

The Dangers of the Therapeutic Culture

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Clinical psychology is in a serious state. Although there are many psychologists who practice therapies with scientifically documented effects and others who perform tests with firm scientific underpinnings, there are also many who do the opposite, who practice psychotherapy that have been proven useless and perform tests that lack all predictive value. For some reason, the kind of corrective forces that have been relatively successful in purging snake oils from somatic medicine have been very inefficient in psychology and some parts of psychiatry.

Many readers are likely to be shocked by these blunt statements, especially readers who are unfamiliar with the subject. For them it may simply sound too improbable that the psychological and psychiatric professions should have many practitioners who are little more than quacks – a few rotten eggs perhaps, but so many that it is really an important social problem? I am afraid that this really is the truth and although it may sound aggressive and confrontational, it is mainly misplaced politeness and fear of seeming one-sided that prevent more scientists from making similar statements.

Before discussing what should be done about it, let me illustrate what I mean by quack psychology. I will do so with the help of two examples: repression of traumatic memories and multiple personalities.

Repression of memories of sexual abuse

Contrary to popular belief, the concept of memory repression was quite marginal in psychological research before the 1980s. Although many researchers had tried to demonstrate its existence ever since Freud made the concept popular, repression had never been demonstrated and was hardly mentioned in textbooks on memory. Then in the late 1980s and 1990s a number of highly publicised cases appeared in which patients (mostly middle-aged women) in psychotherapy claimed to have recovered memories of previously unknown childhood sexual abuse. The idea that various psychological ailments had their roots in sexual abuse caught on among therapists and the public and within a decade many thousands of families had been torn apart and alleged perpetrators convicted to long prison sentences. In one of the most famous cases, Eileen Franklin, who was receiving therapy for depression, “remembered” that her father had committed a murder twenty years earlier and despite a complete absence of any other evidence, the father was convicted of the murder.¹

We are not talking here of people who have not thought about an incident for many years and are suddenly reminded of it. Nor are we talking about people who remember a traumatic incident but who do not want to talk about it because it is painful or embarrassing. The typical claim is rather of someone who has

- (1.) been subjected to repeated sexual abuse for months or years,
- (2.) had no conscious recollection of such abuse during the period in which it occurs, and
- (3.) later recovered detailed memories of the abuse with the help of psychotherapy

To put it simply, there are two competing hypotheses to explain such cases:

Repression hypotheses: The alleged memory may be true and has really been repressed. I shall argue against this hypothesis that it is a) inconsistent with human experience, b) highly implausible on theoretical grounds and c) completely lacking in scientific support.

Therapeutic suggestion hypothesis: The alleged memories are fantasies induced by suggestion from a therapist, possibly with the aid of social workers, police investigators or popular culture. I shall argue that there is pretty conclusive evidence that such psychological mechanisms exist and also that suggestion does occur even if it may sometimes be unintended.

Does repression exist?

Let us first look at the repression hypothesis. It is really quite strange that this idea has caught on so strongly in the popular culture for although it has been a staple cliché in film and literature, it is quite alien to the experience of ordinary people. For instance, have we ever heard of someone who has suffered a traumatic loss, say a close friend or family member, and who is completely ignorant of this fact? Do hospitals regularly get visitors from family members of deceased patients? Do people who have survived concentration camps remember or are their memories of these periods of their lives blank? Are victims of torture known to sometimes forget that they have been tortured? When sexual or other abuse has been independently corroborated by witnesses or by physical evidence, it should occasionally happen that the police are unable to get any information from the victim because the abuse has been repressed. But is this ever a problem for the police? It should be sufficient merely to ask these questions, to realise how foreign the idea of memory repression is to human experience, but for the sceptic there is also scientific documentation of the fact that people remember traumatic events very well. For instance, Wagenaar & Groeneweg concluded that “almost all witnesses remember” a Nazi concentration camp “in great detail, even after 40 years”.² Studies of how people remember catastrophes such as collapsing buildings or hijackings also fail to show repression.³

Repression is also a very implausible idea for theoretical reasons. Why would evolution have equipped us with a mechanism that makes us forget traumatic events that are important for our survival? Surely, evolution should favour those who are good at remembering the facts of abuse as well as the perpetrator. When confronted with this obvious objection, believers in repression usually claim that it is a defence mechanism that has evolved in order to protect us against the anxiety and pain that the traumatic memories evoke.

But this is an incoherent idea. The driving force behind evolution is selective survival and reproduction, not what makes life nice for the organism. If repression were dangerous, which it surely is, evolution would eliminate it even if that meant more anxiety. Anxiety is actually *the point* of traumatic memories – it is there in order to make us avoid dangerous situations and persons. The idea that nature would provide us with an alarm signal (anxiety evoked by a memory) and then put a silencer on the alarm (repression) in order to protect us from the unpleasantness of the alarm signal is simply incoherent. But the repression theory is actually

worse than this. For although the silencer is said to be there to protect us, it also needs to be removed by therapists! Thus, although the anxiety associated with traumatic memories is so serious that nature has to protect us from it, therapists have no qualms about destroying the protection so that the repressed memories can be recovered. It is actually believed both that traumatic memories are so dangerous that evolution had to create a special repression mechanism to protect us from them and that the repression is so dangerous that therapists have to prevent it from functioning. A doctor who interfered with bodily protection mechanisms such as wound healing or inflammatory reactions can be prosecuted, but in certain areas of psychiatry and psychology this is regarded as common sense.

The third argument against the repression hypothesis is that there is simply no scientific evidence for it. Holmes, reviewing attempts to demonstrate repression in experimental psychological research, concluded that “despite over 60 years of research involving numerous approaches by thoughtful and clever investigators, at the present time there is no controlled laboratory evidence supporting the concept of repression.”⁴

A recent experiment by Anderson and Green has shown that subjects can purposefully induce forgetting if they use certain tricks to avoid thinking about a particular item.⁵ This is neither surprising nor relevant to the issue of repression. Firstly, the memory items the subjects were asked to avoid, were words, which is rather different from traumatic experiences of sexual abuse. Secondly, the experiments only showed that the words could be purposefully *forgotten*, not that they were *repressed* in the sense that they were relegated to a separate compartment in the brain where they could remain unavailable for conscious recollection for a decade, yet produce serious mental symptoms, and then recovered intact after psychotherapy. The idea that this study vindicates the claim that sexual abuse can be repressed⁶ cannot be taken seriously.

A lot has also been made of clinical evidence for repression, but again the published literature does not support it. Space will not permit me to review the state of scientific evidence here, but let me briefly mention the main problem. There are a few studies of varying quality that claim that abused children have been unable to recall the abuse for long periods.⁷ However, these studies all suffer from one or more of the following fatal flaws:

- a) Some studies do not differentiate between *not attempting to recall* the abuse and a true *inability* to do so.
- b) Some studies include children less than five years of age and could therefore not exclude infantile amnesia. It is well known that the neural substrate for declarative memory is not developed until about five years of the age.
- c) Many cases of abuse, such as indecent exposure, may not be particularly traumatic for the child and may therefore simply be forgotten. There is no widespread fear that a medical examination or inserting a rectal thermometer is so traumatic that it must be repressed. Why should indecent exposure or fondling, that the child need not interpret as sexual, necessarily be traumatic?
- d) Many victims of abuse are known to deny the event, not because they cannot remember it, but because they find it painful to talk about, perhaps out of feelings of shame. Such feelings may seem irrational and misplaced, but they are known to be quite common among adult rape victims.

To my knowledge, there is no clinical study that meets all these objections and this also seems to be the view among several investigators who have conducted extensive reviews of the subject. In 1995, the British Royal College of Psychiatry set up a working party to evaluate the published evidence for repression and provide guidelines for psychiatrists. They concluded that “no evidence exists for the repression and recovery of verified, severely traumatic events”.⁸ The most extensive review to date is probably *Remembering Trauma* by McNally, who reaches essentially the same conclusion.⁹

It should also be pointed out that there is a conspicuous lack of corroborated case histories in the clinical literature. One highly acclaimed book states that approximately a third of sexually abused victims repressed memory of the abuse and later recovered it.¹⁰ If repression of sexual abuse were nearly as common as this, there should be thousands of individual cases where the abuse, the repression and the subsequent memory recovery could be independently verified. Much of the alleged abuse, after all, takes place in homes with siblings and one other parent. Surely, in at least a small percentage of cases, there would be a witness willing to confirm what had happened. Yet, when the published literature has been searched, not a single case has been found.¹¹

Therapeutic Suggestion

It is hardly necessary to present scientific evidence that it is possible to implant false memories into people by suggestion. It is a quite common historical phenomenon with the witch hunts as perhaps the best parallel to today’s hysteria about sexual abuse. People have related vivid and emotionally charged memories of being abused by aliens from outer space and witnessing ritual child murders in satanic cults, which we know must be false. However, there is also an abundance of laboratory evidence demonstrating that false memories can be implanted by suggestion. Memories of fantasies are, as far as we know, stored in the same way as memories of real events. If we are led to believe that a certain event has taken place and then have memories of fantasies about such an event, the brain will often construct the most plausible scenario, namely that the memories are authentic. Subjects of psychological experiments have been led to relate extremely elaborate stories of events that never took place, yet later appear as clear memories to the subject.¹²

Nor is it difficult to demonstrate that many alleged victims of sexual abuse have been pressured or subjected to strong suggestions. The following is an excerpt from a police interrogation with a girl who has accused her father of sexual abuse. The girl suffered from anorexia and bulimia and spent many months in therapy at a child psychiatry clinic in Sweden.

I: police interrogator. G: girl.

I: I know that you have had anorexia ... what do think caused it?

G: The psychologists ... think it was my father who caused it by what he did ... but that is not something anyone can say since I don't remember myself.

I: But when you say that you don't remember - why is that? Surely you have some little memory fragments of what he did?

G: Yes, I have.

I: Can you tell me about them?

G: No, not the fragments... I am not sure, but it's about incest ... we don't really know how.

I: You remember occasions when it happened?

G: No I don't, there are only certain memory fragments but I cannot get a whole picture of what happened.

I: But you do remember that it was sexual abuse?

G: I don't really know what to say... I don't remember anything ... I remember that he touched me in a certain way ... the staff at the psychiatric clinic interpret it in their own way. I don't know, I can't say...

After a few months of “therapy” the girl started having nightmares about being raped by her father. She was explicitly told that the dreams were memories about to be recovered and if she could only remember them clearly, her anorexia and bulimia would disappear. This girl was actually quite reluctant to accept the suggestions that had obviously been made by the therapist and reinforced by the police interrogator. After a few months of this treatment, however, she agreed to go to trial against the father.¹³

It is difficult to avoid the conclusion that, in cases of alleged repression of memories of sexual abuse, therapeutic suggestion is by far the most plausible explanation. Serious investigators may differ about how secure or obvious this conclusion is, but there can be no question that the weight of the scientific evidence is against repression. Since recovered memory therapy has frequently and obviously wrecked the lives of thousands of people, the burden of proof must surely be on its practitioners.

Do Multiple Personalities exist?

Multiple Personality Disorder (MPD) (sometimes named Dissociative Identity Disorder) is a condition in which the self is supposed to have split into two or more distinct personalities or *alters*. The alters normally have different personality features and sometimes distinct memories and different names. The alters are often described as “assuming control” or “taking possession” of the patient. The cause of MPD is usually said to be childhood sexual trauma. But the concept of MPD is incoherent and lacks empirical support.¹⁴

At first glance, the idea of multiple personalities may not seem all that strange. After all, we know about bipolar (manic-depressive) disease where a person’s personality can change dramatically between extremes of self-confidence and feelings of worthlessness or between restless activity and a complete inability to initiate any activity at all. Swinging between extremes on a single dimension, however, is very different from what is being claimed for multiple personalities. The bipolar patient in the manic phase does not “block out” memories from the depressive phase. Nor does the patient have nicotine dependence in one phase and not in the other or believe himself to have different life histories depending on which personality is “in charge”. In fact, although there are obvious and dramatic differences between the phases, the bipolar patient has a personality that remains quite recognisable through the mood swings. The really strange thing about multiple personalities is that different aspects of personality seem to be coupled such that, for instance, one personality may be dependent on nicotine, use foul language, respond to a particular name or have it’s own memories.

The idea of multiple personalities rests on a pre-scientific view of personality as an autonomous agent that can “take control over”, and must therefore be distinct from, the brain. One could say that it is a modern version of the idea that a person can be “possessed” by evil spirits. But personality is not like that at all. It is a property of the brain, not something

extrinsic that can “use” the brain.

Personality traits result from physical features of the brain. If neurones in the amygdala near the base of your brain are easily triggered, because of their connections or receptor density, for instance, you will probably feel threatened more easily than others and react more often with aggression or flight. The size, connectivity or receptor distribution of other cell groups in your hypothalamus (for instance the nucleus known as INAH3) will determine if you are hetero- or homosexual and it seems likely that features of the serotonin, noradrenaline and dopamine projections in your brain will influence your propensity for depression, drug dependence or energy level. Personality is not something that can split or something that you can occur in several numbers any more than you can have several body shapes.

The fact that many features of your brain are shaped by learning and experience does not affect this argument. Learning can change the synaptic receptors in some brain structure *X* but it does not make the brain grow several parallel *X* structures. Nor is the brain divided into several independent compartments, thousands if we are to believe the believers in MPD.

People are born with and acquire certain modes of reacting. Some are born with a strong need for social approval and they will acquire different ways of interacting with others than those who have a small need for social approval. Some people are more prone to anxiety than others, most likely because the physiology of certain neurotransmitters such as serotonin is slightly different. But there are no isolated compartments some of which are anxiety prone and some of which are not.

Take drug dependence as an example. This can arise because drug molecules can change the biochemical properties of nerve cells in the brain. Nerve cells may adapt, for instance, so that renewed drug consumption is required in order to keep certain neural activity at normal levels or they may reinforce nerve cells responsible for the behaviour of drug consumption. In either case, the molecules are carried by the blood to all parts of the brain and will affect the sensitive nerve cells wherever they are located. They will not remain localised to a particular subset of sensitive neurones, which is related to a particular personality module. If your nerve cells have adapted to nicotine, they will remain so regardless of what personality is turned on or off.

Or take verbal memory. When you learn your name as a child, certain connections in the brain are formed so that the sound of your name causes the reactions in your brain that you describe as hearing your name. You do not have several parallel systems, so that one of them can be switched off and completely different sounds now cause those reactions.

There is no question that many patients display the symptoms of MPD. In saying that the phenomenon does not exist, I am not questioning this fact but rather the assumption that the symptoms are caused by something that can reasonably be described as new personalities taking control over the person. A vastly more plausible explanation is that the condition is a form of conscious or unconscious acting induced by therapists and a culture that encourages belief in MPD.

If the concept of multiple personalities is so incoherent, why has it become so popular that it has even managed to enter the diagnostic manual of the American Psychiatric Association? (In the latest version this manual, DSM IV, MPD is called *dissociative identity disorder*).

I do not know the answer to this question, but it seems clear that it should be sought in popular culture and social psychology rather than in science. Multiple personalities were brought to the psychiatric limelight by the French medical psychologist Pierre Janet and some other researchers in the late nineteenth century, but after World War I a sharp decline in reported instances of multiple personality occurred.¹⁵ Multiple personalities were virtually unknown, a fringe phenomenon in psychiatry, from the early 1920s till the publication of the famous Sybil Case in 1973 that relates how Sybil's therapist Cornelia Wilbur identified 16 different alters in her patient.¹⁶

At the turn of the century, MPD had reached epidemic proportions with tens of thousand of patients. Interestingly, the number of personalities in each patient also proliferated so that, whereas previous cases usually contained only one or two, the mean number of alters increased to 16 in 1989.¹⁷ According to the journalist Jean Acocella, some patients have several thousand alters.¹⁸

We now know that Sybil is essentially a hoax. The psychiatrist Herbert Spiegel, who took care of Sybil when Wilbur was unavailable, has revealed that Schreiber had wanted his help with the book and that she wanted him to endorse the MPD diagnosis because it would be more appealing to the public. According to Spiegel himself, Sybil's alters were the result of therapeutic suggestion. Indeed, when he saw the patient, there was no need to communicate with the alters at all.¹⁹

In a recent review, Lilienfeld and Lynn contrast the posttraumatic explanation for MPD with a Sociocognitive model (SCM), which holds that the condition “results from inadvertent therapist cueing”. They conclude that “A variety of pieces of evidence, including treatment practices of DID proponents, the clinical features of patients with DID before and after psychotherapy, the distribution of DID cases across psychotherapists, data from role-playing studies, and cross-cultural epidemiological data, provide support for several predictions of the SCM.”²⁰

Many other examples could have been given of scientifically pseudoscientific fads (trauma debriefing, primal therapy, traditional psychoanalysis, for instance), but the above should suffice to show that bad science is a serious problem in psychology and psychiatry. Notice here that the argument of this paper would not necessarily be compromised even if I turned out to be wrong in my assessments of repression and multiple personalities. The crucial point is that given the current state of scientific evidence and reasonable standards for evaluating these ideas, they are so implausible that their clinical use cannot be defended.

Consequences of bad therapy

It is hard to exaggerate the human and material costs of quack psychological therapy. In most cases the main consequence of bad medical practice is that patients do not get well, which means that they will unnecessarily continue to suffer from diseases and occasionally die from them. The consequences of quack psychology are very different. They too, of course, include patients who do not get well but continue to suffer from illnesses that, more often than most people realise, may also kill them. But quack psychology also has other effects. Hundreds of people in Sweden (a country with nine million inhabitants) have been sent to jail on evidence with no basis in science. Thousands of people with modest resources have spent large sums of money to pay for worthless, sometimes even harmful treatments. Thousands of families have

been torn apart. The number of relationships that have been poisoned by unfounded suspicions or the number of lives made miserable by a meaningless harping on childhood experiences cannot be calculated but is not negligible. Psychologists and psychiatrists make scientifically unsubstantiated and often clearly erroneous statements of fact on which society and individuals then base important decisions concerning childrearing, education, treatment of criminals and many other things.

It is remarkable that of the more than fifty professors of psychology, not counting an even higher number of associate professors, who are responsible for psychological education in Sweden, only one (Lennart Sjöberg of The Stockholm School of Economics) has spoken out publicly against this outrage.

Sources of Therapeutic Nonsense

Why do the psychological fads develop so easily and why do psychologists so uncritically embrace them? The answers are diverse and mostly obvious.²¹ Patients understandably have an intense desire to understand their suffering, usually in non-medical terms. Although some patients find relief in hearing that their symptoms arise from brain chemistry, many are reluctant to accept that there is something wrong within themselves and prefer explanations that place the problem outside. The idea that the symptoms are caused by a natural reaction to trauma events satisfies this desire. Therapists who, also understandably, empathise with the patients will be biased in the same way. Another factor is that the therapist wants to be seen as doing something, even if nothing really useful can be done. This is a common phenomenon in somatic medicine as well, where doctors sometimes prescribe useless but harmless drugs that often increase the psychological well being of the patient even if they have no effect on the disease. Rather than admitting that the cause of the patient's problems is unknown or untreatable, therapists and patients reinforce each other's beliefs in a pseudoscientific idea. Finally, we must not forget the crass motives of many therapists. Their income as well as their professional identity and social standing may depend on a belief in what they are doing and creates a powerful resistance against critical scrutiny of the therapy they sell.

Though it is easy to identify several mechanisms that make therapists easy victims of pseudoscience, it is also very difficult to do anything about them. These mechanisms are part of the human condition. There is, however, one problem that can and must be addressed.

The Catch 22 of professional associations

One important impediment to a rational clinical psychology is a conflict of interest, a real Catch 22 of professional associations. Although I am only familiar with the situation in Sweden, I have reason to believe that professional associations in many western countries have two incompatible roles by serving both as trade unions and as society's main source of information on the science underlying the profession. Thus, psychological associations have to look after the interests of their members, even when these members base their work on pure pseudo-science. They are supposed to aid their members in various ways including defending them in conflicts with employers and in cases of alleged professional misconduct. They also typically try to cultivate the market for psychological services, for instance by advertising the usefulness and importance of these services.

However, and this is the problem, professional associations are also often the only authority to which society can turn for information on the scientific basis of these services. For instance,

in defining the requirements for licensing psychologists (or medical doctors), the professional associations play key roles. They are also instrumental in shaping the rules of medical insurance and similar matters. One of the clearest examples is probably the *Diagnostic and Statistical Manual of Mental Disorders*, DSM IV, published by the American Psychiatric Association and mentioned above in connection with multiple personalities. The DSM IV is presented as a scientifically based document, although it is now well established that lobbying from interest groups has influenced decisions to include certain diagnoses.²² It is in the interest of the APA's members to have as many conditions as possible classified as psychiatric illnesses. It seems to me that a crucial prerequisite for a healthy development of clinical science (and this goes for somatic medicine as well as for psychology) is that the roles of professional associations as both trade unions and as protectors of scientific therapy be separated.

The waves of irrationality described above have subsided and the number of therapists committed to these particular forms of quack psychology is much smaller than it once was. The forces that create and enable such waves have not disappeared, however, and if nothing is done to control them, it will only be a matter of time before a new craze is upon us.

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¹ Crews 1995; Pendergrast 1995.

² Wagenaar & Groeneweg 1990, p.84.

³ Wilkinson 1983; McNally 2003; Terr 1983.

⁴ Holmes 1990.

⁵ Anderson and Green 2001.

⁶ Conway 2001.

⁷ For references, see Brown *et al.* 1998.

⁸ Brandon *et al.* 1998.

⁹ McNally 2003.

¹⁰ Brown *et al.* 1998.

¹¹ Pope & Hudson 1995; Pendergrast 1995.

¹² Loftus & Ketcham 1994; Ceci & Bruck 1993.

¹³ He was eventually acquitted. It is a sad fact that a professor of psychology in Stockholm, a hitherto respected memory researcher, who has taught thousands of clinical psychologists in Sweden, offered to be a witness for the prosecution and vouch for the authenticity of the girl's memories. Upon learning that an expert with opposing views (the present author) would be present as a witness for the defence, he changed his mind and declined to participate in the trial.

¹⁴ For critical reviews, see e.g. Acocella 1998; Hacking 1995; Lilienfeld & Lynn 2003; Pendergrast 1995; Piper 1997.

¹⁵ Crabtree 1993.

¹⁶ Schreiber 1973.

¹⁷ Ross *et al.* 1989.

¹⁸ Acocella 1998.

¹⁹ Pendergrast 1995; Acocella 1998.

²⁰ Lilienfeld & Lynn, 2003.

²¹ For a detailed discussion of these issues, see Lilienfeld *et al.* 2003.

²² Kutchins & Kirk 1997.