3. False Complaints of Sexual Assault: recovered memories of childhood sexual abuse

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ABSTRACT

False complaints are easily made and carry serious consequences for the accused. Many of those who make false claims sincerely believe the truth of what they report. Some are opportunistic and are consciously lying for personal gain. A special type of false allegation, the false memory syndrome, arises typically within therapy. People report the 'recovery' of memories of previously unknown childhood sexual abuse. The influence of practitioners' beliefs and practices in the eliciting of false 'memories' and of false complaints cannot be overlooked.

The problems of diagnosis, issues of confidentiality and the role of the expert witness as court educator are discussed.

INTRODUCTION

An accusation of sexual misconduct is easily made and hard to refute. Of all forms of sexual misconduct, the most heinous and that arousing the most passionate response is the sexual abuse of children. Current high levels of anxiety about the sexual abuse of children ensure that those accused draw upon themselves the maximum opprobrium. Even where clear evidence of falsity exists, the stigma of accusation tends to linger and there are always those who say that there is never smoke without fire.

In recent years, there has been concern that a significant minority of allegations of sexual assault across all age groups has been fuelled by professional intervention. A new phenomenon, the 'false memory syndrome', has been described amidst acrimonious debate, and a deep division exists within professional ranks between those who advise that an accuser must always be believed and those who recommend caution when dealing with allegations of sexual misconduct.

Both sides of the dispute have been taken up with enthusiasm by the media and lurid tales of sexual abuse and of clinical malpractice abound. The truth is that we have little idea of the true prevalence of either childhood sexual abuse or false accusations and false memories of abuse. The best that can be said is that the sexual abuse of children is a serious social problem that has almost certainly historically been significantly underestimated. False complaints and false memories are fewer in number than true accounts but, nevertheless, represent a worrying proportion of allegations, and each is a potential miscarriage of justice.

FALSE MEMORIES, FALSE ALLEGATIONS

It cannot be overstated that not all accusations, whether made by children or by adults, are false. Sexual abuse, sexual assaults and rape are facts of life. A child who spontaneously reports sexual abuse, an adult who has been raped, or one who reports never-forgotten abuse in childhood but has chosen not to speak of it, are probably reporting accurately. None the less, a proportion of allegations are false. The real problem lies in knowing how to distinguish true claims from false ones. Some allegations are so bizarre it seems incredible that they should be taken seriously, yet they

end in coming before the courts. The recent American experience has shown that innocent persons can be convicted, and that those who are not convicted nevertheless have their lives, reputation and livelihood destroyed.

False memory syndrome

In the 1980s, a number of adult women began to report, during counselling or psychotherapy, the recovery of apparent 'memories' of childhood sexual abuse occurring sometimes decades previously. They accused parents, grandparents and siblings, and sometimes teachers, priests and complete strangers. Some stories were vague, little more than a 'feeling'; others were fantastic, involving multiple adults and children in sadistic and violent orgies. An accusation was frequently followed by confrontation and complete family disruption. Since the first reports appeared the numbers of allegedly or demonstrably false accusations have spread world-wide and many people now speak of an epidemic. False Memory Syndrome societies (FMS) were founded in Philadelphia (1992) and in the UK (1993) to educate professionals about the dangers of false memories and there are now FMS societies in Canada, Australia, New Zealand, Holland, Israel and Sweden, with sporadic cases reported in Norway, Finland and France. It is not entirely clear who first coined the phrase 'false memory syndrome' but it has become a useful shorthand.

A vigorous and acrimonious debate has divided academics and clinicians, centring on the extent to which it is possible to develop amnesia for an extremely traumatic event, and whether such amnesia can be lifted and a true memory for the event be retrieved. In the most general way, research academics have presented evidence to show that such amnesia is unlikely, while clinicians, drawing upon case material, have supported the notion that hideous events are frequently forgotten and later recovered from total amnesia. In the middle of the arguments about forgetting and recovery of memory, the possibility that untested theories and dubious clinical practices may lead to memory distortion and the creation of entirely illusory memories tends to get overlooked.

BELIEF, MYTH AND FOLKLORE

The defining element in 'false memory syndrome' is a belief system.

First, is the belief that almost all sexual abuse has inevitable long-term psychological sequelae and that sexual abuse can reasonably be inferred from current symptoms, even when the patient has no recollection that abuse has taken place.

Second, is the belief that the mind can 'block out' repeated episodes of violent abuse (and the more severe or life threatening the event, the greater the likelihood it will be blocked out) and that these blocked memories can be recovered substantially accurately, often after the passage of decades.

Third, is the belief that the patient must recover full details of past abuse and 'work it through' in order to integrate the past into present experience and so bring about closure. Only in this way can the patient be freed from the pathologizing effects of the past, lose symptoms and move forward. In the service of such memory recovery some practitioners use a range of techniques, including hypnosis, age regression, dream analysis, guided imagery, various forms of creative writing, 'bodywork' (the interpretation of physical symptoms as memories) and drug-assisted abreaction.

These beliefs are widely accepted – indeed, one might almost say that 'everyone knows' them to be true. The cultural context thus serves as a reinforcer of belief, although the evidence in support is scanty at best. High-profile sex cases, including the Clinton affair, recent enquiries into child abuse in care and evidence of international pornography, all heighten the contemporary sexualized atmosphere. In the recent past, allegations of multiple victim, multiple perpetrator rings, such as those at Cleveland and Rochdale, were portrayed in some quarters as a failure of the services to bring the guilty to justice. In our present cultural climate there are powerful social pressures that make it hard to take a measured view of events when faced with the possible sexual abuse of children, whether current or many years previously.

THE GROWTH OF 'RECOVERED MEMORY'

Before the mid-1980s there were a number of retrospective self-report surveys of adult women who described experiencing sexual abuse in childhood. These women had never forgotten their abuse, although they may not have dwelt upon it, or thought about it for years, and had attempted to put it aside. In 1981, Judith Herman, an American psychiatrist and psychoanalyst, first described women who described 'massive repression' of sexual abuse. Her theories caught on and in Boston a network sprang up of therapists who began to look for such 'repressed memories'. This occurred alongside growing awareness that sexual abuse in children had gone unrecognized for a long period, in part due to Freud's theory of infantile sexual fantasy.

A number of high-profile cases brought the phenomenon to the public domain, including the conviction for murder of George Franklin on the basis of a memory recovered under hypnosis by his daughter while in therapy. This conviction was later overturned. In 1994, a father successfully sued a psychiatrist and psychotherapist for encouraging in his daughter false memories of childhood sexual abuse, which destroyed his marriage, his job and his reputation. Another case to catch the headlines was that of Paul Ingram, whose two daughters accused him, during counselling, of sexual abuse. Ingram, a committed Christian, believed his daughters would not lie on so serious a matter and that he must therefore have repressed the fact that he was an abuser. He sought counselling, and with prayer and the help of his pastor 'remembered' long-standing abuse, being a high priest in a satanic cult and multiple acts of cruelty. His wife also came to remember she was a cult member, and the story spiralled out of control, pulling in more and more participants, ultimately including even members of the investigating police force. Eventually he stopped the counselling and retracted all his memories and his confession, but by then it was too late and he was convicted and sentenced. His appeal has been twice turned down and he remains in gaol but many people believe he is entirely innocent. No external evidence of any cult activity was ever found.

LONG-TERM EFFECTS OF CHILDHOOD SEXUAL ABUSE

Any judgement about the long-term effects of sexual abuse, and the capacity of the mind to remember or not remember previous abuse, is made more difficult by failure to agree on a definition of either childhood or sexual abuse. Even to agree on the prevalence of abuse becomes impossible because of differences in definition, leading to figures which range from 6%–65% of girls abused before the age of 18, depending on the survey, and definitions ranging from intercourse, fondling and touching, to leering and lustful looks.

Despite these problems there seems to be reasonable agreement that adult difficulties are not linked to single episodes of minor or non-contact abuse. Most children do not develop long-term harm, although short-term upset is certainly described (Beitchman et al., 1991; 1992; Kendall-Tackett et al., 1992). Not surprisingly, more psychopathology follows more serious abuse, and the use of force, forms of penetration, and abuse by a near relative are the most likely to lead to long-term consequences. However, children are remarkably resilient and a sizeable group show no harmful effects from sexual abuse.

PSYCHOLOGICAL AMNESIA

A distinction is made between 'normal forgetting', which is a process of natural wastage, and repression or dissociation, which are presumed psychological processes that function to keep traumatic events from consciousness.

Pope and Hudson (1995) require that for a study to show empirically that repression (or other putative mechanism for forgetting) occurs the research must demonstrate:

- independent confirmation that the alleged abuse actually took place;
- that the abuse is severe enough that it is unlikely to be forgotten in the normal way; and
- that amnesia occurs that is not due to head injury, intoxication, or other organic cause

for failure to remember, including infantile amnesia.

No studies come anywhere near meeting these criteria.

Evidence for genuine 'recovered memories'

There are a number of studies that seem to show that substantially accurate memories can be recovered from total amnesia. These may be divided into retrospective and prospective studies. In retrospective studies, the investigator examines subjects who currently remember a traumatic event and who claim to have repressed that memory for a period of time. In prospective studies, victims of a known and documented trauma are followed up after a number of years to see if they developed amnesia for the traumatic episode. All these studies are subject to problems, through failure to confirm that the alleged abuse actually took place, the nature of the 'forgetting' and the nature of the 'recovery'.

At present, therefore, research does not support the existence of psychological forgetting. However, there are a number of compelling clinical accounts of individuals apparently recovering forgotten sexual abuse. Unfortunately, the extent of corroboration and the nature and degree of amnesia are often unclear. It would seem that if psychological amnesia of the sort claimed occurs at all, it appears to be rather rare.

Children and adolescents

Although 'false memory syndrome' was originally described in relation to adults, there are a number of parallels in allegations made by children and adolescents. Some of the more spectacular miscarriages of justice in America, later overturned on appeal, involved children in nursery school settings.

There is a small subset of allegations made by children or adolescents that share many characteristics with false accusations made by adults. Typically, a child or adolescent is taken to the doctor, either because of distress or for behavioural abnormalities. On the basis of symptoms a diagnosis of sexual abuse is made; the child is referred for 'counselling' and allegations may follow.

TYPOLOGY OF FALSE ALLEGATIONS

Having outlined the problems of false memory, let me turn to false allegations in general. These fall into three broad categories:

1. Deliberate deceit.
2. Psychiatric illness.
3. Iatrogenic.

Combinations of these categories may occur.

Deliberate deceit

Some allegations arise from malice or as revenge for some real or imagined slight, others from a desire for self-protection and to provide an alibi, a few are a bid for sympathy and attention. For example, false allegations of rape following consensual sex or unwanted pregnancy serve to keep the secret, to appease an adult or to protect a lover. In a study of false rape allegations (Kanin, 1994) more than half were of this sort, while one quarter were malicious and designed to exact revenue, usually against a rejecting male. A few only were made with the aim of attracting sympathy or attention. In the study referred to, an allegation was judged to be false only if the woman herself admitted it, it was confirmed by the investigation and there was a clear motive in explanation. Since the only thing to distinguish between malingering and a psychologically determined act is external benefit, it seems only prudent to seek a motive for the deception before assuming that an allegation is untrustworthy.

Once in a while children also make intentionally false accusations, for example to escape a feared but not sexually abusing parent.

Custody disputes increase the percentage of false allegations, which may rise to as high as 50%. In these cases, the allegation is generally made by a parent on the child's behalf, although the child may be coaxed or coerced into supporting one parent's accusations against another. Sometimes such accusations are deliberately made against a hated spouse but some also arise out of anxious over-concern and misinterpretation or misperception of an innocent act.

Psychiatric conditions

False allegations may be a feature in certain psychiatric conditions, most particularly in the psychoses. For example, a woman in a state of hypomania saw her husband comfort their daughter after a fall and 'knew' instantly that he was sexually abusing her. Following treatment, she withdrew her allegations in shame and distress. In two later breakdowns she experienced the same delusional belief but recovered quickly with treatment.

Here there were other signs of disturbance and it was reasonably easy to arrive at the correct conclusion. The patient responded to treatment of the underlying condition. There is of course nothing to prevent someone with a psychotic illness from having also been the victim of a sexual assault and it may be impossible to distinguish where fact and fantasy divide.

This is more particularly the case in some of the personality disorders, notably the borderline personality disorder, in which transient psychotic episodes compromise the ability to tell fact from fantasy. Many research studies have sought to show a correlation between childhood sexual abuse and the development of a borderline personality disorder but the evidence is equivocal. There appears to be a weak correlation, but whether it is cause, effect or confounding variable remains in doubt. It is by no means clear whether those with borderline personality disorder report sexual abuse as part of their condition, or whether abuse has led to that condition.

In hysterical personality disorder, which is characterized by shallowness of relationships and a desire for attention, there may be a similar difficulty in distinguishing fact from fantasy.

Mythomania of adolescence – pseudologia fantastica

Dupre (1925), in the early part of the century, noted the tendency of adolescents to make false allegations and to tell fantastic stories, and he coined the term 'mythomania'. These children appeared to lie deliberately and consciously but then came to believe their own stories. Dupre also found that such children were initially motivated by malice, a desire for attention often coupled with precocious sexual appetites. They appeared to be highly suggestible and keenly alert to the response of others, particularly adults, from whom they would glean further fuel for their imaginative constructions. A further characteristic in some of these children was a compulsive need to produce more and more fantastic stories.

This account is interesting because it demonstrates that false allegations, of the kind associated with the false memory syndrome, are not wholly new. What appears different is the inclusion of adults and the numbers of those affected, although many have drawn parallels with the witch craze of former days.

More recent research into the tendency towards 'mythomania' suggests that some children are so terrified of being abandoned, shamed or abused that they start lying to buttress their poor self-esteem, and deep down they believe themselves to be worthless.

It can readily be imagined that the combination of a child prone to fantasize, and a professional who uncritically believes all those who claim abuse, could be a lethal one.

Factitious illness, Munchausen syndrome and pathological lying

Dupre's description of the mythomaniacal adolescent has striking similarity to the more extreme and lurid accounts of multiple sexual abuse, ritual and satanic abuse that have been reported recently by adults. A morbid desire for attention, pleasure in the sick role, or more particularly the 'victim' role, pampered and honoured as a martyr, encourages confabulation. Carried to extremes it is but a short step from telling stories to believing them (self-brainwashing) and enacting them in the form of role play. This may account for some cases of dissociative identity disorder (formerly multiple personality disorder), in which sufferers believe their body is host to several personalities. It can be thought of as role playing that has gone out of control leaving the person in the grip of a socially generated form of insanity. The tragedy is that it becomes a

vicious circle in which more attention leads to more disturbance and receives more attention.

Iatrogenic-assisted false allegations

Surveys show that 25% of cases of clearly false allegations of sexual abuse made by children are iatrogenic. They tend to be driven by professionals who have a strong investment in discovering sexual abuse and high belief that certain behaviours are signs of childhood abuse. There is also a naive belief that children do not lie about such matters.

Ceci and Bruck (1995) in a series of elegant studies found that:

- Preschool children are capable of giving reliable testimony. They are more suggestible than older children and children are more suggestible than adults.
- Suggestive and repetitive questions can lead children to mistake both peripheral details and also the central gist of events they experienced and to describe events that never happened to them.
- Non-abused children can create memories of being molested, using source materials supplied by other children.
- Children who are asked to visualize how an event might have happened to them can emerge from counselling with false memories that they were abused.
- There is no way of separating accurate from false memories in children who were interviewed using defective techniques.
- The use of 'anatomically correct dolls' with very young children is not recommended.

Professional biases and beliefs

When professionals believe allegations there is a tendency to operate a confirmatory bias and to disregard information that does not fit. Professionals may behave in a suggestive manner without any awareness of so doing. Suggestion has been argued to be most persuasive when the participants are least aware, a seamless dance in which patient and therapist both lead and follow each other.

In one example in which several children independently gave similar bizarre accounts, the grotesque nature of the allegations was one of the factors that led to their being taken seriously, since the children had no contact with one another. It was later established that there was a network of communication between foster parents, social workers, police officers and other professionals, which may have contributed to the similarity in the accounts. The professionals did not intend to suggest things to the children, yet the suggestions came.

It is worth noting that a few centres and therapists appear to make the diagnosis of 'repressed sexual abuse' and to elicit confirming memories worryingly frequently, whilst most never see it. The same is true of dissociative identity disorder in which the majority of diagnoses come from a few specialist centres. The British False Memory Society can cite several families where allegedly false memories can be traced to the same individual or centre.

Suggestion

Repeated interviews risk contamination of memory. Each new interview incorporates the previous one into the memory and reinforces it, but what is remembered may be what was said last time rather than what actually happened. Repeated retelling, rehearsing a story, has the same effect. A good deal of counselling or therapy involves the reconstruction of past events, piecing together fragments to form a coherent narrative. This tends to include a good deal of unintentional suggestion and rehearsal. Spence (1982) originally drew attention to the tendency of therapists to confuse historical truth with the narrative created during therapy, and to assume that they are one and the same. There is no doubt that a narrative created in therapy can convey important meaning to the patient, regardless of its historical validity. This has become a justification for failure to question or explore even the most bizarre of apparent 'memories'. Instead, it is hallowed as the patient's 'reality' and as such not open to question or confirmation. Clearly, patients do seek to make sense of their experience; unfortunately, as shown by accounts of past lives or alien abductions, the sense at which they arrive may turn out to be nonsense.

THE PROBLEM OF DIAGNOSIS

Not all false allegations are mendacious. What makes the diagnosis so problematic is that the accuser may not be intentionally lying. She may be reporting what she believes to be the truth, as described above. This is particularly the case where counselling or other psychological intervention has occurred.

Psychiatric diagnosis is an imprecise science and is often closer to a form of detective work. There is no simple blood test to assist in diagnosis, or an X-ray of truthfulness or lying. Diagnosis rests upon a combination of the patient's own account of his or her life and circumstances, and of his or her present state of mind, supported by supplementary information from family members and close acquaintances.

Even those whose allegations appear to be spontaneous should be questioned carefully to exclude unwitting external influence. Has a child been watching television, reading something that might stimulate the imagination? False allegations have been stimulated by soap operas, and even Batman has been discovered to have a repressed childhood trauma. Why has an adult chosen this moment to reveal her secret? Were there other influences that might have played an unwitting part in stimulating the imagination? The presence of counselling should raise alarm.

Memory distortion is often seen in depression, where there is a tendency to dwell on negative events and to forget the good times, and as already indicated, memory can be severely distorted in psychotic illness. Prescribed medication for psychiatric conditions has a mixed effect. It treats the underlying illness but may further distort real and imagined events. There are accounts of patients who have recovered new memories of sexual abuse while in hospital and have retracted them once the confusing effects of prescribed drugs, given for other conditions, wore off. Some of those who retract cannot later remember details of the allegations they made.

ISSUES OF CONFIDENTIALITY

In some circumstances, an allegation of sexual assault is made and confidentiality is imposed by the complainant, making enquiry impossible. Nowhere is this more important than in cases of delayed or recovered memory. In this country, there is no duty of care to third parties and clinicians are generally inclined to believe what their patients tell them. Deprived of other information, they may be forced into a one-sided and biased position. I have personally encountered three cases in which a psychiatrist confronted a father with the accusation that he had sexually abused his daughter and then refused to say anything further on the grounds of 'patient confidentiality'. This seems a muddled stance to take. In one of these cases the daughter later retracted her accusation and apologized, but in the other two all contact between the parents and their child has been severed. As these cases have not been reported to the police and no charges have been brought, the parents are deprived of the opportunity to defend themselves.

Sometimes, a careful collateral history at an early stage can show that abuse is unlikely or impossible, and the patient can be gently confronted with inconsistencies and contradictions.

The Royal College of Psychiatrists' guidelines (1997) to good practice recommend that a collateral history should always be sought where allegations follow memory recovery. If this is blocked by the patient's refusal to consent, and while there is no duty of care to those who may be harmed by false allegations, this advice remains difficult to follow.

THE NEED FOR EXTERNAL INDEPENDENT CORROBORATION

Professional credulity often means that any investigation is likely to be meagre and, in any case, psychiatrists are no better than anyone else at distinguishing truth from falsehood or from fantasy. It is essential therefore to seek external and independent confirming evidence.

Often, of course, there will be little or no evidence one way or the other. An important principle is the impossibility of proving a negative, since that which did not happen leaves no trace. The onus must therefore be on those who bring an accusation to prove their

case. This becomes particularly important when the event complained of happened years or decades previously, raising inevitable difficulties for the accused. It is impossible to distinguish between true and false accounts in the absence of confirming evidence.

The nature of any corroboration needs careful study. Much of what passes for corroboration in some research studies is somewhat thin. Contemporary medical or social services records are convincing but rarely available. Evidence that the assault or abuse was told to another person at the time, a note held in a diary, is also compelling. Best of all is a confession. But what should one make of an allegation that someone else, perhaps a sister, was abused or assaulted by the same person? Is that corroboration? And if both have been having counselling, how should that influence one's conclusion? These are not easy questions to answer. When we add into the equation that some men under the emotional stress and distress of an investigation confess to something which they have not done, and that alarming miscarriages of justice mean that even a conviction cannot be assumed to be correct, the picture becomes even trickier.

It will be obvious that disclosure of all medical records is essential if there is any question of psychiatric illness, psychological intervention, counselling or psychotherapy. In relation to children, it is essential to have sight of all social services records, including the investigatory process and any video interviews that may have been made as part of a police investigation. As well as objective information, these documents may be very revealing about the beliefs and biases of investigating teams.

THE ROLE OF THE EXPERT WITNESS

There are two potential roles for the expert witness in relation to false allegations of sexual assault or abuse. The first is to give a medical opinion on the reliability of a prosecution witness, by commenting, for example, on the mental health of the witness. In this situation the expert will have had contact with the witness and is giving a clinical opinion based upon his or her own findings. Experts have also been asked to comment on such matters as the expected behaviour following past sexual abuse. This evidence should be based in research evidence but may often be based upon the expert's clinical experience alone. The best expert will explain that while certain behaviour is not diagnostic it may be shown by a given proportion of individuals.

The second role for the expert is to provide the jury with the tools to arrive at a decision. He or she should not comment on the credibility of witnesses but should review the relevant literature and cover various topics that will enable the jury to grasp the facts. Cross-examination and opposing expert testimony ensure that the credibility of the expert is kept under review, although at times the jury may be swayed as much by confidence and presentation as by content.

The model expert will present evidence neutrally, keeping a fair and impartial balance. In practice, it may not be as easy as that, given the adversarial nature of the British legal system. Counsel, not surprisingly, look to their expert to present evidence in a way that is advantageous to their case and experts may become biased towards their own 'side' and give up some of their neutrality.

FINAL THOUGHTS

Trials involving allegations of sexual abuse are unusual in British justice for requiring a jury to determine both the guilt or innocence of the defendant, and that a crime was committed. A conviction thus becomes a means of 'validating' that abuse took place. Because of the nature of sexual crimes and the general tendency to believe that where there is smoke there must be fire, the accused often finds himself in a position of having to prove his innocence, if not in a court of law at least to his neighbours and associates. This of course flies in the face of justice and science alike.

Sexual abuse calls forth such a strong antipathy in most adults that it has altered the way in which trials are conducted. Sexual abuse 'victims' no longer have to face those whom they accuse in open court; defendants in rape cases are prohibited from cross-examining their accuser in person. These two fairly

new regulations, though well intentioned, carry the subtle allusion that the accuser is a 'victim' who must be protected, and may serve to prejudice opinion against the accused. There is a more or less explicit belief that if a 'victim' is challenged about any part of her (or his) evidence, that experience is itself traumatizing. It is not apparent quite why this should be so, except in the most disturbed of subjects. That it may be distressing, lead to anger and upset, is evident enough, but feeling upset and distressed is not the same as suffering a trauma.

Allegations of sexual assault, whether made by adults or children, should be treated with respect and sympathy but not unquestioned belief. Axioms such as 'believe the patient' or 'children never lie' do not assist and may lead to serious errors. Many clinicians take the view that the truth or otherwise of a complaint is a legal matter and not a clinical one, and that it is not the responsibility of the clinician to establish the facts. My own view is that clinicians do have a responsibility to consider if an allegation is likely to be true or false as part of their diagnosis and should not uncritically accept whatever their patients tell them. Not only may there be serious repercussions for innocent people, the accuser is cut off from her natural support network and risks being treated for a non-existent problem with possible serious consequences to mental health.

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