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False Memories Turned Against the Self

Saul M. Kassin

Department of Psychology

Williams College

Memory construction is a phenomenon that has become intuitive to the experimental psychologist. In recent years, researchers have found that misleading postevent information can alter actual or reported memories of observed visual events (Loftus, Miller, & Burns, 1978; McCloskey & Zaragoza, 1985), particularly among young children (Ceci & Bruck, 1993) and adults under hypnosis (McConkey & Sheehan, 1995). Recent studies suggest that it is possible as well to implant false recollections of words in a list (Roediger & McDermott, 1995) and isolated childhood experiences—such as being lost in a shopping mall—that supposedly had been forgotten (Loftus, 1993).

Despite the apparent ease with which experimenters have been able to tinker with minor recollections of their subjects, this research did not, and indeed could not, prepare us for the kinds of wholesale manipulations of autobiographical memory de Rivera describes. The case studies he presents—of four former psychotherapy patients who recovered “memories” of prolonged child abuse only later to retract these memories—seem incredible, as do the mind-control and narrative models he offers to explain these cases. As de Rivera himself admits:

It is one thing to replace the image of a stop sign with that of a yield sign . . . yet quite another to have a person replace a purportedly happy childhood with a belief that he or she was systematically sexually abused by a previously adored parent.

Surprising or not, a sufficient number of false memory syndrome (FMS) cases have been reported in recent years to shake even clinically minded skeptics prone to trust self-reports of abuse but distrust the retractions of these self-reports. Assuming that some unknowable percentage of FMS cases prove to be legitimate (i.e., where traumas initially reported but later retracted did not occur), psychologists should seek not only to validate each diagnosis, but to identify the social influence processes by which these extreme, heart-wrenching, and self-destructive memories were ever constructed in the first place. De Rivera’s case studies and conceptual analysis provide valuable insights toward this end.

De Rivera proposes two explanations, not mutually exclusive, for the therapy-induced creation of false memories. One is a “mind-control” model in which the therapist overwhelms his or her patient by making an

abuse diagnosis and then supports that assessment by manipulating the patient’s informational and emotional state. This heavy-handed type of influence closely resembles the thought-reform or “brainwashing” techniques previously seen in Korean War prison camps and certain religious cults. In the alternative “narrative model,” the patient primarily leads the therapist, creating a trauma story from the past as a way to understand or lay blame for his or her unhappy current state.

To evaluate these two models, de Rivera interviewed four FMS victims, or retractors, concerning their backgrounds, the memory-induction process they underwent, and their retractions. Using the method of conceptual encounter, de Rivera described the two possible models to each respondent, and together they tried to conceptualize her experience within these frameworks. On a methodological level, this study is flawed in some important ways. First, the sample is small, and we have no basis for accepting de Rivera’s belief that “it appears representative.” Second, de Rivera himself conducted the interviews, a procedure that paves the way for the intrusion of experimenter expectancy effects. Third, all the data concerning the critical induction process were obtained from the retractors themselves—“research partners” with a prior record of deception and with self-justificatory motives that might systematically have corrupted their self-reports. There are two sides to every story, of course, and studies have shown that actors and observers clearly differ in the causal attributions they make (Jones & Nisbett, 1971; Watson, 1982). Thus, one can only speculate about the way the therapists involved in these cases would have depicted the same events.

In light of the foregoing limitations, a result favoring one model over the other should be accepted with caution. In fact, however, de Rivera finds that neither model completely fits the experience of all four retractors and that both perspectives on FMS are necessary for understanding the processes at work. Clearly, aspects of the stories told by Ann, Cath, and Doris conform to the mind-control model. Yet just as clearly, the stories told by Beth and Doris suggest a more narrative account. Thus:

Relatively normal persons from relatively functional families may develop FMS either through the “mind control” of a therapist pursuing a personal agenda or through a process of narrative construction abetted by

a therapist who ignores the defensive position established by the narrative.

Doubtless there are critics of FMS who will balk at the notion that therapists can exert the kind of power de Rivera describes, particularly in his mind-control model. Unfortunately, in this regard, the debate between advocates and critics of so-called recovery therapies seems hopelessly mired in political, cultural, and ideological differences (see Nathan & Snedeker, 1995) and is confounded with broader related concerns about the efficacy of psychotherapy (e.g., Dawes, 1994). This being the case, it would be useful, if possible, to study the same phenomenon in a neutral (i.e., nonclinical) setting. In fact, this is being done.

In recent years, psychologists have discovered a close cousin of FMS in the criminal justice arena. The setting is the police interrogation room, the subject is an innocent crime suspect, and the phenomenon is an *internalized false confession*, wherein an innocent person—anxious, tired, confused, and under the influence of highly coercive methods of interrogation—comes to believe that he or she has committed a violent crime (Kassin & Wrightsman, 1985; for reviews, see Gudjonsson, 1992; Kassin, 1997; Wrightsman & Kassin, 1993). The following stories illustrate the point.

In one case, 18-year-old Peter Reilly returned home one night to find that his mother had been murdered. The police gained his trust and then told him that he failed a lie-detector test (which was not true), which meant that he had to be guilty even though he could not recall the incident. After relentless interrogations, Reilly underwent a chilling transformation from denial through self-doubt, conversion (“Well, it really looks like I did it.”), and a full confession. Two years later, independent evidence revealed that he was innocent (Barthel, 1976).

In a second case, golf course attendant Tom Sawyer was charged with the rape and murder of his neighbor. At first, he was invited to the police station to assist with the investigation. Once there, he was subjected to a grueling interrogation in which he was told that his hair was found on the victim’s body, a claim that was not true. Eventually, Sawyer came to believe that he raped and killed the woman but had forgotten the incident because of an alcoholic blackout: “I guess all the evidence is in, I guess I must have done it” (Jerome, 1995).

In a third case, 19-year-old Bradley Page, a Berkeley student, confessed to murdering his girlfriend. Although the police had not a shred of evidence against Page, and no motive, the detective—after gaining Page’s trust—said that he had flunked a lie-detector test, that he was seen near the body, and that his fingerprints were found on the murder weapon. None of these

claims was true. In the course of the 16-hr interrogation, Page wondered aloud if he could have killed his girlfriend without realizing it. The detective said it happens all the time and helped Page recover his lost “memory.” Based on the statement he produced, the facts of which did not match many aspects of the crime scene, Page was convicted and sentenced to 9 years in prison (Pratkanis & Aronson, 1991).

In a fourth case, Paul Ingram, a deeply religious man, was accused of sex abuse, the rape of his daughter, and satanic cult crimes that included the slaughter of newborn babies. Within a 5-month period, during which Ingram was interrogated 23 times, he was detained, hypnotized, told by a police psychologist that sex offenders often repress their offenses, and urged by the minister of his church to confess. Ingram eventually “recalled” his deeds, pleaded guilty, and went to prison. Yet to this day no material evidence exists to suggest that the crimes had even occurred. And when an expert in the case concocted a phony crime story and accused Ingram of committing it, Ingram confessed—and even embellished the story (Ofshe & Watters, 1994; Wright, 1994).

Other similar cases involving coerced-internalized confessions exist. The names, places, and dates differ, but they all share two factors in common: (a) a suspect who is “vulnerable” (i.e., whose memory is malleable by virtue of his or her youth, naivete, lack of intelligence, stress, fatigue, alcohol, or drug use); and (b) the presentation of false evidence (e.g., a rigged polygraph or forensic tests, a staged eyewitness identification) designed to convince the beleaguered suspect that he or she is guilty. In a recent laboratory test of this two-factor hypothesis, Kassin and Kiechel (1996) found that the presentation of false evidence led individuals who were in a state of uncertainty to confess to an act they did not commit, to internalize that confession, and to confabulate details consistent with that newly created belief.

Despite obvious differences between psychotherapists and their patients and detectives and their suspects, the parallels between FMS and internalized false confessions are striking. In both sets of cases, an authority figure claims to have privileged insight into an experience in the individual’s past. In both, the individual is in a state of heightened vulnerability or malleability with regard to his or her memory. In both, the interactions between expert and individual take place in a private, socially isolated environment devoid of external reality cues. And in both, the expert ultimately convinces the individual to accept a negative and painful self-insight—in the absence of memory—by invoking the concept of repression.

De Rivera’s two-pronged conception of FMS provides a valuable heuristic for isolating the roles played by the therapist (in the mind-control model), the patient

(in the narrative model), and their interaction. In this regard, the work reported in this article suggests three goals for additional research. First, it is important to reexamine the models within a larger sample of retractors, using a standardized protocol, and including reports from the therapists involved in these cases. Second is to trace the processes (e.g., the temporal sequences) with which the various forces operate. In the internalized false confession cases, the interrogations seem to pass through predictable stages: The suspect denies the charge, the interrogator gains the suspect's trust and then presents infallible evidence, the suspect—lacking a memory of the crime—becomes disoriented, the interrogator invokes the repression or “black-out” hypothesis, the interrogator helps the suspect reconstruct the details of the crime, and the suspect comes to believe that he or she is guilty. Does the in-therapy induction of false trauma memories follow a predictable sequence as well, and if so, what is it? Conversely, can de Rivera's conceptualizations be used in law to better understand the phenomenon of internalized false confessions? Third, it is important to know what personal characteristics make people vulnerable to FMS. De Rivera concludes that FMS may develop in “relatively normal” individuals, and—despite the observation that all four retractors described being in trancelike states—he is too quick to dismiss the possibility that FMS victims in general are highly prone to dissociation or suggestion, or possess other traits that predispose a vulnerability to mental control or narrative processes. Indeed, in light of de Rivera's dual focus on the roles of therapist and patient, it would be important to assess therapist characteristics is important as well.

Note

Saul Kassin, Department of Psychology, Williams College, Williamstown, MA 01267.

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