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Discussion

Research and clinical issues in trauma and dissociation: Ethical and logical fallacies, myths, misreports, and misrepresentations



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ABSTRACT

Introduction. – The creation of a new journal on trauma and dissociation is an opportunity to take stock of existing models and theories in order to distinguish mythical, and sometimes dangerous, stories from established facts.

Objective. – To describe the professional, scientific, clinical, and ethical strategies and fallacies that must be envisaged when considering reports, claims, and recommendations relevant to trauma and dissociation.

Method. – After a general overview, two current debates in the field, the stabilisation controversy and the false/recovered memory controversy, are examined in detail to illustrate such issues.

Results. – Misrepresentations, misreports, ethical and logical fallacies are frequent in the general and scientific literature regarding the stabilisation and false/recovered memory controversies.

Conclusion. – A call is made for researchers and clinicians to strengthen their knowledge of and ability to identify such cognitive, logical, and ethical manoeuvres both in scientific literature and general media reports.

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R É S U M É

Introduction. – La création d'une nouvelle revue sur le trauma et la dissociation est l'occasion de faire le bilan des modèles et des théories existants afin de distinguer les histoires mythiques, parfois dangereuses, des faits établis.

Objectif. – Décrire les stratégies et erreurs professionnelles, scientifiques, cliniques et éthiques qui doivent être considérées en prenant connaissance de rapports, d'affirmations et de recommandations en lien avec le trauma et la dissociation.

Méthode. – Après un aperçu global, deux débats qui animent actuellement le domaine, la controverse de la stabilisation et la controverse des faux souvenirs/souvenirs retrouvés, sont examinés en détail pour illustrer ces questions.

Résultats. – Les présentations tendancieuses, les rapports erronés et les erreurs éthiques et logiques sont fréquents dans la littérature générale et scientifique concernant les controverses sur la stabilisation et sur les souvenirs faux/retrouvés.

Conclusion. – Les chercheurs et les cliniciens sont invités à renforcer leur connaissance de telles manoeuvres cognitives, logiques et éthiques ainsi que leur capacité à les identifier, tant dans la littérature scientifique que dans les descriptions générales par les médias.

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The creation of a new journal dedicated to the field of trauma and dissociation as it exists in Europe offers the opportunity not only to take stock of the wisdom, theories, and techniques already formulated by pioneers and expert clinicians around the world, the solid ground on which we may move forward; it is also an

invitation to put on fresh lenses and to determine which questions we must ask – which ethical, clinical, and professional issues we must address – in order to distinguish mythical, and sometimes dangerous, stories from established facts.

On a more practical level, this article will describe a number of strategies that are used, intentionally or otherwise, by researchers, academics, and other professionals when striving to convince their audience. These strategies mislead, misrepresent, oversimplify,

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distract, or generalise in ways that may have a profound influence on what we perceive, understand, and retain as information.

No one would deny that our choice of clinical tools and techniques, when treating traumatised individuals with trauma-related dissociative symptoms or disorders, should be informed by reliable research and valid models. However, current debates relevant to complex trauma and dissociation possess their share of complexity, myths, truths, and lies, and will serve to inform readers of these issues.

Interestingly, although the most widely recognised models, theories, and psychotherapies in the field of complex trauma and dissociation vary in many significant ways, when their founders and representatives confront their views on the ISSTD (International Society for the Study of Trauma and Dissociation) list serve dedicated to the topic of dissociative disorders, these “giants” tend to agree that their actual clinical practices probably differ far less than their theoretical explanations or therapeutic principles for these same phenomena.

1. Integrating alternative practices into the treatment of trauma and dissociation

Beyond these recognised theoretical and therapeutical approaches, be they general, or specific to trauma and dissociation, there is a growing trend of integrating alternative techniques and belief systems with traditional psychology-based therapies, with examples including quantum healing (Chopra, 2015), energy psychology (Feinstein, 2008; Gallo, 2004), neurofeedback (Evans & Abarbanel, 1999; Lubar, Swartwood, Swartwood, & O'Donnell, 1995), traditional or non-Western healing systems (Moodley & West, 2005), such as shamanism (Dobkin de Rios, 2002; Hes, 1975), magnetism (Crabtree, 1993), and pranic healing (Yeh et al., 2004), and even astrology (Bowman, 1999).

Heart rate variability training (Karavidas et al., 2007; O'Hare, 2012) and neurofeedback (Evans & Abarbanel, 1999; Lubar et al., 1995) rely on technology and are based on observable physiological phenomena. However, versions are taught that claim to achieve the same effects without any feedback technology. For example, some therapists teach their clients to take approximately 6 breaths per minute, breathing in for 5 seconds and out for 5 seconds, claiming that this achieves “cardiac coherence” or optimal heart rate variability without any further verification. Such instances of techniques being used by a therapist who does not fully understand or master them do not seem to present any significant risks. The worst case scenario would seem likely to be either a positive outcome through the placebo effect or a lack of any effect at all.

1.1. The potential for harm

The potential effects of other so-called alternative techniques may not always be as innocuous. One example would be copycat versions of EMDR psychotherapy (e.g., in France, DMOKA [DMOKA, 2016], SBA [Réa-Active, 2016], TMO [La voie de l'hypnose, 2016]) that use bilateral dual attention stimulation (BDAS), have not been the object of any research studies, and are taught to people who are not necessarily licensed to practice a mental health profession. Formal and accredited trainings in EMDR therapy, which are limited to mental health professionals, insist on the importance of establishing suitability before applying EMDR and on the need for specific training and experience when working with complex cases. BDAS is the most researched component of EMDR and undeniably plays a key role in the effectiveness of this therapy (Barrowcliff, Gray, Freeman, & MacCulloch, 2004; Christman, Garvey, Propper, & Phaneuf, 2003; Lee & Drummond, 2008; Van Veen et al., 2015).

So if BDAS plays an active and important role in the outcomes of EMDR therapy, does that signify that it will always have a healing

and positive effect, however it is used? To answer this question, one might look to the pharmaceutical industry and the medical field, in which all forms of treatment and medication, including plant-based and “natural” supplements, are considered to have potential adverse effects. In other words, an active ingredient that has the potential to heal may also have the potential to harm, depending on health status, posology, and interactions with other substances, among other factors. In the field of mental health care, perhaps we should proceed with similar caution and remember that it is not because a tool or method has the potential to heal that it cannot have the potential to harm. A technique or approach will only ever be as good as the clinician who uses them.

Similarly, some therapists may underestimate the potentially deleterious impact of techniques inspired by energy psychology (e.g., EFT, TFT, TAT, Reiki, applied kinesiology; Feinstein, 2008; Gallo, 2004) or traditional healing systems, such as magnetism, shamanism, pranic healing (Moodley & West, 2005; Yeh et al., 2004). While some training programmes may extend over several years, others consist of single weekend workshops or short webinars.

1.2. Psychotherapy as a profession

It is safe to assume that most, if not all, mental health professionals consider that the practice of psychotherapy is a profession and that becoming a member of that profession requires extensive training by recognised teachers. The main recognised forms of psychotherapy are taught either over a period of several years, leading to general and specific competencies in the practice of psychotherapy (e.g., cognitive behavioural therapy [CBT], psychodynamic psychotherapy, attachment-based therapy, hypnosis, Gestalt, family systems therapy), or over a much smaller number of days to therapists who are already licensed mental health professionals (e.g., EMDR therapy).

If a non-psychotherapist attended a training or read a textbook describing the procedures of a specific form of psychotherapy, they could learn to apply them but could it legitimately be called psychotherapy? Would it be safe? Would it be efficacious?

Is it a form of Western arrogance that allows us to claim that our Western professions require extensive academic and hands-on training, but that techniques originating within other traditions can easily be acquired during one or several weekend workshops and then applied safely?

If the practice of, for example, CBT, hypnosis, psychodynamic psychotherapy, EMDR therapy, sensorimotor psychotherapy, ego states therapy, requires extensive clinical knowledge and experience, including training in general psychopathology, attachment theory, psychotraumatology, dissociative disorders, case conceptualisation, treatment planning, and continued professional development, among others – then why wouldn't the use of energy psychology techniques (for example) equally require extensive knowledge and experience of, and training in, Chinese medicine, the meridians, Qi, biofields, chakras, bio-electrical and electromagnetic activities of the body?

Of course, the same questioning may be applied to the use of other esoteric, “natural” or “traditional healing techniques”, which are more and more being integrated into counseling and psychotherapy (Moodley & West, 2005).

2. Selection criteria

What criteria might psychotherapists then select to determine which trainings to attend and how techniques may be applied safely?

They may check for published research but should also employ critical thinking in order to spot logical and ethical fallacies as well as remain aware of the potential motives of authors and researchers.

2.1. Scientific validation

One may wonder whether scientific validation is necessary or sufficient before adopting a certain therapeutic approach. Several authors (Persons & Silberschatz, 1998; Roth & Fonagy, 2013; Coyne & Kok, 2014) have questioned the usefulness and relevance of current psychotherapy research. Although research studies may guide our choice of one method over another for the treatment of a specific client and lead to the improvement of our techniques, new approaches are developed because a number of therapists have been creative and “strayed” from conventional and validated techniques. Furthermore, the quality of methodology and design vary greatly between studies, rendering the results difficult to interpret. The simple number of extant published papers can therefore not be considered sufficient to select a specific form of psychotherapy.

This is where critical thinking is crucial. As Pope (1996, 1997) states: “an essential task of psychologists is careful, informed, and comprehensive questioning. They must question their own assumptions, biases, and perspectives, not just once during initial training, but throughout their careers. They must also question claims about scientific discoveries, evidence, and conclusions, no matter how prestigious or popular the source”.

2.2. Logical fallacies

When reading literature or listening to presentations on psychotherapy approaches, clinicians should be aware of a number of logical fallacies that are frequently encountered. Most clinicians have probably fallen for them for time and time – and may even have used them, intentionally or not. A few examples appear in Table 1 (for a more detailed discussion, see Pope & Vasquez, 2016); other forms of logical fallacies will be addressed in sections 2.3 Science vs. “pseudoscience” and 3.1 ISTSS guidelines called into question.

In summary, clinicians should keep in mind that the lack of evidence of a proposal’s truth or validity does not prove its falseness or invalidity. The fact that a technique is said to be natural or traditional does not guarantee its harmlessness. Indeed, if something has the potential to heal, then it comprises a mechanism of action that may also have other possible effects, including harmful ones. In addition, labelling phenomena with specific terms does neither explain nor prove their existence or effect. Finally, therapists must beware of circular and post-hoc arguments, where the affirmation of something is deemed sufficient proof of its truth and concurrence is confused with causation.

Table 1
Logical fallacies.

Type of logical fallacy	Description	Examples
Argument from ignorance fallacy (Ad Ignorantiam)	Follows the format “there is no (or insufficient) evidence establishing that x is true. Therefore x is false” (or vice versa)	There is insufficient evidence that a phase-oriented treatment plan is necessary when treating clients with dissociative disorders. Therefore it is unnecessary and traumatic memories may be processed within the first few weeks of therapy There is no evidence establishing that paranormal phenomena exist. Therefore they do not exist There is insufficient evidence that esoteric techniques may cause harm. Therefore they are harmless
Begging the question fallacy (Petitio Principii or “assuming the initial point”)	Is a fallacy of circularity, in which the premises include the assumption that the conclusion is true	Opium induces sleep because it has a soporific quality If such actions weren’t unethical, then they wouldn’t be prohibited. If such techniques were potentially harmful, they wouldn’t be taught by mental health professionals This technique should be used to treat all traumatised patients because no other technique is as effective at treating traumatised clients
False dichotomy fallacy/fallacy of false choices	Makes the mistake of acknowledging only two options, one of which is usually extreme, from a continuum or other array of possibilities	Either we accept each psychotherapist’s inherent right to freely choose which techniques to use, however esoteric, metaphysical, or unheard of, or we will be restricted to using only methods that have been validated by 20 RCTs [randomised controlled trials] Either we accept the findings of this study demonstrating that stabilisation is unnecessary, or we must admit that we are acting unprofessionally and harming patients by denying them access to effective trauma treatment
Post-hoc fallacy (Post-hoc, ergo propter hoc or “after this, therefore on account of this”)	Confuses presumed correlation with causation	Since dentists play soft background music during work and some of their clients lapse in their oral hygiene between appointments, soft background music causes inadequate oral hygiene Since a number of therapists use certain specific techniques with their patients and some of their patients recover memories of childhood sexual abuse during therapy, these techniques must have created these memories
Nominal fallacy	Makes the mistake of assuming that naming or labelling something is enough to explain it	He doesn’t get along with his colleagues because he’s difficult Parkinson’s patients’ movements are slow because they have bradykinesia Traumatic memories cause clients’ current symptomatology because they are dysfunctionally stored
Naturalistic fallacy	Makes the mistake of logically deducing values (what is good, right, moral, ethical) based only on statements of fact. Transforms an “is” into an “ought”	St John’s Wort is a plant-based remedy, so its use can only be beneficial These techniques stem from an ancient spiritual healing system, therefore they can only do good There is no intervention for trauma that has more empirical support from controlled studies than this one. Therefore, this is clearly the right way to address this problem and we should all be providing this form of therapy to all trauma patients who come to us for help
Genetic fallacy	Infers the true or false nature of a statement from its origin	Since it was a deathbed confession, it must be true Since these memories were recovered while the alleged victim was in therapy, they must be false

2.3. Science vs. “pseudoscience”

Interestingly, such logical fallacies and lapses in critical thinking are not only used to promote new, innovative, or alternative methods and techniques, they also serve to denounce them. Lilienfeld, Lynn, & Lohr (2015) propose a list of ten indicators of “pseudoscience”, including an overuse of ad hoc hypotheses, emphasis on confirmation rather than refutation, an absence of connectivity to other scientific disciplines, use of obscurantist language and the absence of boundary conditions (i.e., claiming a very wide range of applications). Mollon (2007) points out that many of these criteria may apply to established forms of psychotherapy as well. For instance, CBT also uses a jargonistic language (facing your fears is “exposure”, refraining from an activity is “response prevention”, and revising your thoughts is “cognitive restructuring”), and is prescribed for a vast array of psychological and medical conditions, from fibromyalgia to schizophrenia – and it still remains a highly effective evidence-based form of therapy.

Furthermore, authors claiming to “debunk” pseudoscience often resort to strategies, such as a subtle misrepresentation of the targeted approach, disparaging comments regarding the motivations of its developers (ad hominem/ad feminam fallacy: attempting to discredit an argument by attempting to draw attention to alleged flaws of the person making the argument; straw person fallacy: mischaracterizing a person’s position in a manner that makes it appear weak, false, or ridiculous), the selective citation of references to support the author’s narrative, and citing research in a selective manner that creates the impression that there is scant support for the method in question (Mollon, 2007).

Finally, these observations imply that all research methodology and reports, with their assumptions and inferences, whether they appear to confirm or to refute a hypothesis, whether they seem to promote or to discredit a method, must be carefully questioned and rigorously examined for potential bias (Pope, 1996, 1997; Pope & Vasquez, 2016). As therapists and as researchers, we must continue to question claims and conclusions, those we agree with and those we don’t.

2.4. Cognitive manoeuvres

Cognitive strategies of justification and tricks of language also enable the spinning of ethically questionable or objectionable options into seemingly acceptable choices (Pope, 2015; Pope & Vasquez, 2016). None of us is perfect when it comes to ethics, especially in moments when we are tired, on a tight deadline, stressed, angry, or afraid, and at times we even fool ourselves with these ethical fallacies.

In this manner, cognitive manoeuvres may be used to justify questionable actions or simply to avoid thinking about the ethics of our behaviour, and we tell ourselves that it is not unethical as long as no law was broken, as long as our ethics code does not mention the concept or act, as long as we can name others who do the same thing, as long as we did not mean to hurt anyone or did not anticipate the unintended consequences, as long as no one complains, as long as there is literature claiming that it is the right thing to do... (Pope & Vasquez, 2016). Many more examples could be added.

Common language patterns that hide or dilute accountability may also interfere with clear thinking about ethics (Pope & Vasquez, 2016). When a breach of ethics is discovered, instead of a clear apology (*I admit I plagiarised colleagues’ publications and misrepresented data, I’m very sorry for the damage and suffering I’ve caused. I’ve no excuse and I am the only one responsible. I will do everything I can to make things right*), the person may use the

passive voice (*Mistakes were made, sources were inappropriately cited, and some information was inaccurately described*) or use a conditional frame (*If my actions caused any distress to anyone, I apologise*). Other strategies include disguising intentional unethical behaviour with the language of accidents and misfortune, minimising the harm done by highlighting the damage that was avoided, or insisting on what the intention was not (Pope & Vasquez, 2016).

Directly of interest to the field of trauma and dissociation are a number of recurrent or on-going debates, such as the “stabilisation controversy” (Van Vliet, Matthijssen, & Spierings, 2016), which questions the appropriateness of phase-oriented treatment for complex post-traumatic stress disorder (cPTSD) (De Jongh et al., 2016) and the false memory vs. recovered memory debate (Dalenberg et al., 2012, 2014; Lynn et al., 2014; Vissia et al., 2016).

3. Stabilisation controversy

As stated in the introduction to the Expert Consensus Treatment Guidelines for Complex PTSD in Adults (Cloitre et al., 2012), cPTSD has been alternately named Disorders of Extreme Stress Not Otherwise Specified (DESNOS) (Herman, 1992; Pelcovitz, Van der Kolk, Roth, Mandel, Kaplan, & Resick, 1997), PTSD and its associated features in the DSM-IV (APA, 2000), and Enduring personality change after catastrophic events (EPCACE) in the ICD (WHO, 1992). The ISTSS task force selected a definition of cPTSD that covers a range of symptoms derived from these diagnostic descriptions and includes the core symptoms of PTSD (reexperiencing, avoidance/numbing, and hyperarousal) in conjunction with a range of disturbances in self-regulatory capacities. The latter were grouped into five broad domains:

- emotion regulation difficulties;
- disturbances in relational capacities;
- alterations in attention and consciousness (e.g., dissociation);
- adversely affected belief systems;
- somatic distress or disorganisation.

These symptom domains recognise the impairment of emotional, social, cognitive, and psychological competencies that either failed to develop properly or that deteriorated due to prolonged exposure to complex trauma. The treatment for cPTSD, then, emphasises not only the reduction of psychiatric symptoms, but equally, improvement in key functional capacities for self-regulation and strengthening of psychosocial and environmental resources (Cloitre et al., 2012).

The guidelines’ recommended treatment model involves three phases of treatment. The first phase focuses on ensuring the individual’s safety, reducing symptoms, and developing emotional, social, and psychological competencies. The second phase then focuses on processing the unresolved aspects of the individual’s memories of traumatic experiences in view of integrating them into an adaptive representation of self, relationships and the world. The third and final phase of treatment involves consolidation of treatment gains to enhance the individual’s engagement in relationships, work or education, and community life (Cloitre et al., 2012).

3.1. ISTSS guidelines called into question

De Jongh et al.’s (2016) review of these guidelines questions both the validity of the cPTSD construct and the necessity and effectiveness of phase-oriented treatment. It found that “evidence arguing for special stabilization procedures prior to trauma-focused treatment for patients referred to as having cPTSD [is]

weak” but also that “it is well-established that a substantial minority of PTSD patients, with cPTSD or not, remain symptomatic despite receiving empirically supported treatments for this disorder”. The authors warn against delaying or restricting access to effective trauma treatments for patients with cPTSD presentations or inadvertently communicating to them that they are incapable of dealing with their trauma memories, and conclude by suggesting that trauma-focused therapies, rather than phase-based treatment, should routinely be offered to individuals with PTSD associated with multiple or severe comorbidities.

As De Jongh et al. (2016) admit, currently there are no studies that directly examine whether trauma-focused treatments are superior to phase-oriented treatments for more complex or severe PTSD.

If the evidence in support of phase-oriented treatment for cPTSD is not entirely conclusive but the research in favour of strictly trauma-focused therapy for the same population is even weaker or inexistent, then there appears to be no solid logical reason to modify current guidelines. Indeed, the absence or insufficient evidence that a proposition is true does not prove the truth of that proposition’s opposite (appeal to ignorance fallacy). Moreover, one cannot assume that a proposition must be false because an argument or set of arguments offered in support of that proposition are weak, inconclusive, mistaken, or even fallacious (argument to logic fallacy).

There may, however, exist therapists who do offer stabilisation techniques to their patients unnecessarily or for too long, more than is intended by these same ISTSS guidelines. There may be several underlying sources of misunderstanding:

- a confusion between the notions of complex presentation, complex trauma, and complex PTSD;
- the similarities between the ISSTD guidelines for treating dissociative identity disorder (DID) in adults (2011) and the ISTSS Expert Consensus Treatment Guidelines for complex PTSD in adults (Cloitre et al., 2012) in recommending phase-oriented treatment;
- a lack of comprehension of stabilisation and phase-oriented treatment.

3.2. Types of complexity

A complex presentation may simply reflect a comorbidity and/or multiple “single trauma” events, but does not automatically imply complex trauma, which involves repeated interpersonal trauma, often beginning early in life (e.g., childhood abuse or neglect) and occurring throughout the lifespan, but potentially having an onset in adulthood (e.g., individuals exposed to torture or genocide).

Although there are probably many and frequent links between complex trauma and complex PTSD, individuals may develop different strategies in their attempt to cope and to survive adverse childhood and life events, according to a large number of gene × environment interaction variables (Nemeroff, 2016). Complex PTSD is typically the result of exposure to repeated or prolonged instances or multiple forms of interpersonal trauma, often occurring under circumstances where escape is not possible due to physical, psychological, maturational, family/environmental, or social constraints (Cloitre et al., 2012; Herman, 1992). Survivors of complex trauma may show different clinical presentations (Horwitz, Widom, McLaughlin, & White, 2001; Yen et al., 2002), not only or necessarily that of cPTSD. And while cPTSD and dissociative disorders may present simultaneously in some individuals, they are distinct disorders.

The lack of clarity as to the differences between and characteristic attributes of various types of complexity and as to

the distinction between PTSD and cPTSD is compounded by the recent revision of the criteria for PTSD in the DSM-5 (APA, 2013) and the proposed revision in ICD-11 (Maercker et al., 2013). Diametrically different conclusions were reached by the two workgroups, with the workgroup for DSM-5 producing the most complex definition of PTSD to date (20 symptoms and 4 clusters) and the workgroup for the ICD-11 proposing the simplest (6 symptoms and 3 clusters) (Hoge et al., 2016).

3.3. ISTSS or ISSTD guidelines

It is probably safe to assume that a large proportion of clinicians who work with traumatised individuals have heard of the ISTSS and ISSTD guidelines (Cloitre et al., 2012; ISSTD, 2011), since their recommendations are often cited in trainings, consultations, articles, and conferences in the trauma field, but it is equally probable that few therapists have actually read them in detail. Some are probably unaware that there are two distinct sets of directives. So what is their likely take-away message? Beware of complex presentations and, when in doubt, stabilise! And so in the minds of these therapists, there may be a drift in their understanding from guidelines that specifically address cPTSD and DID respectively, to a general recommendation for all “complex” cases, which is a highly subjective notion.

3.4. Stabilisation and phase-oriented treatment

In addition, not only critics of phase-oriented treatment but also misguided but well-intended clinicians may believe that these phases are to be implemented in a linear, sequential fashion, leading to an almost inevitably lengthy stabilisation phase. In reality, the progression often moves back and forth between phases, particularly in complex trauma-related disorders (Herman, 1992; Van der Hart, Nijenhuis, & Steele, 2006; Van Vliet et al., 2016).

So what is needed to proceed with the processing of trauma memories? A useful concept is that of the window of tolerance or optimal arousal zone (Siegel, 1999; Ogden, Minton, & Pain, 2006; Ogden & Fisher, 2015). The treatment of trauma memories requires the patient to remain within, or at the limits of, the window of tolerance. The width of this window is determined by capabilities, such as self-regulation and interpersonal regulation, neuroception – the autonomic nervous system’s ability to distinguish whether situations or people are safe, dangerous, or life-threatening – (Porges, 2011), tolerance of positive and negative affect, and self-compassion.

The degree to which the window of tolerance will be challenged by trauma processing will depend not only on internal characteristics of the individual but also on external factors, e.g., a traumatised individual diagnosed with a psychotic disorder who seeks therapy in a private practice setting is likely to require more stabilisation than one who is treated in a hospital setting with fulltime care and an entire team of mental health professionals.

These regulatory skills, in turn, have been learned from experiences, such as caring compassion from an adult/caregiver, safety in the present, and the possibility of making choices (Van Vliet et al., 2016). When these experiences were absent or insufficiently present in the individual’s life, the corresponding resources and skills will not have had the opportunity to develop fully or at all. Stabilisation serves to create experiences within the therapeutic relationship, in which the patient may acquire these skills and resources, leading to the ability to adopt a loving adult perspective towards the self, to determine when there is safety in the present moment, and to make choices.

The field of EMDR therapy, for example, shows examples of adaptations to the processing of traumatic memories that include

many aspects of stabilisation (Gonzalez & Mosquera, 2012; Van der Hart, Groenendijk, Gonzalez, Mosquera, & Solomon, 2013; Van der Hart, Groenendijk, Gonzalez, Mosquera, & Solomon, 2014) – in these cases, phases one and two follow a parallel path.

It would seem to follow, then, that the decision to use a strictly trauma-focused approach or to adopt a more phase-oriented treatment for traumatised individuals should not be based solely on the diagnosis but rather on the presence of these capabilities, skills, and resources in the person.

4. False vs. recovered memory controversy

Presenters (Engelhard, 2016; Fenouillet, 2015) at international conferences for trauma therapists continue to refer to the existence of false memories, “reminding” their audience that “in the 1990s there were a great many cases where therapy patients had filed legal proceedings against a parent accused of child sexual abuse and the allegations turned out to be false: these memories would have been implanted by irresponsible therapists using suggestive techniques”. They proceed to highlight the need for clinicians to be very careful not to suggest to clients that they may have been victims of childhood sexual abuse. Such general statements need to be carefully questioned and pulled apart to identify the issues that are truly at stake.

Since the “memory wars” of the 1990s, the debate still remains to be settled, although there is much more research available today on the nature of memory.

4.1. The nature of memory

The formation, storage, and retrieval of memories are critical for normal adaptive functioning: it enables goal-directed behaviour, thinking, problem solving, and decision-making. When memories are retrieved, they are susceptible to change, such that future retrievals call upon the changed information. This is called reconsolidation and it ensures the restabilisation and updating of memories. Importantly, most aversive memories that have been studied in the reconsolidation field are relatively mild and “manageable”, whereas the threat in traumatic experiences that lead to PTSD is so massive that it is hardly related to the stimuli used in reconsolidation studies. The experience of a highly traumatic event is devastatingly threatening and terrifying, and this likely activates responses that are quite different from those elicited by a mild threat. In addition, rather than becoming more manageable over time, highly traumatic experiences lead to overwhelming states of fear and panic, and to an inability to extinguish the feeling of fear and associated behavioural and physiological responses (Alberini & LeDoux, 2013; Besnard, Caboche, & Laroche, 2012).

Schacter (1999, 2001) suggested that memory imperfections and distortions can be divided into seven basic categories, or “sins”. There are three types of forgetting (called transience, absent-mindedness, and blocking); another memory “error” is that of intrusive, unwanted memories of arousing or traumatic events (persistence). The remaining three types concern memory distortions: misattribution, suggestibility, and bias. Misattribution occurs when retrieved information is assigned to the wrong source (e.g., attributing something that truly happened to the wrong context); suggestibility refers to the incorporation of inaccurate information from external sources, such as leading questions (e.g., “Did you see the blue car leaving the scene just before the explosion?”), into one’s own memories, and bias involves the distorting influences of our knowledge, beliefs, and experiences on recollection of previous events. Clinicians from the trauma and dissociation field might add that in the case of suggestibility and

bias, inaccurate information may stem not only from external sources, including the perpetrator making post-trance suggestions, but also from dissociative perpetrator-imitating parts, who pursue the objective of not letting the truth be known (Van der Hart et al., 2006).

Although it is generally known today by scientists, therapists, and the general public alike that memory is inaccurate, the crucial point of disagreement between proponents of the trauma model and those of the fantasy model (Dalenberg et al., 2012, 2014; Lynn et al., 2014; Vissia et al., 2016) is not whether false memories exist but whether memories may be repressed or forgotten and then recovered.

The most frequent procedure that researchers use to study the development of false childhood memories is variously called the “lost-in-the-mall” (Loftus & Pickrell, 1995), “familial-informant false narrative” (Lindsay, Hagen, Read, Wade, & Garry, 2004), or “memory implantation” (Wade, Garry, Read, & Lindsay, 2002) methodology. These studies merge suggestive techniques with social pressure: adult participants are presented with a set of descriptions of childhood events provided by familial informants (such as parents or siblings). Among these descriptions is one false event created by the researchers (having generally verified with family members that the participant to their knowledge never experienced this event in childhood). Over the course of two or three sessions, researchers employ suggestive techniques, which they generally refer to as “memory recovery techniques employed in trauma-memory-oriented therapy, such as guided visualisation” (Scoboria et al., 2016), to lead participants to report believing and remembering that the suggested event had actually occurred.

The coding systems used to determine the prevalence and strength of false memories show great variation across studies on memory implantation, which means that meta-analysis is not an appropriate approach for combining their data. Therefore, Scoboria et al. (2016) conducted a mega-analysis, which involves the combination of participant level data from multiple studies by recoding the original data using a single validated system. Their analysis showed that if a false event is suggested, if evidence is provided that the event occurred, if resistance can be overcome, and if imagination is used, then false autobiographical memories and beliefs often arise. Implantation procedures promote a notable degree of false memory creation in a majority of participants and a strong degree of belief is not uncommon.

It should be noted, however, that research studies on memory implantation routinely warn against suggestive techniques that could lead to a belief in false memories of abuse, but do not consider the possibility that, with such suggestive techniques, victims may begin to falsely believe that they were not abused, perpetrators may falsely remember that they are innocent, and other family members may falsely remember information supposedly proving that the abuse never happened (Pope, 1996, 1997; Spiegel, 1997).

Additionally, a memory of traumatic events is not just a visual or narrative memory – in fact, the images and the narrative may be incomplete or missing. There are also the sensorimotor and emotional dimensions, as well as cognitive aspects in the form of beliefs about oneself, the world, and relationships (Ogden et al., 2006; Ogden & Fisher, 2015). There is the terror the child experiences when hearing the father’s footsteps coming down the hall at night. The racing heartbeat, the dry mouth, the feeling that the room is spinning, the clammy hands pressed into fists, the impulse to make oneself as tiny as possible. Afterwards, there is the confusion and disgust at what happened. Smells, sounds, and sensations seem to stick to the child, impossible to remove, wash off, or flee from. Then there is the shame. Feeling dirty, feeling bad, going numb, withdrawing into oneself. Wanting it to stop, hoping someone will notice and do something to make it stop, but unable

to let anyone know because of what the perpetrator said would happen if they told. And long after the abuse has stopped, and even if the person no longer remembers the events, the story is still being told by the body, through its posture, muscular tone, micromovements, startle reactions, range of possible movements and gestures, and habitual patterns (Ogden et al., 2006; Ogden & Fisher, 2015; Van der Kolk, 2014).

4.2. The Fantasy Model vs. the Trauma Model

According to the Fantasy Model (FM), “trauma-memory-oriented treatments” (e.g., hypnosis, pressure to recall, elaborate explanations of memory repression and memory recovery, exposure to autobiographies in which memory has been successfully recovered, journaling, and relaxation exercises) constitute dangerously suggestive practices that put clients and their families at risk (Cara, 2014) by inducing false memories that lead to changes in the views of oneself and of others and to changes in social behaviour such as pursuing legal charges against a parent.

Also referred to as the iatrogenic or sociocognitive model (Lilienfeld et al., 1999; Spanos, 1994), the FM not only questions the veracity of recovered memories, it also considers that DID is a simulated condition caused by high suggestibility or fantasy-proneness, suggestive psychotherapy, and other suggestive sociocultural influences.

In the Trauma Model (TM) (Dalenberg et al., 2012, 2014; Reinders, Willemsen, Vos, Den Boer, & Nijenhuis, 2012), DID is thought to be at the far end of the spectrum of trauma-related psychiatric disorders and related to a combination of factors, such as chronic emotional and physical abuse and neglect and/or sexual abuse from early childhood, insufficient integrative capacity, and lack of affect regulation by caretakers (Dell & O’Neil, 2010; Spiegel, 2006; Van der Hart et al., 2006).

Proponents of the TM acknowledge that false-positive cases of DID have evolved in a treatment setting and that some psychiatric patients imitate DID, but they have also shown that differences exist between authentic and imitated DID (Draijer & Boon, 1999).

It is of note that, to date, only proponents of the TM have studied individuals with DID using brain imaging techniques. A neurobiological study by Reinders et al. (2012, 2016) offers important data that support the TM model as well as a neurobiological model for DID (Reinders et al., 2014), which combines neuroimaging research on the dissociative subtype of PTSD (Lanius et al., 2010).

In a controlled fMRI perfusion study by Schlumpf et al. (2014), actors were recruited to simulate dissociative parts of the personality, namely an ANP (apparently normal part of the personality) and an EP (emotional part of the personality, according to the theory of structural dissociation of the personality; Van der Hart et al., 2006). These actors were then compared to genuine DID patients as ANP and as EP. Results showed that genuine dissociative parts presented different resting states from one another; DID-simulating actors had different perfusion patterns than genuine ANP and EP. Comparisons of neural activity for individuals with DID and DID-simulating controls suggest that the resting state features of ANP and EP in DID are not due to imagination. The findings are inconsistent with the idea that DID is caused by suggestion, fantasy-proneness, and role-playing. A previous fMRI study (Schlumpf et al., 2013) had already showed that DID patients have dissociative part-dependent biopsychosocial reactions to masked neutral and angry faces. As EP, they are overactivated, and as ANP, underactivated.

Most recently, Vissia et al. (2016) compared matched groups on psychological trauma and fantasy measures: diagnosed genuine DID (DID-G), DID-simulating healthy controls (DID-S), diagnosed PTSD, and healthy controls. Additionally, personality state-dependent measures were obtained for DID-G and DID-S; both

neutral personality states (NPS) and trauma-related personality states (TPS) were tested. Their results consistently support the TM of DID and challenge the core hypothesis of the FM. A continuum of trauma-related symptom severity was found across groups, supporting the hypothesis that there is an association between the severity, intensity, as well as age at the onset of traumatisation, and the severity of trauma-related psychopathology.

4.3. The False Memory Syndrome Foundation

Beyond theoretical considerations and scientific arguments, critical thinking and curiosity should extend to questions, such as historical background, proponents’ motives, and misrepresentations by the media. Clinicians may consider the following points in order to formulate their own questions and delve further into these issues.

Elizabeth Loftus, a memory researcher often credited with proving the existence of false memories (Loftus, 1995; Loftus & Ketcham, 1994; Loftus & Pickrell, 1995), is a member of the False Memory Syndrome Foundation’s (FMSF) Scientific Advisory Board (FMSF, 2013).

In 1992, the False Memory Syndrome Foundation (FMSF), an advocacy organisation for people claiming to be falsely accused of sexual abuse, announced the discovery of a new syndrome involving iatrogenically created false memories of childhood sexual abuse.

The FMSF was founded by Pamela and Peter Freyd, after their adult daughter, Professor Jennifer Freyd, privately accused Peter of sexually abusing her as a child. The Foundation’s assumptions are:

- a recovered memory is likely to be false memory;
- recovered memories are usually caused by therapists practicing “recovered memory therapy”;
- it is easy to implant false memories of traumatic events;
- people who recover memories are highly suggestible;
- “False Memory Syndrome” is common;
- alleged perpetrators are immune to FMS (for an in-depth examination of “false memory syndrome”, see Dallam, 2002).

Richard Gardner (2004), the creator of “parental alienation syndrome”, considers that the “parental alienation syndrome (PAS) is primarily a disorder of childhood. The false memory syndrome (FMS) is a disorder of young adults, primarily women. They share in common a campaign of acrimony against a parent”. In reality, these so-called syndromes are both used to discredit the testimony of individuals who claim to have been abused, sexually or otherwise. When adults report that they have recovered memories of childhood abuse, others may claim that they have false memory syndrome. When children do not repress or forget the abuse, if there is no period of amnesia, then some may claim that they have parental alienation syndrome (Ceci & Bruck, 1995; Dallam, 1999).

In *The Witch-Hunt Narrative*, Cheit (2014) demonstrates how a number of journalists, academics, and defence attorneys have created a myth of false accusation and false persecution against child molesters, claiming that there is a “witch-hunt” (campaign of persecution) against accused child abusers. The term witch-hunt was already used in a FMSF Newsletter in 1993 (FMSF, 1993).

Cheit’s book demanded 15 years of research on daycare child abuse cases, including the review of original documents, court transcripts, and medical reports to identify the inaccuracies. Cheit (2014) found that in many of the cases described as witch-hunts, there was credible evidence of child abuse. Among the consequences of the witch-hunt narrative, there is the view that delayed disclosure of sexual abuse, commonly observed with victims of child abuse, undermines the credibility of reports of abuse. The

belief is that it is impossible to forget or banish from memory multiple or chronic events of abuse, in other words, there is a belief that the phenomena of dissociative amnesia and more generally of dissociative disorders do not exist (FMSF, 2014).

A documented case from the Royal Commission into Institutional Responses to Child Sexual Abuse in Australia challenges this belief. Philippe Vincent Trutmann was sentenced to six-and-a-half years in prison in 2005 for sexually abusing 40 young male boarders at the school's Highton campus between 1985 and 1995. Earlier that year, Luke Benson was asked to attend Prahran police station. There, he was informed that Trutmann, one of the school's house assistants, had admitted to sexually abusing him 30 to 40 times over a two-year period. But Benson, who remembers Trutmann as a "father figure," has no recollection of the abuse, although he has been diagnosed with PTSD (Jacks, 2015).

Multiple other published accounts describe how individuals have recovered memories of trauma in adulthood, tracked down the perpetrator, and either elicited a confession or provided evidence for the abuse to the levels of proof necessary in court (Cheit, 1998; Freyd, 1996).

In a prospective study of a non-clinical population (Williams, 1994), 129 women with previously documented histories of child sexual abuse were interviewed and asked detailed questions about their abuse histories to answer the question: "Do people actually forget traumatic events such as child sexual abuse, and if so, how common is such forgetting?" A large proportion of the women (38%) did not recall the abuse that had been reported 17 years earlier. Women who were younger at the time of the abuse and those who were molested by someone they knew were more likely to have no recall of the abuse.

Loftus has often been known to testify for the defence in cases not only of alleged child sexual abuse, but also of other types of assault. She testified for Tim Hennis at his second trial around 1988. He was charged with the murders of a mother and her daughter, and found not guilty. Years later arrived DNA testing. Hennis' DNA was found in the murdered mother's body. He was found guilty by a military court in 2010. This case is no longer cited by false memory advocates (Crook, 2016).

Very recently, Loftus agreed to serve as an expert in Commonwealth of Pennsylvania v. William H. Cosby, Jr. Actor Bill Cosby, who for decades has been pursued by allegations of sexual misconduct, was charged with sexual assault in Pennsylvania on December 28, 2016 (Ember & Bowley, 2016).

Regarding the current case of the Commonwealth of Pennsylvania v. William H. Cosby, Jr., Loftus said in her "Expert Disclosure" that the memories of all 13 witnesses proposed by the Commonwealth "have been tainted". Repressed memories are "folklore" she claims, ignoring the considerable body of evidence supporting recovered memories. As the trial date approaches, we will see if reporters quote Loftus's Disclosure – or wait to see how these claims stand up under cross-examination during the trial (Crook, 2016).

Loftus recently received the John Maddox Prize for promoting sound science and evidence on a matter of public interest in the face of deep, personal hostility; several media reported that she had experienced death threats, lawsuits, personal abuse and a campaign to have her sacked (Ahuja, 2016; Association for Psychological Science, 2016; Sample, 2016).

The media have been much less active in reporting news that shows Loftus in a less favourable light, such as Loftus's resignation from the APA following two ethics complaints or the tactics employed to gain access to a case report subject's identity and family members.

4.3.1. Ethics complaints and resignation

In December 1995, two ethics complaints were filed by Jennifer Hoult and Lynn Crook, each of whom had prevailed in successful

civil suits against their parents for abuse (Jennifer Hoult v. David P. Hoult, 1993 and Lynn Crook v. Bruce Murphy and Lucille Murphy, 1991, as cited in Brand & McEwen, 2016). In each of the complaints addressed to the APA's Ethics committee, Hoult and Crook alleged that Loftus incorrectly portrayed the facts of their legal cases in published articles to attempt to demonstrate that their memories were false.

In an article titled *Remembering Dangerously*, Loftus (1995) argued that repressed memories of child sexual abuse are often the unreliable and implausible products of "invasive therapeutic techniques" rather than memories of genuine sexual abuse (Hoult, 2014). Several pages of the article responded to an article by Kandel and Kandel (1994), which discussed the neurological mechanisms that cause repression and recovered memory, citing the landmark child sexual abuse case of Hoult vs. Hoult. In contrast with the Kandels, Loftus cited the case as an example of unreliable and implausible recovered memories.

In an analysis of *Remembering Dangerously*, Hoult (2014) highlights the following: Loftus relied on an excerpted document of unverified authenticity purported to be a portion of the trial transcript; omitted and altered facts (e.g., modifying the historical sequence of trauma and symptoms and evidence regarding Jennifer Hoult's therapy and testimony, omitting relevant evidence); and provided the plaintiff's full name.

Loftus resigned from the APA via faxed message in January 1996, shortly after the complaints by Hoult and Crook were filed and before the APA received the forms signed by the complainants that were required to open the complaints (Koocher, 2014). Ever since, Loftus has repeatedly sworn under oath that "she had no knowledge of the existence of the ethics complaint prior to her resignation from the APA" (Cheit, 2015).

However, the Hoffman Report (Hoffman et al., 2015a, b), an investigation of the APA's complicity in abusive, traumatising interrogations of political detainees, noted that Loftus was in fact advised by Raymond Fowler (the APA's Executive Vice President and Chief Executive Officer from 1989 to 2003) to resign her membership before a case could be formally opened against her. He later denied that he had done so and appointed one of his deputies to "investigate" how Loftus had found out about the complaint (Hoffman et al., 2015b, p. 484).

4.3.2. A violation of confidentiality for a case study participant

An article by Corwin and Olafson (1997) describes a single case involving the return of a reportedly unrecallable memory of childhood sexual abuse. Both the child's disclosure at age 6 and the young woman's sudden recall of the abuse at age 17 after several years of reported inability to recall the experience had been videotaped. More precisely, the teenager initially states that she remembers telling about the abuse but "It's the memory of if what I said was true that I'm having a problem with". She knows what she said as a child but can no longer remember all of the events. Some moments later, she retrieves the images and the pain of an incident of abuse, while adding that she doesn't know whether her mother's actions were intentional, "I recall. I didn't – that's the first time I've remembered since saying that when I was 6 years old, but I remember".

Several commentaries on this case were published in the same issue of *Child Maltreatment* (Armstrong, 1997; Ekman, 1997; Lindsay, 1997; Neisser, 1997; Putnam, 1997; Schooler, 1997) by researchers and academics in the field who had reviewed the videotapes.

Following the Corwin & Olafson article, Loftus looked through juvenile court records, even those that had been sealed by the court, then hired a private investigator to track down the young woman's biological mother, her stepmother, her foster mother, and her half-brother (Kluemper, 2014). Loftus at times misrepresented

herself to these individuals when requesting to interview them (e.g., introducing herself as Corwin's supervisor to the foster mother).

Loftus and Guyer (2002a) subsequently published an article titled "Who Abused Jane Doe?", claiming that the former stepmother had suggested the "false accusation" that led to the court-ordered investigation and full custody eventually being awarded to the father. The authors included the half-brother's account, although failing to mention that following an accident, he had suffered severe cerebral damage and memory loss. A second article appeared the same year (Loftus and Guyer, 2002b).

It appears that Loftus does not consider that the informed consent of or even direct contact with the person alleged to have "false memory syndrome" are necessary to make the diagnosis. In fact, she has already testified in one case (Seignious vs. Fair, 1998, as cited in Hoult, 2014) that she does not believe that she needs to have a "full and accurate understanding of the facts" of a case to write about it.

5. Conclusion

People around the world recently learned how fake stories outperformed real news on Facebook during the recent US elections (Silverman, 2016). The media have reported on top fake news stories of the year (Fake news, 2016; Ritchie, 2016) and Oxford Dictionaries has declared "post-truth" as its 2016 international word of the year ('Post-truth' declared word of the year by Oxford Dictionaries, 2016), defining it as an adjective relating to circumstances in which objective facts are less influential in shaping public opinion than emotional appeals. Its selection follows June's Brexit vote and the US presidential election.

Both journalists and the general public are even less likely to fact-check information that is presented by scientists, professors, and researchers. When these professionals are skilled in the use of persuasive techniques, such as story-telling, delivering jaw-dropping moments, painting a mental picture with multisensory experiences, quoting an authority, and creating a sense of solidarity by using inclusive language (Cialdini, 1993; Gallo, 2014), their audience will be convinced by the stories it heard and remember a few selected nuggets of simplified information – with the distinct impression that these facts were presented in a scientific, rational, and convincing manner, with no reason to question them.

Whatever proponents of false memory syndrome may claim and however persuasively they tell their stories and anecdotes, dissociative amnesia typically involves fragmented recall of trauma and is rather a retrieval inhibition than a forgetting (Spiegel et al., 2011). It may also involve complete loss of recall for sexual and physical abuse but most commonly, dissociative amnesia is partial, variable, and coexists with memories of trauma (Dalenberg et al., 2014). Studies addressing the accuracy of recovered abuse memories show that these memories are no less accurate than continuous memories for abuse (Schefflin & Brown, 1996). Memory is reconsolidated each time it is accessed and therefore potentially distorted (Bridge & Paller, 2012).

Evidently, this does not disprove the possibility that some clinicians are too suggestive, one way or another, pushing their patients to adopt views that serve to confirm the therapist's own perspective and beliefs.

In their editorial on Ethical Standards, Truths, and Lies, Brand and McEwen (2016) invite readers to imagine a dystopian world, where you cannot believe scientists or national news reporters on topics of memories, sexual assault, or child abuse, where religious leaders and university officials lie about their management of reports of sexual assault. They state: "When a lie has been

embedded in the public consciousness, the truth has a difficult time making itself known. Only those who continue to tell the truth, however unpopular, protect us from such a dystopian world".

In such a world, in our world, it does not suffice to treat traumatised and dissociative individuals skilfully in our offices and clinics, to attend meetings and events with like-minded professionals, while accepting facts complacently, either because they confirm our view (confirmation bias) or because they are professed by figures of authority or notoriety in our field.

As researchers and as clinicians, if we wish to tell and to defend the truth, victims' truth, then we need to sharpen our knowledge of ethical pitfalls, logical fallacies, and cognitive strategies of persuasion; we must apply critical thinking and careful questioning to all clinical, scientific, and general reports on issues such as ethics, alternative practices, clinical guidelines, the nature of memory, the prevalence and consequences of all forms of violence.

Disclosure of interest

The author declares that she has no competing interest.

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