Letters to the Editor: Response to “Reforming Mental Health Care”

August 19, 2014 | Psychotherapy [1], Couch in Crisis [2], Dissociative Identity Disorder [3]

This exchange follows what began with Dr Richard Noll’s article, “Speak, Memory” and the “repressed recovered memory/multiple personality disorder” iatrogenic epidemic of the late 1980s and 1990s.

[Editor’s note: In June 2014, we published “Reforming Mental Health Care: How Ending ‘Recovered Memory’ Treatments Brought Informed Consent to Psychotherapy” by R. Christopher Barden, PhD, JD. Dr Barden’s commentary elicited a number of lively responses. Here we present two letters, along with Dr Barden’s response to the first. This exchange marks the culmination in print of what began with Dr Richard Noll's article, “Speak, Memory” and the “repressed recovered memory/multiple personality disorder” iatrogenic epidemic of the late 1980s and 1990s. We welcome your comments.]

Response to Dr Barden’s “Reforming Mental Health Care”

It is quite understandable why psychologist-attorney Christopher Barden should want to take credit for psychiatric reform and for bestowing informed consent on psychotherapy patients; in this chaotic, complex, multifactorial world one must, I imagine, take credit when one can. It is also understandable that an attorney, even if also a psychologist, might present only one side of a case (that is what they do); for completeness, however, it may be instructive to identify some factors omitted in regard to the changes he noted.

The role of malpractice insurers is omitted. After a few of the huge runaway jury awards to which Dr Barden refers, insurers became quite prompt in settling such cases as, presumably, a form of damage control, especially since dozens, if not hundreds, of such cases, valid and bogus alike, were waiting in the wings. As research on the “other side” began to emerge—studies of how memory actually worked—and defense attorneys learned how to defend such cases successfully, there was a sharp drop in cases when prompt settlement could no longer be relied on. “Reform” did not happen so quickly merely because of successful litigation against practitioners. Indeed, many of us who testify in such cases have not even heard of such a case in years.

The role of the 1992 Lanning report is omitted. The FBI’s Kenneth Lanning became the actual Fox Mulder (X-Files protagonist) when he began to be assigned satanic ritual abuse cases that were claimed to have interstate manifestation, hence, an FBI issue. Approaching, from a pure law enforcement perspective, the claims about murdered persons, ritually sacrificed babies, and the like, he found no physical traces of such events in any instance. That was a tipping point that had no relationship to actual litigation.

The normal role of recall in psychotherapy—and medicine—is omitted (“When did you have your last vaccination?” “I don’t recall, let me think: oh, yes.”). Normal life is rife with memory recovery, as is psychotherapy. Since psychotherapeutic exploration often goes in unexpected directions with unexpected recollections and unexpected effects, it is especially problematic for patients to give informed consent to so many unknowns. When a patient reveals something previously long unrecalled, is that repression? Avoidance? Dissociation? Simple forgetting? It is not often possible to distinguish among these phenomena.

It may be useful to recall that evidence-based practice began in general medicine first, as the ability of the field increased so as to obtain data from an ever-widening pool of sources. While identifying such an evidence base is inherently more complex in psychotherapy, I would agree with Dr Barden that that is probably a good thing.

Thomas G. Gutheil, MD

Dr Gutheil is Professor of Psychiatry at Harvard Medical School, Boston, and a member of the Psychiatric Times editorial board. He has written extensively on forensic memory issues, often pleading for non-hysterical and non-extreme conceptualizations. In the one “memory” case for which Dr Gutheil testified for the defense against plaintiff’s attorney Dr Barden, the defense prevailed. Given the vicissitudes of juries, Dr Gutheil refrains from taking credit for that.
Dr Barden Responds

Many of my colleagues and I spoke out regarding informed consent rights in psychotherapy in 1994: to the US Congress; to juries; to audiences at CME, CPE, and CLE activities; and to the national media.

We focused on several goals in Memory Wars I:

- Protecting vulnerable patients and the public from reckless and abusive repressed recovered memory/multiple personality disorder (RRM/MPD) pseudo-treatments
- Relying on the power of the US legal system and the wisdom of citizen juries to enforce important systemic reforms over the objections of powerful, well-financed mental health industry interests (eg, the American Psychiatric Association [APA], the American Psychological Association)
- Using the newly minted Daubert legal process to exclude unreliable theories such as RRM/MPD from courtrooms
- Teaching, enforcing, and protecting the fundamental human right of informed consent for psychotherapy patients

As history clearly shows, in just a few short years (1994-1997), our multidisciplinary methods essentially achieved these goals, thus bringing rapid, yet profound reforms to the US mental health system. Although Memory Wars I brought informed consent to psychotherapy, closed many MPD clinics, revoked the licenses of leaders of the RRM/MPD movement, and informed/warned millions of consumers via international media, the ongoing debate over the role of the science of memory in mental health, law, and public policy—Memory Wars II—continues.

For those who have not had a chance to review actual case files of RRM/MPD clinics, please read the article, “Cult of Madness” by Ann Zimmerman to see the kinds of abusive practices we sought to end in Memory Wars I.

Dr Gutheil refers to me as a psychologist-lawyer but omits that I was trained and practiced as a child, family, and adult psychotherapist and researcher. I practiced in universities, hospitals, and medical schools, studying coping and resilience in children and families struggling with serious diseases and disabilities. In my early career in health care, I never anticipated becoming a lawyer, much less a litigator for mental health reform.

In mid-1997, as Memory Wars I raged nationwide, I gave Dr Gutheil an opportunity to publicly support the universal right of informed consent. He missed the chance. I recall Dr Gutheil answering my cross-examination by saying, “I guess the question is whether there really is any informed consent to psychotherapy, which I’m not convinced about.”

A few months after Dr Gutheil’s testimony, the $10.6 million settlement in the Burgus v Braun case and the resulting international media firestorm were the final straws in the dramatic collapse of the RRM/MPD industry. Just a few years later, in 2001, following a string of ongoing licensing revocations and Daubert litigation victories, Dr Gutheil reversed course and publicly adopted our 1994 reform position—that psychotherapy patients should receive the protections of informed consent.

Further proof that our coordinated collapse of the RRM/MPD industry and the resulting wave of licensing revocations did indeed bring informed consent to psychotherapy includes the work of Dr Paul Fink, former President of the APA. Dr Fink provided documentary evidence that well into the 1990s prominent leaders in psychiatry simply did not believe psychotherapy patients deserved informed consent protections. Dr Fink wrote, “The foes of psychotherapy have developed an interesting tactic—a demand for informed consent for psychotherapy.”

Additional proof that our Memory Wars I victory of 1997 brought informed consent to psychotherapy includes the 1996 APA “Principles of Informed Consent in Psychiatry,” Section 7, which states: “Psychotherapy: Informed consent developed in the context of invasive procedures and has since been extended to treatment with medication. There has always been uncertainty as to the extent to which the doctrine of informed consent is applicable to psychotherapy” [italics added].

In stark contrast, following our tsunami of coordinated litigation and licensing cases, virtually all experts in psychotherapy, mental health, ethics, public policy, or law—including the once-skeptical Dr Gutheil—have adopted our 1994 reform position that psychotherapy patients do indeed have a fundamental right to informed consent protections. This new and universal acceptance of informed consent protections for psychotherapy patients was surely one of our greatest victories in Memory Wars I.

Dr Gutheil also noted that he testified in the Green v Wallace case—a unique defense verdict. Fortunately for the mental health reform movement, the Green defense verdict had a powerful, paradoxical impact on the settlements of many other cases. Shortly after the Green verdict, the defense attorneys made the extraordinary error of seeking payment of all costs and legal fees from an indigent plaintiff. I remember when defense counsel carefully documented defense costs and fees.
of over $1.2 million compared with the $40,000 expended by the tiny local plaintiff’s law firm I assisted in that case. Following the Green case “loss,” our settlements were larger and more rapidly obtained. As one defense attorney put it, “The Green case showed us it was possible to defeat you in court, Dr Barden, but only if we outspent you $30 to $1” and “only if we spent over $1 million per patient defending these [RRM/MPD] cases.” In effect, the Green case enhanced our reform work. As the public record demonstrates, multidisciplinary team efforts rapidly and successfully ended Memory Wars I. These efforts closed abusive MPD clinics, ended the national wave of criminal prosecutions based solely on “recovered memory” testimony tainted by suggestive therapy, restricted or revoked the licenses of reckless founders of the RRM/MPD movement, informed millions worldwide via media exposes, generated powerful advances in the science of memory and false memory, and ended debate as to whether informed consent protections should be available to psychotherapy patients.

Although this history of reform is well documented, an essential question remains. Why were these extraordinary multidisciplinary team efforts necessary to stop such clearly abusive and dangerous pseudotreatments? Why did Ken Lanning and the FBI have to spend millions investigating and debunking rather obvious pseudomemories? Why didn’t the mental health “guilds”—psychiatry, psychology, and social work—move to end the RRM/MPD industry, voluntarily bring informed consent protections to psychotherapy, issue national health warnings against dangerous RRM/MPD “treatments,” and quickly close one of the most tragic chapters in the history of the mental health system? Why did they leave it to our multidisciplinary teams, citizen juries, and licensing boards to do the heavy lifting of reform? A final question involves our future mental health system. The next time dangerous mental health quackeries stalk the land, will the guilds act to protect patients, or once again circle the wagons and protect colleagues?

I look forward to working with talented professionals like Dr Gutheil to continually improve the mental health system and ensure that patients receive the fundamental protections of informed consent as well as treatments proven safe and effective by credible, reliable science.

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References

Denying Dissociation and Attacking Mental Health Care
Diagnosing dissociation does not make it happen, and denying it does not make it go away. Dr Barden has a vested interest in advocating for a certain point of view in suing psychotherapists. But he has not always prevailed. When he took the Susan Greene case to a North Carolina jury in 1998, the jury found for all defendant mental health professionals, and not for Barden’s client. It seems that Barden is not well informed about dissociative identity disorder (DID) research and treatment. Contrary to his claims, the literature has shown for decades that DID patients improve during treatment. Research on DID treatment includes 10 publications based on an international treatment outcome study involving 280 therapists and their patients (Treatment of Patients with Dissociative Disorders [TOP DD] study).1-4 The TOP DD study showed that consistent treatment
based on DID expert consensus guidelines is associated with decreased dissociation, PTSD, depression, distress, self-harm, suicide attempts, physical pain, and hospitalizations as well as improved functioning—including increased socializing and better school attendance.\(^5\)

Jepsen and colleagues\(^4\) found that symptoms of DID (eg, amnesia) failed to improve when clinicians did not focus on DID symptoms, although other symptoms improved. A meta-analysis of 8 dissociative disorders treatment studies found moderate to large pre- and post-effect sizes across 7 types of symptoms (mean = 0.71).\(^6\) In our recent review we concluded:

The claims that DID treatment is harmful are based on anecdotal cases, opinion pieces, reports of damage that are not substantiated in the scientific literature, misrepresentations of the data, and misunderstandings about DID treatment and the phenomenology of DID. Given the severe symptomatology and disability associated with DID, iatrogenic harm is far more likely to come from depriving DID patients of treatment that is consistent with expert consensus, treatment guidelines, and current research.\(^7\)

Dr Barden wrongly assumes that memory “recovery” is the primary focus of treatment. A survey of DID experts found that at no stage in treatment was the processing of trauma memories one of the most frequently recommended treatment interventions, not even during the middle phase when DID patients occasionally discuss trauma in detail.\(^8\) The experts preferentially advocated teaching of symptom management techniques and practicing containment of traumatic memories. Containment techniques are the opposite of exploring trauma memories and assist patients in achieving greater distance from, and mastery over, intrusive flashbacks of traumatic memories; that actually permits the successful resolution of traumatic memories in treatment.

Barden seems oddly uninformed about research involving the empirically established link between trauma and dissociation published in numerous scientific journals.\(^9\)\(^-\)\(^13\) This type of research is the reason why DID and a new dissociative subtype of PTSD are included in DSM-5.\(^14\)\(^,\)\(^15\)

Dissociation existed long before psychiatry did. We didn’t create it. Treating it well is the least we can do.

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**References**


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