two years previously in 1991 after an anxiety provoking train trip in India where she felt isolated and vulnerable. She stated that she began recalling incidents of sexual assaults from an early age and subsequently sought counselling and psychotherapeutic therapy from psychotherapists and counsellors first in Melbourne and subsequently in Perth.*

246. The complainant also attended upon a group known as the Incest Survivors Association.

247. Gleeson CJ with whom Clarke JA and Hume JA agreed held that the material ought to have been disclosed to the defence, such that a miscarriage of justice occurred.

248. The New South Wales Court of Criminal Appeal in ***Regina v Murre*** considered a case very similar to ***CPK***. In the course of the sentencing proceedings a Victim Impact Statement was tendered and in that statement the complainant said that he had blocked out the incident from his memory for a decade until he had seen the appellant in 1982. It was argued on appeal that suppression by the appellant of his memories of the incident was as significant issue reflecting on the reliability of his evidence. As there were other evidence revealed in the course of the committal proceedings the defence counsel who at that time appeared for the appellant was on notice of the possibility that the complainant had recovered his memory. Adams J found that there was no miscarriage of justice.

249. The Court of Criminal Appeal in ***Regina v Eishauer*** (Unrep) CCA 19 September 1997 considered an appeal arising from a conviction that the Appellant had sexually assaulted his step-daughter. The appellant had pleaded guilty some years earlier to committing a number of offences upon the complainant. At that time the complainant said nothing to anyone of the earlier alleged assaults. She did not remember these offences until 1993 and then the further offences until just before he stood his trial in 1995. The complainant gave evidence that she had recovered a memory of these incidents. At the trial a voir dire was conducted and the trial judge considered whether there was anything that may have prompted the complainant's memory in 1993 and again in 1995. When first asked whether her memory had been prompted by anything in 1995, the complainant said that was when her sister had given her statement. However, she was mistaken in that regard as her sister had made her statements in 1993 and not 1995. Sperling J (Smart J agreeing) held that the convictions be quashed and the Judgment of acquittal be entered on all counts. At p 18 Sperling J said:

> *Common experience does not enable one to say that the memory of painful event, absent for a long time and later experienced, is more likely to be a revived true memory than an honestly experienced, false memory. I do not accept as common knowledge that, in the case of children, memory of abuse is frequently lost and later reliably recovered. The content of the ostensible memories in this case is beyond common experience. There is no common knowledge on which to draw for guidance. To generate false memory of this kind is not common place. To lose memories of this kind for ten years or so and then to recover them is not common place. The case is remote from common experience. There is no common knowledge which is applicable to a case such as this.*

250. His Honour went on to say:

> *It is reasonably possible that MH's memories were true, recovered memories. But it is also reasonably possible that they were honestly experienced false memories. The corollary is that there is, necessary, reasonable doubt concerning the appellant's guilt on reading of the record of the proceedings.*

251. The Irish Court of Criminal Appeal in *The People (DPP) and Nora Wall* [2005] IECCA 140 found (upon the application of the DPP) that there had been a miscarriage of justice arising from the conviction of the Respondent Nora Wall, a former Catholic Nun.

252. Nora Wall faced a joint trial with one Paul McCabe in which she and McCabe were alleged to have raped the complainant Regina Walsh. A key witness relied upon by the prosecution was one, Patricia Phelan who gave evidence that she had observed McCabe raping the complainant and that Nora Wall was present holding the complainant's legs down.

253. Nora Wall faced a joint trial with Paul McCabe who was a homeless and psychiatrically ill alcoholic. The fact that both cases were heard together clearly would have influenced the jury.

254. The Irish Court of Criminal Appeal found that a miscarriage of justice had occurred and that there had been an "unfortunate breakdown in communications or systems failure" between the officers of the Director of Public Prosecutions, the Chief State Solicitor, The Gardia Siochana and Prosecuting Counsel. The Court found that this amounted to a serious defect in the administration of justice. Nora Wall who was formerly known as Sr Dominic had been sentenced to life imprisonment upon her conviction in 1999. Justice Kearns found that newly discovered facts demonstrated a miscarriage of justice. This included a crucial witness at Mr Wall's trial, one Patricia Phelan who admitted to Gardia and another nun that she had lied about having witnessed Ms Wall hold down a young girl while a man raped her. Wall and McCabe had been convicted in June 1999 of

the raping of the complainant, when that complainant was 10 years of age. McCabe was gaoled for 12 years and Nora Wall for life.

255. There was a substantial body of very significant evidence that had not been disclosed by the prosecution including the investigating police to the defence. In respect of the complainant Regina Walsh, she had the following history that had not been disclosed:-

- She had previously made a false allegation that she was raped;
- That she alleged that she had been assaulted and then withdrew the complaint;
- That she had been allegedly assaulted by a female person, the location of whom had never been able to be traced and in respect of which no proceedings had taken place;
- That she had taken an overdose of tablets and had been admitted to a psychiatric ward and undergone psychiatric assessment and treatment;
- That her recollection of events arose as a result of 'flashbacks' and who had no full memory or recall of those events.

256. In respect of the eye witness Patricia Phelan, the following evidence had not been disclosed to the defence:-

- That the prosecution had at a time prior to the trial made a direction that she not be called as a witness as the prosecution had formed the view that she was an unreliable witness;
- That Phelan had made allegations against her late uncle and another male in respect of an alleged rape and that in the course of proceedings in the High Court findings were made adverse to her credibility and reliability;
- That the police officer (Garda Sinead Connolly) who had taken Phelan's statement in respect of the complaint by Regina Walsh was the same police officer who investigated the earlier false complaints made by her against her uncle;
- That the DPP and the Chief State Solicitor had the carriage of the proceedings in the High Court in which findings had been made adverse as to the credibility and reliability of her;
- That she had after the trial, conviction and sentence of the Applicant disclosed to Sr Mona Kileen that she had lied in her statement and that she had given false evidence against the Applicant;

- That Phelan admitted that she had colluded with the complainant Regina Walsh in the giving of the false statement and evidence against the Applicant.

257. In her further statement of 2 April 2001, Patricia Phelan in part stated:-

"*In the trial, held at the Central Criminal Court in Dublin, I gave evidence on oath in the complainant against* ***Nora Wall*** *and Paul McCabe. In evidence, I told the judge and jury that I saw Paul McCabe rape Regina and that* ***Nora Wall*** *was present holding Regina's legs down. I gave other evidence but I cannot remember what. At the time I gave this evidence in Court, I knew it was wrong and against the law but I just wanted to get back at Dominic (ie* ***Nora Wall****). I was also afraid to pull back on my evidence because I thought that once I had made a statement I had to give evidence in court. The reason why I wanted to get back at Dominic was because she used to physically beat me when I was living the Group Homes. She gave me a terrible life and I hated her. I remember ringing Sr. Mona Kileen. She was a good friend of mine for many years. It was during the trial, but I cannot remember much of the details. Some months after the trial, I rang Sr. Mona again. I was very distressed at the time. It was bothering me at this stage about the false evidence I had given in the trial".*

258. The Court of Criminal Appeal made reference to a file note contained within the file of the DPP which was in the following terms:-

"*<u>Evidence of Patricia Phelan</u>*

Local gardai who have dealings with her during previous investigations have found her most unreliable. She never mentioned to the members anything about a rape at any time. Therefore her evidence should not be accepted as accurate".

259. In conclusion, the Court of Criminal Appeal observed:-

"*It is now also accepted by the respondent that there had been significant non-disclosure in this case, including (a) the information that Regina Walsh had made, but not pursued, an allegation of being raped in England and (b) the non-disclosure of Regina Walsh's very proximate and material psychiatric history. It seems to this court that the applicant was further prejudiced during the course of her trial by evidence of which the defence had no prior notification, namely, that Regina Walsh recalled the alleged episodes of rape by reference to 'flashbacks and/or retrieved memory'. There was no scientific evidence of any sort adduced to explain the phenomenon of 'flashbacks' and/or 'retrieved memory', nor was the applicant in any position to meet such a case in the absence of prior notification thereof.*

As previously indicated, this court does not find it necessary on the agreed facts of this case to elaborate a hierarchy of the newly –discovered facts which either singly or cumulatively amount to a miscarriage of justice. Virtually all of the newly-discovered facts are facts of significance which confirm the court in its view that there has been a miscarriage of justice in this instance."

Admissibility of the testimony of a witness who has undergone EMDR/hypnosis

260. The issue of whether the testimony of a witness who has undergone EMDR should be admissible in a criminal trial, and if so, under what circumstances, was first addressed in Australia by an Appellant Court in *Tillott* (1995) 38 NSWLR 1; 83A CrimR 151; sitting on appeal from a decision of Matthews J in *Jamal* (1993) 69 A CrimR 44.

261. Abadee J, in the leading Judgment in *Tillott* (with Grove J and James J expressly agreeing) refers to a 2-tier test for admissibility. In essence, there are two different perspectives to be considered. On the one hand the proponent of the evidence and on the other hand the opponent.

262. Where a witness, other than the accused, has undergone EMDR procedural hypnosis, his or her evidence is not rendered inadmissible but before it will be admitted, a threshold onus is cast upon the proponent of the evidence to prove that it is "safe" to admit.

263. The quality of "safety" is **not** dependent upon a comparison based on an examination of a witnesses pre and post hypnotic memory but on an examination of the EMDR or hypnosis procedure to see if there has been compliance with the "safety guidelines" generally being those set out in McFelin (1995) 2 NZLR 750.

264. The second issue only arises if the evidence is established to be admissible by the proponent. The question is whether, as a matter of discretion, the evidence ought to be excluded on grounds of unfairness; see generally *Tillott* at 72. The onus is on the party seeking to exclude the evidence.

265. It is irrelevant, as to the question of the admissibility of the evidence, that EMDR was administered to the witness for a therapeutic purpose rather than as an investigative or forensic tool. *Tillott* at 29. The mere fact that the witness has undergone EMDR gives rise to the need to apply "the safe guiding procedures…. As a condition of the admissibility of the evidence", *Tillott* at 33.

266. The critical threshold question for admissibility is whether the witness has undergone EMDR in fact, **not** whether the witnesses memory has been revived by it. The question of admissibility turns on whether the procedural safe guards have been complied with, not with EMDR did or did not play any role in relation to memory or return of memory. *Tillott* at 57.

267. Non-compliance with the safe guards creates a specific difficulty in testing the reliability of the evidence, in determining for example whether the witness was at risk of confabulation or suggestibility, or whether the witness was conscious or in a trance at any time during the treatment. The inability to test matters of this kind may render the trial unfair. *Tillott* at 39.

268. Abadee, J set out in some considerable detail the procedural safeguards to be applied in determining the proper use of procedure such as hypnosis and EMDR on prospective witnesses in criminal cases. His Honour referred to *R v McFelin* (1985) 2NZ LR 750 and *R v Jenkyns* (1993) 32 NSWLR 712 and the provisions of the Californian Evidence Code (see pp 55 and following pages). It is submitted that the following are minimum standards which must be applied:-

(i) An adequate record must be made of the witnesses memory before the procedure is applied. This record must be in writing and or in some other reliable form.

(ii) The treatment session, including consultations before and after the administration of EMDR or hypnosis must be video taped.

(iii) The treatment itself should be conducted in a way which prevents the influencing of the memory of the potential witness either by suggestion or by some other means.

(iv) The onus is on the party seeking to have the evidence admitted to prove that it is safe to admit it.

269. A pre-condition to the admissibility of the evidence is compliance with the procedural guidelines. Where those guidelines have not been followed, the fact that the evidence is safe to admit cannot be established to the necessary standard of proof and it is consequently inadmissible as a matter of law. This is subject to considerations that post *Evidence Act* 1995 a Court will need to examine such issues having regard to the provisions of s.137 of the *Evidence Act* 1995. *Regina v KG* (2001) NSWCCA 510

Guidelines v Requirements

270. The guidelines, or "procedural safeguards", (as they are also referred to by Abadee J at 40) must be acknowledged to be important, almost essential requirements. It is submitted that the failure to comply with the rules must have the consequence that the evidence obtained otherwise then in accordance with the guidelines should not be admitted.

The Dangers of EMDR

271. There are specific dangers with hypnotically (and EMDR) elicited testimony.

272. Abadee in *Tillott* at 37C:-

> *"In my view within her Honour's own findings (referring to Jamal's case) there are enough similarities or risks associated with EMDR to conclude that they are the same or similar to those found in hypnosis. These findings are stated by Her Honour. They include that it is theoretically possible for EMDR to revive or enhance a person's memory of a traumatic event in his or her past (see at 551). Further that Dr Shapiro, the discoverer of EMDR, emphasises there is no guarantee that a memory that emerges from EMDR will be accurate (at 559). Until more is known about EMDR one must accept the risk as with hypnosis, that the subject might be sufficiently suggestible so as unwittingly to adopt information received from the therapist as part of his or her own memory (at 560). One must accept that there is at least a danger that any "new" memory retrieved through EMDR could well be a distorted memory, either as a result of external input or as a result of an unconscious confabulation on the part of the subject (at 560-561). There is a risk of confabulation with (and without) EMDR for persons who are troubled by memory gaps and who try to fill them" (561)*

The Need for Safeguards

California

273. In California an exclusionary rule in relation to hypnotically induced evidence has been established. *People v Shirley* 31 Cowl 3D 18 1982; *People v Guerra* 690 P 2 D 635 (1984). The Supreme Court of California refused to admit hypnotically induced evidence because of the problems and dangers associated with this type of evidence. In *Guerra* "ultimately concluded that evidence hypnotically – aided recall should be excluded as being intrinsically unreliable" – See Abadee J in *Tillott* at 26F.

274. 190. As Abadee J observes (at 26B) the "Californian Evidence Code" was past temper the effect of the exclusionary rule decision of the Supreme Court of California in *Guerra*". The Californian Evidence Code constitutes "procedural safeguards" in the form of legislative requirements.

275. The relevant provisions of the Californian Evidence Code (per *Tillott* at 29) are:-

> *(a) The testimony of a witness is not inadmissible in a criminal proceeding by reason of the fact that the witness has previously undergone hypnosis for the purpose of recalling events which are*

the subject of the witness's testimony, if <u>all</u> (emphasis added) of the following conditions are met:-

(1) The testimony is limited to those matters which the witness recalled and related prior to the hypnosis.

(2) The substance of the prehypnotic memory was preserved in written, audiotape, or videotape from prior to hypnosis.

(3) The hypnosis was conducted in accordance with <u>all</u> (emphasis added) of the following procedures:-

(A) A written record was made prior to hypnosis documenting the subject's description of the event, and information which was provided to the hypnotist concerning the subject matter of the hypnosis

(B) The subject gave informed consent to the hypnosis

(C) The hypnosis session, including pre and post hypnosis interviews, was videotape recorded for subsequent review.

(D) The hypnosis was performed by a licensed medical doctor or psychologist experienced in the use of hypnosis and independent of and not in the presence of law enforcement, the prosecution, or the defence.

(4) Prior to admission of the testimony, the court holds a hearing pursuant to s.402 of the Evidence Code at which the proponent of the evidence proves by clear and convincing evidence that the hypnosis did not so affect the witness as to render the witness's prehypnosis recollection unreliable or to substantially impair the ability to cross-examine the witness concerning the witness pre-hypnotic recollection. At the hearing, each side shall have the right to present expert testimony and to cross-examine witnesses.

(b) Nothing in this section shall be construed to limit the ability of a party to attack the credibility of a witness who has undergone hypnosis, or to limit other legal grounds to admit or exclude the testimony of the witness".

276. as already been submitted, the threshold question for admissibility is whether the witness has undergone hypnosis in fact, not whether his or her memory has been revived by it. *Tillott* 30B

New Jersey

277. Abadee J in *Tillott* discusses the New Jersey decision of Pashman J in *State of New Jersey v Hurd* 432 A2d 86 (1981):-

> *"... the New Jersey Court laid down certain procedural requirements for admissibility of hypnotically-refreshed memory in order to reduce (not to eliminate) the risks associated with hypnosis. It was a decision very much to the forefront of those American decisions prescribing procedural safeguards for the admissibility of such testimony, and one which appears to have been also adopted and reflected in the Californian Evidence Code which was in turn adopted by the New Zealand Court of Appeal in McFelin (1985) 2 NZLR 750".*

278. Pashman J in *Hurd* at 96 held that the language used is one of requirements:

> *"To provide an adequate record for evaluating the reliability of the hypnotic procedure, and to ensure minimum level of reliability, we also adopt several procedural requirements based on those suggested by Dr Orne and prescribed by the trial court, 173 N.J Super at 363, 414 A 2d 291. Before it may introduce hypnotically refreshed testimony, a party must demonstrate compliance with these requirements".*

279. Pashman J at 96 and 97 sets out six requirements including:-

> "*Fifth, all contracts between the hypnotist and the subject must be recorded. This will establish a record of pre-induction interview, the hypnotic session, and the post-hypnotic period, enabling a court to determine what information or suggestions the witness may have received during the session and what recall was first elicited through hypnosis. The use of videotape, the only effective record of visual cues is strongly encouraged but not mandatory".*

280. The necessity of compliance with the requirements is discussed at 97:

> *"We recognise that this standard places a heavy burden upon the use of hypnosis for criminal trial purposes. [Here footnote 6 appears] This burden is justified by the potential for abuse of hypnosis, the genuine likelihood of hypnosis and error, and the consequent risk of injustice. Hypnotically refreshed memory must not be used where it is unlikely to be accurate evidence. The burden of proof we adopt here with assure strict compliance with the procedural guidelines set forth in this opinion. It will*

also limit this kind of evidence to those cases where a party can convincingly demonstrate that hypnosis was a reasonably reliable means of reviving memory comparable in its accuracy to normal recall.

Footnote 6: As a minimum requirement, we believe that the recording of a session is essential; otherwise the opponent will have no effective way to challenge the credibility of the testimony at trial" (emphasis added).

New Zealand

281. The decision of McFelin [1985] 2 NZLR 750 is relied upon by the Crown in support of its argument that failure to comply with the requirement to videotape is not fatal to admissibility. In particular at 754:

> *"Some of the more exacting precautions, such as videotaping, may not always be available in this country. We do not suggest that the omission of videotaping or failure in any other respect to comply with any of those detailed guidelines, should automatically cause the evidence of a witness to be ruled out in New Zealand"*.

282. However the Court goes on to acknowledge at 754:

> *"Obviously the greater the safeguards, the greater the likelihood that the evidence will be admitted. For, unless the hypnosis has been accompanied by safeguards which the Judge considers reasonable in the particular circumstances, it may become necessary to exclude even evidence of the subjects pre-hypnotic recollections"*.

283. The decision in McFelin does not reduce the necessity for strict compliance with the procedural safeguards but rather contemplates 'standards to be aimed at as far as reasonably possible" (*McFelin* at 755).

284. The procedural safeguards discussed in *Tillott* are disseminated wider than the legal domain. They have in effect become industry standards, and it is submitted that the failure to comply with these procedural safeguards, and in particular the requirement to record on videotape contact between the hypnotist and witness, falls short of standards to be aimed at as far as reasonably possible.

285. The judgment in *McFelin* acknowledges that:

> *"While naturally they do not deal with admissibility in evidence, guidelines similar to parts of the Californian provision and aimed at ensuring verifiable independence and freedom from suggestion in hypnotic sessions with potential witnesses have been formulated for instance at Scotland Yard ("the British Guidelines") and in recommendations by the Australian Society of Hypnosis and the New Zealand Psychological*

Society … Unlike the British Guidelines, they go to the length of insisting on video- recording all contacts between the hypnotist and the witness".

286. It should be noted that the decision of *R v McFelin* was delivered on 6 August 1985. The caution adopted by the Court at that time to imposing a 'requirement' to video record was based on a perception that such facilities may 'not always be available in this country'. However, such a position is no longer reasonable when the availability of video recording equipment is so widespread that access to such equipment is not a problem and the considered opinion of both jurists and psychologists is that video recording is an essential procedural safeguard.

287. An important issue that can also arise in this context is that of the added feature of delay. There are authorities that support the proposition that the combination of delay and evidence that is affected by therapies including that of recovered memory can be such that a Stay, in an appropriate case would be granted. See *R v D* 13 CRNZ 306; *W v R* 16 CRNZ 33.

288. In *R v D* Fisher J granted a Stay in a case involving a delay of 16 to 24 years between the alleged offending and the making of the complaint. This delay, itself, was not necessarily fatal however the further delay in which the proceedings took in combination with the validity of memories produced by repressed or recovered memory therapy was such the Stay was granted. His Honour at para [40] referred to articles by eminent authors including Nigel Hampton QC "Recovered Memory Syndrome v False Memory Syndrome" (1995) NZLJ 154 and Dr F Goodyear-Smith; "Review of Or Was Eve Merely Framed: Or Was She Forsaken?" (1995) NZLJ 230. In the latter article Dr Goodyear-Smith says [p231]:-

> *"Many women with poor self-esteem and dysfunctional lives feel that something is terribly wrong with their lives and wonder if it has been caused by childhood abuse which they have repressed. The basis of repression theory is that episodes of sexual abuse in childhood can be robustly repressed (instantly banished to the unconscious) and then recalled intact through memory recovery techniques or in other circumstances where the anxiety surrounding the event is removed.*
>
> *To date, there is no specific research which verifies this theory. Most studies involve retrospective self-reporting from clinical populations, and are hence anecdotal accounts which are impossible to confirm or deny. The only prospective study measures "not recalling" but not repression.*
>
> *There is however substantial evidence on how easy it is to implant false memories which come to be believed as true.*
>
> *Moreover, about 10 per cent of the population are easily suggestible and susceptible to hypnosis. Investigation of hypnosis has shown that there is no guarantee of increased accurate recall, but there is a likelihood of*

inaccurate recall but increased confidence that it is true. Many of the techniques used by therapists or advocated in self-help books to enhance or recover memories are actually hypnotic in nature, although often not recognised as such by those using them."

Fisher J at para [25] said:-

"Post-Hypnotic testimony was considered by the New Zealand Court of Appeal in R v McFellin [*1985] 2 NZLR 750, 753, 754; (1985) 1 CRNZ 549, 551-553. Under the current state of scientific understanding, testimony of that particular kind is to be excluded on objection from the defence unless the judge is satisfied that it is safe to admit it in the particular circumstances. Even then it is to be admitted only if it satisfies strict controlling guidelines. There is suggestion of hypnosis in the present case but the cautious approach required in that field seems equally appropriate here. It is also interesting to note Dr Goodyear-Smith's reference to the risk of hypnosis effects during RMT in general intended or otherwise."*

289. In ***W v R*** a Stay was granted in relation to one of the complainants namely ***B*** involving uncertainties arising from recovered memory of the complainant, the lack of detail in her evidence, the lack of co-operation and the specific prejudice in relation to the death of *B's* grandmother who could not be called as a witness.

CONCLUDING REMARKS

290. There are no doubt many who would regard the remarks that I have made in this paper being other than supportive of victims of sexual assault. There is no doubting that sexual assault is a significant social problem within the community.

291. Allegations of sexual assault, frequently arise. It is important to recognise that not every person accused of sexual assault must be guilty. Likewise, not every person who recounts a memory of being sexually abused is necessarily recounting a truthful memory. As I have endeavoured to show, memory is very much a malleable concept. The perception that a person's memory is analogous to a photograph is one that is often recounted throughout the community. Commonsense and extensive studies have demonstrated that memory is a complex process essentially of a reconstructive nature.

292. In dealing with sexual assault the trend has been to compartmentalise such cases in a way that they are to be regarded as a distinct type of offence to be dealt with by rules that increasingly restrict an accused's capacity to defend an allegation. All within the community ought to be concerned that the fundamental rights of an accused, which are after all their to protect the innocent as the guilty are not so emasculated that the right to a fair trial in cases involving allegations of sexual assault will no longer be available.