

Memory on Trial

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As a psychiatrist with experience in hypnotherapy, I am often called upon to evaluate a patient who presents with memory loss (amnesia). In this paper I would like to review a number of factors that I draw upon when evaluating this loss of memory. In effect I am putting memory (or rather, lack of memory) on trial with each case I evaluate. Since current accusations of sexual abuse and counterclaims of false memories are resulting in increased interactions between the legal and medical professions, I felt it would be helpful to discuss some of the events, diagnoses, and factors related to hypnosis that are pertinent. This is not an exhaustive list, and it draws heavily on my clinical experience as a clinical psychiatrist over the past twenty years.

The following, then, are factors to be considered in evaluating a patient for possible psychogenic amnesia, that is, a memory loss that is not due to organic causes such as head trauma, influences of chemicals, or neurological diseases.

I. THE CONTINUUM OF HYPNOTIC CAPACITY

In basic terms, hypnotic capacity is the ability to enter a trance state. A trance state is an altered state of cognitive functioning which can come about by a variety of causes such as trauma, hypnosis and drugs such as sodium amytal ("truth serum") and alcohol. The ability to go in such a state appears to fall along the bell curve continuum. That is, a small percentage of the population (approximately 15%) are relatively poor trance responders, about the same percentage are high trance responders, while the bulk of the population has moderate capacity. It is the group in the high end that have an unusual ability to enter deep trance states. This includes the ability to develop psychogenic amnesia for the period that person is in a trance. This is the same group of trance responders that a stage hypnotist is looking for in the stage volunteers. He knows certain subjects can readily enter deeper trance states and as well may have posthypnotic amnesia for the time they are on stage.

It is important to understand this continuum of hypnotic or trance capacity. Thus, not everyone who is traumatized has the capacity to develop amnesia. For the most part, it is only those with high hypnotic capacity who develop amnesia when severely traumatized. Thus, when evaluating patients who complain of amnesia secondary to trauma, I do an evaluation for hypnotic capacity. I expect it to be high if the amnesia is on a psychogenic basis. Invariably this is the case. In effect then, it is a relatively small percentage of the population who will develop a psychogenic amnesia secondary to trauma. Though trance capacity is higher in children, much of this capacity also persists into adulthood. Some studies suggest there is a genetic basis to trance capacity. Having a high trance capacity, however, does not mean one was traumatized.

II. OTHER FACTORS TO BE CONSIDERED IN ASSESSING WHETHER A TRAUMA RESULTED IN A REPRESSED MEMORY

A. Suppression

In this case, unpleasant events are purposely put out of our memory, that is, one tends to push away embarrassing events which happened in the past. Such memories are often recalled when the mind is jogged by reference to the event. This is a normal defense mechanism and is not the type of forgetting we are concerned with an evaluating psychogenic amnesia.

B. Simple Forgetting

Not all memories are stored. The mind is no longer considered to be a tape recorder that has every detail recorded if we were to just look in the right place.

C. Memory Not Recorded

Concussion to head and other neurological conditions can interfere with the process of transferring short-term to long-term memory. Certain drugs such as alcohol and benzodiazepines such as triazolam (Halcion) can interfere with memory formation.

D. Malingering/Lying

The legal profession need no further comment on this aspect to be considered in evaluating amnesia.

E. Munchausen's Syndrome (Factitious Disorder)

In this condition patients feign an illness for psychological purposes. In my own clinical experience, some of these patients begin to believe their own story and I wonder if this may be the process involved in some cases who present with false memories and who appear to believe their own pseudomemories.

F. Munchausen's by Proxy

Some parents, for example, bring their own children from hospital to hospital with factitious illnesses. It is a vicarious form of factitious disorder acted out through their child.

G. Fantasy Prone Personality/Grade 5 Syndrome

Wilson and Barber,¹ described a group of highly hypnotizable persons who are so highly trance prone that they have difficulty distinguishing their own fantasy from reality. For them, their fantasies are "as real as real". They estimated this group is in the top 4% of the population in reference to hypnotic capacity. Herbert and David Spiegel² described a somewhat similar group of hypnotic virtuosos who are able to readily enter trance states. The Spiegels called this phenomenon the Grade 5 Syndrome (based on certain characteristics of a measurement scale they developed called the Hypnotic Induction Profile). Coincidentally, they estimated 5% of the population have this unusual capacity for trance phenomena. These may be factors which could explain why some people might have false memories (that is, they can believe their own fantasized memory).

H. Pseudomemory

It has been known that hypnosis can lead to false memories which can inadvertently be suggested by a therapist.³ High hypnotic/trance responders are more prone to inadvertent (or leading) suggestions by a therapist. Such unconscious acceptance of suggestion can happen even if the patient is not in a formal trance. High trance responders can slip into a trance state spontaneously whether it is due to trauma from an abuser, a stress of a therapy session, or an appearance in a courtroom. While they may appear quite alert, they still may be unconsciously influenced by whoever is interviewing or questioning them.

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1. S.C. Wilson & T.X. Barber, "The Fantasy-Prone Personality: Implications for Understanding Imagery, Hypnosis and Parapsychological Phenomena" in A.A. Sheikh, eds., *Imagery: Current Theory, Research and Application* (New York: John Wiley & Son, 1982) at 340-347.
 2. H. Spiegel & D. Spiegel *Trance and Treatment: Clinical Uses of Hypnosis* (New York: Basic Books, 1978).
 3. American Medical Association, "Council Report, Scientific Status of Refreshing Recollections by the Use of Hypnosis" (1985) 253 *Journal of the American Medical Association* 30.

III. THE DISSOCIATIVE DISORDERS

These are distinct clinical syndromes which are generally found in those with high trance capacity (the ability to dissociate). Many contain symptoms that could warrant an additional diagnosis of *Post Traumatic Stress Disorder*, officially classified under an Anxiety Disorder.⁴

While initially I may merely be assessing a patient for amnesia, I realize that all such patients potentially could also suffer additional symptoms and could fit into one of these disorders. These include:

A. Dissociative Amnesia

Formerly this was called psychogenic amnesia. In this disorder, a patient may present with a gap in memory. For example, a young woman recalled being on a bus, then had a memory blank for about 15 minutes after which she was accosted by a group of men as she left the bus. They took her to the field to rape her. They were scared off when they heard people coming. The patient had regained her memory at that moment but did not know the intervening events until the therapy session.

B. Dissociative Fugue

This was formerly called psychogenic fugue. This is the case where someone not only has amnesia, but wanders to another location. A number of years ago, a woman had apparently travelled to Florida from another state without any memory of who she was or where she came from. Until she was identified through the media showing photographs, she was called Jane Doe. Later, psychological factors were discovered which explained the dynamics of her fugue. She recovered her memory and resumed a normal life.

C. Dissociative Identity Disorder

This, until the year 1994, was known as Multiple Personality Disorder. Most cases have been sexually/physically traumatized in early childhood. The "personalities" that form are hypnotic creations of a tranceable child as the child tried to cope with the abuse by creating imagery protectors. Unfortunately, these imaginary companions at this early stage of personality development take on the delusional belief that they are separate people. There can be amnesia as the mind switches between these created internal mind

4. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 3d ed. (Washington, D.C.: American Psychiatric Association, 1994).

states. Since the patient may experience the altered states as auditory hallucinations within the head they have been, at times, erroneously diagnosed as psychotic such as schizophrenia. Though the medical profession has been slow in altering earlier teaching paradigms (stating that this disorder of Multiple Personality Disorder/Dissociative Identity Disorder was rare), it has now officially recognized that this is a genuine disorder, and not nearly so rare as was once thought.

D. Depersonalization Disorder and Atypical Dissociative Disorders

Depersonalization Disorder and Atypical Dissociative Disorders (classified as "not otherwise specified") are mentioned here by name but for the purposes of this talk, I need not go into the medical details.

E. Post Traumatic Stress Disorder (PTSD)

PTSD is more commonly recognized in association with vietnam veterans. PTSD patients display an array of symptoms including autonomic hyperarousal, psychic numbing, avoidance behaviours and reexperiences of traumatic events, that is, flashbacks and nightmares. While a host of these symptoms are also seen in dissociative identity disorders, the amnesic episodes may or may not be present in PTSD. In my experience, many PTSD patients with significant dissociative experiences are high trance responders. Possibly when the trauma occurs in adulthood, after personality formation is complete, traumatized adults may not be able to develop multiple personality but can develop other dissociative experiences like amnesia or fugue states or PTSD.

IV. THE CONCEPT OF TRANCE STATES

There are many definitions of "hypnosis". I will quote one taken from a recent book which I believe will be of interest to lawyers:

*Hypnosis is an altered state of consciousness, characterized by intensified concentration of awareness on certain suggested themes, along with diminished interest in competing perceptions. Subjects who are hypnotized experience perceptual and sensory distortions and enhanced abilities to utilize normally unconscious mechanism.*⁵

Rather than consider hypnosis as a state, I think of it only as one of a number of techniques that can access an altered mental state called the "Trance State". Other techniques which can induce trance states include trauma, fear, formal hypnosis, guided

5. A.W. Schefflin & J.L. Shapiro, *Trance on Trial* (New York: Guilford Publications, 1993).

imagery, self-hypnosis, meditation (in good trance responders) and chemicals such as alcohol and sodium amytal. To think that people go into trance states only with formal hypnosis is rather naive. I am sure many in the legal profession have witnessed some very interesting "spontaneous" trance experiences caused by the stress of a court proceeding on a high trance responder.

Thus in evaluating an amnesia on a psychogenic basis, I keep in mind that there are a number of ways that this could be induced, such as trauma, hypnosis, drugs, etc., as listed above.

V. CAUTIONS IN THE USE OF FORMAL HYPNOSIS

1. Both true and false memories could be elicited by the use of hypnosis and I believe it can be impossible, at times, to be certain of the accuracy of the memory.
2. A therapist may consciously or even unconsciously influence a patient's response under hypnosis, especially if that person is a high trance responder.
3. A person's belief in a memory recalled under hypnosis can be enhanced even if the memory is inaccurate.⁶
4. Because of the above, the use of hypnosis could negatively influence the capacity of the person to be a witness in court. Special precautions must be used if hypnosis is to be used in a legal case.⁷

VI. CAUTIONS RELATED TO THE TRANCE CAPACITY OF PATIENTS WHO MAY APPEAR IN COURT

A. For the Therapist to Know

1. False memories are a real possibility. One should be cautious in considering legal actions without other supporting evidence.⁸

6. American Medical Association, "Scientific Status of Refreshing Recollection by the Use of Hypnosis" (1918-1923) *Journal of the American Medical Association* 253.

7. A.W. Schefflin, "Avoiding Malpractice Liability" (1993) 34:1 *American Society of Clinical Hypnosis Newsletter* 6.

8. F.H. Frankel & C.W. Perry, eds., "Statement on Memories of Sexual Abuse" *International Journal of Clinical and Experimental Hypnosis* at 261 (1994) XLII.

2. True memories are a real possibility. Just because a memory has come in the course of hypnosis, does not mean it was suggested or false. Hypnosis can open amnesic barriers to repressed or dissociated memories. That some people suggest that trauma cannot result in a repressed or dissociated memory flies in the face of clinical experience and medical history.
3. The so called "false memory syndrome" is a valid phenomenon. Care must be taken in evaluating patients. Consideration should also be given that actual abusers could ride the coattail of the false memory phenomenon and try to debunk a victim who has a "true memory syndrome".
4. The use of hypnosis enhances transferences and counter transferences. It is incumbent on the therapist to understand that some patients may be more vulnerable and that the therapist must be very cautious about transgression of the therapeutic boundaries.
5. High trance responders may hallucinate the face of an abuser on the therapist. The therapist must be skilled to prevent such events, and should quickly ground the patient to reality if such distortions appear.
6. Some patients are very angry at authority figures, and some therapists are beginning to be concerned about false accusations by abuse victims. Some psychiatric residents are considering refusing to treat sexual abuse victims due to the backlash against therapists (for allegations of implanting false memories of abuse).
7. Not all memory is processed in the same manner. Traumatic memory (implicit memory) may initially be recalled in a different manner than normal (explicit) memory.⁹ Therefore, experiments with non-traumatic memory may not always be pertinent when applied to traumatic memory recall.

B. For the Lawyer and Judge to Know

1. The fear of authority figures, like facing a judge or lawyer, may result in some patients having difficulty giving a history due to episodic dissociation during the interview.
2. Trance prone subjects could well dissociate in the courtroom. This could result in inability to recall events, answering from a different state or personality state with rather unexpected answer, or even spontaneously regressing to a child-like state.

9. B.A. Van der Kolk, "The Body Keeps the Score: Memory and Evolving Psychobiology of Post-Traumatic Stress" (1994) 1:5 *Harvard Review of Psychiatry* 253-165.

3. The risk of visual contact with, or even merely hearing the voice of, an abuser in the courtroom, could induce terror or bring to mind the distant memory of a warning by that abuser not to talk. Sometimes a subtle act, such as rubbing the nose by the abuser, could act as a cue to reinforce a previous threat for silence. Certainly, I believe there is a role for courtroom screens, or even a separate room with T.V. interaction.

In closing, I believe vulnerable complainants, such as abuse victims with recovered memories, can be better managed by having the psychiatric profession share the phenomenology of trauma, and memory recovery, with the legal profession. An active dialogue between legal and psychiatric professionals will result in reduced stressors, for all involved, in court proceedings.