SPECIAL PERSPECTIVES

The Potential Conflict between Clinical and Judicial Decision Making Heuristics

Eric Rassin M.Sc.,* & Harald Merckelbach Ph.D.

The Gudjonsson Suggestibility Scale (GSS; Gudjonsson, 1984) was introduced as a tool for identifying suspects who are at risk of making false confessions. High GSS-scores indicate a greater risk of making false confessions. Recently, some authors have claimed that low GSS-scores can be used to support the credibility of recovered memories. This new application broadens the use of the GSS in two ways. First, low GSS-scores are considered to possess diagnostic value. Second, the GSS is advocated as a practical tool in clinical settings. This article critically evaluates such a clinical application of the GSS. Our main argument has to do with the incompatibility of basic clinical and judicial decision making heuristics. Psychotherapists, and other medical professionals, should base their decisions on different parameters than judicial professionals. Compared to judicial heuristics, clinical heuristics can be characterized as more empathetic, less critical, and less conservative. Given these differences, clinical conclusions (including those about the accuracy of recovered memories) cannot be easily translated into judicial decisions. If they do enter the judicial domain, these conclusions may lead to dubious forensic decisions. Copyright © 1999 John Wiley & Sons, Ltd.

In his often-cited book, Gudjonsson (1992) offered a detailed analysis of suspects who tend to make a false confession when they are subjected to stressful interrogations. He also introduced the Gudjonsson Suggestibility Scale (GSS: Gudjonsson, 1984) as a practical tool for identifying such suspects. There is now good evidence...
to show that people who score high on this scale are at risk of making false confessions in an interrogative context (see e.g., Gudjonsson, 1992; Merckelbach, Muris, Wessel, & Van Koppen, 1998). By implication, high GSS-scores suggest that memories surfacing during an interrogation-like situation should be interpreted with caution. Recently, some authors have advocated the use of the GSS in the opposite direction. That is, these authors argue that a low GSS-score indicates that a client’s memories are not the product of suggestion and can, therefore, be considered to be reliable. For example, Leavitt (1997) employed the GSS with patients who claimed to have recovered memories of traumatic events. Leavitt noted that these patients had lower scores on the GSS than patients without recovered memories. Accordingly, he concluded that the “results indicate that patients who recover memories were remarkably less suggestible than the clinical field has been led to believe by advocates of false memory.” He added that “these findings appreciably challenge advocated theories of suggested memory” (p. 265). Likewise, Hammond (1995, p. 108) remarks that “with my abuse patients, I now take part of one interview to administer the Gudjonsson Scale of Interrogative Suggestibility.” He then goes on to argue that “if the parents of a patient who scored lower on these scales were to allege that the therapist created false memories, these measures would confirm the low probability that this occurred” (p. 108).

At first sight, it may seem legitimate to interpret low GSS-scores in this way. Yet, a closer analysis reveals that such a line of reasoning is highly problematic. The problems that arise when low GSS-scores are used to buttress the veridicality of recovered memories boil down to a conflict between clinical and judicial heuristics. The forensic psychologist who employs the GSS in the traditional way contributes to a type of judicial decision making that is calibrated so as to minimize false positive errors (i.e., diagnosing innocent people as guilty). On the other hand, the psychotherapist who employs the GSS in the way proposed by Leavitt (1997) and Hammond (1995), is guided by a type of clinical decision making that attempts to minimize false negative errors (e.g., ignoring a patient’s traumatic history when, in fact, it represents a significant etiological factor). Yet, the GSS is a forensic tool that does not allow for such clinical decision making.

The purpose of the present article is to highlight the different decision making heuristics employed by clinical and judicial professionals. In our view, these differences may play a critical role when clinicians (e.g., psychotherapists) act as expert-witnesses in court cases that involve recovered memories. Note that patients with recovered memories often report a variety of psychiatric symptoms (e.g., eating disorder, depression, dissociation; see Gudjonsson, 1997). To the extent that these symptoms are attributed to childhood abuse and accusations are leveled against parents, the accused may find themselves held responsible for the consequences of their alleged past behavior. In this way, the potential conflict between clinical and judicial heuristics in recovered memory cases bears on the issue of mental illness and responsibility.

In the sections that follow, we first briefly discuss the GSS and the recovered memory debate. While the potential conflict between clinical and judicial heuristics may occur in other domains as well (e.g., the interpretation of brain images offered as evidence in court; see Kulynych, 1996), both themes provide an ideal background against which this conflict can be analyzed in more depth. We then turn to
the different parameters that guide clinical and judicial decision making. Next, preliminary data are presented to suggest that clinical and judicial heuristics are not only normative, but also empirical rules. Following this, we return to the GSS and the way its scores can be interpreted and try to illustrate how, in a judicial context, clinical heuristics might lead to dubious conclusions.

**THE GUDJONSSON SUGGESTIBILITY SCALE**

Interrogative suggestibility is defined by Gudjonsson (1992) as “the extent to which, within a closed social interaction, people come to accept messages communicated during formal questioning, as the result of which their subsequent behavioral response is affected” (p. 115). One core aspect of this definition is that the person receiving false information comes to believe that the information is correct. By definition, the person involved does not know to what extent he or she is suggestible. This makes suggestibility inaccessible through self-report. With this in mind, Gudjonsson (1984) developed a test in which suggestibility is measured through a mini-experiment. Basically, this test consists of a story that is read out to the patient or suspect. After a short retention interval, he or she has to reproduce the story (free recall). Next, he/she is asked 20 questions, 15 of which are leading in the sense that they contain post hoc misinformation. After this, the patient or suspect is told in an authoritative manner that he/she has made a number of errors and must answer the questions for a second time. “Yield” refers to susceptibility to leading questions (scores on the yield-scale range from 0 to 15). “Shift” pertains to the tendency to change answers as a result of social pressure (scores on the shift-scale range from 0 to 20, since 20 questions are asked). Additionally, a total score can be computed by summing the yield- and shift-scores (total scores range from 0 to 35).

The GSS renders information about memory performance, confabulation, and susceptibility to leading questions, repeated questions, and social pressure. As to the interpretation of GSS-scores, Gudjonsson (1992) found that healthy individuals have a mean score of 4 on the yield-scale (SD = 3), 2.5 on the shift-scale (SD = 2.2), and 7 points on the total score (SD = 5). Scores above average should be considered indicative of greater suggestibility. Accordingly, confessions of suspects scoring high on the GSS deserve a critical evaluation, since there is an increased risk of false internalized confessions (e.g., Kassin, 1997; McCann, 1998).

**THE RECOVERED MEMORIES CONTROVERSY**

Recovered memories are recollections of childhood traumatic events that were inaccessible for a long period and then are recovered during psychotherapy. These memories are considered to be important by some clinicians for several reasons. To begin with, they may provide a rationale for the patient’s present complaints. Second, a widespread belief among clinicians is that confrontation with past traumatic experiences will promote resolution of trauma-linked symptoms (see e.g., Merckelbach & Wessel, 1998; Poole, Lindsay, Memon, & Bull, 1995).
Whereas some authors claim that recovering veridical traumatic memories during therapy is a common phenomenon (e.g., Dalenberg, 1997), others are more skeptical about the accuracy of such memories. According to the skeptics, the idea of recovering accurate trauma memories rests on a number of dubious assumptions (Loftus, 1993). For example, a necessary assumption for those who believe in the accuracy of recovered memories is that individuals tend to react to trauma with an inhibitory process (i.e., repression or dissociation) that produces total amnesia. Yet, in their thorough review of research on this issue, Pope, Hudson, Bodkin, and Oliva (1998, p. 210) concluded that “prospective data as yet fail to demonstrate that individuals can develop dissociative amnesia for traumatic events” (see also Lilienfeld & Loftus, 1998). Furthermore, studies on active suppression of memories generally show that such maneuvers produce paradoxical results in that memories become hyperaccessible (see, e.g., Rassin, Merckelbach, & Muris, 1997, 1999; Wegner, Quillian, & Houston, 1996). Also, if traumatic memories can be forgotten, the question remains whether such memories can be recovered fully and accurately during therapy. With these criticisms in mind, some skeptical authors have proposed alternative explanations for the phenomenon of recovered memories. Thus, Loftus (1993, 1996) argued that recovered memories may be pseudomemories that develop as a consequence of suggestive interventions by psychotherapists. Indeed, there is now a large literature on the experimental induction of pseudomemories which shows that, under certain circumstances, people can be misled to believe that they have experienced things that actually never happened. For example, one of the mechanisms thought to produce pseudomemories is imagination inflation. That is, the mere process of repeatedly imagining an event can, indeed, result in an inflated belief that the event actually happened (Loftus, 1996). It is plausible to assume that in a therapeutic context such imagination inflation effects are even stronger than in laboratory experiments, especially when suggestive techniques such as hypnosis and guided imagery are applied (Lindsay & Read, 1994; Poole et al., 1995; for a review on suggestion in psychotherapy, see Lundh, 1998).

In response to skeptics’ arguments, some clinicians have advocated the use of the GSS as a tool to assess whether patients are susceptible to the induction of pseudomemories during psychotherapy. By this view, higher than average GSS-scores would indicate that the risk of pseudomemories is present, whereas relatively low GSS-scores would make a pseudomemory scenario less likely (Leavitt, 1997; Hammond, 1995).

It is important to note that the debate on the accuracy of recovered memories does not only touch on therapeutic or academic issues. After all, recovered memories of abuse or molestation may lead to criminal investigation and civil lawsuits against the alleged perpetrator (e.g., parents). Likewise, recovered memories that turned out to be pseudomemories have, in some cases, led to lawsuits against therapists who were held responsible for the development of these memories (see Gutheil & Simon, 1997). In what follows, the legal ramifications of recovered memories are our main concern. To illustrate the type of problem that we attempt to elucidate, we recently came across a Dutch court case in which a clinical psychologist testified about the veridicality of a psychiatric patient’s memories of childhood abuse that were recovered during therapy. The psychologist administered the GSS to the patient and reasoned that it was unlikely that
the recovered memories were the product of suggestive treatment techniques because the patient’s GSS-scores were relatively low and, so, the recovered memories had to be truthful.

DIFFERENT SENSITIVITY AND SELECTIVITY PRIORITIES

This case exemplifies how clinical and legal issues sometimes interact in a rather problematic way. Thus, the question arises to what extent these issues are compatible. In the case of the GSS, one may argue that they are not compatible. That is, interpreting high GSS-scores as alarming ("legal application") does not imply that low GSS-scores indicate veridicality ("clinical application"). This point becomes clear, once one looks at the basic decision making heuristics in clinical and legal contexts.

The work of clinicians (e.g., psychotherapists) is aimed at promoting the well-being of their patients (Adshead, 1997). In fact, curing and palliation should be the most important purpose of clinical activity. Given the obligation to act in the best interests of their patients, therapists would rather administer an unnecessary treatment than to overlook a disease. Subjecting a patient to a treatment regime when he does not need a treatment is not a big mistake, as long as the treatment has no serious side-effects. In the clinical context, ignoring a potentially threatening symptom is considered to be a serious error. In other words, therapists will give priority to sensitivity over selectivity when diagnosing and treating symptoms. That is, they will act so as to maximize the detection of pathology. The risk that some positively diagnosed patients are, in fact, healthy ("false positives") is considered to be a necessary evil. If clinicians decide to be more conservative in their diagnoses, this would decrease the number of false positive diagnoses, but the pay-off of this would be an increase in the number of false negatives (i.e., the frequency of ignored diseases). Thus, in the clinical context, false negatives are worse than false positives.

In a criminal context,1 the central actors are suspects rather than patients. The doctrine here is that the suspect is innocent until proven guilty. Furthermore, one of the cornerstones of contemporary western criminal justice is that conviction of innocent people should be avoided. Indeed, criminal law contains an elaborated set of rules that aim at reducing the risk of such false positive errors. Basically, the possibility of convicting an innocent person is considered worse than discharging a guilty suspect. In other words, legal decision makers follow a rather conservative strategy. Thus, in the judicial context, selectivity of convictions is important, perhaps even more important than sensitivity.

Formulated in this way, clinical and judicial heuristics are difficult to reconcile. In the clinical domain, a false positive error is acceptable, whereas in the legal domain, such an error is unacceptable. Meanwhile, different ways of evaluating false positives may coexist and this is not problematic as long as the domains remain separate. Yet, serious problems may occur when clinical and legal decisions intertwine.

1 The heuristics discussed here apply to both criminal and civil procedures.
DIFFERENT APPROACHES TO THE CREDIBILITY OF STATEMENTS

Clinical and judicial professionals not only rely on divergent heuristics; they also seem to have a different concept of truth. Clearly, in court, factual evidence is important. Eventually, court decisions should be based on objective truth (or approximations thereof). Fair trial principles dictate that testimonies and other evidence—especially against the suspect—are carefully weighed in order to establish historical truth.

In a clinical context, such strict demands are not necessary and might even be counterproductive. As clinicians are more anxious about ignoring diseases than treating non-existing ones, they will readily accept a patient’s narrative. Thus, if a patient claims to have been sexually abused by his/her parents, the therapist will start by believing that the alleged abuse did take place. Some therapists go even further and argue that the question of whether or not the abuse took place is not really important. The fact that the patient thinks he or she was abused is in itself reason enough to talk about the traumatic event, considering that the patient will in some way benefit from such therapy sessions (see McNulty & Wardle, 1994). It is not the therapist’s task to evaluate the credibility of statements that clearly occupy the patient. In the words of Greenberg and Shuman (1997) “The basis of the relationship is the therapeutic alliance and critical judgment is likely to impair that alliance” (p. 52). Recently, Shuman, Greenberg, Heilbrun, and Foote (1998) summarized this point as follows: “While there is strong disagreement about the human capacity to repress and subsequently retrieve accurate memories, there is a consensus that it is unnecessary and potentially harmful for the therapist to attempt to validate the historical accuracy of the patient’s disclosures in therapy” (p. 517).

DIFFERENT ALPHA’S

A related difference between clinical and judicial decision making has to do with the type of scientific routine on which both disciplines rest. Clinical diagnoses and treatments are mainly based on empirical research. Such research generally involves studies with samples of patients or healthy volunteers who are assigned to experimental and control conditions. In this way, empirical data are obtained and then subjected to statistical testing. When this is done, alpha is conventionally set at 0.05. In other words, scientists tolerate a 5% risk of being wrong.

In contrast, judicial decision making is guided by historically and politically based traditions that are codified in the form of laws. One important feature in this context is that decisions in court should not contain uncertainty levels of 0.05. Wagenaar, Van Koppen, and Crombag (1993) demonstrated that an alpha of 0.05 corresponds with a diagnostic value of 19 (i.e., 95 divided by 5). These authors argue that, at least under Dutch law, a relatively certain conviction requires a diagnostic value of as high as 240 (which corresponds with an alpha of 0.004). Again, at least from a normative point of view, judicial decisions seem to be more conservative than are clinical science decisions.
Some Preliminary Data on Decision Making Heuristics

Clinical and judicial heuristics may be quite different in normative terms, but that alone does not prove that such differences are also present in real-life situations. To examine whether clinical and judicial professionals focus on different aspects of the same case vignette, we conducted two pilot studies.

Study 1

In the first study, 12 licensed psychotherapists (eight women) were asked to read the following case vignette. “Under Dutch civil law, it is possible for citizens to change their family name. A request thereto must be addressed to the Ministry of Justice. The request should contain enclosures in which arguments are provided. One good argument is that the mental well-being of the individual who is applying for the change of his or her name is at stake. Imagine that someone (John) approaches you. John (35 years) says that he was abused by his parents during his youth. As a result of this, his family name continually reminds him of his unpleasant childhood. John would like you to write a psychological evaluation in which his current distress is discussed. He intends to use that evaluation as an enclosure to his request. It is obvious that John is suffering and that he attributes this suffering to his family name. John’s parents, however, strongly deny having abused John when he was young. Would you, in this case, be willing to write a psychological evaluation?” Participants ($M = 31.3$ years, $SD = 6.9$, range = 22–44) had to choose by ticking a visual analog scale (VAS) ranging from 0 (“certainly not”) to 100 (“certainly yes”). They were also invited to provide arguments for their choice.

The mean score on the VAS was 51.3 ($SD = 31.9$). Scores ranged from 3 to 92 and this indicates that there was little agreement among psychotherapists about how they would decide in this case. As to the arguments provided by the psychotherapists, the five clinicians scoring in the upper part of the VAS mentioned that John’s feeling of discomfort was the most important criterion for their decision to write a report in favor of John’s wish to change his name. Of the seven therapists with lower scores, four said that they needed more information before they could reach a decision and three doubted whether changing his family name would be beneficial to John. Only four therapists mentioned the potential legal implications in this case. Of these four, three stated that the potential negative consequences for John’s parents should be of no influence to their decision. Only one therapist reported that he would insist on including a statement prohibiting the use of his evaluation in a lawsuit.

These results suggest that the psychotherapists are more concerned with therapeutic than with legal issues, even in cases in which it is evident that there are potentially far-reaching legal consequences (e.g., John starting a civil lawsuit against his parents). Admittedly, more than half of the therapists scored low on the VAS, but, from the reasons provided by them, it can be concluded that, on the whole, they were not motivated by legal concerns. In passing, it should be mentioned that the case vignette was inspired by a real case in which one of us...
acted as an expert witness for the lawyers of the parents. In that case, a general practitioner, a psychiatrist, and a psychologist were willing to write a report about the causal connection between John’s history of abuse and his wish to change his family name.

**Study 2**

In the second study, participants had to read a case vignette and were subsequently asked to choose between two alternatives. One alternative reflected a preference for clinical heuristics, while the other option reflected a preference for judicial heuristics. This study relied on a student sample ($M = 21.8$ years, $SD = 1.8$, range $= 20–26$), consisting of 27 psychology students and 17 law students. They were instructed to read the following story. “A man (Mr. A) claims that he was a victim of molestation. A few weeks ago, he wanted to park his car when at the last moment somebody else (Mr. B) squeezed his car into the parking lot. Mr. A confronted Mr. B and they got into an argument. This argument developed into physical violence. At the moment, several weeks after the incident, Mr. A still suffers from bruises and chronic headaches. In order to get access to insurance paid treatment for these complaints, he needs an expert declaration containing the diagnoses of ‘traumatic bruises’. Suppose that such diagnosis is made, Mr. B will be held responsible by the insurance company for all costs. Furthermore, the diagnosis of ‘traumatic bruises’ may lead to criminal proceedings against Mr. B. Suppose further that you are the clinician and you have to choose between either of two alternatives. Mr. A will be treated and Mr. B will get into trouble, or Mr. A won’t be treated and Mr. B won’t get into trouble.” Participants gave their opinion, using a VAS ranging from 0 (“no treatment”) to 100 (“treatment”).

Psychology students had a mean score of 49.2 ($SD = 24.8$), while law students had an average score of 36.4 ($SD = 31.3$): $t(42) = -1.5, p = .07$. Although this difference is only marginally significant, it suggests that psychology and law students tend to process this type of case information on the basis of divergent heuristics, with psychology students focusing on the potential victim (Mr. A) and law students emphasizing the position of the potential suspect (Mr. B). Admittedly, the difference was rather small, but this may be attributed to the fact that the study relied on students rather than professionals. Full blown heuristics may not yet be present in students. Furthermore, it should be noted that in a hypothetical case like this, participants are made familiar with both sides (i.e., victim and suspect). Yet, in real life, clinicians tend to see patients, while lawyers tend to see suspects. Thus, there are good reasons to believe that the current findings represent an underestimation of the real differences between both groups of professionals and the heuristics on which they rely.

**WHY THE GSS IS NOT A MEASURE OF CREDIBILITY**

We now return to the application of the GSS. The original purpose of the GSS was to identify a certain type of false confession. High GSS-scores may be used by lawyers or forensic experts as evidence that the suspect is highly suggestible and...
may produce false confessions under certain circumstances. From this perspective, low GSS-scores have little or no significance. That is, they can not be used as an argument against false confessions or as an argument in favor of the claim that the suspect is, indeed, guilty. In short, GSS-scores are meant to be used in only one direction: high scores raise questions about the veridicality of confessions (especially when these confessions are retracted), while low GSS-scores are meaningless. Consider a suspect who scores extremely low on the GSS. Would that imply that this person’s confession was not contaminated by suggested information? We do not think so. From the definition of suggestibility that we presented earlier, it follows that the process of incorporating post hoc misinformation in one’s memory or confession depends on several factors, namely the persuasiveness of the communicator, the credibility of the suggested information, the context of transmission, and the receiver’s suggestibility. As the GSS mainly taps the latter factor, it can not be ruled out that in certain situations, the three other factors are strong enough for misinformation to be transmitted successfully even in the absence of the fourth element. To take this argument one step further, it can be argued that even if a confession was not suggested, there may be other reasons than suggestibility for a suspect to make a false confession, such as lack of memory, or compliance (Gudjonsson, 1989, 1992).

In sum, then, in the legal context, high GSS-scores can be useful to support the argument that a suspect has (false)ly confessed because of his or her tendency to be suggestible. On the other hand, low GSS-scores can not be used against a suspect, because the GSS is not an index of credibility.

CONFLICTS IN COURT

With the differences between clinical and judicial heuristics in mind, it is easy to see that serious complications may occur when issues discussed during therapy give rise to legal consequences such as lawsuits and criminal investigations. For example, a patient’s parents (who are accused of having abused their child) may become involved in what was discussed during therapy (e.g., Gudjonsson, 1997; Loftus, 1997). If therapists administer the GSS to their patients and in doing so, intend to counter accusations about having induced pseudomemories, the basic clinical heuristic (i.e., assuming that the patient is telling the truth) is implicitly present. This explains why some therapists think that it is legitimate to interpret low GSS-scores as supportive of credibility. Yet, as discussed above, such an interpretation does not meet the standards of legal decision making: low GSS-scores are not acceptable as evidence against a suspect, and neither do they provide an argument for the authenticity of memories.

While our discussion focuses on the GSS, it has a broader relevance, as it touches on the compatibility of clinical and forensic roles in court. In sum, clinical statements in court run the risk of being too patient centered and too liberal about credibility as compared to legal standards. In their article on conflicts between clinical and forensic roles, Greenberg and Shuman (1997) list ten reasons for therapists not to act as expert witnesses on behalf of their patients. One of these reasons is that in therapy the patient is the therapist’s client, while in court the attorney or judge is the therapist’s client. Furthermore, the neutral and detached
attitude that is required for an expert witness is incompatible with the empathic and supportive attitude required in therapy. Clearly, the goals of therapy and forensic evaluation are quite different. Consequently, interpretations or opinions derived from therapy sessions should not be used in an unqualified way in judicial decisions. In the words of Greenberg and Shuman (1997) “Therapists are not typically trained to know that the rules of procedure, rules of evidence, and the standard of proof is different for court room testimony than for clinical practice” (p. 51). Similar arguments have been advanced by Hagen (1997). Hence, therapists can unknowingly do harm to third parties (such as parents of patients) whenever they support their patients’ testimonies in court. An example of how therapists’ expert witness testimonies can be harmful is the circular PTSD argument (see also Boeschen, Sales, & Koss, 1998; Greenberg & Shuman, 1997). Imagine a psychotherapist who is currently treating a patient for post-traumatic stress disorder (PTSD). The diagnosis of PTSD was reached on the basis of what the patient had told about his involvement in a car accident. Concurrently, the patient has initiated a civil lawsuit against the person who allegedly caused the accident. If the therapist in this case testifies that, given the consequences of the accident (i.e., the PTSD), his or her patient’s testimony is truthful, this expert-witness testimony would be highly problematic. Note that in order to be diagnosed as suffering from PTSD, one must have been exposed to a traumatic event that involved actual or threatened death or serious injury (APA, 1994). Thus, the therapist who treats his or her patient for PTSD implicitly accepts the trauma narrative of the patient. The therapist’s assumption that a trauma took place is, however, based on clinical concerns. It does not meet the requirements that are necessary for legal decision making. If the therapist testified that the trauma described by his patient has to be taken seriously, the therapist would increase the risk that others (other people involved in the accident) are held responsible for damages. In the words of Faust and Ziskin (1988): “A determination that the clinical criteria have been met does not establish satisfaction of the legal criteria” (p. 32).

CONCLUSION

In this article, we discussed why low GSS-scores should be ignored rather than be interpreted as buttressing the credibility of confessions or recovered memories. Some of our arguments pertain to the GSS, but others have a broader relevance. The arguments that we discussed can be summarized as follows. To begin with, low GSS-scores do not rule out the possibility that the respondent’s narrative was the result of suggestion. It may well be the case that other factors (such as persuasiveness of the communicator) resulted in pseudomemories. Second, concluding that a memory or confession is not the product of suggestion does not imply that the narrative is therefore accurate: there may have been other reasons for making inaccurate statements, such as memory flaws, confabulation, or compliance. Third, there are fundamental differences between clinical and judicial decision making such that legal requirements for truthfulness are far more conservative than clinical assumptions about truthfulness. These differences led Greenberg and Shuman (1997) to conclude that therapists should not enter the courtroom arena before undergoing special training in legal heuristics. Without such training, therapists
may do harm, in that they—unknowingly—mislead judges when presenting clinical “facts” as legal evidence. The risk of misunderstandings between clinical and judicial professionals is clearly present when therapists start using low GSS-scores as an argument for the accuracy of recovered memories.

Problematic clinical testimony poses a dilemma that has eloquently been described by Faust and Ziskin (1988). These authors argued that once judges (and juries) note that clinicians’ claims are often not met by the quality of their testimonies, judges may come to distrust any clinical testimony. Faust and Ziskin (1988) argued that “The courts, having learned to distrust clinicians’ claims, may refuse to admit testimony based on truly useful knowledge and methods despite more than adequate supportive studies” (p. 35). Ten years later, APA Monitor quotes psychologist David Shapiro who emphasizes a similar point: “We’re starting to see a lot of cases that specify the restrictions that will be placed on psychological evidence. And the trend is rather disturbing. It looks like admissibility of psychological testimony is going to be extremely narrow” (Sleek, 1998, p. 34).

REFERENCES
