THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

Bentley D. Price, Circuit Court Judge

Appellate Case No. 2020-000804

John Doe, ……Appellant,

v.

Bishop of Charleston, a Corporation Sole, and The Bishop of the Diocese of Charleston, in his official capacity……Respondents.

AMENDED RECORD ON APPEAL
Volume 3 of 3

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STATE OF SOUTH CAROLINA)
)
COUNTY OF CHARLESTON)

IN THE COURT OF COMMON PLEAS
THE NINTH JUDICIAL CIRCUIT

EXHIBIT B

Settlement Agreement

John Doe #66
v.
The bishop of Charleston, a Corporation Sole, and
The Bishop of the Diocese of Charleston, in his official capacity
CASE NO.: 2005-CP-10-2053

John Doe #66A
v.
The bishop of Charleston, a Corporation Sole, and
The Bishop of the Diocese of Charleston, in his official capacity
CASE NO.: 2005-CP-10-3293

John Doe #53
v.
The bishop of Charleston, a Corporation Sole, and
The Bishop of the Diocese of Charleston, in his official capacity
CASE NO.: 2005-CP-10-4913

See Terms attached on Ext. #1

In a mediation conducted on this _____ day of _____, 2006, the above named parties agreed to the following terms:

1. _____ shall pay to _____ $_____;
2. Plaintiff/Respondent will execute a general release dismissing all claims on account of the matters raised in the above captioned lawsuit;
3. Plaintiff/ Respondent will cooperate in having a dismissal with prejudice entered by the court; and
4. The parties shall split the mediation fees _____.

_____

By: _____
(Print Name)
Its: _____
Dated: _____

_____

By: _____
(Print Name)
Its: _____
Dated: _____

EXHIBIT "4"

EXH. #1

General Terms of Settlement:

1. PARTIES Agree to create settlement class, subject to Court approval of:
   - (a) ACTUAL VICTIMS OF DIOCESE ABUSE
   - (b) SPOUSAL &/or Parent claim deriving from victims abused

2. Class settlement FUND will be for $12,000,000 FUNDED AS FOLLOWS:
   - (a) $5,000,000 by Letter of Credit, subject to Banks willingness to issue. With a further obligation to procure additional Letter of Credit with $7,000,000 limits once the $5,000,000 Letter of Credit has been drawn down to $1,000,000.

3. DETAILS of claims process in settlement class action shall be developed & include a payment matrix based on nature & severity of claims.

(17)

4. Court shall be asked to approve attorneys' fees for class counsel at between $950,000 + $2.5 million, subject to Defendants obtaining credit to secure the obligation.

5. [redacted]* shall be paid _____

[redacted]* shall be paid _____

[redacted]* shall be paid _____

[redacted]* shall be paid _____

* COLLECTIVELY paid $460,000 to be divided among the Gentlemen above after accepted an agreed to.

6. If the Court fails to approve settlement class and/or provision of class settlement, the compromise settlement with the individuals in "5." above shall not be effected and shall proceed to settlement in the amounts set out in "5." above with appropriate general releases and/or dismissals with prejudice executed in favor of defendants.

[redacted]

(3)

7. These terms are in the form of an offer by Defendants & shall be acted upon with reasonable promptness by Plaintiff / Claimants named in "1." above.

James Deahy, Attorney

June 14, 2006

ON BEHALF OF DEFENDANTS

Attorney in and with authority of the Diocese of Charleston.

THIS AGREEMENT IS SUBJECT TO ARBITRATION PURSUANT TO SECTION 15-48-10, CODE OF LAWS OF SOUTH CAROLINA (1976).

STATE OF SOUTH CAROLINA)) COUNTY OF DORCHESTER)	IN THE COURT OF COMMON PLEAS FOR THE FIRST JUDICIAL CIRCUIT CASE No. 06-CP-18-1310 CASE No. 06-CP-18-1311 CASE No. 06-CP-18-1636
John Doe #53, John Doe 66, John Doe 66A, John Doe 67, Jane Doe 1 and Jane Doe 2 and Rachel Roe individually and as representatives of classes of people similarly situated, Plaintiffs, vs. The Bishop of Charleston, a Corporation Sole, and The Bishop of the Diocese of Charleston, in his official capacity, Defendants.	**SETTLEMENT AND ARBITRATION AGREEMENT**

EXHIBIT tabbies C

This Settlement and Arbitration Agreement (hereinafter "the Agreement") is made this 12th day of January, 2007, by and between the John Doe #53, John Doe 66, John Doe 66A, John Doe 67, individually and as representatives of a class of other persons similarly situated as victims of sex abuse allegedly committed by agents or employees of the defendants in this action, and/or Jane Doe 1, Jane Doe 2, and Rachel Roe, individually and as representatives of parents or spouses who have suffered a loss of consortium as a result of sexual abuse upon John Doe #53, John Doe 66, John Doe 66A, and John 67 or members of their class, and The Bishop of Charleston, A Corporation Sole, and The Bishop of the Diocese of Charleston in his official capacity (hereinafter "the Diocese"). This Agreement may be signed in counterparts. This Agreement represents the formal "Settlement and

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Arbitration Agreement" formalizing the agreement reached between the Representatives[1] and the Diocese and supersedes all other agreements and/or writings previously executed by the parties. This Agreement is intended to effectuate the complete and total settlement of civil actions captioned above as well as 2005-CP-10-2053, 2005-CP-10-3293, and 2005-CP-10-4913, and all other claims which were alleged or may have been alleged by the Representatives and the individuals who they represent in their capacity as class representatives. It is further understood that this Agreement must be submitted to a court of competent jurisdiction for approval and that certain provisions survive this agreement even if other provisions are not approved.

WHEREFORE, for and in consideration of the promises set forth herein and other good and valuable consideration, the sufficiency of which is hereby acknowledged, the Parties hereby agree as follows:

1. **FORMATION OF CLASSES.** Plaintiffs shall move in a timely manner for the creation of plaintiff classes against the defendants as follows:

A. All individuals born on or before August 30, 1980 who, as minors, were sexually abused[2] at any time by agents or employees of the Diocese of Charleston who have not previously had any similar claim adjudicated, resolved, or released. (Hereinafter "the Primary Class")

B. The spouses and parents of all individuals qualified pursuant to the Primary Class and who suffered a loss of the abused individual's consortium, and who as spouses or parents have not previously had any similar claim adjudicated, resolved, or released. (Hereinafter the "Consortium Class")

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1 The class representatives will be referred to throughout this Agreement as "the Representatives."

[2]"Sexual abuse," as used throughout this agreement and in the class definitions, is any lewd or lascivious act committed on, about, or with a minor by an agent or employee of the Diocese in which the actor knew or should have known that the act may have the effect of arousing, appealing to, or gratifying the lusts, passions or sexual desires of the agent or employee of the Diocese or of the minor.

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The Diocese agrees to take no position as to the creation of the plaintiff classes and to cooperate with the provision of information reasonably necessary for the approval of such class or classes. The individuals who fall in either class defined above shall be entitled to make a claim against the settlement fund, pursuant to the terms and conditions set forth in this agreement and the order approving class certification. The individuals in either class shall hereinafter be referred to as "Claimants."

2. **APPROVAL OF AGREEMENT BY COURT.** In addition to the plaintiffs requesting that the classes stated above be certified, the plaintiffs shall also submit this Settlement and Arbitration Agreement for approval by the court pursuant to SCRCP Rule 23. Should the court deny approval of the certification of the classes substantially defined in paragraph 1 above, the court will be separately asked to approve the conditions of paragraph 4, below. Plaintiffs reserve their right of appeal of any denial of class certification. Approval of the settlement shall be on such terms and conditions as the court may fix. All participation is subject to any term and condition of the approval of the classes set out in the court's order. Provided, however, that this is voluntary settlement agreement and that either the Diocese or the Representatives may interpose an objection to any of the court's rulings on the settlement agreement or claims process and may withdraw from this settlement if its terms are materially altered by the court.

3. **SETTLEMENT FUND AND DISTRIBUTION METHOD.** The parties agree to jointly ask the court to approve the terms of the Settlement Agreement, as mediated June 13 and 14, 2006, as follows:

a. The Diocese shall fund the settlement with two irrevocable letters of credit or other guaranteed pool of funds in the amounts of $5 million and $7 million, respectively. Upon disbursement from the initial letter of credit or from an aggregate amount equaling or

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exceeding $4 million, then in that event, the Diocese shall take such action necessary to have the secondary $7 million dollars immediately available for disbursement. Both letters of credit (or other pools of funds) shall be guaranteed by the issuing bank to be available as of the date of the approval of this Agreement. In the event the Diocese is unable to obtain letters of credit, it will nevertheless be obligated to pay all sums awarded by the court or the Arbitrator and to deposit funds for this purpose as set forth above. This Agreement supersedes any prior agreement of the parties.

b. With regard to the claim of any Claimant, the Diocese will pay the Claimant to settle such claim an amount of money to be determined through the arbitration process set forth herein. The arbitration shall be conducted by Marvin Infinger, Esq. (hereinafter "the Arbitrator"). If for any reason Mr. Infinger is unable to continue to serve as arbitrator, the parties shall agree to a successor arbitrator. If the parties are unable to agree to a successor arbitrator one shall be appointed by the court.

c. Awards shall be based on the criteria set forth herein and the Arbitrator will make awards as follows:

Type of Alleged Abuse	Minimum Payment	Maximum Payment
Limited inappropriate touching on the victim	$10,000.00	$18,500.00
Improper touching by the perpetrator upon the victim or by the victim upon the perpetrator, such as fondling of genitalia, limited masturbation, and other types of sexual contacts.	$20,000.00	$55,000.00
Aggravated touching of the genital area by the perpetrator on the victim or by the victim upon the perpetrator. These types of abuse include, but are not limited to, oral sex, (either on the victim or by the victim on the perpetrator) or other aggravated circumstances.	$60,000.00	$125,000.00
Egregious acts, such as sodomy, any act		

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accomplished by force or coercion, or repeated acts involving any type of sexual activities over extended period of time causing serious damage.	$150,000.00	$200,000.00
Loss of consortium (Parent or Spouse)	$20,000.00	

The criteria for the Arbitrator to determine the amount of the award for a sexual abuse claim shall include, among other things, the type of abuse, its duration and the extent of injuries suffered by the Claimant. In cases in which the claim is for loss of consortium, the award shall be $20,000.00 for each parent of the Claimant, and $20,000.00 for the spouse of the Claimant. The Arbitrator shall not consider any liability issues, including, but not limited to, defenses such as lack of negligence or notice, statute of limitations, and charitable immunity. The award issued by the Arbitrator shall be left to the sole discretion of the Arbitrator and shall not be subject to objection, review, appeal or suit brought by any Claimant or the Diocese.

d. For every claim presented, the arbitrator shall make an express written determination as to (1) whether the Claimant is, in fact, a member of one of the plaintiff classes, (2) whether the claim is *bona fide*, and (3) the amount of the award, if any. In the event that the Arbitrator determines that a Claimant is not a member of one of the plaintiff classes and/or that the claim is not *bona fide*, the claim shall be denied and the Claimant shall receive no award. By participating in the claims process, the Claimants and the Diocese expressly waive any and all rights of appeal of any and all decisions of the Arbitrator, including decisions made on whether the individual is a member of the class, whether the claim is *bona fide*, and the amount of any damages which were suffered.

e. Any individual, including his/her parents and spouse, whose claim has been otherwise adjudicated, settled or resolved, is barred from filing a claim or collecting from any funds of this class.

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f. The identity of all Claimants shall be kept strictly confidential except that the Diocese's counsel and those associated with the Diocese necessary for the performance of the terms of this agreement, the Arbitrator, Class Counsel and their staffs may have such access necessary to effectuate this Agreement and the court's orders on the same. Counsel before the court should take appropriate steps to ensure that access is provided to staff on an "as needed" basis. Any individual who has access to the actual name of any Claimant shall sign a court approved confidentiality and restraining agreement prohibiting the disclosure of the name of any Claimant. The name of the Claimant, his or her social security number, and the amount of his or her award will be provided to the escrow agent for purposes of distributing the award at the conclusion of the claims process.

g. Subject to approval of the court, any person wishing to make a claim must do so within 120 days of the initial notice of final approval of the settlement in a form approved by the court. The form may be obtained from Class Counsel by contacting it as provided in the court approved notice and should include at least the following information:

1. The name, date of birth, social security number, preferred address, telephone number, and email address of contact for the Claimant and, if the claim is made in a representative capacity, the name of the representative and the ward and the nature of the relationship;
2. Name of the abuser, location at which the abuse occurred, the time period during which the abuse occurred, and relation of the victim to the abuser; [i.e. priest/altar boy; coach/ basketball player]
3. A brief statement sufficient to advise the parties of the nature of the claim and the acts complained of;

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4. A brief summary of any claimed injury or damages;

5. Name of parents, whether they are living or deceased;

6. Name of spouse (if any);

7. The form must be signed and dated; and

8. Any other information or documents Claimant deems necessary for a determination of his or her claim. Documentary evidence may be supplemented as provided for herein.

h. Class Counsel shall assign an anonymous name and/or numbering system to each claim made. Thereafter, the claim must be referred to by its claim number. The name of the claimant and the claim number will be provided to the Diocese lawyers and to the Arbitrator pursuant to the confidentiality provisions established herein.

i. Class Counsel will transmit the Claim Form only to counsel for the Diocese for its review pursuant to paragraphs 3(l), (m) and (n). At the conclusion of the claim review by the Diocese, Class Counsel shall transmit the Diocese's response to the Claimant. The Claimant will have fifteen (15) days to make any response or take any action Claimant deems necessary and provide the same to Class Counsel who will transmit it to the Diocese. If the Claimant has elected to obtain psychological testing and use it in support of his or her claim, Claimant should provide it to Class Counsel promptly upon receipt. Thereafter, Class Counsel will submit the entire claim package to the Arbitrator and request a hearing.

j. The Arbitrator shall schedule the Claimant's Arbitration within 90 days of submission of the claim to him. The arbitration shall be conducted pursuant to the South Carolina Uniform Arbitration Act, S.C. Code Ann. § 15-48-10, et seq., unless the Act conflicts with this Agreement or the court's order(s) in this matter, in which case the Agreement and order(s)

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shall control. In any event, as to all issues, the orders of the court shall control.

k. While the class has Class Counsel, the parties acknowledge that the Claimant may have an attorney of his or her own choice for any part of the claims process. If an attorney is selected by the Claimant, all information concerning the claim or claims process shall be sent to the attorney for the Claimant.

l. Upon receipt of any Claim Form from any Claimant, Class Counsel shall forward the claim form to Counsel for the Diocese. Counsel for the Diocese shall have thirty (30) days from receipt of the claim to review the claim to verify the accuracy of the information presented and to determine the Diocese's position on whether the Claimant is a member of one of the plaintiff classes and whether the claim is *bona fide*. If the Diocese acknowledges that the Claimant is a member of a plaintiff class and that the claim is *bona fide*, the proceedings before the Arbitrator shall be to determine the damages suffered by the Claimant within the parameters of paragraph 3(d).

m. If the Diocese objects to the claim, the Diocese shall submit an original and a copy of a written objection to Class Counsel stating why the Claimant is not properly a member of one of the plaintiff classes and/or why the claim is not *bona fide*, and attaching (to the original and the copy) any documents or other supporting evidence which the Diocese wishes to tender (such as a death certificate showing that the alleged perpetrator could not have committed the acts complained of at the time and place alleged). Class Counsel shall transmit a copy of the Diocese's objection and exhibits to the Claimant or the Claimant's attorney.

n. If the Diocese makes a timely objection to the claim, the Arbitrator shall rule on the Diocese's objection after a hearing at which Counsel for the Diocese and Claimant (and/or Claimant's counsel if the Claimant elects to be represented) and/or Class Counsel shall be

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permitted to make argument. The Arbitrator may, in his sole discretion, schedule such hearing on the same day as, and immediately prior to, the Arbitration of the Claimant's claim for damages, or at some other time in advance of such Arbitration. The Arbitrator shall be the sole determiner or the Claimant's membership in one of the plaintiff classes and of the *bona fides* of the claim, and his decision shall be final and not subject to appeal. If at any time prior to the Arbitration of the claim for damages the Arbitrator determines that the Claimant is not a member of one of the plaintiff classes and/or that the claim is not *bona fides*, the Arbitrator shall notify the parties of such determination and shall not proceed with the Arbitration on the claim for damages. By participating in the claims process, the Claimants and the Diocese expressly waive any and all rights of appeal of any and all decisions of the Arbitrator, including decisions made on whether the individual is a member of the class, whether the claim is *bona fides*, and any damages which were suffered.

o. Upon submission of the claim, Class Counsel will notify the Claimant that he or she has the opportunity to have a psychological assessment and counseling by Dr. L. Randolph Waid. The Claimant may make this election at the time of his or her claim being filed. The Diocese agrees to pay Dr. Waid, on behalf of the Claimant, for no more than three (3) sessions. Any assessment of any Claimant by Dr. Waid will be provided to the Claimant who may submit it to the Arbitrator as part of the Claimant's damages proof; however, this assessment shall be kept confidential and will not be shared with the Diocese. The payments of counseling fees to Dr. Waid shall be over and above any award made by the Arbitrator and shall not be charged to the Claimant, but shall be paid from the fund.

p. At the Claimant's hearing, a presentation shall be made by or on behalf of the Claimant concerning his or her damages suffered as a result of the alleged abuse. Each arbitration

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hearing shall be no longer than two (2) hours. At Claimant's arbitration hearing, the Claimant must appear unless he or she is a minor, incompetent, serving in the military (or merchant marine), deceased or otherwise unavailable for medical, psychological, or other substantial reasons. The Claimant and/or his or her attorney may present other evidence relating to the abuse and injury, including without limitation, affidavits under oath or under the pains and penalties of perjury, from persons with relevant information, medical records, and/or forensic evaluation. Claimant may submit any information, records or testimony bearing upon damages for consideration by the Arbitrator, including videotape and audiotape testimony. Counsel for the Claimant may make comment upon the damages sustained by the Claimant. Before the close of the Claimant's arbitration hearing, Counsel for the Claimant may notify the Arbitrator that the Claimant intends to supplement the information, records or testimony submitted at Claimant's arbitration hearing with written records or information which is to be received by the Arbitrator no later than 21 days after the close of the arbitration hearing. The Arbitrator shall consider no information, records or testimony unless submitted by the Claimant or Claimant's Counsel with the exception of the Diocese's written statement as described in paragraph (q), below. In the event that the Claimant does not appear in person, the Claimant must appear by telephone or video conference. The Claimant may submit a forensic evaluation or a statement from a health care professional, but shall not be required to do so. The Claimant may have any person or persons of his or her choosing speak at the hearing.

q. Counsel for the Diocese shall not be present at said arbitration hearing regarding damages; however, the Diocese shall be entitled to provide a written submission concerning the Claimant's damages. No person other than the arbitrator shall be present at the hearing

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without the consent of the Claimant. If the Claimant requests, a representative of the Diocese, who is not an attorney, may be present at Claimant's arbitration hearing for purposes of pastoral support. The Claimant shall be entitled to have present at said hearing any of his/her family, friends, health providers, or other individuals requested by the Claimant.

r. After the Arbitrator has rendered his decision, but not before, the Claimant may be invited to meet one on one with the Bishop of Charleston or his designee for religious, spiritual, and pastoral support. No Claimant is obligated to meet with the Bishop or his designee.

s. Any materials of whatever nature submitted by Claimant or on his behalf to the Arbitrator, in connection with the arbitration process which is in any way related to the arbitration awards issued by the Arbitrator shall be returned to the Claimant or his or her counsel by the Arbitrator with the award. The Arbitrator shall not reveal the evidence or written arguments presented during the course of the arbitration hearing to anyone other than those present in the Arbitration or Class Counsel.

t. The Arbitrator shall issue a written award in conformance with the requirements of paragraph 3(d) no later than twenty (20) days after the close of the Arbitration hearing to and deliver same to Class Counsel, counsel for the Diocese, and Claimant and/or Claimant's counsel. Anyone connected with the claims process in any fashion is bound to maintain the confidentiality of each individual Claimant.

u. All costs associated with the management of the class shall be paid from the settlement fund. The fees and costs described herein include those incurred by the Arbitrator, Class Counsel, the escrow agent, Dr. Waid and any other fees and costs approved by the court.

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v. The court approving this Agreement has the authority to enforce any Arbitration award. The Diocese consents to judgment being entered against it in any federal and/or state Court having jurisdiction. The parties release the Arbitrator from any liability arising from any act or omission in connection with the arbitration hearing conducted herein. By participating in the claims process, each Claimant and the Diocese expressly waive any and all rights of appeal of any and all decisions of the Arbitrator, including decisions made on whether the individual is a member of the class, whether the claim is *bona fides*, and any damages which were suffered.

4. **SETTLEMENT OF REPRESENTATIVE'S AND POINT CLAIMANT'S CLAIMS.** In consideration of the work, effort, time, stress, psychological pain, damages, liability proof, embarrassment, family turmoil and other issues relevant, the class representatives and/or point plaintiffs shall receive settlement funds as follows:

John Doe #53	$160,000.00
John Doe 66	$100,000.00
John Doe 66 A	$100,000.00
John Doe 67	$100,000.00
Jane Doe A	$30,000.00
Jane Doe B	$30,000.00
Rachel Roe	$30,000.00

It is understood and agreed that the claims of these claimants are released and these settlement funds will be paid by the Diocese regardless of whether the class certification and settlement are approved by the court.

5. **ATTORNEYS FEES.** In consideration of the substantial efforts of plaintiffs' counsel (past

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and future), their substantial accomplishments in effectuating the settlement, and the work past and future and their role as class counsel, the parties agree to submit to the court the determination of the amount of attorneys fees which shall be paid to the plaintiffs' class counsel by the Diocese. However, it is specifically agreed that in no event shall such counsel receive fees of neither less than $950,000.00 nor more than $2.5 million to be paid to such counsel by the Diocese from the fund referred to in paragraph 3, above, all as determined by the court. Such payment shall be made to Richter & Haller, LLC on behalf of itself no later than ten (10) days after award by the court. The award of attorneys fees as set forth above in this paragraph specifically contingent upon the Court approval of this class certification and settlement agreement.

6. **PAYMENT OF CLAIMS.**

A. W. Ellison Thomas, CPA shall serve as an independent escrow agent for the payment of all sums due from the settlement fund. The escrow agent shall be provided unrestricted access to the settlement funds obtained in compliance with this agreement and will make all payments directly against the fund as set out in this agreement, order of the court, or any award made by the Arbitrator to the individual or entity to be paid. The escrow agent will be compensated at an hourly rate approved by the court and will be from the settlement fund. The escrow agent shall provide an accounting of his disbursements at the conclusion of the claims process to Class Counsel, the Diocese, and the court.

B. No later than thirty (30) days after the final Arbitration award is issued, the escrow agent and the Arbitrator will confer and agree that the total amount of all awards after the payment of all costs and fees, does not exceed the amounts provided for in paragraph 3(a). In the event that the total due exceeds the amounts provided for in paragraph 3(a), then each award shall be reduced on a *pro rata* of the net settlement fund. This revised award list shall be provided

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to Class Counsel and the Diocese, if necessary.

C. Once the Arbitrator and escrow agent determine the final amount of each award, the escrow agent shall disburse the award from the settlement funds within fifteen (15) days of the final determination of the awards. The awards are to be paid to the Claimant directly or through his or her counsel. After all necessary disbursements any remaining letters of credit and/or funds will be returned to the defendants and/or letters of credit will be cancelled.

D. Any party may bring perceived errors in an award based on an interpretation of this Agreement to the attention of the Arbitrator with notice to the other party. However, the Arbitrator's decision on any such question is final. By participating in the claims process, the Claimants and the Diocese expressly waive any and all rights of appeal of any and all decisions of the Arbitrator, including decisions made on whether the individual is a member of the class, whether the claim is *bona fides*, and any damages which were suffered.

7. **PASTORAL OUTREACH AND PROTECTION OF CHILDREN BY THE DIOCESE.**

The parties understand and acknowledge that the Diocese has done or will do the following:

a. Comprehensive Policies. For the protection of children and the care of sexual abuse survivors, the Diocese has adopted a set of comprehensive policies called "The Policy of the Diocese of Charleston Concerning Allegations of Sexual Misconduct Or Abuse Of A Minor By Church Personnel" (the "Policies"). The Policies set forth the Diocese's unmitigated condemnation of child sexual abuse and its commitment to work to prevent sexual abuse, deal responsibly with accusations, and reach out with pastoral care for victims. The Policies are reviewed and updated every two years.

b. Reports Of All Accusations To Solicitor. Pursuant to the Policies, the Diocese reports all accusations of child sexual abuse it receives to the Solicitor of the county in which the

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accusation arises or, where applicable, to law enforcement authorities in other states, and cooperates fully with all criminal investigations and prosecutions.

c. Victim Assistance Minister. Pursuant to the Policies, the Diocese has established, among other things, a Victim Assistance Minister ("VAM"), who is available to all victims of child sexual abuse allegedly committed by an agent or employee of the Diocese. The VAM can be reached at 1-800-921-8122. The VAM coordinates the Diocese's pastoral response to those who come forward, and works with victims to facilitate the healing process. Where appropriate, the VAM also assists victims in obtaining and paying for psychotherapy, on a confidential basis.

d. Sexual Abuse Advisory Board. Pursuant to the Policies, the Diocese has established, among other things, a Sexual Abuse Advisory Board (the "Board"). Although the Bishop of the Diocese has the ultimate decision-making responsibility in cases presented to the Diocese, the Board has the responsibility to advise the Bishop in particular cases. The Board also assists the Bishop in the review of the Policies that occurs every two years, and makes recommendations to the Bishop concerning any proposed revisions to the Policies. The Board consists of at least five (5) members, of whom four (4) are independent lay people who are not priests or employees of the Diocese.

e. Presentation By Class Representatives or Members To The Sexual Abuse Advisory Board. The Diocese welcomes the suggestions of the Class Representatives (or members) regarding the provisions and implementation of the Policies. The Diocese therefore agrees to permit the Class Representatives to make a presentation to the Board in advance and/or as part of the next two regularly scheduled two year policy reviews so that the views of the Representatives can be heard and considered as the Diocese undertakes such review.

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8. **RELEASE.** When the Claimant submits his claim form, he or she shall execute the Release attached as Exhibit 1 and deliver that Release to Class Counsel. Class Counsel shall hold the Release in escrow until the award is delivered and payment is made, as provided herein. If payment is not made by Diocese pursuant to the Agreement, these copies are null and void and will be destroyed. The Diocese will provide a release to each Claimant as set out on Exhibit 2 through Class Counsel upon receipt of the Claim Form for the review under paragraphs 3(l), (m), and (n).

9. **DISMISSAL OF ACTIONS.** The actions pending against the Diocese shall be dismissed with prejudice pursuant to the terms and conditions set by the court in its order on class certification.

10. **MISCELLANEOUS PROVISIONS.** This Agreement, with attached Exhibits, constitutes the entire agreement between the Representatives, the Claimant, and the Diocese. To address omissions, inadvertent mistakes, or matters which arise after the execution of this Agreement, each Claimant agrees that this Agreement may be modified, amended or supplemented to effectuate the intent of the parties under such terms and conditions set by the court approving this Agreement. It is acknowledged that each party has participated in the drafting of this Agreement, and that any claimed ambiguity should not be construed for or against any Party. This Agreement shall be construed under and in accordance with the laws of the State of South Carolina. Any dispute concerning this Agreement which arises after this Agreement is approved by the court shall be resolved by the Arbitrator. The decision of the Arbitrator regarding any such dispute is final and binding. The terms and conditions of this Agreement shall be binding and inure to the benefit of each of the Parties, their counsel and respective successors, heirs and assigns. It is further understood and agreed by Claimant that this Agreement is not to be construed as an admission of liability upon the part of any of the released parties, but rather as a good faith settlement of disputed claims. The Claimant states and warrants that he or she is the sole owner of the claims involved, and that such

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claims have not been assigned, encumbered, or transferred. Where applicable herein, the masculine gender shall include the feminine gender and the feminine gender shall include the masculine gender.

Executed this 12th day of January, 2007.

FOR THE CLASSES:

Lawrence E. Richter, Jr.
CLASS COUNSEL

Witness

FOR THE DEFENDANTS:

+ Robert J. Baker

The Most Rev. Robert J. Baker
THE BISHOP OF CHARLESTON, IN HIS OFFICIAL CAPACITY AND FOR THE BISHOP OF CHARLESTON, A CORPORATION SOLE

Witness

EXHIBIT 1

CLAIMANT'S GENERAL RELEASE

_____ ("the Claimant") for and in consideration of the promises and undertakings contained in the Settlement and Arbitration Agreement, the sufficiency of which is hereby acknowledged, hereby remises, releases and forever discharges The Bishop of Charleston, a Corporation Sole, and The Bishop of the Diocese of Charleston, in his official capacity, ("the Diocese"); any present or former bishops, archbishops or cardinals of the Diocese, in both their individual and official capacity; any entities affiliated with the Diocese; and present or former priests, deacons, other clergy, brothers, nuns, agents, servants, officers, trustees, directors, supervisors, attorneys, employees, volunteers, insurers, predecessors, successors, assigns, subsidiaries and affiliates of the Diocese, including without limitation any such person accused of committing or negligently causing or permitting sexual abuse with respect to the Claimant or members of the Claimant's family (all of the foregoing hereinafter collectively referred to as the "Released Parties") of and from any and all debts, demands, actions, causes of action, suits, accounts, covenants, contracts, agreements, damages, judgments, executions, orders, and any and all claims, demands and liabilities whatsoever of every name and nature, whether in LAW, in EQUITY, or otherwise which the Claimant ever had, now has, or which Claimant or Claimant's successors hereinafter can, shall, or may have by reason of any matter, cause or thing whatsoever from the beginning of the world to the date of this Release, and whether such claims are now known or unknown, including without limiting the generality of the foregoing, any and all claims made or that might have been made in any pending claim or suit. With respect to any claims arising from or related to an act or acts of abuse which have formed the basis of a claim or suit against the Diocese

RJB

or persons or entities employed by or affiliated with the Diocese, the Released Parties covered by this Release shall also include any other persons or entities whether or not they are employed by or affiliated with the Diocese. This release does not apply to persons or entities who are not persons or entities employed by or affiliated with the Diocese with respect to any claims arising from or related to an act or acts of abuse that have not formed, or could not form, the basis of a claim or suit against the Diocese or persons or entities employed by or affiliated with the Diocese.

IN WITNESS WHEREOF, the Claimant has set his/her hand and seal to this Release as of the ____ day of _____, 200____.

_____ _____

Print Claimant's Name Claimant's Signature

_____ _____

Witness Witness

+ RJB

EXHIBIT 2

DIOCESE LIMITED RELEASE

The Roman Catholic Bishop of Charleston and the Bishop of Charleston in his official capacity, a Corporation Sole ("Diocese"), for and in consideration of the promises and undertakings contained in the Settlement and Arbitration Agreement, the sufficiency of which is hereby acknowledged, hereby forever remises, releases and forever discharges _____ ("the Claimant") and Claimant's heirs, attorneys (including their law firms, agents, servants, or employees), executors, predecessors, parents, successors, agents, servants, employees, and assigns of and from any and all debts, demands, actions, causes of action, suits, accounts, covenants, contracts, agreements, damages, judgments, executions, orders, and any and all claims, demands and liabilities which were or could have properly been raised in any form or fashion arising from the incidents alleged by Claimant in his claim submitted pursuant to the Order Approving Class Certification and Settlement Agreement (date to be inserted) in cases numbers 06-CP-18-1310 and 06-CP-18-1311, Claimant's participation in the class process set out in said Order, including any assertions of the Bishop arising from the validity or fraudulent nature of any claim, and/or any defense or claim which was or may have been raised by the Bishop in defense to the Claim or any suit which was or could have been filed against the Bishop but for the Claimant's participation in the claims process set out in the Order referenced herein, whether such claims are now known or unknown. It is the intention of the parties that the Diocese is fully and finally releasing the Claimant from any liability asserted by it against him or her arising from the Claimants assertion of sexual abuse.

IN WITNESS WHEREOF, the Bishop of Charleston has set his hand and seal to this Release

+RJB 20

as of the date written below.

_____

The Bishop of Charleston, a Corporation Sole

By: _____

Its: _____

Date: _____ Witnessed by: _____

+ RJB

21

STATE OF SOUTH CAROLINA)
)
COUNTY OF DORCHESTER)

IN THE COURT OF COMMON PLEAS
FOR THE FIRST JUDICIAL CIRCUIT

CASE No. 06-CP-18-1310
CASE No. 06-CP-18-1311
CASE No. 06-CP-18-1636

John Doe #53, John Doe 66, John Doe 66A, John Doe 67, Jane Doe 1 and Jane Doe 2 and Rachel Roe individually and as representatives of a class of people similarly situated,

v.

The Bishop of Charleston, a Corporation Sole, and The Bishop of the Diocese of Charleston, in his official capacity,

Defendants.

ORDER OF THE COURT

The Court having been advised, as evidenced by the writing attached hereto as Exhibit A, that all pending motions, objections, rules to show cause, and any such related matters amongst the parties in this class action proceeding have been resolved with prejudice, and that all appeal rights of all "objectors" are waived, said agreement is hereby approved and made the Order of this Court.

AND to this extent PP acknowledged and PP

AND IT IS SO ORDERED!

Further, it is ordered that, as to any settlement funds in this matter, any restriction or impediment to the disbursement of any such funds heretofore imposed by this Court are lifted, removed, and extinguished. This class settlement shall immediately proceed as provided for in the Settlement and Arbitration Agreement entered into on January 15, 2007 and that certain Order of this Court in this matter dated July 30, 2007.

AND IT IS SO ORDERED!

PP 1 of 3

Furthermore, in the Court's Order of July 30, 2007 approving the Class settlement, the Court made reference to the existence of individuals who, according to the Diocese, (1) were potential class members; (2) came forward to the Diocese at some time in the past with their allegations of child sexual abuse; (3) never resolved their potential claims; and (4) were entitled to receive *actual notice* of the proposed class settlement pursuant to the agreement of the parties and earlier instructions from this Court (hereinafter referred to as "Actual Notice Class Members"). The Defendants have asked the Court to clarify how the settlement process will treat the Actual Notice Class Members. Accordingly, this Order clarifies and, where in conflict, supersedes the Court's Order of July 30, 2007.

Actual Notice Class Members shall have 120 days from receipt of actual notice of the class settlement to present their claims to an Arbitrator in the same manner as provided for in the Settlement and Arbitration Agreement. Actual Notice Class Members who present their claims more than 120 days after they receive actual notice of the settlement shall be barred from participation in the settlement process and shall be treated like any other class member who has failed to timely present a claim to the class settlement fund. Both the Arbitrator's fees and the claimant's recovery (if any) shall be paid by the Diocese, and not by the class settlement fund, because the settlement fund may already have been subject to a final accounting by the time such claims are processed.

AND IT IS SO ORDERED!

Furthermore, the Court has appointed Desa Ballard, Esq. as a non-testifying consultant in evaluating and addressing the issues before the Court in this matter, as all counsel was made aware of in a August 29, 2007 Order. Payment for Ms. Ballard's services shall be made from the

2 9/2/2013

Class settlement fund within ten (10) days after the settlement funds are released from the Court's supervision.

Diane S. Goodstein
Presiding Judge

This 31 day of August 2007
Florence, South Carolina

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	IN THE COURT OF COMMON PLEAS
John Doe, Plaintiff, v. Bishop of Charleston, a Corporation Sole and The Bishop of the diocese of Charleston, in his official capacity, Defendants.	Civil Action No.: 2018-CP- 10-03929 **MOTION TO QUASH DEPOSITION SUBPOENA BY NON-PARTY ELIZABETH HARTNETT DIAMOND**

Now comes Non-party Elizabeth Harnett Diamond ("Ms. Diamond"), by and through counsel, pursuant to Rule 45(c) SCRCP, and hereby files this Motion to Quash (the "Motion") and requests that this Court quash the subpoena for her deposition, which is scheduled for Monday November 18, 2019 at 1:30 pm. In support of this Motion, Ms. Diamond presents the following.

1. On November 4, 2019, Plaintiff issued a subpoena and noticed the deposition of Ms. Diamond. Exhibit A.

2. Ms. Diamond is not a party to the lawsuit and had no involvement with the allegations of sexual abuse raised against her deceased brother in the lawsuit.

3. On November 14, 2019, Ms. Diamond received a medical note from her treating physician's office, stating that she suffers from atrial fibrillation and requesting that she not be involved in "any legal situations until her atrial fibrillation is under control." Exhibit B.

4. On the afternoon of November 14, 2019, Ms. Diamond's counsel contacted Plaintiff's counsel to inform him that Ms. Diamond is unable to attend her deposition for the aforementioned medical reasons.

5. Ms. Diamond's counsel requested that Plaintiff's counsel withdraw the subpoena and consider not deposing the witness at all because of her medical condition and because she has no information remotely relevant to the lawsuit.

6. Ms. Diamond's counsel immediately provided a copy of the letter from her treating physician's office.

7. On November 15, 2019, the Parties exchanged email communications regarding the deposition. Ms. Diamond's counsel again requested that the deposition be canceled and suggested that Plaintiff's counsel conduct the deposition upon written questions, pursuant to Rule 31 SCRCP, as an alternative.

8. Plaintiff's counsel ultimately refused to cancel the deposition and now threatens to conduct extensive discovery on Ms. Diamond's medical condition (requesting medical records and depositions of her treating physicians) if she does not present for her deposition, as scheduled.

9. Plaintiff's counsel has never articulated a reason why this deposition is time-sensitive or must be conducted next week.

10. Simply stated, Ms. Diamond is not medically fit for a deposition, and to force her to attend a deposition in her current medical state would impose an unreasonable and unfair burden on a third-party witness.

11. Counsel for Ms. Diamond hereby certifies that he conferred with Plaintiff's counsel in a good faith effort to avoid the filing of this Motion.

For the above-stated reasons and pursuant to Rule 45(c) SCRCP, Ms. Diamond hereby moves to quash the subpoena and for the issuance of a protective order providing protection from any future attempts to compel her deposition until such time that her treating physician provides medical clearance.

Furthermore, Ms. Diamond seeks an order requiring Plaintiff to reimburse her for the time and expense incurred with the filing of this Motion.

Respectfully submitted,

s/Robert E. Sumner, IV

Robert E. Sumner, IV (SC Bar #71728)
Butler Snow, LLP
25 Calhoun Street, Suite 250
Charleston, SC 29401
Telephone: 843/277-3700
Email: robert.sumner@butlersnow.com

Counsel for Non-party
Elizabeth Hartnett Diamond

November 15, 2019
Charleston, SC

EXHIBIT A

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON John Doe, Plaintiff, vs. Bishop of Charleston, a Corporation Sole and The Bishop of the Diocese of Charleston, in his official capacity, Defendants.	IN THE COURT OF COMMON PLEAS FOR THE NINTH JUDICIAL CIRCUIT CA No. 2018-CP-10-3929 **NOTICE OF DEPOSITION OF ELIZABETH HARTNETT DIAMOND**

TO: Elizabeth Hartnett Diamond

PLEASE TAKE NOTICE that the attorneys for Plaintiff will take the oral testimony by deposition of the below named individual at the time and date listed below. Said deposition will be taken before a qualified notary public in the offices of **The Richter Firm, LLC, 622 Johnnie Dodds Blvd., Mt. Pleasant, SC 29464.** This deposition is to be taken pursuant to Rule 30 of the South Carolina Rules of Civil Procedure.

Said deposition is being taken for pre-trial discovery, for use at trial and for such other purposes as may be permitted by law. The deposition will continue from day to day until completed.

Elizabeth Hartnett Diamond
November 18, 2019 at 1:30 pm

Signature block to follow on next page

THE RICHTER FIRM, LLC

By: Lawrence E. Richter, Jr.
622 Johnnie Dodds Blvd.
Mt. Pleasant, SC 29464
(843) 849-6000

ATTORNEYS FOR PLAINTIFF

Nov. 4, 2019
Mt. Pleasant, South Carolina

STATE OF SOUTH CAROLINA

ISSUED BY THE COMMON PLEAS COURT IN THE COUNTY OF CHARLESTON

John Doe, Plaintiff

v.

SUBPOENA IN A CIVIL CASE

Bishop of Charleston, et al., Defendants

Case Number: 2018-CP-10-03929

Pending in Charleston County

TO: Elizabeth Hartnett Diamond
[redacted]
Charleston, SC [redacted]

☐ YOU ARE COMMANDED to appear in the above named court at the place, and time specified below to testify in the above case.

PLACE OF TESTIMONY	COURTROOM
	DATE AND TIME , AM

☒ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify at the taking of a deposition in the above case.

PLACE OF DEPOSITION	DATE AND TIME
The Richter Firm, LLC 622 Johnnie Dodds Blvd. Mt. Pleasant, SC 29464	November 18, 2019, 1:30PM

☐ YOU ARE COMMANDED to produce and permit inspection and copying of the following documents or objects in your possession, custody or control at the place, date and time specified below (list documents of objects:

PLACE	DATE AND TIME

☐ YOU ARE COMMANDED to permit inspection of the following premises at the date and time specified below.

PREMISES	DATE AND TIME
	, AM

ANY SUBPOENAED ORGANIZATION NOT A PARTY TO THIS IS HEREBY DIRECTED TO RULE 30(b)(6), SOUTH CAROLINA RULES OF CIVIL PROCEDURE, TO FILE A DESIGNATION WITH THE COURT SPECIFYING ONE OR MORE OFFICERS, DIRECTORS, OR MANAGING AGENTS, OR OTHER PERSONS WHO CONSENT TO TESTIFY ON ITS BEHALF, SHALL SET FORTH, FOR EACH PERSON DESIGNATED, THE MATTERS ON WHICH HE WILL TESTIFY OR PRODUCE DOCUMENTS OR THINGS. THE PERSON SO DESIGNATED TESTIFY AS TO MATTERS KNOWN OR REASONABLY AVAILABLE TO THE ORGANIZATION

I CERTIFY THAT THE SUBPOENA IS ISSUED IN COMPLIANCE WITH RULE 45(c)(1), AND THAT NOTICE AS REQUIRED BY RULE 45(b)(1) HAS BEEN GIVEN TO ALL PARTIES.

Lawrence E. Richter, Jr. • 11/4/19 Lawrence E. Richter, Jr.

Attorney/Issuing Officer's Signature — Date — Print Name

Indicate if Attorney for Plaintiff or Defendant

Attorney's Address and Telephone Number :

The Richter Firm, LLC, 622 Johnnie Dodds Blvd., Mt. Pleasant, SC 29464

843-849-6000

Clerk of Court/Issuing Officer's Signature — Date — Print Name

Pro Se Litigant's Name, Address and Telephone Number :

SCCA 254 (05/2015)

(See Rule 45, South Carolina Rules of Civil Procedure, Parts (c) & (d) on pages 2 and 3)

PROOF OF SERVICE

SERVED	DATE	FEES AND MILEAGE TO BE TENDERED TO WITNESS UPON DAILY ARRIVAL
	PLACE	☐YES ☐ NO AMOUNT $
SERVED ON		MANNER OF SERVICE
SERVED BY		TITLE

DECLARATION OF SERVER

I certify that the foregoing information contained in the Proof of Service is true and correct.

Executed on

SIGNATURE OF SERVER

ADDRESS OF SERVER

Rule 45, South Carolina Rules of Civil Procedures, Parts (c) and (d):

(c) Protection of Persons Subject to Subpoenas.

(1) A party or an attorney responsible for the issuance and service of a subpoena shall take reasonable steps to avoid imposing undue burden or expense on a person subject to that subpoena. The court on behalf of which the subpoena was issued shall enforce this duty and impose upon the party or attorney in breach of this duty an appropriate sanction, which may include, but is not limited to, lost earnings and a reasonable attorney's fee.

(2)(A) A person commanded to produce and permit inspection and copying of designated electronically stored information, books, papers, documents or tangible things, or inspection of premises need not appear in person at the place of production or inspection unless commanded to appear for deposition, hearing or trial. A party or an attorney responsible for the issuance and service of a subpoena for production of books, papers and documents without a deposition shall provide to another party copies of documents so produced upon written request. The party requesting copies shall pay the reasonable costs of reproduction.

(B) Subject to paragraph (d)(2) of this rule, a person commanded to produce and permit inspection and copying may, within 14 days after service of the subpoena or before the time specified for compliance if such time is less than 14 days after service, serve upon the party or attorney designated in the subpoena written objection to inspection or copying of any or all of the designated materials or of the premises—or to producing electronically stored information in the form or forms requested. If objection is made, the party serving the subpoena shall not be entitled to inspect and copy the materials or inspect the premises except pursuant to an order of the court by which the subpoena was issued. If objection has been made, the party serving the subpoena may, upon notice to the person commanded to produce, move at any time in the court that issued the subpoena for an order to compel the production. Such an order to compel production shall protect any person who is not a party or an officer of a party from significant expense resulting from the inspection and copying commanded.

(3)(A) On timely motion, the court by which a subpoena was issued, or regarding a subpoena commanding appearance at a deposition, or production or inspection directed to a non-party, the court in the county where the non-party resides, is employed or regularly transacts business in person, shall quash or modify the subpoena if it:

(i) fails to allow reasonable time for compliance; or

(ii) requires a person who is not a party nor an officer, director or managing agent of a party, nor a general partner of a partnership that is a party, to travel more than 50 miles from the county where that person resides, is employed or regularly transacts business in person, except that, subject to the provisions of clause (c)(3)(B)(iii) of this rule, such a person may in order to attend trial be commanded to travel from any such place within the state in which the trial is held; or

(iii) requires disclosure of privileged or otherwise protected matter and no exception or waiver applies; or

(iv) subjects a person to undue burden.

(B) If a subpoena:

(i) requires disclosure of a trade secret or other confidential research, development, or commercial information, or

(ii) requires disclosure of an unretained expert's opinion or information not describing specific events or occurrences in dispute and resulting from the expert's study made not at the request of any party, or

(See Rule 45, South Carolina Rules of Civil Procedure, Parts (c) & (d) on pages 2 and 3)

(III) requires a person who is not a party nor an officer, director or managing agent of a party, nor a general partner of a partnership that is a party, to incur substantial expense to travel from the county where that person resides, is employed or regularly transacts business in person, the court may, to protect a person subject to or affected by the subpoena, quash or modify the subpoena or, if the party in whose behalf the subpoena is issued shows a substantial need for the testimony or material that cannot be otherwise met without undue hardship and assures that the person to whom the subpoena is addressed will be reasonably compensated, the court may order appearance or production only upon specified conditions.

(d) Duties in Responding to Subpoena.

(1)(A)A person responding to a subpoena to produce documents shall produce them as they are kept in the usual course of business or shall organize and label them to correspond with the categories in the demand.

(B) If a subpoena does not specify the form or forms for producing electronically stored information, a person responding to a subpoena must produce the information in a form or forms in which it is ordinarily maintained or in a reasonably usable form or forms.

(C) A person responding to a subpoena need not produce the same electronically stored information in more than one form.

(D) A person responding to a subpoena need not provide discovery of electronically stored information from sources that the person identifies as not reasonably accessible because of undue burden or cost. On motion to compel discovery or to quash, the person from whom discovery is sought must show that the information sought is not reasonably accessible because of undue burden or cost. If that showing is made, the court may nonetheless order discovery from such sources if the requesting party shows good cause, considering the limitations of Rule 26(b)(6)(B). The court may specify conditions for the discovery.

(2)(A) When information subject to a subpoena is withheld on a claim that it is privileged or subject to protection as trial preparation materials, the claim shall be made expressly and shall be supported by a description of the nature of the documents, communications, or things not produced that is sufficient to enable the demanding party to contest the claim.

(B) If information produced in response to a subpoena is subject to a claim of privilege or of protection as trial preparation material, the person making the claim may notify any party that received the information of the claim and the basis for it. After being notified, a party must promptly return, sequester, or destroy the specified information and any copies it has and may not use or disclose the information until the claim is resolved. A receiving party may promptly present the information to the court under seal for a determination of the claim. If the receiving party disclosed the information before being notified, the receiving party must take reasonable steps to retrieve the information. The person who produced the information must preserve the information until the claim is resolved.

EXHIBIT B

Carolina Arrhythmia Consultants, P.A.

Brett Baker, MD, FACC
Bryan H. Frain, MD, FACC

Board Certified
Cardiac Electrophysiology
Cardiology

Date: 11/14/2019

Re: Ms. Elizabeth Diamond

Ms. Diamond is currently dealing with atrial fibrillation which we are trying to control. We would ask that she not involved in any legal situations until her atrial fibrillation is under control.

Thank you,

Olivia Covert NP-C

Comprehensive Arrhythmia Management
Tides Medical Arts Center • 180 Wingo Way • Suite 204 • Mt. Pleasant, South Carolina 29464
Telephone 843-534-1770 • Facsimile 843-534-1767

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF CHARLESTON	)	Civil Action No.: 2018-CP-10-3929

John Doe,

Plaintiff,

vs.

Bishop of Charleston, a Corporation Sole, and The Bishop of the Diocese of Charleston, in his official capacity,

Defendants.

NOTICE OF FILING SUPPLEMENTAL / REPLY AFFIDAVITS IN SUPPORT THE DIOCESE'S MOTIONS FOR SUMMARY JUDGMENT

Pursuant to Rule 6(d), Defendants Bishop of Charleston, a Corporation Sole, and the incorrectly named party "the Bishop of the Diocese of Charleston, in his official capacity," (hereinafter collectively "the Diocese") submit the attached supplemental or reply affidavits in support of the Motions for Summary Judgment regarding Plaintiff's Amended Complaint and causes of action.

1. Affidavit of Dr. Elizabeth Loftus
2. Affidavit of Dr. James Hudson
3. Affidavit of Dr. Janine Shelby
4. Affidavit of Dr. Monica Applewhite

TURNER, PADGET, GRAHAM & LANEY, P.A.

s/Richard S. Dukes, Jr.
Richard S. Dukes, Jr. (SC Bar No.: 16563)
40 Calhoun Street, Suite 200 (29401)
Post Office Box 22129
Charleston, South Carolina 29413-2129
Telephone: 843-576-2810
Facsimile: 843-577-1646
Email: rdukes@turnerpadget.com

Alan G. Jones, (SC Bar No.: 100141)
200 E. Broad Street, Suite 250
Post Office Box 1509
Greenville, South Carolina 29602
Telephone: 864-552-4626
Facsimile: 864-282-5989
Email: agjones@turnerpadget.com

December 10, 2019

ATTORNEYS FOR DEFENDANTS

STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

IN THE COURT OF COMMON PLEAS

CIVIL ACTION NO.: 2018-CP-10-03929

John Doe,

Plaintiff,

v.

The Diocese of Charleston, a Corporation Sole, and the Bishop of the Diocese of Charleston, in his official capacity,

Defendants.

AFFIDAVIT OF DR. ELIZABETH LOFTUS

Personally appeared before me, Dr. Elizabeth Loftus, who swears and deposes as follows:

1. The undersigned is over the age of 21, and has personal knowledge regarding the matters herein.

2. I have reviewed materials in this action in order to assess the memory aspects of John Doe ("Plaintiff") related to this case. These include depositions, affidavits, and other legal documents. I was asked to review these materials and also to offer opinions regarding the relevance of scientific research in the area of human memory.

Professional Qualifications

3. My opinions are based on my extensive experience in academic psychology, in both teaching and research. I hold the position of Distinguished Professor at the University of California, Irvine. My Ph.D. is in Psychology from Stanford. I am an author of more than 600 published papers, the majority of which concern the topic of human memory. I have published more than 20 books, at least five of which deal almost exclusively with the subject of memory, including a college textbook called *Human Memory*. I have received seven honorary doctorates for my research on

memory. I was elected to the National Academy of Sciences, in recognition of my long-standing research program on human memory. I have held tenured academic positions at major universities and in that capacity I have taught courses in human cognition and memory at the university level for more than 40 years. As a result of my research and work in this area, I have been asked to consult with and present to law enforcement, including the FBI and CIA. The attached *curriculum vitae* provides a summary of my experience and qualifications in psychology more generally, and human memory in particular.

Brief Overview of Human Memory Research

4. The experimental study of human memory dates back more than a century to the groundbreaking work of Hermann Ebbinghaus (1913), who showed how memory fades and weakens over time. This fading has been called one of the "seven sins of memory" by Harvard psychologist Daniel Schacter (2001). Over the last century there have been thousands of studies of human memory published in peer reviewed journals and summarized in many books (including the comprehensive summary by Brainerd and Reyna (2005)).

5. The scientists have shown that memory does not work like a video recording device. We do not simply record events and play them back later. The process is much more complex. In fact, retrieving a memory involves a constructive or reconstructive process. That is, retrieving memory is accomplished by combing traces from an original experience with other bits and pieces of information that are acquired from other sources, after that original experience is over (See Loftus, 2005).

6. The scientists have shown that memory does not work like a video recording device. We do not simply record events and play them back later. The process is much more complex. In fact, retrieving a memory involves a constructive or reconstructive process. That is, retrieving

memory is accomplished by combing traces from an original experience with other bits and pieces of information that are acquired from other sources, after that original experience is over (See Loftus, 2005).

7. It is virtually impossible to tell the difference between a true memory and false one without independent corroboration. Moreover even people who have extraordinarily good memories are susceptible to memory distortion from suggestion (Patihis et al., 2015). This is not a matter of deliberate lying on the part of the reporting person; but is what can occur when people have been led to truly believe that something occurred to them that is false. The experimental work is supplemented by many real-life cases in which false memories have been planted in the minds of ordinary people through the process of suggestion (e.g. Loftus & Ketcham, 1994; Pendergrast, 1999). False memories have led to extraordinary trauma for many innocent people. For example, Cardinal Bernadin was falsely accused of abuse, and when he wrote his memoire before he died, he said that his cancer and the false accusation were the worst things that had happened to him in life.

Analysis

8. There are a number of relevant facts in the current case that make this information particularly pertinent. It is my understanding that Plaintiff claimed in approximately 2016 that he was sexually abused by two teachers at Sacred Heart Catholic School decades earlier when he was approximately age 12-14 He claimed many instances of abuse, including oral and anal sex. He claims these memories were repressed for more than four decades. The concept of repression is deeply controversial (as I explain below). So a question arises as to whether the memory reports that emerged decades later were a product of some other process than actual memory recovery, such as suggestive influences in the life of the plaintiff.

9. Plaintiff appears to be claiming that he repressed his memories of abuse before approximately 2016, and stated so explicitly in his numerous places, including his amended complaint. He told a therapist (Whalen) that the memories were repressed until he experienced depression after heart bypass surgery. Given the evidence that he is claiming he has recovered repressed memories, it is important to understand more fully what is known about that subject of repressed memory. Briefly, the idea that one can repress horrible brutalization into the unconscious and reliably recover the experiences later has received virtually no credible scientific support. The notion is best described as folklore that continues to be advanced by some mental health professionals who uncritically accept abuse reports, no matter how dubious, and claims of repression, no matter the lack of scientific support.

10. Although "repressed" and "recovered" memories are frequently depicted in popular novels, television series, and Hollywood movies, there is no general acceptance in the scientific community that this phenomenon can actually happen. Twenty five years ago, Dr. David Holmes, Professor at the University of Kansas, reviewed sixty years of efforts to find support for repression and concluded that there was no credible scientific support (Holmes, 1990).

11. The picture has not changed in the ensuing years. Richard McNally, previously mentioned, is a Harvard University clinical psychologist and tenured faculty member. He put it this way in his meticulously researched and widely cited book "Remembering Trauma," published by Harvard University Press (2003, p. 2):

> i. Until the mid-1990's debates about trauma and memory were hampered by vitriolic accusations issuing from both sides and by the scarcity of clinically relevant scientific data. During the last few years, matters have improved

dramatically. An outpouring of research has clarified many of the most contentious issues…

ii. The evidence points to three conclusions. First, people remember horrific experiences all too well. Victims are seldom incapable of remembering their trauma. Second, people sometimes do not think about disturbing events for long periods of time, only to be reminded of them later. However, events that are experienced as overwhelmingly traumatic at the time of their occurrence rarely slip from awareness. Third, there is no reason to postulate a special mechanism of repression or dissociation to explain why people may not think about disturbing events for long periods. A failure to think about something does not entail an inability to remember it (amnesia.)

12. Some mental health professionals claim that there is a good deal of evidence for this kind of amnesia. They cite highly controversial and questionable references for their beliefs. Yet many psychiatrists, psychologists, and memory researchers vehemently disagree that these studies prove that repression exists. These studies have been analyzed carefully and the conclusion has been reached, by me and others, that it is misleading to use them as proof of amnesia.

13. Dr. McNally points out common flaws inherent in those studies which are frequently used to support the concept of repressed memory, such as:

- asking subjects whether there was ever a time – duration often unspecified – when they were *unable* to remember their traumatic experience;
- misinterpreting not thinking about a trauma for a long time as being unable to remember it;

- failing to appreciate that most people have gaps in their memory for childhood and that efforts to remember result in the illusion of heightened amnesia for childhood;

- failing to realize that some molested children do not understand their experience as sexual abuse when it occurs, but later reconceptualize it as such;

- failing to verify that the trauma actually happened or merely relying on subjects' claims that corroboration is available;

- failing to distinguish between failure to report traumatic experiences and inability to remember them;

- failing to conduct follow-up interviews to determine why subjects did not mention traumatic experiences known to have occurred;

(McNally, Remembering Trauma, p. 227).

14. Most compellingly, McNally concludes: "The notion that the mind protects itself by repressing or dissociating memories of trauma, rendering them inaccessible to awareness, is a piece of psychiatric folklore devoid of convincing empirical support." (McNally, 2003, p. 275). The evidence points to the opposite conclusion - most people who have suffered horrible traumas have the problem that they cannot forget and the memories keep intruding. Given the minimal evidence for this kind of repression of memory, and the ample evidence for the power of suggestion to create false memories, the latter explanation for this dispute deserves serious consideration.

15. I am prepared to testify at trial about the workings of human memory, the effects of suggestion on memory, the mechanism of creation of false memories, and the characteristics of false memories. Moreover, I would identify some of the suggestive activities that may have occurred in the current case. These suggestive activities can explain how it is that a person might go from having no memory, or very minimal memory of sexual abuse, and even denying memory of abuse, to later having elaborate memories for sexual abuse, if the memories are false.

16. I am prepared to testify at trial about the workings of human memory, the effects of suggestion on memory, the mechanism of creation of false memories, and the characteristics of false memories. Moreover, I would identify some of the suggestive activities that may have occurred in the current case. These suggestive activities can explain how it is that a person might go from having no memory, or very minimal memory of sexual abuse, and even denying memory of abuse, to later having elaborate memories for sexual abuse, if the memories are false.

17. Each of my opinions is stated to a reasonable degree of scientific certainty. I reserve the right to supplement this opinion if and when further discovery becomes available.

FURTHER AFFIANT SAYETH NOT.

Elizabeth Loftus

Dr. Elizabeth Loftus

Sworn to and subscribed before me this
the _____ day of November, 2019.

_____
Notary Public for State of California

My commission expires:_____

_____, 2019

CALIFORNIA ALL-PURPOSE ACKNOWLEDGMENT **CIVIL CODE § 1189**

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)
County of Orange)

On October 30, 2019 before me, Isaiah Lopez, Notary Public,
Date *Here Insert Name and Title of the Officer*

personally appeared Dr. Elizabeth Cotter
Name(s) of Signer(s)

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

ISAIAH LOPEZ
COMM. # 2265618
NOTARY PUBLIC - CALIFORNIA
ORANGE COUNTY
My Comm. Expires Nov. 9, 2022

Signature _____
Signature of Notary Public

Place Notary Seal Above

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☐ Trustee ☐ Guardian or Conservator
☐ Other: _____
Signer Is Representing: _____

STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

IN THE COURT OF COMMON PLEAS

CIVIL ACTION NO.: 2018-CP-10-03929

John Doe,

Plaintiff,

v.

The Diocese of Charleston, a Corporation Sole, and the Bishop of the Diocese of Charleston, in his official capacity,

Defendants.

AFFIDAVIT OF DR. JAMES HUDSON

Personally appeared before me, Dr. James Hudson, who swears and deposes as follows:

1. The undersigned is over the age of 21, and has personal knowledge regarding the matters herein.

2. Attached to this affidavit is a prepared report and exhibit, ***Exhibit A***.

3. If I were to testify from the witness stand regarding my qualifications as an expert witness, my opinions in this case, and the bases for those opinions, that testimony would be substantially the same as ***Exhibit A***.

4. I incorporate by reference ***Exhibit A*** as if restated fully in this affidavit.

SIGNATURE ON FOLLOWING PAGE

FURTHER AFFIANT SAYETH NOT.

Dr. James Hudson

Sworn to and subscribed before me this
the 29 day of November, 2019.

Notary Public for State of Massachusetts

My commission expires: May 02, 2025

November 29, 2019

KELLY A. LABOY
Notary Public, Commonwealth of Massachusetts
My Commission Expires May 2, 2025

STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

IN THE COURT OF COMMON PLEAS

CIVIL ACTION NO.: 2018-CP-10-03929

John Doe,

Plaintiff,

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The Diocese of Charleston, a Corporation Sole, and the Bishop of the Diocese of Charleston, in his official capacity,

Defendants.

CERTIFICATE OF SERVICE

I hereby certify that this _____ day of December, 2019, a copy of _____

_____ has been served upon other counsel of record by placing same in the United States Mail, postage prepaid, to:

Lawrence E. Richter, Jr.
Jennifer S. Ivey
The Richter Firm, LLC
622 Johnnie Dodds Blvd.
Mt. Pleasant, SC 29464

Attorneys for Plaintiff

_____

Kari A. Jones

Re: John Doe v. The Bishop of Charleston, et al.

EXPERT REPORT
James I. Hudson, M.D., Sc.D.
October 16, 2019

I. Qualifications

My name is James I. Hudson, M.D., Sc.D. I am a Professor of Psychiatry at Harvard Medical School and Director of the Biological Psychiatry Laboratory at McLean Hospital in Belmont, MA, which is Harvard's principal psychiatric teaching hospital. I am the author of more than 400 peer-reviewed scientific communications, including articles, chapters, reviews, proceedings of meetings, and books on many areas of psychiatry. In particular, I have researched and published widely on the diagnosis and treatment of mood disorders, anxiety disorders, substance abuse, and eating disorders; the effects of sexual abuse; the "repressed memory" controversy; methodological considerations in the design and interpretation of studies; and many other topics. In addition, I have taught these topics to numerous students at the pre-doctoral, medical-school, and post-doctoral levels at Harvard Medical School. I also have more than 35 years of clinical experience in treating or consulting on more than 2,000 patients with a wide range of psychiatric disorders, including hundreds of individuals who have reported that they have experienced sexual abuse, and individuals reporting other traumatic experiences. The attached curriculum vitae provides a more detailed summary of my professional experience and qualifications.

Over the last 30 years, I have been retained by attorneys around the United States to provide expert opinion in over 50 cases, including many cases involving the "repressed memory" controversy. In the course of my work on these cases, I have provided expert testimony at numerous hearings or trials in state and federal courts. These cases have involved civil and criminal proceedings, and I have been retained by attorneys representing both plaintiffs and defendants.

II. Scope of Report and Materials Reviewed

I was asked to consider the question of whether the plaintiff, Mr. John Doe, "repressed" and subsequently "recovered" the memories of the alleged sexual abuse by two teachers in the fall of 1970. I reviewed the following documents provided by the law firm of Turner, Padget, Graham & Laney: complaint; answer to complaint; plaintiff's responses to first interrogatories; medical records from Dorothy Whalen, LICSW; and four deposition transcripts (John Doe; Mrs. John Doe; Dorothy Whalen; and Jason Flassing).

III. Did Mr. Doe Have "Repressed Memories" with Subsequent "Recovered Memories"?

Mr. Doe has alleged that he was sexually abused by two teachers, Hal Brooks and Chris Hartnett, employed by Sacred Heart School in Charleston, SC, in the fall of 1970 (at the age of 13) [complaint, ¶12; response to interrogatories, p. 11; Mr. John Doe deposition, pp. 113-117]. A summary of the specifics of the allegations is as follows:

> "Plaintiff [Mr. Doe] was taken on a field trip by Mr. Hartnett where he was supposed to be going to a museum in Columbia. Instead Mr. Hartnett took him to a house party in Columbia where Mr. Brooks was also present. Plaintiff was given alcohol and marijuana and was forced into both oral and anal sex by both perpetrators. At some point Mr. Harnett and Mr. Brooks took the Plaintiff to a bar outside Columbia where they left him. Plaintiff then had to hitchhike back home to Charleston. To the best of his recollection, he was about 13 years old at the time.
>
> "Defendant Mr. Hartnett abused him inside a classroom at Sacred Heart School and behind the stage at the school hall. Mr. Hartnett also inappropriately touched him between the school and rectory buildings at Sacred Heart." [Response to interrogatories, p. 11]

At some time point after these alleged incidents of sexual abuse had occurred, Mr. Doe claims that he then developed loss of memory for all of the incidents [Whalen deposition, p. 16], and alleges that "his memory was repressed" [complaint, ¶16]. He claims that this putative loss of memory for the incidents lasted for years until later in adulthood, until at some point he became able to "recover" these previously inaccessible memories. The time of this adult "recovery" of the memories is somewhat unclear from the materials available to me, but it appears that it was not later than 2016 [John Doe deposition, pp. 121-123; Whalen deposition pp. 16-17; response to interrogatories, p. 16]. In short, on the basis the materials available to me at this time, it appears that Mr. Doe is claiming to have experienced "repressed memory" and subsequent "recovery of memory" after an intervening period of many years of amnesia. However, it would appear from the records reviewed that no qualified health practitioner has ever made a diagnosis of "repressed memory" in Mr. Doe's case.

The term "repressed memory," as used in forensic settings throughout the United States, refers to the notion that an individual could become literally *unable* to remember a traumatic event, as opposed to merely developing ordinary forgetfulness for the event. In cases of ordinary forgetfulness, an individual would still be able to remember the event if reminded about it or asked about it. By contrast, the hypothesis of "repressed memory" proposes that an individual could somehow expel the memory of a traumatic event from consciousness, such that he or she could not remember the event even if directly asked about it. However, the hypothesis of "repressed memory" allows that at some point, perhaps years later, the individual could somehow "recover" this previously inaccessible memory.

Note that the notion of "repressed memory" should also be distinguished from various other forms of amnesia, such as infantile amnesia, amnesia due to head injury or intoxication, and so-called "global amnesia" – a rare phenomenon in which an individual develops amnesia for an entire block of autobiographical information (e.g., the individual's name, address, occupation, etc.), as opposed to developing amnesia only for a traumatic event.

In the present case, it appears that Mr. Doe is claiming to have "repressed memory" for traumatic events that would seem normally unforgettable (e.g., anal sex). Mr. Doe is clearly not claiming simply ordinary forgetfulness. There is also no evidence that Mr. Doe's alleged amnesia is attributable to other factors, such as infantile amnesia, head injury, intoxication, or other biological factors.

Having introduced the above terminology, I have several opinions, all to a reasonable degree of scientific and medical certainty, regarding the theory of "repressed memory." The basis for these opinions is spelled out in detail in Appendix A of this report, where I provide a detailed critique of the concept of "repressed memory" entitled, "Analysis of the Scientific Validity and Acceptance of 'Repressed Memory' Theory." I summarize these opinions briefly here:

1) Traumatic experiences are strongly memorable. As most people know from personal experience, terrifying or painful experiences are vividly remembered long after they have happened. This impression is supported by numerous scientific studies where individuals who were known to have experienced a traumatic event were evaluated for psychological symptoms that they displayed after the event had occurred. In Appendix A, I have summarized 77 such studies, evaluating more than 10,000 victims of various traumas. None of the studies reported a case of any individual who was neurologically intact and beyond the age of early childhood who was unable to remember the traumatic event that he or she had experienced.

2) Nevertheless, some have claimed that it is possible for certain people to "repress" the memory of a traumatic event – that is, to become *unable* to remember the event because the memory is somehow excluded from consciousness. This theory is often termed the theory of "repressed memory."

3) However, the theory of "repressed memory" (sometimes also called "systematized dissociative amnesia") is not generally accepted in the relevant scientific community. Indeed, the annual number of peer-reviewed scientific articles published worldwide on the theory of "repressed memory" has fallen almost to zero in the last ten years. Specifically, as shown in Appendix A, the leading medical search engine, PubMed, yielded a total of only 73 articles written in the entire world scientific literature in the last nine years that were identified by the search term "dissociative amnesia" (which is the term now used to cover "repressed memory" and several other forms of amnesia). By contrast, when one enters other psychiatric diagnoses for comparison, one finds that PubMed identified 3,072 articles for panic disorder; 4,867 articles for anorexia nervosa; 6,590 articles for obsessive compulsive disorder; 13,049 articles for attention-deficit/hyperactivity disorder; and 18,263 articles for bipolar disorder. As can be

seen, the rate of publication on "dissociative amnesia/repressed memory" is tiny in comparison to that for other psychiatric disorders. Moreover, within the 73 articles on "dissociative amnesia," the great majority describe forms of amnesia other than "repressed memory." Indeed, there are fewer than ten articles describing purported cases of "dissociative amnesia/repressed memory" in the last nine years indexed by PubMed. When one compares this number – only one or two such articles per year – against the hundreds or thousands of papers published annually regarding other psychiatric disorders, it becomes clear that there is hardly any remaining scientific attention to the notion that individuals could develop amnesia for a seemingly unforgettable traumatic event, and then somehow recover this memory at a later date.

4) Although the theory of "repressed memory" has been the subject of peer review and publication, none of these publications has successfully demonstrated the existence of "repressed memory" in a methodologically sound manner.

5) No medical or psychological test can provide objective verification that an individual has "repressed" a memory or has later "recovered" the memory after a period of "repression." Thus, a diagnosis of "repressed memory" is ultimately based only on an individual's self-report of having experienced amnesia – and such self-reports have been shown in peer-reviewed studies to be unreliable.

6) Given the absence of an objective test for "repressed memory," and the consequent need to rely on individuals' self-reports, there is no way to calculate an error rate when the diagnosis of "repressed memory" is proposed – and indeed that error rate may well be 100%.

Since there is no methodologically sound scientific evidence for the existence of "repressed memory," what would explain Mr. Doe's claim that he "repressed" and later "recovered" the memory of his alleged experiences of sexual abuse? Logically, there are two scientifically plausible explanations for his account, namely 1) that some or all of the alleged sexual contact actually occurred, and that Mr. Doe was in fact *able* to remember the abuse prior to 2014, despite his claim to the contrary; or 2) that the alleged sexual contact did not in fact occur, and that the reason Mr. Doe was unable to remember it is that it did not exist to be remembered in the first place.

Each of these two explanations, in turn, logically divides into two subcategories. The first two of these are that: 1a) some or all of the sexual contact actually occurred, and Mr. Doe knows that he has always been able to remember it, but is deliberately feigning that he had amnesia; or 1b) some or all of the sexual contact occurred, but Mr. Doe genuinely believes (albeit erroneously) that he was unable to remember it. The second two subcategories are that: 2a) the alleged sexual contact did not in fact occur, and Mr. Doe knows this, but is intentionally fabricating the story; or 2b) the alleged sexual contact did not in fact occur, but Mr. Doe has unintentionally developed false memories for these events, and now believes (albeit erroneously) that they actually happened. In many instances where an individual is alleging "repressed memory," the actual case may be a combination of the above four possibilities.

Let me elaborate further with regard to explanation 1b. Even assuming, for purposes of discussion, that one could prove that the abuse happened exactly as described, one still also has the burden to prove that Mr. Doe was *unable* to remember the abuse. In this case, however, from the records I have reviewed, there appears to be no independent or objective evidence that Mr. Doe actually experienced amnesia relating to the putative abuse. Rather, there is only his personal statement that he could not remember it. However, research has shown that such statements are not trustworthy, because individuals may genuinely believe that they had forgotten an event for a long period of time, even though it can be proven that they were in fact able to remember the event during that period of alleged amnesia. This type of error has been called the "forgot-it-all-along" effect (Schooler, Bendiksen, & Ambadar, 1997).

Many studies have demonstrated this phenomenon of forgetting of prior remembering under laboratory conditions. For example, Geraerts and colleagues (Geraerts et al., 2006) recruited study participants who reported a history of sexual abuse, some of whom claimed to have always remembered the abuse and others of whom claimed that they had forgotten, and subsequently "recovered" memories of the abuse. The investigators also recruited a third group of participants reporting no history of abuse. In one experiment, the investigators presented subjects from all three groups with a memory task involving words ("visit 1"). Following the presentation, the subjects returned for two further visits at which they received two successive cue-recall tests of their memory for the words (visits 2 and 3). The investigators found that at the time of visit 3 (the second round of cue-recall testing), subjects often forgot that they had remembered a given item at the time visit 2 (the first round of cue-recall testing); in other words, they forgot that they had previously been able to remember the item. Interestingly, these errors – forgetting of prior remembering – were more frequent in the participants who claimed to have forgotten and subsequently "recovered" memories of childhood sexual abuse, as compared to the group of participants who had always remembered sexual abuse and as compared to the group who reported no history of sexual abuse. These findings suggest that individuals claiming to have recovered previously forgotten memories of childhood sexual abuse were more prone to the "forgot-it-all-along" effect.

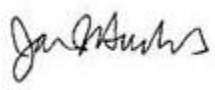
Geraerts and colleagues then considered a possible criticism of their findings, namely that underestimating one's previous remembering of neutral words might not necessarily indicate a tendency to underestimate prior remembering of autobiographical events such as sexual abuse. Therefore, in a second experiment, the investigators again recruited the same three types of participants: those reporting continuous memories of childhood sexual abuse, those reporting that they had forgotten and subsequently "recovered" memories of sexual abuse, and participants reporting no history of sexual abuse. Participants in all groups were then asked at visit 1 to recall various childhood events that they had experienced. Subsequently, the participants were reevaluated regarding their recall of these childhood events after two months at visit 2 and after a further two months at visit 3. As in the previous experiment involving words, participants often failed at visit 3 to recall that they had successfully remembered a given autobiographical event at visit 2. Once again, these errors of underestimating prior remembering were more common in the group reporting a history of

"recovered" memories of childhood sexual abuse as opposed to the group reporting continuous memories of abuse and the group reporting no history of abuse. The investigators concluded that individuals claiming to have "recovered" previously forgotten memories of childhood sexual abuse were likely more vulnerable to "forgot-it-all-along" errors than other individuals. These and other reports (Arnold & Lindsay, 2002; Padilla-Walker & Poole, 2002; Raymaekers, Peters, Smeets, Abidi, & Merckelbach, 2011) demonstrate that one should not accept at face value an individual's self-report that he or she had been unable to remember an event at an earlier point in time.

The above discussion represents only an example of an analysis of one of the four possibilities under consideration. It is beyond the scope of my report to attempt to discriminate among these possibilities in detail in Mr. Doe's case. However, it is my opinion, to a reasonable degree of scientific and medical certainty, that one or a combination of these four possible explanations (rather than "repressed memory") accounts for Mr. Doe's claims regarding his memory for the events in question. In other words, regardless of which of these possibilities (alone or in combination) is true, Mr. Doe did not "repress" and subsequently "recover" "memories" of the alleged sexual abuse by Mr. Brooks and Mr. Harnett.

In summary, the scientific literature has shown that traumatic events are strongly memorable. Nevertheless, some have claimed that it is possible to "repress" the memory of a traumatic event, such that the individual becomes *unable* to remember the event afterwards. However, this theory of "repressed memory" is not scientifically valid. It is not generally accepted in the relevant scientific community; it has never been demonstrated to occur in a methodologically sound peer-reviewed published study; and it is not subject to any ascertainable error rate. Therefore, if an individual claims to have "repressed" the memory of a traumatic event, it follows that either 1) the event occurred and the individual was actually able to remember it, despite his or her claim to the contrary, or 2) the event did not occur and the "memory" represents either a fabricated or a false memory, despite his or her claim to the contrary.

Respectfully submitted,



James I. Hudson, M.D., Sc.D.

IV. References

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Appendix A

ANALYSIS OF THE SCIENTIFIC VALIDITY AND ACCEPTANCE
OF "REPRESSED MEMORY" THEORY

I. Introduction and Definition of the Term "Repressed Memory"

To begin with, I note that this analysis constitutes a summary (together with numerous updates) of a recently published chapter that I have co-authored in a volume published by West Group, summarizing the scientific status of the hypothesis of "repressed memory," (H. G. Pope & Hudson, 2012) (hereinafter referred to as the "Pope-Hudson 2012 Chapter"). This chapter is provided as a supplement to th is analysis. This analysis also contains additional scientific material that has appeared in the interval since the publication of the 2012 Chapter.

In order to address the scientific status of the "repressed memory" hypothesis, it is first necessary to define our terms.

When I use the term "repressed memory" or "repression" in the following analysis, I am referring to the hypothesis that an individual could develop amnesia for an *entire traumatic event*, such that the person was unable to remember the event for a prolonged interval afterwards. In addition, the hypothesis of "repressed memory" allows that at some later date, an individual would be able to "recover" the previously "repressed" memory of a traumatic event, even though that individual had previously been unable to remember that traumatic event during the interval prior to the memory "recovery."

These terms – "repressed" and "recovered" memory – *have generally been defined in forensic settings throughout the United States in the same manner that I have just defined them above*. In a typical forensic case, an individual experiences a traumatic event, such as childhood sexual abuse at, say, age 13, and then claims to have lost all conscious access to this memory starting at some point after the abuse occurred. The individual typically claims that he or she was able to remember other events from this period of life (e.g., going to school, other activities as a teenager, etc.), but claims that he or she was unable to remember the childhood sexual abuse for a prolonged period until the "recovering" this memory many years or decades later. For example, the individual might claim to have "recovered" the memory at age 35, and might seek to toll a statute of limitations by claiming that he or she was unable to remember the sexual abuse prior to that time, and hence was unable to discover the injury until age 35.

Note that "repressed memory" must *not* be confused with ordinary forgetfulness, or with simply finding the memory so distressing that the individual did not want to think about it. Mere forgetfulness or mere avoidance of a memory would clearly not be sufficient to toll the statute of limitations in my example above, because the individual must establish that he or she was *unable to discover* the episode of sexual abuse because he or she was *unable* to remember it. Clearly, if one could toll a statute of limitations purely on the grounds of simple

forgetfulness, then the concept of a statute of limitations would effectively cease to exist. Therefore, setting aside any semantic considerations about what psychological professionals may mean by the term "repressed memory," the fact remains that for *forensic* purposes, the term "repressed memory" must indicate specifically that an individual was literally unable to remember an event.

It follows that the term "repressed memory" does *not* refer to cases where an individual had simply not recalled a given event for a long period of time, but would have been perfectly capable of recalling the event if specifically asked about it. For example, most people, if asked, can recall events from when they were in elementary school, and can probably also recall various details from a particular class – perhaps even a traumatic event in which they were scolded by a teacher or embarrassed in front of their classmates. They may not have thought about these events in years, but this does *not* represent "repressed memory," as it must be defined for forensic purposes, because these individuals were still *able* to remember the events.

Finally, it is useful to clarify what is meant by "unable to remember." In the example in above, the claim of "repressed memory" would imply that someone could have approached our hypothetical plaintiff prior to the time of his memory "recovery" at age 35 and asked him, "do you remember, when you were 13 years old, that [defendant] performed [a sexual act] with you?" Under the hypothesis of "repressed memory," our plaintiff would reply in complete honesty, "no, I have no memory of any such thing." However, after the plaintiff's putative "recovery" of the formerly "repressed" memory at age 35, he then would be able to report that he could in fact remember these events for which he formerly had amnesia.

II. <u>There are Many Scientifically Recognized Forms of Forgetfulness or Apparent Forgetfulness, and These Must *Not be Confused* with "Repressed Memory"</u>

Ordinary forgetfulness: Having now defined the term "repressed memory," it is important to be certain that this term is not confused with other, scientifically accepted, forms of forgetfulness or amnesia. First, as already explained above, "repressed memory" must not be confused with simple ordinary forgetfulness, as illustrated by our example above of memories of being in grammar school. Such memories are not "repressed," because the individual would be able to recall them specifically asked. Similarly, it is commonplace that one may simply develop a better understanding of an event at a later time point after it happened. For example, one might be touched inappropriately as a child, but not recognize this event as sexual abuse because one was too young to understand what was happening. Then, as an adult, one might be reminded of the event, reflect upon it from the vantage point of an adult, and recognize that it was in fact an episode of sexual abuse. But again, this scenario does not represent a "recovery" of a "repressed memory," because the individual was always *able* to remember the event, even though they did not fully understand its significance at the time that it happened.

Ordinary forgetfulness misconstrued as "repressed memory": It should also be noted that individuals may *believe* that they were unable to remember a traumatic event during some earlier period of life, even though in fact they were perfectly able to remember that event. Indeed, both individual published case reports and subsequent scientific studies have shown that individuals may often *forget that they were able to remember* an event. I will discuss this research in greater detail below. And even more detailed discussion of these studies is supplied in section § 20:10, Part 1 of the Pope-Hudson 2012 Chapter.

Thus, it is important to realize that it is insufficient for individuals to merely *believe* or *claim* that they were unable to remember a traumatic event, since such claims have been demonstrated to be very fallible.

Amnesia due to biological causes: The hypothesized phenomenon of "repressed memory" likewise should not be confused with amnesia due to biological causes, such as the amnesia that might occur as a result of a head injury in a car accident, or following an epileptic seizure, or as a result of a "blackout" attributable to drug or alcohol intoxication. In one respect, these types of biological amnesia are somewhat similar to "repressed memory," in that the individual is unable to remember a block of time. However, in contrast to the notion of "repressed memory," the individual with biological amnesia is never able to *recover* the memory because a biological insult to the brain has prevented the memory from being encoded in the brain at the time. In other words, stated colloquially, the memory is never laid down on the brain's "hard drive" in the first place, and thus by definition cannot later be recovered. Moreover, biological amnesia also differs from "repressed memory" in that "repressed memory" presumably applies to a traumatic event, whereas biological amnesia would affect memory for *all* events, good and bad, in a given time interval, regardless of whether they were traumatic or not.

Early childhood amnesia: Another form of amnesia due to biological causes is the amnesia that we all experience for events that occurred in the first years of early childhood. Once again, amnesia for events occurring at ages 1 or 2 does not represent "repressed memory," because it is simply attributable to the biological immaturity of the developing brain, and thus has a simple neurological origin, rather than being a response to a traumatic experience. Like other forms of biological amnesia, memories of very early childhood cannot be recovered, because the immature brain was not sufficiently developed to encode them in the first place. Also like other forms of biological amnesia, early childhood amnesia affects memory for *all* events, good or bad, regardless of whether they were traumatic or not. Indeed, many people will report that their earliest childhood memories involve traumatic childhood events, rather than benign events – and this is exactly the opposite of what would be predicted by the hypothesis of "repressed memory," which would claim that one more frequently should have amnesia for traumatic events than for benign events. In short, early childhood amnesia is entirely different from, and should not be confused with, the notion of "repressed memory."

Incomplete encoding: Likewise, "repressed memory" should not be confused with the common phenomenon of amnesia for certain *parts* of a traumatic experience. For example, if one is threatened with a gun, one may remember vividly what the gun looked like, but may not

be able to remember the assailant's face, because all of one's attention was focused on the threat of the gun. This is not "repressed memory," but a normal phenomenon known as "incomplete encoding," in which one focused on elements critical to their survival (i.e., the threat to their life posed by the gun) while ignoring less critical aspects of the situation (the assailant's facial appearance). By contrast, the theory of "repressed memory" would postulate that it would be possible for someone to develop amnesia for the *entire* traumatic experience of being threatened with a gun.

Generalized amnesia: In rare cases, individuals are seen who develop global amnesia for their entire identities, or for an entire block of decades of time. In a typical case of such global amnesia, an individual may be brought to an emergency department with no knowledge of his or her name, address, occupation, or any other identifying features. In other cases, the individual may still retain the memory of some autobiographical information, but may lack all memory of events that happened over, say, the last 14 years. In some of these rare cases of generalized amnesia, it is possible to identify a neurological lesion in the brain that has caused the phenomenon, but sometimes cases of generalized amnesia are observed where it is not possible to identify a specific neurological etiology. Such cases are sometimes called, by default, "psychogenic amnesia," because there is no documented neurological cause. However, it should be recognized that the absence of a recognizable neurological lesion provides no evidence that the amnesia was caused purely by some psychological problem. Moreover, generalized amnesia is different from "repressed memory" for a traumatic event in any case, in that the individual experiences amnesia for an *entire block of time or even a lifetime of information, encompassing events both good and bad, traumatic and nontraumatic, rather than selective or systematized amnesia for a particular traumatic experience*.

Feigned amnesia: There are also scientific reports of individuals who may feign amnesia even though they are actually able to remember. Such cases clearly do not represent "repressed memory," in that the "repressed memory" hypothesis presumes that the individual's amnesia is genuine rather than feigned. Feigned amnesia may be apparently intentional (e.g., a murderer who claims to have amnesia for his act of murder, but later admits to having been able to remember his actions). Alternatively, feigned amnesia may be seemingly unintentional, as in the case of so-called "*pseudoneurological" or "functional" amnesia*, where the amnesia may occur in conjunction with other apparently feigned symptoms, such as pseudoseizures or pseudoanesthesia.

It is of relevance that the international standard for psychiatric diagnosis, the International Classification of Diseases, has acknowledged that pseudoneurological "amnesia" represents a legitimate diagnosis. The International Classification of Diseases, 10th Edition, (ICD-10) classifies "dissociative amnesia" under the heading of "F44—dissociative (conversion) disorders," along with "dissociative convulsions," "dissociative anesthesia and sensory loss," and other pseudoneurological symptoms. In this instance, ICD-10 is using the term "dissociative amnesia" in the context of disorders that have no genuine biological basis in the brain. Thus, ICD-10 is indicating that "dissociative amnesia," (the category that would be most closely

related to "repressed memory") is effectively a feigned symptom, such that its relationship to true amnesia is similar to the relationship of pseudoseizures to true seizures.

For a more detailed discussion of feigned amnesia, please see § 20:14 in the Pope-Hudson 2012 Chapter.

Deliberate nondisclosure: Many scientific studies have documented that individuals will often simply choose not to disclose sensitive information that they actually remember perfectly well. Such nondisclosure is particularly common when individuals are asked about sensitive topics such as alcohol or drug use, history of legal infractions or incarceration, or HIV status. It would of course be naïve to mistakenly diagnose such deliberate nondisclosure as "repressed memory," because in fact such individuals are perfectly capable of remembering the events, but have simply chosen to withhold the information.

Summary: In summary, there are many forms of forgetfulness, amnesia, or seeming amnesia that are well recognized by scientists, and that are abundantly documented in the scientific literature. These include **1) ordinary forgetfulness; 2) biological amnesia; 3) incomplete encoding for part of a traumatic event; 4) generalized amnesia; 5) feigned or pseudoneurological amnesia; and 6) deliberate nondisclosure.** It is critical that one not confuse these well-known and scientifically accepted phenomena with the highly controversial notion of "repressed memory," which is not scientifically accepted. As will be shown in the course of the remainder of my discussion below, there are no published scientific studies of human forgetfulness or amnesia that cannot be readily explained by one or more of the above six well-recognized phenomena. Thus there is no need to postulate the existence of a novel hypothesis, namely "repressed memory," to explain any of the existing studies in the scientific literature.

III. It is Important to Avoid Several Other Terms Currently in Use, Because They Have Ambiguous Meanings and Hence are Potentially Misleading

"Dissociation": There are a number of other terms that sometimes appear in both forensic and scientific documents, but which unfortunately have no agreed-upon meaning, and hence may be seriously misleading as a result of their ambiguity. One of these terms is "dissociation." The term "dissociation" has been used in the scientific literature to describe a wide range of very different phenomena. For example, when one is intensely focused on a task, one may fail to pay attention to surrounding events or to the exact passage of time, and this phenomenon is sometimes called "dissociation." Alternatively, in situations involving severe anxiety, one may feel that everything going on around oneself is unreal or as if "in a dream." This common phenomenon, which is technically called "depersonalization" or "derealization" in psychiatry, is also often labeled as a form of "dissociation." The ambiguity of the term "dissociation" becomes even more evident when one looks at the widely used Dissociative Experiences Scale, which contains 28 individual items presumed to be features of "dissociation." These items include such ordinary phenomena as becoming so absorbed in watching television that one

becomes unaware of events going on around oneself, or staring off into space and not being aware of the passage of time, or talking aloud oneself. But also included among these items is the phenomenon of having auditory hallucinations (people who "hear voices inside their head that tell them to do things or comment on things that they are doing"). Thus, the term "dissociation" has become so broad and so ambiguous that it can be used to describe everything from ordinary distractibility to full-scale hallucinations. Indeed, one major research group with expertise in this area conducted a study on the features of "dissociation" and concluded that the term as a "misnomer." This study (Briere, Weathers, & Runtz, 2005) is discussed and cited in the Pope-Hudson 2012 Chapter, section § 20:16, Part 1.

Widespread use of the term "dissociation" provides no evidence that scientists accept "repressed memory": Since the term "dissociation" is so broad and has such a wide range of meetings, it is not surprising to see that this term frequently appears in scientific papers. However, the frequent use of this term does *not provide any evidence that scientists accept "repressed memory,"* since the term "dissociation" covers a wide range of different phenomena, many of which have nothing to do with the hypothesis of "repressed memory" at all.

"Dissociative amnesia": An even more misleading term, with similar ambiguity of meaning, is the term "dissociative amnesia." In the past, many writers have used this term as though it were synonymous with "repressed memory," – and even I have used term in prior publications in earlier years as though it were synonymous with "repressed memory" (e.g., (H. G. Pope, Poliakoff, Parker, Boynes, & Hudson, 2007a). However, it has become obvious in recent years that numerous peer-reviewed scientific papers are using the term "dissociative amnesia" to refer to phenomena entirely different from "repressed memory," such as incomplete encoding, generalized amnesia, and even pseudoneurological amnesia – terms that I have just discussed above. For a detailed presentation of the ambiguity of the term, "dissociative amnesia," together with citations to specific scientific articles that use this term in entirely different ways, please see the Pope-Hudson 2012 Chapter, section § 20:16, part 2.

Use of the term "dissociative amnesia" provides no evidence that scientists accept "repressed memory": Since the term "dissociative amnesia" has so many different meanings, it should be avoided in forensic settings because of its potential ambiguity. As just mentioned, the term "dissociative amnesia" has now come to embrace various phenomena that are scientifically accepted (e.g., incomplete encoding, generalized amnesia, and pseudoneurological amnesia) together with another phenomenon that is highly controversial and not scientifically accepted, namely "repressed memory." Therefore, recent articles using the term "dissociative amnesia" provide no evidence that scientists accept one particularly dubious subcategory of "dissociative amnesia," namely "repressed memory." I will discuss these recent articles in a subsequent section of this report.

"Traumatic amnesia": The term "traumatic amnesia" is also sometimes used as if it were synonymous "repressed memory," but should also be avoided because of its potential ambiguity. In particular, the term "traumatic amnesia" is also widely used in neurology to refer

to amnesia caused by biological trauma such as a head injury. Thus, I will avoid the term "traumatic amnesia" in the following discussion as well.

"Psychogenic amnesia": As already mentioned above, the phenomenon of global amnesia, wherein individuals may forget their entire identities, or entire decades of time, is sometimes referred to as "psychogenic amnesia" by default in instances where no clear neurological etiology can be demonstrated. However, as also noted above, there is no methodologically sound evidence that such amnesia is in fact caused by psychological factors, simply because investigators have failed to identify a specific neurological lesion in certain cases. In any case, the term "psychogenic amnesia" should not be confused with "repressed memory," because "psychogenic amnesia" can refer to generalized amnesia for an individual's entire history or entire identity, rather than for a particular traumatic event. Thus, the term "psychogenic amnesia" must also be avoided because of ambiguity.

"Recovered memory": Some individuals use the term "recovered memory" to refer to memories that have allegedly been "recovered" after a prior period of "repression." However, the term "recovered memory" is also widely and commonly used to refer to the more ordinary phenomenon of recalling something after an interval of ordinary forgetfulness. Therefore, the term "recovered memory" should also be avoided because of its potential ambiguity. Specifically, all scientists recognize that individuals can experience an ordinary "recovered memory" for something that has been forgotten for a while, but this does not imply that scientists accept that individuals could "recover" a memory for something that had been "repressed" – i.e., that the individual had previously been completely *unable to remember*.

IV. Studies of Brain Mechanisms Provide No Evidence of the Existence of "Repressed Memory"

It should also be recognized that various mechanisms have been proposed to explain how "repressed memory" might hypothetically occur – i.e., how the brain might hypothetically be able to develop amnesia for a seemingly unforgettable traumatic event. Such studies include both human and animal studies involving cellular biology, neuroimaging of the brain, and other such scientific methods. But once again, the putative psychological or neuropsychological mechanism by which "repressed memory" might hypothetically occur in the brain is irrelevant to the question of whether or not the hypothesis of "repressed memory" is scientifically accepted in the first place. In other words, *speculations about how the brain might hypothetically "repress" a memory do not tell us whether real people actually can "repress" a memory*.

To illustrate the above logic with an analogy, consider the observation that animals with larger brains are generally more intelligent than animals with smaller brains: dogs are more intelligent than sparrows, and people are more intelligent than dogs. Consider also the abundant evidence that on average, men have larger brains than women. Combining these two observations, one might speculate that men are smarter than women. But such speculation

would be valueless, or even worse than valueless; to assess the question of relative intelligence, one would need to test actual men and actual women.

By analogy, in our present discussion of the notion of "repressed memory," we must not be distracted by speculations about possible mechanisms whereby "repressed memory" could hypothetically occur. Instead, we must focus on the question of whether "repressed memory" actually *does* occur – and as will be shown, there are no methodologically sound scientific studies that have ever shown that this phenomenon actually occurs in real human beings.

V. The Theory of "Repressed Memory" is Not Generally Accepted in the Relevant Scientific Community

Having now carefully defined our terms in sections I-III above, I will now demonstrate that the hypothesis of "repressed memory" does not even remotely approach the threshold of having achieved general scientific acceptance. I will also demonstrate that the hypothesis of "repressed memory" has never been documented to exist in any methodologically sound peer-reviewed scientific studies. Finally, I will demonstrate that even if one were to examine studies that purport to demonstrate "repressed memory" (or that have been misinterpreted as evidence of "repressed memory"), these studies exhibit no demonstrable error rate.

A. There is large literature of recent peer-reviewed scientific studies in prestigious journals, together with major chapters and books published by internationally recognized scientists, which have repeatedly questioned the validity of "repressed" and "recovered" memory.

Over the last 25 years, numerous peer-reviewed articles have appeared in major scientific publications, questioning the validity of the hypotheses of "repressed" and/or "recovered" memory (e.g. (Berntsen & Rubin, 2014; Boakes, 1995; Bonanno, 2006; Bonanno et al., 2002; Brandon, Boakes, Glaser, & Green, 1998; Brown, Nicholson, Aybek, Kanaan, & David, 2014; Campbell, 1995; Epstein & Bottoms, 2002; Frankel, 1993, 1995; Geraerts et al., 2006; Giger, Merten, & Merckelbach, 2012; Goodman et al., 2003; Hayne, Gary, & Loftus, 2006; Holmes, 1990; Huntjens, Verschuere, & McNally, 2012; Kihlstrom, 1997, 2002, 2004; Lief, 2003; Lindsay, Hagen, Read, Wade, & Garry, 2004; Lindsay & Read, 1995; E. Loftus, 1993; E. F. Loftus & Davis, 2006; E.F. Loftus & Pickrell, 1995; Lynn et al., 2014; Lynn, Lock, Loftus, Krackow, & Lilienfeld, 2003; McElroy & Keck, 1995; McHugh, 1995, 2008; R. McNally, 2003; R. J. McNally, 2007; R. J. McNally & Geraerts, 2009; Merskey, 1996; Ofshe & Singer, 1994; Paris, 1996; Patihis, Ho, Tingen, Lilienfeld, & Loftus, 2014; Patihis, Lilienfeld, Ho, & Loftus, 2014; Piper, 1997; Piper, Lillevik, & Kritzner, 2008; Piper, Pope, & Borowiecki, 2000; H. Pope & Hudson, 1995; H. G. Pope, Jr., Hudson, Bodkin, & Oliva, 1998; Rofé, 2008; Schacter & Curran, 1995) These include peer-reviewed articles in many of the world's most prestigious medical and psychiatric journals, such as the *New England Journal of Medicine*, the *Lancet*, the *American Journal of Psychiatry*, and many others.

Prestigious scientists in these major publications have referred to "repressed memory" as "a piece of psychiatric folklore," (R. McNally, 2003) a "fairy tale belief," (Hayne et al., 2006) and the "clinician's cold fusion" (Bonanno, 2006).

In the face of these publications and commentaries, it would be impossible to assert that there is any "general acceptance" of the "repressed memory" hypothesis in the relevant scientific community; in fact, there is widespread and vociferous skepticism.

As a scientist and psychiatrist who is educated and trained in the scientific method, who participates in designing studies and carrying out research for testing hypotheses, and who is readily familiar with the threshold of required agreement in the scientific community before a particular phenomenon is considered "generally accepted," I state here that the "repressed memory" hypothesis has not even remotely achieved "general acceptance" in the relevant scientific community.

Indeed, as my colleagues and I have also noted in a recent publication (H. G. Pope, Barry, Bodkin, & Hudson, 2006), scientific studies of "repressed memory" rose to a sharp peak in the 1990's, and then rapidly waned, with a large portion of recent papers expressing skepticism of "repressed" and/or "recovered" memory. I will discuss this survey, together with subsequent analyses looking at the number of scientific studies regarding "repressed memory" published over the last several decades, in greater detail below.

B. Even if the "relevant scientific community" were narrowed down from the overall scientific literature to actual psychiatrists, the evidence demonstrates that there is still no "general acceptance" of the "repressed memory" hypothesis.

In my opinion, to a reasonable medical certainty, the material cited above in section A alone clearly demonstrates that there is no general scientific acceptance of "repressed memory." However, even if one were to assume that the writers of the above publications could somehow be dismissed or ignored, perhaps by alleging that they are not truly members of the "relevant scientific community," and arguing that the real "relevant scientific community" is instead represented by the opinions of actual psychiatrists, rather than by scientific publications, the evidence still shows that there is no general acceptance of "repressed memory."

Specifically, in a study published in the prestigious peer-reviewed *American Journal of Psychiatry* (H. G. Pope, Jr., Oliva, Hudson, Bodkin, & Gruber, 1999), we surveyed 301 board-certified psychiatrists and asked them if they felt that "dissociative amnesia" should be included without reservations in the American Psychiatric Association's diagnostic manual, *DSM-IV*. Only 35% of the psychiatrists responded that "dissociative amnesia" should be included without reservations, with 48% feeling that it should be included only with reservations (for example as a "proposed" diagnosis in the Appendix), 9% feeling that it should not be included at all, and 9% having no opinion.

This finding is particularly striking when it is remembered that the term "dissociative amnesia" *embraces several phenomena that are widely accepted by scientists (e.g., incomplete encoding and generalized amnesia) in addition to embracing "repressed memory,"* as noted above. Therefore, one might assume that some psychiatrists responding to our study, even if they were highly skeptical of "repressed memory" *per se*, would still endorse the broader term "dissociative amnesia," because the term is sometimes used to describe legitimate and accepted phenomena. In light of this consideration, it becomes even more striking that only 35% of psychiatrists endorsed inclusion of this term without reservations. These data provide objective quantitative evidence that there is no consensus among board-certified psychiatrists about the validity of "repressed memory."

We have also published a similar survey of Canadian psychiatrists (Lalonde, Hudson, Gigante, & Pope, 2001), showing that these individuals displayed even greater skepticism about the validity of "dissociative amnesia" – and, by extension, greater skepticism about particularly controversial subcategory of "repressed memory" – than their American counterparts.

There are no subsequent studies using similar methodology that show an opposite finding; in other words, in more than 15 years since the appearance of my study there have been no quantitative surveys suggesting that there *is* a consensus among psychiatrists or psychologists on the validity of "repressed memory."

It is important to note that some proponents of "repressed memory" have attempted to favorably interpret surveys by arguing that a substantial majority of practicing clinicians feel that "repressed memory" is either valid or at least "possibly" valid. There are two major fallacies to this argument. First, practicing clinicians are not the "relevant scientific community," since clinicians may or may not have sufficient scientific training to be able to evaluate the merits of a theory such as "repressed memory." Indeed, in many states of the United States, individuals can hold themselves out as "therapists" with very little academic training. The informal observations of such therapists may be useful in generating hypotheses, but they are not properly utilized for *testing* hypotheses. For these reasons, as I have noted above, articles in the peer-reviewed scientific literature represent the true gauge of the opinions of the relevant scientific community.

Second, even if one were to assume that all clinicians were somehow legitimate scientists, it is not appropriate to pool responses of "possibly" valid with responses of "valid." For example, many scientists would agree that there is "possibly" some form of life on Mars, at least on a bacterial level. A search for evidence of such life on Mars is currently underway. But the fact that many scientists think that this is "possible" does not mean that it is *generally accepted* in the relevant scientific community that there actually is life on Mars.

C. Consensus statements by various medical and psychiatric organizations indicate no general scientific acceptance of "repressed memory."

Over the years, various professional organizations, such as the American Psychiatric Association, American Psychological Association, American Medical Association, and the British Royal College of Psychiatrists have issued policy or consensus statements bearing on the issue of "repressed memory" (American Medical Association, 1994; American Psychiatric Association, 2000; American Psychological Association Working Group on Investigation of Memories of Childhood Abuse, 1998; Royal College of Psychiatrists, 1997). All of these statements note the *controversy* surrounding the issue of "repressed" and "recovered" memory – showing, once again, that there is no *consensus* in the scientific community about the validity of these entities. The statements all strongly caution about accepting "recovered" memories at face value, and all acknowledge that false memories of sexual abuse or other traumas can occur.

One must not be misled by the fact that none of the consensus statements flatly states that "repressed memory" is *invalid*. This fact in no way implies that "repressed memory" is *generally accepted*. Specifically, it is entirely contrary to the advancement of science and the scientific method to assume *a priori* that a hypothesized phenomenon is valid until it is proven invalid. Rather it is the burden of those proposing a given hypothesis, such as the hypothesis of "repressed memory," to show that the relevant scientific community considers it to be *valid*.

Stated differently, it is not my scientific burden to show that "repressed memory" has been *rejected* by a substantial majority of the scientific community, because this approach would fallaciously assume that the hypothesis of "repressed memory" is automatically valid at the outset. Instead it is the burden of "repressed memory" advocates to produce evidence that the hypothesis of "repressed memory" has come to be *accepted* by a substantial majority of the scientific community. There is nothing in any of the position statements, with their many precautions, to support the latter; the only statement that arguably comes close is the American Psychiatric Association statement in 1993 of the possibility that "…these coping mechanisms result in a lack of conscious awareness of the abuse for varying periods of time." But by 2000, this statement no longer exists, and has been changed to "In the presence of severe or prolonged stress, people may suffer an impairment of the retention, recall and accuracy of the memories."

In reviewing these position papers, it is also important not to be misled by statements to the effect that events such as sexual abuse can be "forgotten" for long periods of time and later remembered. As I have already cautioned above, mere *forgetting* does not equal "repressed memory." To qualify for "repressed memory," one would have to be *unable* to remember an entire traumatic event. No position statements from any medical or psychiatric organizations suggest that there is any scientific consensus that individuals could become *unable* to remember a traumatic event – i.e. to have the memory inaccessible to consciousness for an interval of time, and yet later be able to "recover" the memory.

As a scientist and psychiatrist familiar with the applicable threshold of acceptance applied to other hypothesized medical phenomena in determining whether there is "general acceptance," I state here unequivocally that the material in Parts A, B, C above provides overwhelming evidence that "repressed memory" is *not* generally accepted in the scientific community.

D. Inclusion of "dissociative amnesia" as a diagnosis in *DSM-5* provides no evidence of general acceptance of "repressed memory."

Some advocates of "repressed memory" have noted that the diagnosis of "dissociative amnesia" is included in *DSM-5*, the most recent edition of the official diagnostic manual of the American Psychiatric Association (American Psychiatric Association, 2013). However, as explained above, the term "dissociative amnesia" embraces both scientifically legitimate and accepted memory phenomena (e.g., incomplete encoding, global amnesia, etc.) together with the dubious and highly controversial phenomenon of "repressed memory." Therefore, even though *DSM-5* recognizes the broad and heterogeneous category of "dissociative amnesia," it does not follow that *DSM-5* indicates general scientific acceptance of the questionable *subcategory* of "repressed memory."

By analogy, scientists in the field of zoology agree that there exists a category of "equine mammals," which includes horses and zebras. However, there are also equine animals that are pure fantasy, such as unicorns. Just because scientists accept the existence of "equine mammals," it does not follow that scientists accept unicorns. **Similarly, to claim that by recognizing "*dissociative amnesia*," *DSM-5* therefore demonstrates general scientific acceptance of "*repressed memory*," would be analogous to saying that by recognizing the existence of "*equine mammals*," scientists generally accept the existence of *unicorns*.**

I would note that DSM-5 describes various categories of "dissociative amnesia," including "localized," "generalized," and "systematized" forms of "dissociative amnesia" – and the latter might be interpreted by some people as evidence that DSM-5 implicitly recognizes "repressed memory." However, even if one were to accept this position, the fact remains that the committee writing this portion of DSM-5, in their own publications describing the writing process (Spiegel et al., 2013; Spiegel et al., 2011), fails to cite any recent scientific articles describing cases that would meet our definition of "repressed memory." Instead, the recent articles about "dissociative amnesia" cited by the committee are largely articles about global amnesia, cases likely attributable to incomplete encoding, or other phenomena.

E. Further evidencing a lack of "general acceptance," cases of individuals with putative "repressed memory" have largely disappeared from the scientific literature in recent years.

The technique of bibliometric analysis: The paucity of recent peer-reviewed scientific articles reporting cases of "repressed memory," as just noted in my comments regarding DSM-5 above, provides *objective, quantitatively testable,* documentation of the absence of general scientific acceptance of the concept of "repressed memory." We can perform such a test using

the technique of "bibliometric analysis." This method – the tracking of publication rates for scientific articles on a given topic – is a well-established field, with hundreds of papers published in this area over the last 20 years. The methods of bibliometric analysis were developed in sociology starting more than 40 years ago, and are presented in detail by Menard (Menard, 1973). As summarized by Sprock and Herrmann (Sprock & Herrmann, 2000):

> The method used here, called bibliometric analysis, was developed in sociology as a means of studying the dissemination of scientific knowledge (see Menard, 1973). Bibliometric analyses use quantitative methods to describe patterns of scholarly communication and include procedures such as publication counts (bibliographic analysis) and citation analysis. Computerized databases have facilitated literature reviews, the identification of articles on particular topics, and the use of references as data for bibliometric studies.

Bibliometric analysis has been used in the past to assess the degree of clinical interest and scientific acceptance regarding various diagnostic categories in psychiatry. For example, Mendlowicz and colleagues (Mendlowicz, Braga, Cabizuca, Land, & Figueira, 2006) examined publication trends for the diagnoses of "social phobia" and "avoidant personality disorder." They found that publications regarding social phobia increased steadily over a 25-year period, whereas publications about "avoidant personality disorder" were infrequent or even declining, leading the authors to conclude that "it is unlikely that the publication of scientific articles on APD [avoidant personality disorder] will provide the empirical evidence required to validate this disorder in a foreseeable future." Over the years since the analysis by Mendlowicz et al., publication rates for "avoidant personality disorder" have continued to be feeble, reinforcing the impression of these authors that "avoidant personality disorder" may not be a valid psychiatric disorder, but merely a cluster of features seen in patients who have primary anxiety disorders such as social phobia. Thus, bibliometric analysis suggests that "avoidant personality disorder" has not gained general acceptance in the relevant scientific community.

Bibliometric analysis has also been used as a metric for assessing whether a given disorder merited inclusion in DSM. For example, Blashfield et al. (Blashfield & Intoccia, 2000) have tracked publication rates for personality disorders and published a paper specifically suggesting criteria for inclusion of a given psychiatric diagnosis in the DSM. One of these criteria is that the disorder should show an adequate publication rate – that is, sufficient scientific interest to suggest that the disorder is scientifically accepted (Blashfield, Sprock, & Fuller, 1990). In particular, these authors suggest that for inclusion in the DSM, an article should have generated at least 50 scientific papers within the past 10 years, including at least 25 empirical studies. This recommendation should be viewed with recognition that it was written in 1990, when the overall flow of scientific papers was much less than it is currently. Specifically, if one looks at PubMed, one of the largest and most widely used medical search engines, and enters the search term "psychiatry," one finds that the annual number of published articles brought up by the search term was between 7,000 and 8,000 for the years 1988-1990. By comparison, the annual number of such articles in 2016 to 2018 ranged from 32,000 to more than 40,000.

Thus, extrapolating the criteria of Blashfield et al. from 1990 to 2019, it would seem reasonable to expect at least 200 scientific papers, including 100 empirical studies, over the last decade to consider a diagnosis scientifically accepted today. As I will show below, the notion of "repressed memory" does not even remotely approach this "inflation-adjusted" criterion of 100 empirical studies required to merit inclusion in DSM-5.

Applying bibliometric analysis to the topic of "repressed memory": in 2006, we conducted a survey of the number of papers published annually about various diagnostic entities in psychiatry (H. G. Pope et al., 2006). To do this, we entered various diagnoses, such as "anorexia nervosa," "schizophrenia," and "alcohol abuse" as search terms or keywords into PsycINFO, a major medical index, in order to find out how many articles had been published in a given year that referred to the particular diagnosis in question. For each of the three diagnoses just mentioned, we found that there was a steady flow of new published papers over the last two decades, with a gradual increase, on average, in the number of papers appearing with each passing year. However, when doing a similar search, entering the terms "repressed memory" and "dissociative amnesia" into PsycINFO, we found that there was a sharp peak of articles in the 1990s, followed by an equally sharp decline thereafter. Specifically, we found more than 100 publications in our search using these keywords for the year 1997, but by 2001-2003, the annual number of such publications had dropped to only about 25. Furthermore, upon reviewing the publications generated by our PsycINFO search for the year 2003, we only found two explicit cases of individuals with putative "repressed memory" among all publications for 2003 combined. We have also conducted subsequent analyses, looking at 2004 (H. G. Pope, Barry, Bodkin, & Hudson, 2007b) and 2005 (H. G. Pope, Barry, Bodkin, & Hudson, 2007a); these updated analyses continued to show waning scientific interest in "repressed memory," continuing skepticism about the concept, and hardly any reports of cases. In our paper, we also tracked the annual publication rates for 25 other psychiatric diagnoses from 1990 to 2003, using the same methods. All showed a steady or rising rate of annual publications; none showed the "bubble" pattern of "repressed memory," where a brief period of fashion was followed by a withering of interest. These findings further demonstrate that "repressed memory" has not attained general scientific acceptance.

Updated bibliometric analysis through 2018: To bring these findings up to date, I have performed an updated analysis, by looking at the term "dissociative amnesia" in the PubMed search engine, for the last nine full years, from 2010-2018. This search yielded only *73 articles* throughout these nine most recent years on the topic of "dissociative amnesia." I then compared the number of articles generated by PubMed over the same nine-year period for five other psychiatric diagnoses: panic disorder, anorexia nervosa, obsessive-compulsive disorder, attention-deficit/hyperactivity disorder, and bipolar disorder. As will be seen in Figure 1, the number of scientific articles on "dissociative amnesia" in the last nine full years is extremely small in comparison to the number of articles on any of these other psychiatric diagnoses. Indeed, on average, there have been only 8.1 articles per year on "dissociative amnesia," as compared to 341 articles per year on panic disorder, 541 articles per year on anorexia nervosa, 732 articles per year on obsessive compulsive disorder, 1,450 articles per year on attention-

deficit/hyperactivity disorder, and 2,029 articles per year on bipolar disorder. In short, "dissociative amnesia" has an extremely small presence in the scientific literature – again indicating that there is little scientific attention on this topic.

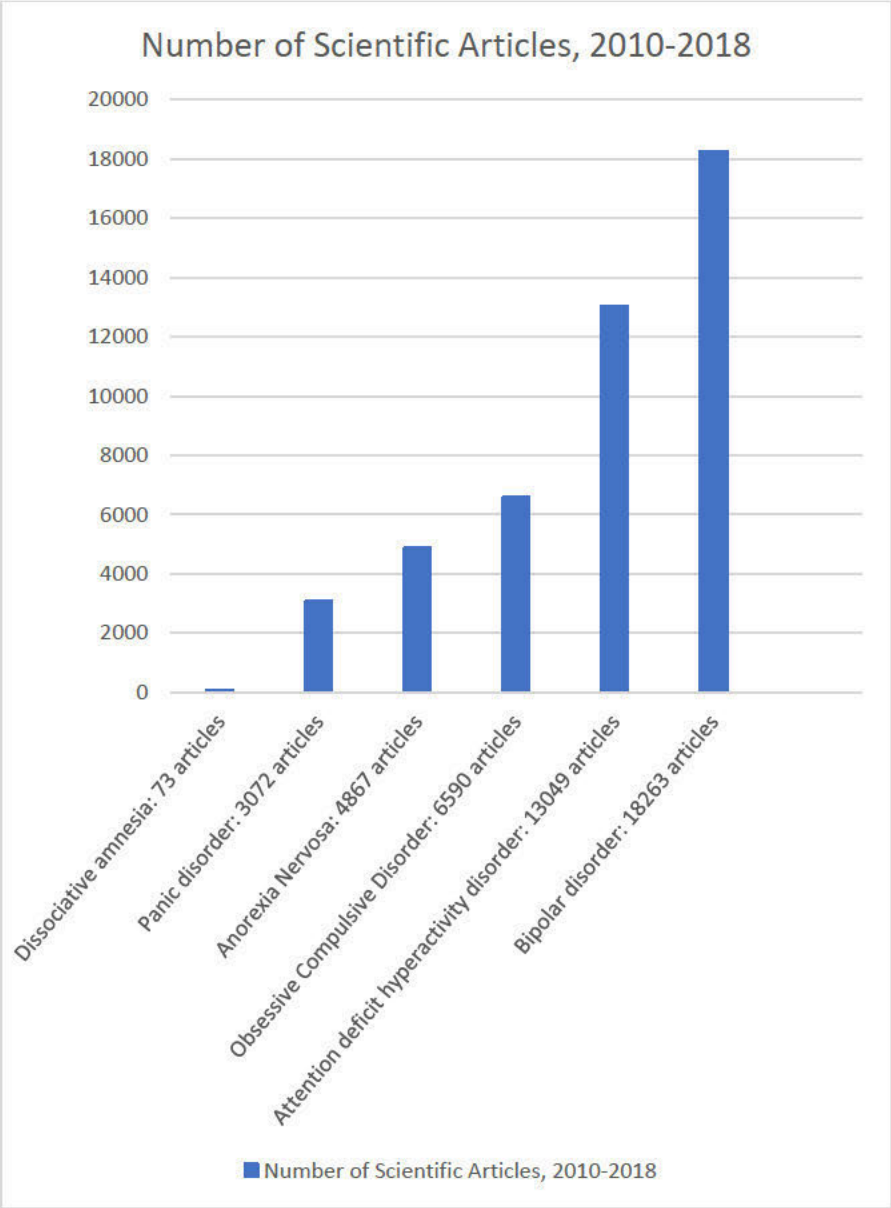

Figure 1. Number of published scientific articles identified by the PubMed search engine for "dissociative amnesia" and five representative comparison diagnoses in the four-year period from 2010-2018.

Furthermore, when we break down the small group of 73 articles on "dissociative amnesia" from 2010-2018, we find that most of these articles did not actually describe any cases of "repressed memory" at all. For example, many of the articles described only cases of generalized amnesia, where individuals developed amnesia for their entire identities, or for months or years of their lives, embracing both good events and bad, rather than developing amnesia for a specific traumatic event. For example, Staniloiu and colleagues (Staniloiu, Markowitsch, & Kordon, 2018) describe 28 cases of "dissociative amnesia," in which almost every individual is reported to have lost memory for his or her "total life." Similarly, many of the other 73 papers described cases of generalized amnesia for an individual's entire identity or amnesia for months or years of time (e.g., (Chechko et al., 2018; Comparelli, Kotzalidis, Di Pietro, Casale, & De Carolis, 2013; Kuo, Lee, & Yang, 2013; Tripathi, Bharath, Desai, & Mehrotra, 2013). Clearly, these cases of generalized amnesia are entirely different from "repressed memory," in which individuals are claimed to selectively lose their memory for a traumatic event while still having a normal memory for non-traumatic items such as their address, their occupation, or where they went to school or church.

Another large segment of the 73 articles is composed of reviews or comments on the literature that do not present any data or actual cases of their own (e.g., (Dieguez & Annoni, 2013; Granacher, 2014; Sar, 2014; Spiegel et al., 2011)). Yet another large group of articles consists of studies where the diagnosis of "dissociative amnesia" was made on the basis of items on an interview instrument or an answer on a self-administered questionnaire. For example, many of the 73 articles used the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D) (Steinberg, 1994) to diagnose "dissociative amnesia" (e.g.,(Belli et al., 2017; Ural, Belli, Akbudak, & Tabo, 2015; Weniger et al., 2013; Yayla et al., 2015)). However, the SCID-D does not ask whether the patient has experienced amnesia for a traumatic event, but instead asks more generally about "gaps in your memory" or "hours or days that seem to be missing" or finding yourself "in a place away from home and being unable to remember who you were." Thus, one could obtain a diagnosis of "dissociative amnesia" on the SCID-D even if one had never actually had amnesia for a specific traumatic event. Among the 73 articles, still others describe amnesia associated with neurological diseases, such as traumatic brain injury (Iselin, Le Brocque, Kenardy, Anderson, & McKinlay, 2010) or encephalitis (Witt et al., 2015); some express skepticism about claims of amnesia for committing a crime (Giger et al., 2012; Peters, van Oorsouw, Jelicic, & Merckelbach, 2013), and others express skepticism about the notion that trauma can cause amnesia or dissociation in the first place (Berntsen & Rubin, 2014; Lynn et al., 2014).

In summary, after subtracting out all of the various categories of articles above, we are left with only with a small fraction of the original 73 articles that actually present data or cases suggestive of "repressed memory." When we compare this number – only one or two such articles per year – against the hundreds or thousands of papers published annually regarding other psychiatric disorders, it becomes clear that there is hardly any remaining scientific attention to the notion that individuals could develop amnesia for a seemingly unforgettable traumatic event, and then somehow recover this memory at a later date.

Possible objections to my above analysis: In conclusion, I consider seven possible objections that might be raised in response to the analysis above and explain why none of these objections has merit.

First, people have claimed that dissociative amnesia is a common phenomenon in individuals with posttraumatic stress disorder and use this claim to support their opinion that "dissociative amnesia" is generally accepted in the scientific community. Therefore, is it possible that scientists are actually writing many articles about "dissociative amnesia," but these articles are classified instead under the term "posttraumatic stress disorder" in PubMed, and therefore were missed in the bibliometric count? If we go into PubMed once again, and enter the term "posttraumatic stress disorder," we find 10,340 articles published between 2010 and 2018. But if we then look for publications about posttraumatic stress disorder that also include the keyword "dissociative amnesia," (i.e., publications that come up in PubMed when we enter the terms "posttraumatic stress disorder" and "dissociative amnesia" together in the search bar), we find that there have been only nine such publications worldwide from 2010 through 2018. This is telling evidence that scientists clearly accept the diagnosis of "posttraumatic stress disorder," but that practically no scientists are writing about "dissociative amnesia" as a feature of posttraumatic stress disorder.

One might try to argue that perhaps scientists do accept the notion of "dissociative amnesia" in patients with posttraumatic stress disorder, but they simply have not included "dissociative amnesia" as a keyword when they published their papers. However, this argument does not withstand inspection. When a scientist submits a paper to a peer-reviewed journal, the journal will typically ask the author to suggest five or more keywords as part of the submission process. Therefore, if one were submitting an article about, say, neuroimaging findings in people with posttraumatic stress disorder, one might provide a string of keywords such as "posttraumatic stress disorder," "war trauma," "neuroimaging," "MRI," and "hypothalamus," – or some similar string. After accepting the article, the journal would typically use the suggested string of keywords, but might change one or more of the keywords or add additional keywords of its own. But even though papers typically have five or more keywords, we find from PubMed that out of more than 10,000 papers on PTSD, only nine papers listed "dissociative amnesia" as *any* of the keywords.

Indeed, even if we do a search using the terms "posttraumatic stress disorder" and the far broader generic term "amnesia," there are still only 50 articles for 2010 through 2018 – and many of these articles are about amnesia caused by traumatic brain injury, which is of course completely unrelated to "dissociative amnesia."

A second possible objection to our findings is that "dissociative amnesia" is a rare disorder, and that there would be fewer publications on rare disorders as opposed to common disorders. However, according to estimates from DSM-5, in any given year, 1.8% of the American population will exhibit dissociative amnesia, which translates as more than *5 million individuals* with this disorder in the United States alone in any given year. This 12-month prevalence figure is in the same general range as the estimated 12-month prevalence for panic

disorder (2.5%), obsessive-compulsive disorder (1.2%), attention-deficit/hyperactivity disorder (2.5% of adults) and bipolar disorder (1.8%), according DSM-5 estimates, and far greater than the 12-month prevalence for anorexia nervosa quoted by DSM-5 (0.2%). Thus, the dearth of publications on "systematized dissociative amnesia"/ "repressed memory" cannot be explained by alleging that "repressed memory" is scientifically accepted, but simply rare.

Third, it might be argued that there would be many publications for disorders supported by extensive research funding, but fewer publications for disorders that lack extensive funding. Perhaps "repressed memory" simply does not get much research funding. However, even if we assume that there is a correlation between research funding and publication rates, it must be remembered that research funding itself is correlated to a degree with clinical acceptance of a disorder: disorders that are widely recognized will tend to generate research funding, whereas disorders that are not widely accepted will be less likely to generate funding. Therefore, lack of funding by itself is an inadequate explanation for the lack of publications on "repressed memory."

Fourth, one might speculate that some disorders are more exciting than others, and that scientists may publish disproportionately about interesting and exotic disorders to the detriment of more commonplace disorders. This phenomenon has been suggested with regard to publications about neurological conditions (Al-Shahi, Will, & Warlow, 2001), where it was found that the number of publications in 1998 about stroke and transient ischemic attack was small relative to the number of people who actually experience strokes and ischemic attacks, whereas publications about certain rare neurological conditions (e.g., Creutzfeldt-Jakob disease) were frequent relative to the very small number of actual cases. However, when we look at actual numbers, we see that there were 42 articles about Creutzfeldt-Jakob disease versus 4,562 about stroke and transient ischemic attack during the year 1998. Therefore, even though the proportion of articles about stroke was still small relative to the massive numbers of actual people with stroke, the rate of publication was still robust. Thus, this argument cannot be used to explain away the dearth of articles on "systematized dissociative amnesia."

Fifth, it might be claimed that scientists actually agree on the validity of "dissociative amnesia," and that since this issue is no longer controversial, there are few publications. But this argument is clearly false, because other disorders with established validity, such as anorexia nervosa or obsessive compulsive disorder, have continued to generate hundreds or even thousands of publications every year.

Sixth, it might be argued, as some have (Clement, Singh, & Burns, 2003), that an analysis restricted to PubMed would miss articles that were not indexed in PubMed, and that an ideal search should use multiple search engines in order to capture the full range of publications on a given diagnosis. Although it is certainly true that PubMed does not capture all published articles, this argument would not be relevant for our comparison of publication rates across different diagnoses using PubMed across the board, since the searches for all of the different diagnoses would be similarly limited by the use of a single search engine. Moreover, it could be argued that it is actually superior to use PubMed alone, because this search engine is restricted

to well-recognized scientific journals (so-called "indexed journals"), and thus excludes lower-level journals and "fringe" journals that are less likely to represent the views of the mainstream scientific community.

Seventh, it might be argued that the term "dissociative amnesia" does not capture all of the articles written on the subject, because some may be listed under other search terms such as "repressed memory," "recovered memory," "psychogenic amnesia," or "traumatic amnesia." However, the first three of these alternative terms collectively yielded only about two dozen articles in 2010-2018 not already captured by the term "dissociative amnesia," and the term "traumatic amnesia" generates almost entirely neurological studies involving the aftereffects of traumatic brain injury and other biological injuries. Moreover, a similar argument could be applied to comparison diagnoses in a bibliometric analysis. For example, the term "anorexia nervosa" would likely fail to capture many papers discussing anorexia nervosa but classified under keywords such as "eating disorders."

In conclusion, even when we allow for some possible effects associated with the seven potential methodological objections enumerated in the paragraph above, these effects still could not account for differences on the order of a hundredfold between articles on "dissociative amnesia" and articles on other DSM-5 diagnoses. Moreover, when we look at articles in the last seven years that specifically address the so-called "systematized" subtype of dissociative amnesia – which corresponds to the concept of "repressed memory" as it is generally used in the courts – the number of such articles is only a small fraction of the overall articles on "dissociative amnesia," so that we are now talking of differences on the order of the thousand fold between articles on "systematized dissociative amnesia" and articles on other diagnostic entities. A difference of this magnitude is so large that it cannot possibly be explained on the basis of the seven possibly confounding factors discussed above. Thus, our bibliometric analysis admits to only one plausible interpretation, namely that "dissociative amnesia" has garnered almost negligible scientific interest, and thus has failed to gain acceptance in the general scientific community.

F. Popular belief in "repressed memory" provides no evidence that the theory is accepted in the relevant scientific community.

Another equally spurious argument about "repressed memory" is that portrayals of this hypothesized phenomenon appear often in Hollywood movies, novels, dramas, and television shows, and that this popular acceptance is somehow evidence of scientific acceptance. But the fact that a concept enjoys *popular* belief provides no logical evidence that the *relevant scientific community* accepts the concept. For example, many mothers will claim that chicken soup is helpful for the common cold, but this popular belief has no support among infectious disease researchers, and we would certainly not allow an expert witness to testify to a jury about the medical benefits of chicken soup. Similarly, many elephant owners in Southeast Asia reported that their animals somehow anticipated the December 26, 2004 earthquake and tsunami in the Indian Ocean, and ran away from the shore well in advance of the earthquake – but

seismologists would tell us that it is not scientifically accepted that elephants can predict earthquakes. Popular belief must not be confused with scientific acceptance.

Indeed, my colleagues and I have published a scientific study suggesting that "repressed memory" is little more than a Victorian-era myth: nowhere in the literature of the world prior to 1780, in any published work, in any language, in fiction or in nonfiction, is there even a single description of an individual who exhibited a "repressed memory" (H. G. Pope, Poliakoff, et al., 2007a). Instead, "repressed memory" emerged as a romantic philosophical notion in the 1780's, long before it was ever portrayed as a "scientific" notion. (*Note that this paper employs the term "dissociative amnesia," rather than "repressed memory," because the paper was written prior to the time that we recognized that the term "dissociative amnesia" had become an ambiguous term that could be misleading, as described previously. Therefore, in reading the paper today, is important to recognize that the paper is specifically talking about the concept of "repressed memory" as it is defined here in this analysis, and does not refer to the heterogeneous and ambiguous term, "dissociative amnesia.")*

The paper reporting this study begins by noting that real psychological phenomena, which genuinely occur in human beings, such as delusions, hallucinations, dementia, depression, anxiety, and even neurologically induced amnesia, appear in published works throughout the ages – because writers observed these phenomena in people around them, and then described these phenomena in their works. Now if "repressed memory" were a genuine psychological phenomenon – an innate capacity of the brain to banish from consciousness the memory of a traumatic event – then in the thousands of years prior to 1780, numerous people would have witnessed individuals who exhibited this phenomenon, and then described cases of "repressed memory" in the course of written works. Consequently, one would expect to find numerous examples of "repressed memory" in both nonfictional works and fictional characters before 1780.

To test this question, we advertised in three languages on more than 30 Internet web sites and discussion groups, and also in print, offering $1,000 to the first individual who could find a case of "repressed memory" for a traumatic event in any fictional or nonfictional work before 1800. The search generated more than 100 responses from individuals all over the world; it produced numerous examples of ordinary forgetfulness, infantile amnesia, and biological amnesia throughout works in English, other European languages, Latin, Greek, Arabic, Sanskrit, and Chinese before 1800, but no descriptions of individuals showing "repressed memory" for a traumatic event. Eventually one individual found a case a few years before 1800, in 1786, and was awarded the $1,000 prize. However, this case does not change our fundamental argument that "repressed memory" is merely a recent romantic notion; it simply sets the threshold for the development of this belief a couple of decades earlier than we had originally postulated.

The absence of cases of "repressed memory" before 1780 cannot be explained simply by arguing that our ancestors understood or described psychological phenomena so differently as to make these descriptions unrecognizable to modern readers – because spontaneous

complete amnesia for a major traumatic event, in an otherwise lucid individual, is so graphic that it would be recognizable even through a dense veil of cultural interpretation. More specifically, our ancestors were certainly capable of describing trauma in their written works, and they were certainly capable of describing individuals with amnesia (such as amnesia due to head injury or dementia, for example). Therefore, if our ancestors had witnessed anyone who developed amnesia for a traumatic event, they would certainly have been capable of writing such a description – even if they did not fully understand what they had witnessed. By analogy, our ancestors had a very different notion of delusions and hallucinations from that which we have today, but descriptions of delusions and hallucinations are nevertheless readily recognizable in numerous works written prior to 1780. Therefore, if "repressed memory" existed, why would it not be identifiable in numerous texts as well?

Our paper considers several other arguments such as the one above, and concludes that there is no plausible manner in which "repressed memory" could be a genuine human psychological phenomenon, and yet somehow never appear in any written work prior to 1780. One is left, by default, with the conclusion that "repressed memory" is simply a romantic notion peculiar to our recent Western culture.

For a full scientific discussion of the above points, I refer the reader to our published paper, together with our published responses to writers who have questioned our findings (H. G. Pope, Jr., Poliakoff, Parker, Boynes, & Hudson, 2009, 2010; H. G. Pope, Poliakoff, Parker, Boynes, & Hudson, 2007b, 2007c).

In summary, the findings of the paper can be reduced to a single sentence: if "repressed memory" were a genuine phenomenon that occurred often individuals who had experienced trauma, how is it possible that no one, anywhere, in any language, in any culture prior to 1780, ever happened to notice and describe even a single case?

G. Laboratory studies of "forgetting" provide no evidence that "repressed memory" is generally accepted in the scientific community.

Laboratory studies have been conducted where individuals attempted to deliberately remember certain stimuli (such as words in a word list) and to forget others (Anderson & Green, 2001; Anderson et al., 2004). Although these studies suggest that people have some control over their ability to remember or forget words on a word list, this observation does not permit any inference that there is a scientific consensus that individuals can develop complete amnesia for a traumatic life event.

More generally, as already discussed above, any discussion of laboratory observations is tangential and potentially misleading, in that it merely distracts us from the real question of whether there is a scientific consensus on the validity of "repressed memory" for actual human beings experiencing actual traumatic events in real life. To leap from laboratory studies using word lists, brain-imaging results, or other such data, to the question of "repressed memory" in

real life represents a similar fallacy. Relying on such studies as evidence of "repressed memory" is an example of drawing conclusions without a scientific basis.

H. Looking at all of the evidence above, and even taking the position most favorable to proponents of "repressed memory," one could not possibly maintain that the concept of "repressed memory" is *generally accepted* in the relevant scientific community.

Looking at all of the material presented in sections A through G above, and even when interpreting this material from a position most favorable to advocates of "repressed memory," one would still, at an absolute minimum, have to concede that the concept of "repressed memory" is at the very least *controversial*. But even by admitting that "repressed memory" is *controversial*, we are already admitting that "repressed memory" is not *generally accepted* in the relevant scientific community, since it is logically contradictory to conclude that a concept is controversial and yet is simultaneously generally accepted.

Note, as a corollary to the above paragraph, it is not the burden of those who challenge the general acceptance of "repressed memory" to demonstrate that "repressed memory" is generally *rejected* in the relevant scientific community. Rather, it is sufficient for them to demonstrate simply that it is *controversial*, because this demonstration alone establishes that the concept is not *generally accepted.*

VI. Peer Reviewed Publication Concerning "Repressed Memory" has Resulted in Rejection of the "Repressed Memory" Hypothesis by the Scientific Community, Both on Grounds That it Has Not Been Proven and Because Proponents of Repressed Memory Rely Upon Studies with Substantial and Obvious Flaws That Do Not Meet Basic Scientific Standards

A. Studies of trauma victims overwhelmingly show *no* evidence of "repressed memory."

An enormous literature of studies of individuals who had experienced numerous types of trauma has shown that individuals remember traumatic events vividly. To illustrate this fact, the Pope-Hudson 2012 Chapter contains a list and table (Appendices A and B of the Chapter) showing a non- review of studies covering more than 11,000 individuals who had experienced all manner of traumas in 77 studies. These studies contain no mention of anyone who was *unable* to remember an entire traumatic event for any reason other than the ordinary known causes of amnesia, such as 1) head injury, drug intoxication, or other biological insults to the brain, as discussed above; or 2) the amnesia of early childhood, wherein memories for most events before age 5 and virtually all events before age 3 are lost because the brain is still developing, as discussed above. Also, one must exclude, in reviewing these studies, cases where individuals reported amnesia merely for some piece of a traumatic event, since this phenomenon may well represent so-called "incomplete encoding," as explained above (e.g., having a memory of a gun, but not the assailant's face, after an incident being threatened with a gun).

Moreover, an exhaustive review was conducted of the aftereffects of childhood sexual abuse, published by Kendall-Tackett, Williams, and Finkelhor in 1993 (Kendall-Tackett, Williams, & Finkelhor, 1993). This review examined 45 studies covering 3,369 individuals who had experienced childhood sexual abuse; although the review documents numerous sequelae of sexual abuse reported by the various studies, "repressed memory" for the abuse never appears anywhere in the review. This finding is particularly remarkable when it is considered that Linda Williams, one of the co-authors of this article, was the same Williams whose 1994 study (described below) is often cited as evidence of "repressed memory" by proponents of the hypothesis.

Adding up the more than 14,000 individuals reported in more than 120 studies covered by the above reviews, it is inconceivable that "repressed memory" could be a valid and generally accepted scientific hypothesis, yet not be demonstrated in a single unequivocal case reported throughout this vast literature. Of course, it should be acknowledged that the investigators in many of the 120 studies did not specifically ask the study participants about "repressed memory" *per se*. However, if "repressed memory" were a genuine phenomenon, it is inconceivable that none of the 120 studies would have commented, even in passing, about even a single case of "repressed memory" among the 14,000 individuals who had experienced trauma.

Given the numerous prestigious scientific papers that question "repressed memory," as described above, together with the even more numerous studies of thousands of individuals who had experienced trauma that fail to show evidence of "repressed memory," as just cited, it is clear that the peer-reviewed scientific literature offers no consensus that the theory is valid.

While there are some peer-reviewed papers that do purport to provide evidence, or are claimed by others to provide evidence, for "repressed memory," it must be remembered that even if one accepts these latter papers completely at face value, this still would not permit the conclusion that there is a scientific *consensus* regarding "repressed memory"; instead, there is a scientific *controversy* regarding "repressed memory." Furthermore, there are many severe methodological deficiencies in papers purporting to accept "repressed memory," several of which I summarize in sections B through E below.

B. Retrospective studies purporting to document "repressed memory" fail to meet basic scientific standards and are scientifically almost valueless.

As mentioned above, there are some studies that do purport to show "repressed memory," or studies that have at least been interpreted by some writers as providing some evidence of "repressed memory." However, the great majority of these studies are *retrospective* investigations. In retrospective studies, individuals in the present are asked to recall whether or not they had a period of purported forgetting in the past. In the typical retrospective study, a sample of subjects (say, 1000 college students) is surveyed to ask if they recall having ever been sexually abused. A certain percentage will answer "yes" (say, 100 of the students). These individuals are then asked if there were ever a period of time during which

they could not remember the abuse. Almost always, at least some of the individuals will answer "yes" to this question. I refer to studies of this type as "do-you-remember-if-you-forgot" studies.

Some proponents of "repressed memory" have inappropriately interpreted these studies as evidence that the individuals actually "repressed" the memory of the abuse for some period of time. But in fact, such studies provide no acceptable scientific evidence of "repressed memory" at all. First, most of the studies failed to obtain confirmation that the purported episode of recalled sexual abuse actually occurred. Second, even if the episode did occur, almost none of the studies made an effort to *validate* the meaning of a "yes" answer to the question about having forgotten the event for a period of time. For example, a "yes" might mean that the subject simply had not thought about the event for some period of time, but it does not mean that the subject was *unable to remember* the event during that period of time. We could not conclude that "yes" responses indicated actual "repressed memory" unless we could go back in time, meet the individuals during the period of purported amnesia, and ask them specifically if they remembered the episode of sexual abuse in question, as explained in our hypothetical example above. Without such validation, a "yes" answer is uninterpretable. This issue has been discussed in detail in the Pope-Hudson 2012 Chapter and elsewhere (H. G. Pope, 1997).

One group of investigators did attempt to assess the validity of a "yes" answer in a retrospective study. Melchert and Parker (Melchert & Parker, 1997) surveyed 429 adults and asked them about a history of childhood abuse. Of these, 111 reported a history of sexual abuse, 78 a history of physical abuse, and 101 a history of emotional abuse. The investigators then asked the individuals, "has there ever been a time when you could not remember the sexual/physical/emotional abuse that happened to you?" The investigators received a "yes" answer from 22 of the subjects who reported childhood sexual abuse. They then asked, "If there was a time when you could not remember the abuse, why do you think you couldn't remember it?" Among the various options for answering this question were "because I didn't' want to think about it," and "because I was afraid of remembering it." The option closest to "repressed memory" was "because I simply had no memories of it ever happening." Remarkably, among the 46 subjects reporting they had forgotten one of the three forms of abuse, *there was not a single individual who endorsed the response, "because I simply had no memories of it ever happening."* This finding graphically illustrates the fallacy of equating a "yes" response in any retrospective study with "repressed memory." Even if some of the subjects had responded that they had "no memories of it ever happening," one still would not have a scientifically valid test, because there is no assurance that these subjects would actually have displayed amnesia in real life if we were to go back to the time of the purported forgetfulness and ask them directly and contemporaneously whether they remembered the episode of abuse. Indeed, this point highlights a fundamental flaw in the process of attempting to retrospectively assess amnesia in cases alleging "repressed" and "recovered" memory: for those who claim that a memory has been "repressed" in the past and is now "recovered," there is no scientifically valid method to establish that these individuals were, in fact, *unable* to remember the event at some point in the past.

A further source of error in retrospective studies is that people may *believe* that they were unable to remember, whereas in fact they have forgotten that they actually were able to remember. For example, there are cases where individuals believed that they had forgotten an experience for many years, and then were surprised when others told them that they had, in fact, remembered and discussed the experience during the period of alleged amnesia (Schooler, Bendiksen, & Z., 1997). I have already discussed this phenomenon above, and I will discuss it in greater detail in section C immediately below.

A subsequent study by Epstein and Bottoms (Epstein & Bottoms, 2002) also used the "do-you-remember-whether-you-forgot" design and concluded that the recollection of having forgotten reported by subjects would "*not* meet the [legal] standard set by the more common delayed discovery doctrine adopted by many states to accommodate repressed memories of abuse…" [p. 222; italics mine].

The mere number of retrospective studies of the above "do-you-remember-whether-you-forgot" type – about 60 studies over the last 15 years – does not heighten the validity of the findings. Even if there were 150 or 250 studies with the same flaws, this would not make "repressed memory" any more scientifically credible. For example, there have been many thousands of documented Elvis sightings since the time of Elvis Presley's death. But the sheer number of such sightings does not permit the scientific inference that Elvis is alive.

Recent *case reports* purporting to document "repressed memory" are also almost valueless. Such reports are sometimes advanced in favor of "repressed memory," claiming to show individual instances of "repressed" and "recovered" memories of childhood trauma. Two such case reports that are sometimes cited are those of Duggal and Srofe (Duggal & Sroufe, 1998) and Corwin and Olafson (Corwin & Olafson, 1997). However, these reports disintegrate upon critical inspection. With regard to Duggal and Srofe, an analysis by Piper and colleagues (Piper et al., 2000) concludes (page 196), "in sum, Duggal and Srofe offer neither evidence that the child experienced any traumatic, memorable event nor evidence that if she did, it occurred beyond the age of childhood amnesia. The authors also fail to support their contention that the respondent's putatively recovered memory accurately reflected some childhood mistreatment." Similarly, with regard to Corwin and Olafson's case of "Jane Doe," an investigation by Loftus and Guyer (E. F. Loftus & Guyer, 2002) exposed numerous flaws in the report that undermine its credibility. Loftus and Guyer conclude, "in sum, we believe that there are ample reasons to doubt whether Jane Doe was physically or sexually abused by her mother and to doubt much of the 'supporting evidence' used to support the abuse hypothesis."

C. Recent laboratory investigations provide a simple, scientifically tested, alternative explanation for cases where individuals may come to believe that they have "repressed" and subsequently "recovered" a memory. Specifically, such individuals have suffered from ordinary forgetfulness, and there is no need to postulate some special mechanism of "repression" to explain their experiences.

A recent series of elegant laboratory investigations, conducted by the research group of Richard McNally and colleagues at Harvard University, has provided a simple and compelling explanation for the phenomenon where adult individuals may come to believe that they have "repressed" and subsequently "recovered" a memory of childhood sexual abuse. This explanation is well summarized by Dr. McNally in one of his recent papers (R. J. McNally, 2007), and therefore I quote it at some length here:

> "In our research program, the typical recovered memory participant reports having been nonviolently molested (e.g., fondled) by a trusted adult (e.g., uncle) on 1 or more occasions, and having been confused and upset, but not terrified. Aged only 7 or 8 years, the average survivor did not fully understand the unpleasant experience as sexual abuse. Understanding such episodes as sexual abuse likely amplifies its negative emotional impact and hence its memorability. In the absence of such understanding, the episode is less likely to be as memorable as it would otherwise be. Lacking a conceptual framework for the molestation, the CSA [childhood sexual abuse] survivor managed not to think about the experience for many years, and this ordinary forgetting was fostered by the absence of reminders (e.g., perpetrator moved away). Years later, the abuse survivor encounters reminders that trigger recollection of the long-forgotten experience from the perspective of an adult. Because the event was not understood when it occurred and was not experienced as traumatic, no special dissociative mechanism is needed to explain why the person did not think about it for so long. Once CSA survivors in our research program have recalled the event as adults, usually outside the context of therapy, they tend to experience intense distress, and nearly one third of them qualify for PTSD." (p. 1086)

In a paper, entitled "A New Solution to the Recovered Memory Debate," (R. J. McNally & Geraerts, 2009), McNally and co-author Elke Geraerts expand upon the above explanation and provide scientific documentation from studies in their own laboratory to support it. Specifically, they point out that in their studies, many adults who had apparently experienced childhood sexual abuse indicate that they were not terrified or extremely traumatized at the time of the abuse, but merely perceived the experience as bizarre, disgusting, or confusing. As children, these individuals typically failed to understand the experience as sexual or abusive at the time, and thus failed to perceive it as particularly striking or memorable. Therefore, especially in the absence of reminders about the sexual abuse, these individuals hardly ever thought about it in the ensuing years, even though there was in fact no evidence that they were actually *unable* to remember it. Indeed, in some cases, these individuals simply forgot the fact that they had recalled the abuse from time to time, thereby giving themselves the illusion that they had had amnesia for it.

Indeed, McNally's research group has shown, under laboratory conditions, that many individuals could recall specific autobiographical events during one visit to the laboratory, and then would forget that they had remembered these events when they returned to the laboratory two months later and were asked specifically whether they had remembered the events at the time of the previous visit (Geraerts et al., 2006). This experiment provides graphic evidence that individuals can feel that they have "recovered" a memory of an event, even though in reality they were demonstrably able to remember the event earlier. Thus, there is no need to postulate a novel brain mechanism of "repressed memory" to explain the phenomenon where individuals report that they have recently "recovered" a memory that they believe was previously inaccessible.

D. Prospective studies purporting to document "repressed memory" also contain fatal scientific flaws.

As the above paragraphs have illustrated, retrospective studies are fraught with severe methodological flaws, including the simple fact that people demonstrably forget that they were capable of remembering all along. Therefore, a more scientifically valid method for testing the validity of "repressed memory" is through *prospective studies*. In prospective studies, a traumatic event is known to have occurred, and subjects are interviewed at a later date to see if they remember the experience.

Although this design is fundamentally sound if correctly performed (see Section VII below), the available prospective studies *provide no acceptable scientific evidence* that "repressed memory" actually occurred in any of the cases (for a detailed discussion of these studies, see the Pope-Hudson 2012 Chapter section § 20:24, Part 5c).

For example, subjects in some prospective studies were under age five, and in some cases even under age one, at the time of the purported trauma, and hence likely to have experienced amnesia simply as a result of ordinary childhood amnesia (a phenomenon attributable to the immaturity of the developing brain, as discussed above, and having nothing to do with "repressed memory"). Second, many of the available prospective studies provided inadequate documentation that the purported traumatic event actually occurred. Third, some studies included individuals who had experienced relatively minor episodes of sexual abuse (for example, simply being touched inappropriately, perhaps only on a single occasion) – which may not have been perceived by a young child as particularly memorable, and hence simply forgotten (as described above). Fourth, and most importantly, subjects in some of the studies (most notably the often-quoted study of Williams (Williams, 1994)) were *never actually asked* whether or not they remembered the purported episode of childhood sexual abuse; instead, they were simply asked about memories of sexual abuse or traumatic events in general. If subjects did not mention the index episode of sexual abuse when asked, the investigators *did not follow up and specifically ask the subjects about their known abuse incident to find out whether the subjects remembered it or not*.

It is a grave error to conclude that *nondisclosure* of an event indicates that one has *repressed the memory* of that event. This fact is demonstrated in an extensive body of studies that have consistently revealed substantial rates of underreporting by people interviewed about all manner of life events. For example, a series of studies undertaken by the United States Department of Health, Education, and Welfare (reference citations in the Pope-Hudson 2012 chapter) addressed the question of whether individuals would correctly report known events from their past to interviewers. One study, for example, found that 28% of individuals interviewed by trained researchers failed to report a one-day hospitalization they were known to have undergone within the previous year. In another, 35% of respondents, when interviewed, did not report a doctor's visit that had occurred within the past two weeks. In another example, 54% failed to report a hospital admission occurring within 10 to 11 months prior to the interview. Nondisclosure has also been documented in many other studies in settings in which people are interviewed about sensitive or embarrassing information, including alcohol consumption, cigarette smoking, drug use, history of drunk driving charges, arrest records, HIV infection, epilepsy, history of psychiatric disorders, and history of having been a victim of a crime. Examples of underreporting relative to crime can be seen in a 1981 report from the National Crime Survey, wherein known crime victims underreported burglaries by 14%, robberies by 24%, and assaults by 64%. These findings are consistent with underreporting when interviewees are asked about sexual abuse. These findings completely undermine the notion that such nondisclosure can be equated with "repressed memory."

Another prospective study of childhood physical and sexual abuse by Della Femina et al. (Della Femina, Yeager, & Lewis, 1990) provides graphic evidence that nondisclosure should not be erroneously equated with "repressed memory." In this study, the investigators interviewed a group of 69 young adult men about whether they had been abused as children. Eighteen of the 69 men in this group denied on interview that they had been abused in childhood, even though the investigators had old records showing that the abuse had actually occurred. However, Della Femina et al. did not make the error of assuming that these men exhibited "repressed memory," and instead managed to go back and perform "clarification interviews" with eight of these 18 men. In the clarification interview, the investigators asked the men directly about their known history of abuse, and importantly *all of these men admitted that they actually remembered the abuse, but had simply chosen not to disclose it at the time of their initial interview*. This finding illustrates once again that it is inappropriate and naïve to take initial non-disclosure at face value as evidence of "repression." Failure to disclose, for a variety of reasons, is a well-known and well-documented occurrence in survey studies.

Another large prospective study by Goodman et al. (Goodman et al., 2003) followed 175 individuals who had experienced documented childhood sexual abuse and failed to find evidence of any "special memory mechanisms unique to traumatic events" (p. 117). The study cautioned that "failure to report CSA [childhood sexual abuse] should not necessarily be interpreted as evidence that the abuse is inaccessible to memory…" (p. 113).

The conclusions of Williams and colleagues are even further repudiated by another recent study by Bonanno and colleagues (Bonanno et al., 2002), who interviewed 67 individuals

who had experienced documented child sexual abuse, obtained from records of Child Protective Services in Washington DC. These individuals were at least age 6 at the time of the documented abuse (and hence unlikely to be the subject of infantile amnesia). All had experienced genital contact or penetration from a family member. The investigators interviewed these individuals at a mean 7.1 years after the initial abuse assessment. First, without disclosing their knowledge of the subjects' history of sexual abuse, the investigators simply asked the interviewees to describe "the most distressing event or series of events they had ever experienced." In response to this question, only 44 (66%) of the interviewees described the experience of sexual abuse, whereas 23 (34%) did not. This figure is very similar to that obtained in the Williams study, where 38% did not disclose their known index episode of sexual abuse when asked a generic question. However, Bonanno and colleagues did not make Williams' error of assuming that the non-disclosers had "repressed" the memory. Instead, they conducted a subsequent structured interview asking more directly about sexual abuse experiences. On this second interview, virtually all of the non-disclosers acknowledged experiences of sexual abuse, with only two subjects still denying abuse. Interestingly, these two subjects were rated as showing high levels of shame on interviewing, suggesting that they had not forgotten their abuse experience, but were still intentionally withholding the information from the interviewer. Bonanno and colleagues make no suggestion that these two individuals were "repressing" their memories.

In summary, as I have discussed in greater detail in the Pope-Hudson 2012 Chapter, there are currently a total of seven prospective studies of memory of childhood sexual abuse, and none provides any satisfactory evidence of "repressed memory." Specifically, four of the studies, including the Della Femina, Goodman, and Bonanno studies cited immediately above, together with one other study by Widom and Morris (Widom & Morris, 1997), do not even purport to show evidence for "repressed memory," and all of these four studies specifically mention the issue of nondisclosure as a phenomenon that may readily explains participants' failure to report a known episode of sexual abuse. The remaining three studies, which include the Williams study just cited, together with two other much smaller, even more seriously flawed studies (Bagley, 1995; Burgess, Hartman, & Baker, 1995), are sometimes claimed to show evidence of "repressed memory," but none has provided any evidence that non-reporting was in fact attributable to "repressed memory," as opposed to simple nondisclosure, together with factors such as ordinary forgetfulness and early childhood amnesia.

Moreover, as I have reviewed in the Pope-Hudson 2012 Chapter, various prospective studies of memory in individuals who had experienced traumas other than childhood sexual abuse – such as disasters, witnesses to disaster, kidnappings, concentration camps, accidental injuries, and medical procedures – have also failed to provide any evidence that individuals "repressed" their memories in these situations. In cases where forgetfulness or amnesia were reported, these could be readily explained by the ordinary causes of memory deficits that I have reviewed at the beginning of this chapter, without any need to hypothesize a novel mechanism such as "repression."

In summary, therefore, no prospective study has ever demonstrated that a group of individuals actually "repressed" the memory of a traumatic event, as opposed to simply forgetting it or simply choosing not to disclose an event that was actually remembered.

E. An extensive literature studying combat trauma, the Holocaust, natural disasters and the like similarly fails to demonstrate evidence for "repressed memory."

In the Pope-Hudson 2012 Chapter, I also discuss in some detail the literature surrounding other types of trauma, such as wartime combat, torture, and natural disasters. Once again, a detailed review of this literature fails to show any acceptable scientific evidence that any of the individuals who had experienced trauma actually displayed "repressed memory." The reader is referred to my chapter for a full discussion of these materials; I summarize them briefly in the next few paragraphs.

Combat Trauma. A thorough analysis of the extensive literature studying combat trauma fails to produce valid evidence to support the "repressed memory" hypothesis. Those studies that have described amnesia in wartime situations, beginning with World War I, cannot reasonably be interpreted as describing amnesia from "repressed memory," because combat veterans were vulnerable to numerous ordinary biological causes of amnesia, such as loss of consciousness, grand mal seizures, severe sleep deprivation, profound fatigue and weight loss, and other neurological insults. Other widely documented factors place further interpretive limits on such studies. These include several studies in which either hypnosis or barbiturates – both of which can stimulate confabulation – were used to "reconstruct" memories of combat situations. Also, a number of investigators conducting wartime studies suspected malingering among those who reported amnesia, with some investigators even suggesting that most cases of combat neurosis and amnesia involved exaggeration or malingering, amidst terror and anxiety that were genuine. A few studies failed basic methodological requirements by failing to document traumatic events, and many of the studies offered only a collection of case reports subject to a high risk of false positive findings. An example of this phenomenon includes a case reported of "recovered memories" by Korean War veterans who remembered being present with a particular veteran, Edward Daily, at the No gun Ri massacre 40 years earlier (Moss, 2000). However, United States military records indicated that Daily was never present at No gun Ri, and instead had been working as a clerk and a mechanic in the prosaic 27th Ordinance Maintenance Company, well behind the front lines. Thus, these veterans' "recovered memories" of having been with Mr. Daily were false.

A review of combat trauma literature demonstrates that the most prevalent cognitive disturbance in psychologically traumatized combat veterans is the intrusive recollection of terrifying events, i.e., the remembrance of traumatic events all too well. As is true with many people who suffer from psychiatric disorders, veterans with chronic stress reactions report problems with everyday memory and concentration. Such reports do not provide evidence of "repressed memory." In short, decades of literature devoted to combat trauma have failed to establish evidence of "repressed memory."

The Holocaust, Genocide, and Torture. Although several studies of prisoners of war and Holocaust survivors describe the usual disturbances of concentration and memory typically seen in depressed and anxious individuals, none report patients who "repressed" the memory of their trauma. An example of this is seen in Wagenaar and Groeneweg's study of survivors of Camp Erika, a German prison camp in World War II (Wagenaar & Groeneweg, 1990). This study is sometimes erroneously cited as evidence favoring "repressed memory." The results of this study, however, showed that all subjects remembered the camp very well even upon interview 40 years later. It is not surprising that the survivors had forgotten various details of the experience after four decades; in any case, this forgetfulness was random and not confined to the traumatic events.

Several other studies of concentration camp survivors, sometimes cited as evidence of "repressed memory," do not survive inspection and application of basic scientific methodological criteria. Many cases of purported amnesia appear to be due to biological problems, such as loss of consciousness from head injury or other neurological insults. Furthermore, prisoners who endured months or years of repeated traumas cannot reasonably be expected to remember every traumatic event individually, and therefore this kind of forgetfulness has nothing to do with "repressed memory." It simply represents the normal human tendency to forget individual events from a series of many similar events. Finally, studies have established that concentration camp survivors are often reluctant to describe gruesome memories.

Disaster Victims. Certain studies of victims of disasters, both natural and manmade, are also sometimes cited as evidence of "repressed memory." Some of the studies described individuals who had amnesia for the disaster as a result of biological factors such as head injury, or as a result of childhood amnesia. However, none of the studies demonstrates that any individuals "repressed" the memory of the disaster. Indeed, many of the 77 studies presented in the Pope-Hudson 2012 Chapter Appendix A and B concerned disasters. Throughout these studies, individuals remembered the events vividly. One such example is the 1998 study by McFarlane, which found that firefighters who appeared more traumatized remembered events *better* than those who were traumatized less (McFarlane, 1998).

In summary, the most salient cognitive disturbance in combat veterans who have been psychologically traumatized is the intrusive recollection of horrifying events. The study of Holocaust victims and others subjected to repeated abuse and chronic deprivation imposed by other human beings demonstrates the retention of memory even after decades. Disaster victims likewise retain memories all too well. Decades of study focused upon trauma in these areas have failed to provide evidence of "repressed memory." For further details on these matters, I again refer to the Pope-Hudson 2012 Chapter, where I have discussed in greater detail methodological considerations regarding wartime studies, Holocaust studies, disaster studies, and others, and explained in detail why none of these studies provides valid scientific evidence for the existence of "repressed memory." Many of these same methodological deficiencies have been noted by other writers in the scientific literature (for example, Professor McNally's recent book, *Remembering Trauma* (R. McNally, 2003)).

VII. Although the Hypothesis of "Repressed Memory" Can be Tested, No Methodologically Sound Test Has Demonstrated That "Repressed Memory" Can Actually Occur

A. "Repressed memory" is a readily testable hypothesis, and there is fundamentally no serious disagreement among scientists about the criteria that would be required to test it.

In Section VI above, I have summarized the scientific flaws of *retrospective studies, individual case reports*, and *prospective studies*. However, it would be perfectly possible to conduct a scientifically sound test of the validity of "repressed memory," using a prospective study *if properly designed*.

As proposed in the Pope-Hudson 2012 Chapter, and also discussed in my earlier publications (H. Pope & Hudson, 1995; H. G. Pope, Jr. et al., 1998), a prospective study offering a satisfactory demonstration of "repressed memory" must satisfy two simple criteria. First, there must be evidence that a given traumatic event actually did occur. Second, there must be evidence that a group of individuals developed amnesia for the event, and that this amnesia cannot be explained by any of the more ordinary causes of forgetfulness or seeming forgetfulness enumerated in section II – such as ordinary forgetfulness, biological amnesia, early childhood amnesia, etc. In particular, one would also need to exclude the possibility of deliberate nondisclosure by individuals who actually did remember, and be certain not to misclassify such individuals as having amnesia.

A scientifically acceptable prospective study would therefore collect a large group of individuals who had experienced trauma, where the trauma was clearly documented, where the individuals were over age five at the time that the trauma occurred, where no biological causes of amnesia were present, and where the event was sufficiently traumatic that no ordinary person would be expected to forget it. Then, an investigator would interview these people some years after the time of the trauma, and ask them if they remembered the event. If any of the subjects initially denied remembering the trauma, the interviewer would follow up with a description of the known event and ask them again, in order to assess whether they were in fact *unable* to remember the event. If a substantial number of participants in this hypothetical study continued to report amnesia for the traumatic event even with this follow-up questioning, and there was no reason to expect that they would have any reason to be deliberately feigning amnesia, we would then have good scientific evidence that "repressed memory" actually occurs.

These two simple criteria represent the minimum that scientific methodology requires – but there is *no published study even remotely approaching these criteria that has ever shown a group of people who developed amnesia for a traumatic event.* As I have explained above, the prospective studies currently published that most closely approach these minimum methodological criteria have explicitly *failed* to find any evidence of "repressed memory" among individuals who had experienced childhood sexual abuse or other traumas.

B. Testing the validity of "repressed memory" would not be unusually difficult, and there is no logical reason to relax the scientific standards for testing this theory.

On a scale of complexity for the design and execution of scientific studies, the criteria for a test of "repressed memory" are not particularly complicated. Basic scientific standards require these criteria and no reasonable scientist would settle for a study that failed these criteria.

Specifically, if a study claimed that people developed "repressed memory" for a putative traumatic event, but there existed no satisfactory evidence that the event actually occurred, no reasonable scientist could accept the study as valid. For example, if one reads news reports about an individual who had recovered "repressed memory" about a battle in the Korean War, but military records indicated he was not in combat in Korea at the time (as in the example described above), such a case would not provide evidence of "repressed memory."

With respect to the second criterion, no reasonable scientist would assume that someone has developed "repressed memory" if it turns out that there was a simpler explanation for the purported forgetting. If an individual experienced a trauma, but was only one year old at the time, this would represent ordinary childhood amnesia, rather than "repressed memory." If an individual were drunk on alcohol, and had no memory of the events of the previous night, this again would not constitute "repressed memory." If a child were touched in an inappropriate way on a single occasion at age seven, and cannot recall the event at age 25, this again would not represent "repressed memory," because the event may not have been perceived by the child at the time as particularly traumatic – and thus was forgotten via ordinary forgetfulness.

Finally, if an individual initially denies remembering an event on general questioning, no reasonable scientist would take this denial at face value as proof of "repressed memory" without some confirmation that the individual truly could not remember the event – given the decades of studies confirming the tendency of individuals to not disclose or to underreport events in multiple contexts. Graphic evidence of the importance of such confirmation is shown in the study by Della Femina et al. (Della Femina et al., 1990) concerning childhood physical and sexual abuse, described above. The evidence of the Della Femina study illustrates a point that I have emphasized earlier: that it is inappropriate and naïve to take initial non-disclosure at face value as evidence of "repressed memory." Failure to disclose, for variety of reasons, is a well-known and well-documented occurrence in survey studies. Another example of the importance of follow-up interviews is the study of Bonanno and colleagues that I have described above. This study also illustrates graphically that simple non-disclosure must not be misinterpreted as evidence of "repressed memory."

In short, *documentation of the trauma, exclusion of alternate causes of forgetfulness, and exclusion of nondisclosure* are not arbitrary criteria, nor are they excessively demanding criteria; they are simply the minimum elements that scientific methodology would require for proof of "repressed memory." Any study that adequately addresses these three criteria

represents an adequate test of the "repressed memory" hypothesis. The study of Della Femina et al., just described is a good example of a study that does meet these criteria. This study shows that it is feasible to do a study meeting the required scientific criteria – but in this methodologically sound study, we find no evidence that "repressed memory" actually occurs.

In conclusion, "repressed memory" is a scientific hypothesis that readily admits to scientific testing. It is fallacious to imply, as some have done, that it would be virtually impossible to perform a satisfactory scientific test of the validity of the "repressed memory" hypothesis. Admittedly, well-designed studies might be time-consuming and expensive. But just because a hypothesis is expensive to test does not constitute grounds to waive scientifically valid testing and accept the hypothesis as true after engaging flawed methodologies.

VIII. Neither Error Rates Nor Any Controls or Standardization Exist as to the Theory of "Repressed Memory"

A. It is impossible to estimate an "error rate" because the underlying studies are invalid.

Retrospective studies: As previously noted, most *retrospective studies* have used some variation on the "do-you-remember-if-you-forgot" methodology. As set forth in Section VI, Part B, it is not possible to draw the conclusion that any of the "yes" responses in these studies represents a valid instance of "repressed memory," regardless of the percentage of "yes" responses obtained. This is graphically illustrated by the example of the Melcher and Parker study (Melchert & Parker, 1997) described above, where *none* of the 46 individuals claiming to have "forgotten" an episode of abuse indicated that they "simply had no memories of it ever happening." In other words, the results of the Melchert and Parker study would suggest that if we had assumed that these 46 individuals had "repressed" their memories, the error rate would have been 100% in this instance. More generally, without being able to go back in time and ask subjects directly if they remember an event, there would be no way to measure error rate in the retrospective studies.

Prospective Studies: I have summarized the methodological deficiencies of *prospective studies* in Section VI, Part D. As noted, one of the most serious methodological deficiencies in some of these studies is the fact that individuals who had experienced various traumas were asked in general terms about their memory of traumatic experiences, but were *never specifically asked* if they remembered the particular traumatic event that the investigators knew that they had experienced. As I have repeatedly explained above, non-disclosure does not demonstrate "repressed memory." For example, the above-mentioned study of Della Femina and colleagues described eight young men who denied a history of childhood abuse on initial interview, even though the investigators possessed evidence that these men had experienced childhood abuse. On a follow-up interview, however, when these men were specifically asked about their known abuse history, all eight acknowledged that they did in fact remember the abuse, but had elected not to disclose it at the initial interview. In other words, had these eight men been classified as cases of "repressed memory," the *error rate once again would have*

been 100%. Therefore, in more general terms, it is impossible to estimate an error rate in prospective studies, because every case of putative "repression" in the studies might be erroneous due to non-disclosure.

B. It must be remembered that the burden of proof rests on those who seek to establish that "repressed memory" is scientifically validated.

Since it is impossible to know the error rate in studies of "repressed memory" as explained immediately above, one might ask whether, in some of the available retrospective and prospective studies, the error rate is *not* 100%, and whether some percentage of the cases in these studies *might be* genuine cases of "repressed memory." However, as I have explained above, this approach to the question of whether the "repressed memory" hypothesis is valid defies proper scientific method. It is never the burden of science to prove that a novel hypothesized phenomenon is *not* valid. This approach turns logic upside down and violates a fundamental principle of science: that when a new hypothesis of causality is proposed, it remains unproven until other, already established causes have been excluded. As was stated by Isaac Newton, "we are to admit to no more causes of natural things than such as are both true and sufficient to explain their appearances" (Newton, 1726). Stating the same principle in more colloquial terms, to assume that "repressed memory" is valid until science disproves its existence would, from a legal vantage point, be comparable to allowing testimony about Martians to be admissible in court, because there is no irrefutable scientific proof that Martians do *not* exist. "Repressed memory" is a popular notion, perhaps arguably even a common notion, but it is important to recognize that however *popular* this notion may be, that fact does not place the burden on science to prove its *nonexistence*. It is the burden of proponents to prove that "repressed memory" theory is valid.

IX. <u>Conclusion</u>

In summary, although "repressed memory" is a testable hypothesis, 1) it has never been demonstrated to occur in any methodologically sound peer-reviewed published scientific study; 2) it is not subject to any known or potential error rate in the studies attempting to find it; and 3) it is not generally accepted by the relevant scientific community. Indeed, "repressed memory" is at best a highly controversial hypothesis – and, a hypothesis that is controversial cannot, by definition, be considered generally accepted.

X. References

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STATE OF SOUTH CAROLINA	IN THE COURT OF COMMON PLEAS
COUNTY OF CHARLESTON	CIVIL ACTION NO.: 2018-CP-10-03929
John Doe, Plaintiff, v. The Diocese of Charleston, a Corporation Sole, and the Bishop of the Diocese of Charleston, in his official capacity, Defendants.	**AFFIDAVIT OF DR. JANINE SHELBY**

Personally appeared before me, Dr. Janine Shelby, who swears and deposes as follows:

1. The undersigned is over the age of 21, and has personal knowledge regarding the matters herein.

Professional Qualifications

1. I am a trauma psychologist, with expertise derived from a career dedicated to the study, assessment, and treatment of trauma survivors. I am an Associate Clinical Professor in the School of Medicine at UCLA and a part-time faculty member at California State University, Long Beach. Recently, I was honored to serve as the 2017-2018 Drake Guest Professor and Distinguished Fellow at Kobe College in Hyogo, Japan. In addition to my trauma-focused academic, supervisorial, and clinical employment, I work as a forensic consultant and expert witness, primarily in areas related to psychological trauma. In former professional roles, I served as the Clinical Director of the Santa Monica-UCLA Rape Treatment Center, the Director of Training and Lead Forensic Interviewer in the child advocacy service at Harbor-UCLA

Medical Center, and the Founder/Director of Harbor-UCLA's Child Trauma Clinic. At Harbor-UCLA, I taught and supervised psychology and psychiatry trainees to diagnose, use psychological assessment instruments, and treat traumatized individuals. I also directed the child and adolescent psychological assessment program there for several years.

2. I completed my undergraduate degree in Psychology at Samford University in Birmingham, Alabama and earned an M.S. in Community Counseling at the University of South Alabama, in Mobile, Alabama. Following my doctorate from the University of Miami in Coral Gables, Florida, I completed a post-doctoral fellowship in Child and Adolescent Psychology through the Division of Child and Adolescent Psychiatry at Harbor-UCLA Medical Center. I have been licensed in the state of California since 1997, and I am trained as a child abuse forensic interviewer, a Registered Play Therapist-Supervisor, certified in the practice/supervision of several evidence-based treatments for trauma survivors, and experienced in the administration of a wide array of psychological assessment instruments.

Documents Reviewed in Developing Opinions

Legal

1. Affidavit of John Doe (7/11/19)
2. Amended Complaint (8/29/18)
3. Plaintiff's Responses to Defendant (6/7/19)
4. Deposition of John Doe 888 (9/12/19)
5. Deposition of Mrs. Doe 888 (9/12/19)
6. Plaintiff's Responses to Defendant's First Interrogatories to Plaintiff

Expert Report

7. Report of Sally M Duffy, Ph.D. (11/26/19); Notes of Sally M. Duffy, Ph.D. (11/15/19)

Medical/Mental Health

8. Deposition of Jason Flassing, Psychiatric Physician's Assistant (9/19/19); Medical Records from Shane Sherbondy, MD's practice (4/3/17-7/23/19)
9. Deposition of Dorothy Whalen, LISW-CP (9/19/19); Notes of Greenville Therapy Center/Dorothy Whalen, LISW-CP (beginning 6/16/16)
10. US Department of Veterans Affairs records of Dr. Rick Thode, Ph.D. (1/23/16, with prior evaluations on 7/15 and 7/29 of 2014; 8/7 and 8/20 of 2015)

Other Sources

11. Diagnostic and Statistical Manual, Fifth Edition (DSM-5)
12. International Society for Traumatic Stress Studies (ISTSS)
13. National Center for PTSD
14. Specialty Guidelines for Forensic Psychologists

Parameters of Use

This report was generated pursuant to Mr. Doe's case against the Diocese of Charleston et al. This report does not constitute an independent mental examination (IME). I did not conduct an evaluation of the Plaintiff and am therefore, unable to render diagnostic impressions of him. This report focuses solely on issues related to the Plaintiff's medical, social, and psychological history and diagnoses as well as his reported history of psychological and sexual abuse and its subsequent effects on him over time. This report also addresses characteristics of trauma-related disorders, trauma-related diagnoses, evidence-based therapy methods for mental disorders, and the possible

ramifications of using various therapeutic methods to treat trauma-related disorders and/or to provide treatment in forensic contexts. The opinions and conclusions contained within this report are based on data available to me at this time. I reserve the right to supplement and/or alter the information, conclusions, or findings of this report if additional information surfaces.

In assessing claims of psychological injury, the examiner must consider evidence that both supports and refutes a claim. My comments are intended to analyze the relevant issues in this case, but do not negate Mr. Doe's courage in surviving the many traumatic events he has reportedly endured. Per the records, it appears that Mr. Doe has faced many challenges and hardships, which I respectfully acknowledge.

Allegation

In his affidavit, Mr. John Doe reported that he recently came to learn that while he was a child (i.e., other records indicated that his age was 11- or 13-years of age) and attending church and school at Sacred Heart, he was sexually molested by two teachers, Hal Brooks and Chris Hartnett. His statement further indicated that he was molested repeatedly, over a period of years and at various locations. During his deposition, Mr. Doe reported that Mr. Hartnett performed fellatio on him three times, and then took him on a trip to Columbia where a "party" involving oral and anal sex occurred between Mr. Hartnett, Mr. Brooks, and Mr. Doe. Mr. Doe said the incident involved cannabis and alcohol. Mr. Doe further said that they went to a bar, where he was kissed by a third man who "excused himself" when he realized that the Plaintiff was male. Mr. Doe said Mr. Hartnett and Mr. Brooks left him at the bar, and he had to find his own way back to Charleston. During his deposition, Mr. Doe could not answer questions about whether

additional incidents occurred or whether he had any awareness of these events during the next several years.

Opinions to a Reasonable Degree of Certainty

1. ***Brief history of Plaintiff's adverse event exposure.*** According to multiple records, testimony, and Dr. Duffy's report, the Plaintiff has an extensive history of multiple adverse events. During his deposition, Mr. Doe acknowledged that he and his father had "some rough times" between the time he was five- until he was 12-years old. When asked, Mr. Doe clarified that he "was in trouble pretty much all the time," primarily related to academic difficulties. He also identified that part of the issue in his relationship with his father was that his father "drank," and was, per other records, a "mean drunk." During her deposition, Ms. Whalen indicated that the Plaintiff's father had been both physically and emotionally abusive toward him, and was "an alcoholic, enraged and beat him. [sic] Had a difficult relationship with his father." During his deposition, Mr. Doe also reported that a teenage baby-sitter fondled him and forced him to engage in fellatio (i.e., other records indicate he was five- or six-years of age at the time). As yet another adverse event, Mr. Flassing reported that someone had provided the Plaintiff with LSD when he was 12-years old, and that he was subsequently treated in a hospital. As an adult, Mr. Doe joined the USMC, but spent a year in substance abuse recovery before being honorably discharged. As a profound traumatic stressor, multiple records describe a fire that killed Mr. Doe's wife and children. Ms. Whalen identified this as one of the major causes of Mr. Doe's subsequent depression symptoms. Additional adverse events befell Mr. Doe in his adulthood. Per Ms. Whalen , Mr. Doe reported that his grandchildren had been

molested. Also, one of Mr. Doe's children/stepchildren had cancer, he has a number of chronic and past acute medical conditions, he was terminated from his employment, and he has faced significant financial stressors involving his mortgage. Each of these stressors must be considered in terms of their influence on Mr. Doe's overall psychological status. **Any current symptoms he has must be carefully evaluated to determine whether and to what extent they may be proximal to one, several, or the combination of the adverse events he has endured**.

2. ***Medical conditions and medication side effects***. Records indicate Mr. Doe suffers from or has suffered from a range of medical conditions, several of which have known impact on mental status (e.g., myocardial infarction and altered mental status, diabetes and fatigue). The Plaintiff's medical history is positive for several medical conditions, including chronic pain in his cervical spine, left knee pain, left elbow pain, two myocardial infarctions, type II diabetes, partial knee replacement surgery, kidney stones, S/P cholecystectomy, and irritable bowel syndrome, obstructive sleep apnea. Furthermore, several prescription medications used by Mr. Doe have side effects that mimic depression symptoms, sleep disturbance, and other psychological difficulties. In addition, the Plaintiff was reported to consume several cups of coffee per day. Dr. Duffy described the Plaintiff's medication regimen as including alprazolam .5 mg qd, lisinopril 2.5 mg. qd, fluoxetine 20 mg qd, carvedilol 3.125 mg. bid, clopidogrel 75 mg qd, metformin 500 mg qd, eszopiclone 3 mg qhs, and Jardiance 25 mg qd. Dr. Duffy's report does not discuss the side effects of these medications, combinations of medication, and potential impact of high daily caffeine consumption on the Plaintiff's symptoms. **Any current psychological symptoms Mr. Doe has must be carefully**

evaluated to determine whether and to what extent they may be proximal to his medical conditions and/or past or current medications for these medical conditions, and caffeine side effects.

3. **Symptoms and Diagnoses**. Mr. Doe has a long history of psychiatric/psychological issues and treatment, beginning when he was a child. Mr. Doe reported receiving mental health services as a child, but he did not recall the content of his childhood sessions. As an adult, he sought mental health treatment from the VA. Mr. Doe has received a variety of diagnoses and rule out diagnoses, with consistent themes emerging around PTSD, a depressive disorder, and anxiety symptoms or an anxiety disorder. Mental health records indicate that Mr. Doe has strong genetic predisposition for depression and Obsessive-Compulsive Disorder (OCD). Per Dr. Thode's mental health records (7/15/14), his early diagnostic impressions were listed as a V code, with rule out diagnoses for Major Depressive Disorder with Anxious Distress, PTSD, and Unspecified Neurocognitive Disorder. In Dr. Thode's subsequent (1/23/16) records, Mr. Doe was described as seeking treatment to reduce depression, anxiety and survivor's guilt. He was then diagnosed with Unspecified Depressive Disorder with Anxious Distress, Generalized Anxiety Disorder, and Other Specified Trauma- and Stress-Related Disorder, with rule out disorders of Persistent Complex Bereavement and Obsessive-Compulsive Disorder. Dr. Thode's records further reflect that Mr. Doe had sub-optimal sleep duration (e.g., 4- to 6-hours per night), no childhood memories between of 6- and 10- years of age, and a history of drug abuse and successful rehabilitation. During his later treatment with Ms. Whalen, Mr. Doe reported that he had sleep initiation problems (i.e., "can't sleep because of flashbacks"), though he had

reported sleep maintenance problems earlier with Dr. Thode. During his deposition, Mr. Flassing indicated that the Plaintiff had PTSD as well as Major Depressive Disorder. However, Mr. Flassing showed difficulty differentiating PTSD from the symptoms of depression and reported that it is sometimes hard to distinguish PTSD from depression. PTSD is characterized by intrusive re-experiencing and avoidance symptoms, whereas depression does not contain these elements. It is unclear why Mr. Flassing found it difficult to distinguish the two disorders. Further, Mr. Flassing was asked to describe Mr. Doe's PTSD symptoms, Mr. Flassing responded with "significant depressive symptoms and severe anxiety," as well as "significant nightmares, and racing thoughts. Although nightmares are part of PTSD criteria, racing thoughts are not PTSD symptoms, significant depressive symptoms suggest a depressive disorder and significant anxiety symptoms are more typically associated with an anxiety disorder. (PTSD is a trauma-related disorder.) Later, Mr. Flassing was asked whether Mr. Doe had flashbacks (i.e., trauma symptoms) related to his wife and children dying in a fire. He responded, "I do believe that would be probably some of the symptoms of his depression. . .he would describe symptoms of seeing their bodies." Seeing unwanted images of dead bodies is consistent with PTSD and not characteristic of depression. **In sum, some of Mr. Doe's symptoms are consistent with likely outcomes of individuals with childhood sexual abuse histories similar to the events described by Mr. Doe and many are consistent with other disorders, conditions, or other types of trauma.**

4. **Psychopharmacological treatment**. Mr. Flassing reported that there were "not as many medications as we would like to be able to treat PTSD. . . but we do treat his

major depressive disorder." According to the National Center for PTSD, there are two FDA-approved medications for PTSD: Sertraline (Zoloft) and paroxetine (Paxil). Mr. Flassing did not address this during his discussion of his treatment rationale. Further, Mr. Flassing said that he opted to prescribe Ativan based on his assumption that Mr. Doe did not have a history of substance abuse. When asked, he said that he based his assumption on a question that pertained only to alcohol use. As described earlier, Mr. Doe has a significant history of problematic substance use. Further, Ativan is not an FDA approved pharmacological intervention for PTSD and is widely known to have sedating effects that likely contribute to depression symptoms. Mr. Doe has had a large number of medication trials, combinations of medications, and problematic side effects. Mr. Flassing reported Mr. Doe's side effects, including sleep disturbance, amotivation, and increased dream activity (i.e., from Trintellix). During his deposition, Mr. Doe also described Trintellix as leading to nightmares, during which he said he hit his wife. **Mr. Doe's medications/ combinations should be carefully evaluated to determine whether they were producing or exacerbating his symptoms, as some of these medications/combinations are known to elevate risks of unwanted consequences, negatively alter behavior, and/or have mood-lowering effects.**

5. ***Etiology of any claimed damages*. In her report, Dr. Duffy reported Mr. Doe's symptoms in a manner that appeared to attribute most of his symptoms, which could have been derived from a number of his prior adverse events, to the incidents reported in this claim.** In contrast, Ms. Whalen made clear during her deposition that the Plaintiff's symptoms were related to three traumatic experiences (i.e., initial sexual abuse at six-years of age, later sexual abuse at 11-years of age, and

the deaths of his family members). However, during her deposition Ms. Whalen endorsed the idea that Mr. Doe's view of the world is based on a lifetime of experiences, only one part of which is related to the teachers. Although Dr. Duffy identified several significantly adverse events in the Plaintiff's history, she did not describe the relative contribution of any of these events to the symptoms and/or mental disorders ascribed to him. For example, Dr. Duffy's report recited Mr. Doe's history of childhood sexual abuse at the age of six years, "an abusive rejecting father," estrangement from his wife, and the death of his wife and two sons related to a house fire. She further indicated that this resulted in Mr. Doe's depression and two suicide attempts, and that he was diagnosed with PTSD "from this event" in 2015. Dr. Duffy argued that the sexual abuse that occurred by the baby-sitter was "apparently not as traumatizing as the later abuse by the teachers," but she did not appear to have explicitly assessed this issue, and offered no justification for this claim (apart from her speculation that she had more of a relationship with the teachers than with the "older boy" [teenage babysitter]. It is difficult to understand the rationale for minimizing an individual's first sexually abusive experience, and even more difficult to comprehend the minimization of this/these incident(s), given the vulnerable age during which the abusive incident(s) was/were reported to have occurred. Dr Duffy's rationale that the later abuse by teachers was more proximal and/or damaging because it occurred in a context of significant trust, in a setting wherein children are deemed to be safe, and by someone who held power over him may also apply to the abuse reportedly perpetrated by the baby-sitter.

6. ***Issues Related to the Diagnosis of PTSD***. Dr. Duffy seemed to conflate Mr. Doe's possible past and current symptoms (e.g., using the fact that he dropped out of school as evidence of current PTSD avoidance [of school]). Thus, it was not clear which symptoms she regarded as current and which were regarded as historical or as conjectured historical symptoms. Mental health diagnoses are based upon strict criteria involving set time frames. An individual meets criteria for Posttraumatic Stress Disorder (PTSD) only if he or she manifests current symptoms. Dr. Duffy's inclusive list of symptoms included a) "non-volitionally repressed memories" involving not remembering that he was in the 7th grade; flashbacks, nightmares, suspiciousness, exaggerated startle response, hypervigilance, depersonalization, derealization, avoidance (from his middle school drop-out), and sense of foreshortened future. It is noted that the latter is no longer listed as a PTSD criterion based on the most recent DSM 5, which was published in 2013. Per the DSM 5, symptoms must not be attributable to the effects of substance. Dr. Duffy did not determine how she concluded that the Plaintiff's reported substance use during the same time frame was unrelated to his memory difficulties in the seventh grade. This is particularly noteworthy, given that LSD can alter memory structures and cannabis is known to impair memory functions. **These issues fall in contrast to DSM 5 diagnostic guidelines.**

7. ***Misattributions or possible misattributions***. As the DSM 5 notes, "Not all psychopathology that occurs in individuals exposed to an extreme stressor should necessarily be attributed to PTSD. The diagnosis requires that trauma exposure preceded the onset or exacerbation of pertinent symptoms." (p. 279). Dr. Duffy

attributed the Plaintiff's history of running away (i.e., he "ran away 8 times") as a "way to avoid a school setting where the abuse occurred," but this is not supported by evidence. Dr. Thode's records indicated that Mr. Doe said he "ran away to get away from his dad a lot." Mr. Doe's own statement during his deposition fell short of Dr. Duffy's assumption (i.e., Mr. Doe said that that he ran away multiple times across time but did not know why he did so). Moreover, it is far more likely that a youth would run away from home because of incidents occurring at home, than because he/she seeks to avoid their school. This, more likely scenario, was not addressed in Dr. Duffy's report. Dr. Duffy also seemed to override the Plaintiff's attribution that he dropped out of school because he was "a failure academically." Instead, she concluded the primary reason for his departure from school was "the abuse he sustained from the teachers at his elementary school." Further, Dr. Duffy reported that the Plaintiff's cannabis use was "probably related to the [sexual] abuse," though research suggests that the best predictor of adolescent cannabis use is the absence of parental monitoring. As yet another example, Dr. Duffy described Mrs. Doe's report of Mr. Doe's physical abuse toward her (i.e., other records described severe nightmares) "when the repressed memories began to resurface," in which Mr. Doe has physically attacked his wife in his sleep. Dr. Duffy concluded in her report that this is "consistent with worsening PTSD," which "can be associated with recovered traumatic memories." It is not clear what the basis is for this claim, but more likely explanations for suddenly beginning to behave aggressively toward one's wife of several years are medication side effects (as described by both Mr. Doe and Mr. Flassing) or a medical condition. If the aggression is more pervasive than implied in the records, other known

correlates to intimate partner violence include witnessing intimate partner violence during childhood, childhood physical abuse, holding an ideology that promotes physical violence in intimate relationships, belonging to a culture or subcultural group that supports male dominance and physical aggression in intimate relationships, psychopathology (particularly sociopathy, narcissism, and borderline personality disorder) and other disinhibiting factors, such as substance use. **In sum, Dr. Duffy's report contains several attributions for the cause of Mr. Doe's behaviors and difficulties based on insignificant or unclear evidence to support such claims.**

8. ***Highly unusual symptoms***. **Dr. Duffy reported symptoms that are unlikely to be directly related to the sexual abuse reported in this claim.** Specifically, the Plaintiff was said to avoid crowds, will not go into a mall, and have compulsive behaviors. Some of these symptoms are more consistent with an anxiety disorder, such as agoraphobia, than PTSD. During her deposition, Mrs. Doe reported that her husband has had manic episodes since 2012. She further stated that "He's been taking that medicine and he hits me. And the last time he beat me up it was really bad. And he can't help it. Even if I stop him he doesn't know that I -- that it's me. And he doesn't know he did it. And he done it many times." As described earlier, physically attacking his wife in her sleep because of nightmares about the events described in this claim approximately 50 years earlier would be an extremely rare manifestation of intrusive re-experiencing, and is much more likely to be attributable to other medical or psychological causes.

9. ***The Plaintiff's report of recovered memories***. The Plaintiff reported to Dr. Duffy that "pieces of memory" started to return while seeing Dr. Thode at the VA and that one

day it was "like a bomb went off" with emotionality he could not control. In her discussion and conjecture, Dr. Duffy said that the reality of suppressed and repressed memories will "eventually be proven" but she provided an unclear basis for this assertion. She acknowledged that there "continues to be considerable contention in the profession regarding suppressed memories, repressed memories, and recovered memories." She seemed to provide support for the presence of suppressed and repressed memories by claiming that "empirical and laboratory experiments simply cannot duplicate clinical and field environments." The basis of this statement is problematic for two reasons. First, the term "empirical" refers to a wide range of research methodologies and is not limited to laboratory experiments. Second, field-based studies occur commonly and guide scientific understanding alongside laboratory-based research.

A central issue of this case is the degree to which Mr. John Doe is able to accurately report on abuse he claimed to recall abuse after a delay of several decades. Such memories are implicitly subject to distortion and bias. There are many factors that shape memory. Mr. Doe's LSD and other substance use around the same time as the abuse described in this claim may have influenced his perception of events. In describing the Plaintiff's mental health history, Dr. Duffy indicated that he was diagnosed with Obsessive Compulsive Disorder (OCD) at the VA. She further notes a family history among close biological relatives of OCD or OCD-like tendencies. Some individuals with OCD experience terrifying images of a horrendous or graphic nature as part of their OCD symptoms. As another issue, there is some evidence of Mr. Doe's positive response bias. For example, Dr. Duffy noted in her report that the

Plaintiff's claim of having a "damn good life until he remembered that crap [abuse by teacher(s)]" is untrue. As another example, Dr. Duffy's report pointed out that the Plaintiff indicated he had a "fairly close" relationship with his three sisters, but his wife refuted this assertion. As a third example, records report Mr. Doe's sense that his employment was wrongfully terminated or terminated due to nefarious reasons. However, during his deposition, his wife indicated that Mr. Doe was "let go" from Publix over a conflict involving him eating something that store personnel said he did not have permission to eat. There is less indication of intentional, negative response bias from the records made available to me, though I did not examine Mr. Doe. It is beyond the scope of my role to draw conclusions about whether or not the sexual abused described in this claim took place. It is within my scope, however, to convey that recovered "memories" are subject to inaccuracies and biases, and that suggestible individuals are particularly at risk for believing in the accuracy of events that may have occurred differently or may not have occurred at all. This is not to say that the abuse Mr. Doe claimed did *not* occur, but is intended to point out **some of the reasons that a reduced level of confidence in such recovered "memories" is necessary.**

10. In her report, Dr. Duffy concluded, it "appears that the memories regarding the abuse started to be recovered during this treatment or possibly immediately prior to seeking such treatment." It is curious why, rather than merely positing a connection between treatment-seeking and the events described in this claim, she did not simply interview the Plaintiff carefully about the timeline of his "recovered" recollections.

11. ***Memory-related issues***. In her report, Dr. Duffy's seemed to initially refute the possibility that the Plaintiff may suffer from possible memory impairment. As support

for this notion, she argued that his "recovered" memories "suggest a lack of actual dementia and organic memory loss and impairment." This line of reasoning is circular in nature. Later in her report, Dr. Duffy acknowledged Mr. Doe's report of impaired memory, concentration, decision-making ability, cognitive discontinuity, and word-retrieval problems.

12. ***Absence of Psychological Assessment Measures in the Examination***: No standardized, normed psychological assessment measures were reported in Dr. Duffy's report. The use of the multi-source, multi-method approach in forensic evaluations is part of best practice standards for forensic evaluations. It is important to supplement clinical impressions with standardized normed, forensically sound psychological assessment data in order to obtain objective data alongside the more subjective data derived from interviews.

13. ***Dr. Duffy's Discussion of Treatment-related Issues***. In her report, Dr. Duffy differentiated inadvisable treatment methods from research-supported treatment methods. Consistent with a wealth of evidence, Dr. Duffy named CBT (i.e., cognitive behavior therapy) as a recommended treatment modality, but then listed "music" among several other "recommended" modalities (music was used by Ms. Whalen as a therapeutic technique). Dr. Duffy summarized, "all of which are considered to be appropriate treatment approaches in these kinds of cases." **To my knowledge, music is not listed as an evidence-based practice by any body, organization or agency tasked with listing evidence-based treatments for trauma-related disorders.** Similarly, neither "music" nor music therapy is listed as a recommended treatment in

the treatment guidelines issues by the International Society for Traumatic Stress Studies.

14. ***Treatment.*** Although CBT has the most research support and shows generally high response rates for the treatment of both PTSD and depressive disorders (particularly when combined with evidence-based pharmacological approaches), **Ms. Whalen does not appear to be providing CBT.** In her notes, Ms. Whalen sometimes described her treatment methodology as CBT and other times as "supportive therapy," or some other approach. Similarly, during her deposition Ms. Whalen described her therapeutic approach as "client-centered" and she described methodology consistent with that approach (i.e., unconditional positive regard). Both during her deposition and in her notes, Ms. Whalen referred to the use of some CBT techniques during her work, but her descriptions lacked the systematic approach that characterizes CBT. Ms. Whalen's approach, though likely accepting and warm, seems to have omitted many requisite CBT components and techniques known to be helpful (i.e., use of standardized assessment instruments, clarification of onset/frequency/severity of symptoms, use of weekly homework assignments, and emphasis on systematically targeting and processing traumatic experiences/altering cognitions). Thus, it appears that several forms of therapy may have been provided at once.

It was not clear that best practices for exposure-based treatments were followed. In her notes, Ms. Whalen indicated that in her intervention with the Plaintiff, she "reviewed childhood memories from PTSD," but description of this technique was provided, nor was there evidence that Mr. Doe's distress level (i.e., collection of SUDS) was monitored to ensure Mr. Doe remained within the window of therapeutic

arousal. As Dr. Duffy referenced, CBT has a strong research base. CBT is the gold standard for the treatment of PTSD according to the ISTSS guidelines, National Center for PTSD, and several other agencies and organizations formed to identify best practice standards and evidence-based treatments. It is unclear what, if any effect, the absence of a known, effective treatment had on Mr. Doe.

As a separate area of concern, Ms. Whalen indicated in her deposition that she intended to use the Kubler-Ross model to focus on grief and loss as Mr. Doe's primary treatment focus, although Mr. Doe's posttraumatic symptoms, at least according to Dr. Duffy, persist. First, the Kubler-Ross phasic model has been soundly discredited, and it is well established that individuals do not move through five distinct stages of grief/loss. Second, it is not clear why the clinical focus would be shifted to grief and loss given that the processing of the traumatic events does not appear to have taken place and PTSD symptoms are reported at high levels. The prevailing wisdom and practice regarding posttraumatic grief is to process traumatic experiences prior to focusing on grief. Posttraumatic symptoms interfere with grief-related processes (i.e., when individuals have not processed the traumatic events, their attempts to grieve usually turn to recalling the traumatic incident, which interferes with grief-related processes).

Basis for My Opinions

I have provided specific bases for my opinions in each section, as described previously. The more general bases for my opinions involve research evidence, thirty years of experience treating and assessing traumatized individuals, my specialty training in trauma-related disorders, and knowledge of the ways in which trauma typically manifests, evidence-based treatments for

trauma and trauma-related assessment methods. In developing my opinions, I relied on the Diagnostic and Statistical Manual, Fifth Edition (DSM 5; APA, 2013), the practice guidelines from the International Society for Traumatic Stress Studies (ISTSS), practice guidelines from the National Center for PTSD, and the specialty guidelines for forensic psychologists.

Conclusions

Mr. Doe has a significant history of extremely adverse experiences. He has been reported to have both genetic loading for and a history of depressive episodes and OCD symptoms. During at least one prior depressive episode, he reportedly attempted suicide shortly after the death of his estranged wife and children. A second suicide attempt was also noted shortly thereafter. Another depressive episode reportedly began on or about 2011, per Mrs. Doe, though Mr. Doe described at depressive episodes immediately following the death of his family and in 1992. The onset of Mr. Doe's symptoms is not clearly aligned with the events described in this claim, given that he began to receive psychological services prior to the events reported in this claim. Thus, at least some proportion of his past psychological distress is related to other factors. If he experienced the sexual abuse he reported, Mr. Doe would have likely suffered from trauma-related symptoms contemporaneously. There is no direct evidence of this, though his parents are not available to interview. Though most individuals experience recovery over time, some individuals continue to suffer from PTSD symptoms. It appears that Mr. Doe has not been receiving CBT, the treatment with the strongest evidentiary base. The odds of recovery are increased for most people who obtain mental health treatments scientifically demonstrated to work. It is an unusual trajectory to have symptoms increase—rather than decrease—over time. Because Mr. Doe reports experiencing multiple traumatic events, the relative contribution of each, specific traumatic event must be weighed and proportioned. With a reasonable degree of psychological certainty and

based on the records available to me, I can opine that Mr. Doe reports many symptoms, some sound consistent with experiences common among other childhood sexual assault survivors, and some of which are not generally characteristic of childhood sexual abuse sequelae. It is also extremely likely that his early childhood familial experiences have left a lasting impression and are reflected in a significant proportion of his mental health concerns.

As a final note, the Plaintiff's Responses to Defendant First Interrogatories to Plaintiff reads as follows: "Abuser Hartnett was very feminine in his appearance, movements, actions. He was a lifelong bachelor, was never in the presence of females, always males…" These statements perpetrate troubling and inaccurate stereotypes about child abusers, the majority of whom are heterosexual men with available sexual partners. Having feminine behavioral characteristics, being single, and/or being gay is not a predictor of child sexual abuse and is both irrelevant in this case and misleading.

FURTHER AFFIANT SAYETH NOT.

_____
Dr. Janine Shelby

Sworn to and subscribed before me this
the _____ day of November, 2019.

_____
Notary Public for State of California

My commission expires:_____

_____, 2019

perpetrate troubling and inaccurate stereotypes about child abusers, the majority of whom are heterosexual men with available sexual partners. Having feminine behavioral characteristics, being single, and/or being gay is not a predictor of child sexual abuse and is both irrelevant in this case and misleading.

FURTHER AFFIANT SAYETH NOT.

Jan Shelby PhD

Dr. Janine Shelby

Sworn to and subscribed before me this
the 10 day of ~~November~~ December, 2019.

Notary Public for State of California

My commission expires: 10/3/2020

ABRAHAM ABRICA
Notary Public - California
Los Angeles County
Commission # 2166713
My Comm. Expires Oct 3, 2020

December 10., 2019

STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

IN THE COURT OF COMMON PLEAS

CIVIL ACTION NO.: 2018-CP-10-03929

John Doe,

Plaintiff,

v.

The Diocese of Charleston, a Corporation Sole, and the Bishop of the Diocese of Charleston, in his official capacity,

Defendants.

AFFIDAVIT OF DR. MONICA APPLEWHITE

Personally appeared before me, Dr. Monica Applewhite, who swears and deposes as follows:

1. The undersigned is over the age of 21, and has personal knowledge regarding the matters herein.

Professional Qualifications

2. My name is Monica Applewhite and I have a Ph.D. in social work and am an expert in the field of social work and child sexual abuse, including but not limited to the historical evolution of policies and laws in the United States to protect children from sexual abuse, the education, screening, monitoring, development of risk management policies for the protection of children from abuse, the organizational response to allegations of child sexual abuse, the behaviors and tactics of child molesters and the standards of care for child protection from the early 1930's to today. I have spent the past 27 years utilizing research in the area of child sexual abuse in organizations in order to assist organizations in developing best practices.

3. I have worked with more than 300 organizations that serve children and youth to investigate allegations of misconduct, assess the risk of programs and implement programs to prevent and respond properly to incidents and allegations of abuse. I am currently the director of Confianza LLC, which is a consulting firm specializing in standards of care and the dynamics of abuse in educational, social service and religious environments. A list of my specific clients and my current curriculum vitae are attached (Appendix A).

Documents Reviewed in Developing Opinions

4. The case materials I have reviewed in this case are as follows:
   - Complaint filed August 2, 2018
   - Answer filed March 19, 2019
   - Amended Complaint filed August 29, 2018
   - Plaintiff's Responses to First Interrogatories
   - Plaintiff's Response to First Requests for Production
   - John Doe Medical Records
   - Chris Harnett Personnel File
   - Affidavit of Harold Brooks
   - Deposition of John Doe
   - Deposition of Mrs. John Doe
   - Deposition of Dorothy Whalen
   - Deposition of Jason Flassing
5. In addition to the case materials, I have relied upon other documents in formulating my opinions. A list of these materials is attached (Appendix B).

Opinions to a Reasonable Degree of Certainty

6. The bases for the following opinions are my educational background, professional experience, review of the relevant literature, and the materials in this case. Additional information regarding the bases for these opinions is contained in the section that follows.

7. In my review of the materials, I have not seen evidence or testimony to suggest that Christopher Hartnett or Harold Brooks was known to have a "predilection toward sexually assaulting young boys," "sexual interest in children," or to have acted "inappropriately on the interest." John Doe stated that he did not tell anyone that he was abused and that he did not recall the abuse until many, many years later. Similarly, the case materials do not contain information to suggest others made reports of abuse either before or after 1970 and 1971.

8. The knowledge base regarding sexual abuse of minors and the associated skills and protocols designed to prevent, detect, investigate and respond have developed on an incremental basis from the 1930's until today. Any examination of reasonable levels of care must be considered within a historical framework that acknowledges the recent growth in understanding and awareness of dynamics, warning signs, and many other dimensions of sexual abuse prevention, detection and

response. The events under consideration in this case are alleged to have occurred approximately 50 years ago, in 1970 and 1971.

9. In 1970 and 1971, little was known by professionals about the dynamics of acquaintance-type sexual abuse. There were no books, journals, educational programs or research focusing on this type of sexual abuse. Most experts in the field did not believe that sexual contact between an adult and a child was harmful to the child. Therefore, while it may have been believed that this form of sexual contact was "wrong," the extent of distress that could be caused by sexual abuse was not known by professionals or the public. It was not until after 1979 that professionals first began to recognize the short and long-term effects that could be caused by what was later called "acquaintance abuse."

10. During the period of time prior to and including the early 1970's, organizations that served children had no established methods for screening and selection of personnel to work with children. Criminal records and sexual offender registries could not be accessed by youth organizations, warning signs of sexual offenders had not yet been identified by professionals, and there were no published resources for screening adults to work with children. As such, there were no recognized screening and selection standards to uphold during the timeframe under consideration.

11. The prevention and detection of child sexual abuse involves a specialized and complicated set of activities specifically designed for this purpose. Routine methods of screening, training, supervision, and monitoring that are designed to address other areas of human service often do not detect the subtle distinctions of behavior that are unique to the relational acquaintance abuse. In 1970 and 1971, sexual abuse was still a taboo topic, the prevalence, effects and dynamics of sexual abuse had not been studied, and virtually no professional literature existed. Guidelines and best practices for prevention, detection and response in schools and religious organizations did not exist and had not yet been conceptualized.

12. In 1970 and 1971, the criminal justice system in the United States had not yet established procedures for the investigation of acquaintance sexual abuse in organizations. CAPTA was passed in 1974, giving the first substantial funding to the development of Child Protective Services to states around the country and eventually leading to established offices of investigation, which still focused on abuse that occurred within families. Therefore, there were no

standards or guidelines for investigations for school or church officials to follow even if an incident or allegation of abuse was known during this timeframe.

13. During 1970 and 1971, public and private schools, religious organizations and other organizations that served children had no established protocols for preventing or addressing sexual abuse or exploitation of children. The Federal Government of the United States had not yet established or even considered regulatory practices for organizations that serve children or youth such as exist today.

14. In 1970 and 1971, schools, churches and other organizations that serve children had not yet developed protocols or standards for supervision and monitoring of adults who work with children. There were no federal or state resources to assist with these efforts, no professional literature to guide supervision, and no examples were available such as would be on the internet today.

15. In 1970 and 1971, the concept of "warning" which is also called "community notification" or sharing of information about sexual offenders was not yet contemplated by law enforcement or private citizens. It was not until 1990 that the criminal justice system in the United States began to consider informing citizens that convicted sexual offenders were moving into their neighborhoods, and then only for violent, convicted offenders.

16. In 1970 and 1971, as offensive as it may be to modern sensibilities, most professionals did not recognize that sexual contact with a familiar adult was likely to be traumatic for a child. In fact, sexual contact between adults and children was commonly treated as a "childhood behavioral problem." With this as the prevailing paradigm of the time, there were no established protocols to assist with the traumatic effects of sexual abuse or to facilitate the healing process. In other words, therapists were not trained to address the trauma of sexual abuse and defined therapy for healing after sexual abuse did not yet exist in the early 1970's.

Bases for My Opinions

17. The events that are the subject of this litigation are alleged to have occurred approximately 50 years ago. In the area of sexual abuse, the intervening 50 years have been a time of exponential growth in awareness, resources, and law. Therefore, when formulating opinions as to whether actions were reasonable, it is essential to begin by establishing the relevant standards of care for the time period in which decisions and actions were taken.

18. The basis for determining whether or not an individual behaved in a responsible manner is normally to compare the actions of the individual in question with what would be expected of a reasonable person at the time. The difficulty with actions that relate to sexual abuse is that the development of information that is available regarding the problem has increased so dramatically in the past 20 years that most people are unaware of how the problem was viewed 20, 30 or 50 years ago. This lack of information leads them to believe that what is considered reasonable by today's standards should be applied to the decisions and actions of the past. The inaccuracy can be corrected by carefully defining the standards of care according to the knowledge and guidance that were available to decision-makers during the timeframe in question.

19. Standards of care with respect to sexual abuse may be defined through comparison with the following benchmarks:

    - *Federal and State laws that address sexual crimes, sexual abuse of children, sexual offenders, reporting laws, and access to criminal records.*
    - *Federal and State regulations and guidelines for organizations that serve children and youths. For example, federal guidelines for public schools and state child care licensing standards.*
    - *State of professional knowledge regarding the specific form of abuse, such as stranger assault, incest, acquaintance abuse, child to child abuse, and other forms of abuse. Knowledge areas include but are not limited to prevalence, damage to victims, and treatment of offenders.*
    - *State of public knowledge and general awareness regarding the specific form of abuse.*
    - *Resources available to assist organizations in the prevention and response to the specific form of abuse, such as professional journal articles, books, guidelines and sample policies offered by foundations or associations.*
    - *Practices and standards maintained by similar organizations and programs.*

    The principle to follow is that decision-makers in organizations can only utilize knowledge that was known and guidelines that were established (See Appendix B).

20. As early as the 1930's, "sexual psychopathy" laws were passed to provide for the psychiatric treatment and, at times, civil commitment of convicted sexual offenders. These laws reflected the pervasive thinking of the times: forcible rape of children was against the law. State statutes and investigations focused on violent offenders, stranger rape and sexually motivated murder. Language used in state statutes and other writings did not reflect a contemplation of incest abuse

or other, more subtle forms of sexual abuse (Sutherland, 1950), stating that "practically all sex crimes were committed by 'degenerates,' 'sex fiends,' 'sexual psychopaths,' and 'sex killers.'" This left little room for an allegation of sexual abuse by an employed, non-criminal, other-wise "upstanding citizen." Treatment-based sentencing for sexual offenders (even violent offenders), whereby sexual offenders were placed into residential treatment programs instead of prisons, was common from the 1950's through the 1980's.

21. Beginning in 1944, a number of states began to enact "sexual offender registration" statutes to track and maintain a database of names and identifying information regarding known sexual offenders. California was the first to develop a sexual offender registry and the trend spread through the US until 1967. It is important to note that these sexual offender registries were not accessible to child-serving organizations for use in background checking and were not available to the public at large to assure their own safety. Information contained in the registries was considered confidential. Law enforcement officers were not permitted to share the information with citizens, but were instructed to use the registries strictly as an aid in pursuing criminal investigations and convictions. (Matson & Lieb, 1996). In fact, in most states, the release of information about sexual offenders was actually a crime until after the 1990's.

Timeline of Legislation Regarding Sexual Abuse

1984: President Ronald Reagan opened the National Center for Missing and Exploited Children.

1990: Washington State Community Protection Act became the first state law that allowed ordinary citizens to have *access* to information about violent sexual offenders in their neighborhoods. This opened the door for community notification laws in the United States.

1993: National Child Protection Act permitted individual states to pass legislation that would allow entities within their own states to access national criminal records. Prior to this, no state in the country could permit organizations to access national criminal background checks.

1994: First law requiring states to create Sexual Offender Registries.

1994: New Jersey's Megan's Law was the first law allowing law enforcement to notify neighbors when a convicted, paroled violent sexual offender would be moving into their neighborhood.

1998: Volunteers for Children Act was the first national law allowing private organizations in all states to access the FBI database of criminal records for the purpose of screening volunteers.

2006: First national law requiring states to allow online access to Sexual Offender registries.

2006: First national law requiring Adoptive and Foster Parents to have criminal background checks.

22. As of 1990, not a single state in the United States had a provision to notify communities when a dangerous, sexually violent predator was being paroled and had plans to move into the neighborhood. Today, all 50 states have laws that address public access to information when dangerous, convicted sex offenders move into their neighborhoods. While acquaintance offenders in organizations rarely qualify as "sexual predators" according to the law, community notification of sexual offenders is an important benchmark in understanding the developing standard of care because it demonstrates a fundamental shift in thinking from protecting the right of privacy for the offender to releasing information for sake of protecting the public. Below is a description of the development of this practice in the criminal justice system nationally.

23. Colorado was the first state to enact a mandatory child abuse reporting law in 1963. By 1969, all states in the United States had some form of abuse reporting law. Prior to this, it was not only legal for professionals working with children to fail to report obvious abuse, most police departments did not have programs in place specifically to respond to reports of crimes against children. Child welfare departments were still tied to the Humane Society and the Society for the Prevention of Cruelty to Animals until the 1970's when police departments began to establish their own procedures for processing and responding to reports of child abuse.

24. Prior to 1975, there were at least three pervasive beliefs about sexual offending against children: 1. Sexual abuse is rare. 2. Children "collude" with adults in having sexual contact, and 3. That sexual abuse is unlikely to cause harm. Each of these pre-1975 beliefs will be examined in more detail in the discussion that follows.

Belief that sexual abuse was rare. One of the facts which took an inexplicably long time to gain acceptance, was the alarming frequency with which sexual abuse occurs in mainstream society. When Sigmund Freud first proposed to his colleagues at the Vienna Society for Psychiatry and Neurology that his patients had been sexually involved with adults, he was summarily dismissed and told by Richard von Krafft-Ebing that his theory "sounds like a scientific fairy tale" (Hunt, 1993, p.181). Freud eventually abandoned the proposal that the activities actually occurred and replaced it with a theory that suggested that children were merely "fantasizing" about sexual contact with adults (Laws & Marshall, 2003). Even with reasonably accurate studies of the prevalence of child sexual abuse first published in 1929 (Hamilton, 1929; Terman, 1938), the professional literature did not acknowledge the prevalence of sexual abuse until many years later. A noted sociologist summed up the prevailing notion by stating, "The problem of incest is peculiar in several respects. Statistically its occurrence is negligible. Because of this

infrequency, the extent of its disruptive effect on human group life is minor," (Blumer, 1969). Thus, prior to 1975, the prevailing belief among professionals and the general public was that child sexual abuse was an extremely rare phenomenon.

Belief that children "collude" with abuse. Prior to 1975, children who were sexually abused who did not run or scream or otherwise prevent their own abuse were essentially blamed or considered responsible for the sexual activity between themselves and an adult (Virkkunen, 1975). In 1937, Bender and Blau described working with 5 to 12 year-old incest victims, "The history of the relationship in our cases usually suggested at least some cooperation of the child in the activity, and in some cases the child assumed an active role in initiating the relationship…It is true that the child often rationalized with excuses of fear of physical harm or the enticement of gifts, but these were obviously secondary reasons."

In 1953, Kinsey wrote that "in many instances, incestuous experiences were repeated because the children had become interested in the sexual activity and more or less actively sought repetitions of their experience." In 1975, Henderson stated in a psychiatry textbook that "the daughters collude in the incestuous liaison and play an active and even initiating role in establishing the pattern" (p.1536). The 1972 edition of the Comprehensive Textbook of Psychiatry stated the following: While police records of parents' complaints that their child has been molested do provide some clue as to the prevalence of this sexual deviation, other factors must be taken into consideration. For example, the adolescent "Victim" in such a complaint may, in fact, have concealed his or her age, and behaved in a deliberately seductive manner. Furthermore, children lend themselves to fondling and to lap sitting, which may be accompanied by friction with adult genitalia. As Anna Salter discussed in 1988, it is essential to understand that the notion of "collusion" was embedded in the mainstream mentality, and not an idea solely held by a "fringe element" of mental health professionals.

Belief that when sexual abuse does occur, it is unlikely to cause harm. A third pervasive concept in the pre-1975 professional literature was the belief that there were few, if any, negative consequences for children who were involved in sexual contact with adults (Mohr, Turner, & Jerry, 1964). Sloane and Karpinski (1942) stated that "the view that sexual relations with adults (including incest) among children are not basically destructive is confirmed by the observations of Ramussen and Bender and Blau."

25. In 1951, in a follow-up to Bender's earlier examination of the effects of childhood sexual contact with adults, Bender and Grugett reported, "In contrast to the harsh social taboos surrounding such relationships, there exists no scientific proof that there are any resulting deleterious effects (p. 827). Alfred Kinsey (1953) one of the first researchers to establish how widespread sexual abuse was, concurred. He promoted the idea that sexual abuse is not inherently harmful, but that it is the reactions of our society that cause any harm that may result. He wrote: It is difficult to understand why a child, except for its cultural conditioning, should be disturbed at having its genitalia touched, or disturbed at seeing the genitalia of other persons, or disturbed at even more specific sexual contacts....Some of the more experienced students of juvenile problems have come to believe that the emotional reactions of parents, police officers, and other adults who discover that a child has had such contact, may disturb the child more seriously than the sexual contacts themselves. (p.121) The perception that sexual abuse was either not harmful or probably not harmful was widely held until later studies called into question the beliefs regarding "no harm."

26. In 1975, a leading authority (Walters, 1975) wrote, "virtually no literature exists on sexual abuse of children." Henry Kempe's first edition of The Battered Child in 1968, made no mention of child sexual abuse. Later, in a 1977 address to the American Academy of Pediatrics, he described child sexual abuse as a "hidden pediatric problem and a neglected area." Sexual abuse of boys, grooming-type acquaintance abuse, and warning signs of sexual offenders were not well-researched until well after 1985.

27. During the early 1980's, although therapists, social scientists and child protective services agencies were developing an understanding of the dynamics of incest offending and other forms of child abuse within families during the late 1970's and early 1980's, virtually none of the research or discussion focused on acquaintance abuse or "extra-familial sexual abuse" or the sexual abuse of boys.

28. In 1982, the first National Symposium on Child Sexual Abuse was held in Denver, Colorado. The organizers and participants did not address acquaintance abuse at all and specifically outlined the forum as focusing solely on sexual abuse that occurred within families. In a review of empirical research findings regarding sexual abuse victims, Browne and Finkelhor (1982) elected not to address sexual abuse of boys because, "Few clinical, and even fewer empirical, studies have been done on boys and it seems premature to draw conclusions at this point." So dim was

the recognition that boys could also be sexually abused, that Russell's ground-breaking community-based research study did not even attempt to study males (Russell, 1983).

29. In addition to a paucity of empirical research, virtually no federal or state funding was committed to furthering the understanding or prevention of abuse within organizations, despite the prevalence of abuse in state-funded out of home care and public school systems. There had yet to be a large-scale research survey to describe or guide the sexual abuse prevention practices of organizations that serve children or to assist in the identification of "best practices" for prevention and response.

30. During the 1980's, researchers began to discover that it is possible for sexual abuse to cause serious and long-term effects. Initial effects were found to include fear, sleep disturbance, ambivalent hostility, active defiance, disruptive behavior in the family, aggression and antisocial behavior with peers, inappropriate sexual behavior, shame and feelings of guilt. In addition to these initial effects, studies of adult survivors of sexual abuse also identified long-term effects that may include depression, suicide attempt and other self-harm behaviors, anxiety, eating disorders, dissociative disorders, compromised self-esteem, hostility and fear in interpersonal relationships, and problems in sexual functioning and substance abuse (Browne & Finkelhor, 1986; Alter-Reid, Gibbs, Lachenmeyer, Sigal, & Massoth, 1986).

31. Although some of the individual research findings were obtained prior to the 1980's, the gathering and synthesis of the findings led professionals to recognize the gravity of outcomes for children who had experiences of abuse. This was a key element for raising public awareness for the need to prevent sexual abuse, rather than just responding properly.

32. In 1986, the National Center for Missing and Exploited Children published the first authoritative manual on the investigation of child sexual exploitation. The manual was one of the first such works to focus attention on "Acquaintance Offenders" and was intended for use by law enforcement officers and other criminal justice professionals who might encounter this type of offender (Lanning, 1986; 1992). Child Molesters: A behavioral analysis was the first clear articulation of standards for investigating sexual abuse by acquaintances, particularly those who gain access to children through child-serving organizations.

Key Resources Regarding Sexual Abuse

- 1974, CAPTA: The Child Abuse Prevention and Treatment Act provided federal funds to states in support of prevention, assessment, investigation, prosecution, and treatment activities. CAPTA also established the Child Welfare Information Gateway.
- 1997: National Collaboration for Youth published *Screening Volunteers to Prevent Child Sexual Abuse: A Three-Step Action Guide.*
- April, 1998: The United States Department of Justice published *Guidelines for the Screening of Persons Working With Children, the Elderly, and Individuals With Disabilities in Need of Support.*
- 2002: The Points of Light Foundation and the Volunteer Center National Network published *Volunteer Screening: Part of an Integrated Risk Management Program.*
- 2007: The Centers for Disease Control published *Preventing Child Sexual Abuse Within Youth-serving Organizations: Getting Started on Policies and Procedures.*

33. During the early 1970's, the majority of youth-serving organizations in the United States did not have screening procedures designed to prevent a sexual offender from becoming involved with the organization and gaining access to children. These organizations did not yet have access to the criminal records of applicants, sexual offender registries were not available to the public, and child welfare records were kept for state use only. Major developments in screening and selection did not occur until many years later, beginning in the late 1990's, a number of organizations banded together to form the National Collaboration for Youth. One of the primary purposes of the Collaboration was to develop resource materials to assist in the prevention of sexual abuse; it was made up of organizations like the YMCA and Big Brothers that had experienced many episodes of sexual abuse by employees and volunteers. Most of their efforts focused on screening and selection of volunteers.

34. In order to "recognize warning signs" an individual or representative of an organization must a) recognize certain behaviors as boundary violations, and b) know that boundary violations are signs of sexual abuse. In this area, we have the most recent developments in the field of sexual abuse by acquaintance offenders, that is, the subtle distinctions between a dedicated professional who cares about youth and the signs of an adult who is initiating a sexual relationship with a minor. It is only within the post 2002 era, that these differences or "warning signs" have become part of the arsenal for prevention of abuse and indeed, this is an area in which more research and education is still needed. Below is a discussion of the development of this knowledge and practice in organizations.

35. When acquaintance abuse first emerged, inappropriate behavior with minors was not addressed as part of a larger pattern of sexual abuse. The concept of "grooming" or using a slow process of preparing a child to be abused was not understood to be evidence of the possibility of sexual contact with children. Today, we understand that acquaintance sexual offenders take steps to ensure that children feel comfortable with them physically and emotionally before the contact ever becomes sexual. Grooming most often consists of gaining the trust of children and their parents through friendship, kindness and consistency in the relationship. Over time, the acquaintance offender increases focus on the child or children who are targeted for abuse – taking them "under his wing," helping the child and family in ways that are genuinely needed, spending time, energy and money on the child or children. They slowly increase physical contact and affection, making physical contact the norm, rather than the exception. "Accidental" touching of private body parts are often part of the boundary testing. Acquaintance offenders also test the child's ability to keep secrets by involving the child in using alcohol or cigarettes and then asking the child not to tell. Pornography is commonly used for grooming as well.

36. Until recently, grooming behaviors were most often viewed in isolation instead of as part of a pattern: they were not understood as the part of sexual abuse we can see. As a result, most investigations of sexual abuse, either criminal investigations or organizational investigations focused on determining whether or not an individual event of sexual abuse did or did not occur, rather than including additional information about the overall pattern of interacting with children that was characteristic of the individual. Early descriptions of this pattern could be found in the professional literature by 1988 (Lang & Frenzel, 1988) but the knowledge did not become readily available to the public until after 2002.

37. **Educational programs for prevention.** Prior to 1985, the majority of youth organizations had not yet developed educational programs for children or parents to help prevent sexual abuse. It was approximately 1997 - 1998 when most youth organizations in the United States began implementing abuse prevention programs which included abuse prevention training for volunteers and employees. The training varied from location to location, but generally included segments on the definitions of physical, emotional and sexual abuse, as well as strategies for prevention. The strategies most often included recognizing signs and symptoms of children who may be sexually abused and how to respond if a child discloses abuse. Many programs also included "characteristics" of pedophiles that listed "over-involvement with children, single, male, relates easily with children, and under 35" as characteristics to watch for in staff and volunteers. Both

signs of abuse in children and characteristics of offenders presented some problems with respect to prevention. The trouble with recognizing signs of abuse in children was that the signs, such as "moodiness" or "withdrawal" could be signs of many different problems in childhood and adolescence, not just sexual abuse; and the difficulty with using characteristics of adults was that the characteristics did not actually differentiate adults who were not safe with children from those who were.

38. **Policies for prevention.** I am not aware of any professionals who were studying sexual offenders who targeted children through organizations or who were assisting organizations to develop policies and procedures for prevention in the early 1970's. The first governmental resources and guidelines addressing incest sexual abuse were published in the late 1970's. There were no professional journals or trade publications to guide youth-organizations in the prevention of sexual abuse within organizations.

39. The first published works that were of practical use to organizations were published for law enforcement in 1986 and human service professionals in 1988. In 1988, *Sexual Abuse: A Journal of Research and Treatment* published a piece that was among the first research-based articles with direct usefulness to youth organizations. The article was entitled "How Sex Offenders Lure Children" (Lang & Frenzel, 1988). This study was limited only to perpetrators against girls and interestingly uses the term "stranger-perpetrated sexual assault" to differentiate extra-familial offenders from incest offenders. This nuance of language demonstrates the foreignness of the concept of acquaintance sexual offending even as late as 1988.

40. **Centers for Disease Control.** In 2007, the Centers for Disease Control published a resource for child and youth serving organizations. This document, entitled, Preventing Child Sexual Abuse Within Youth-serving Organizations: Getting Started on Policies and Procedures is described on the CDC website as a resource "to assist youth-serving organizations as they begin to adopt prevention strategies for child sexual abuse." The document identifies six key components of child sexual abuse prevention for organizations:

    - Screening and selecting employees and volunteers
    - Guidelines on interactions between individuals
    - Monitoring behavior
    - Ensuring safe environments

- Responding to inappropriate behavior, breaches in policy, and allegations and suspicions of child sexual abuse
- Training in child sexual abuse prevention

This 2007 federally-funded resource demonstrated the on-going needs of organizations and continuing evolution of the standards of care.

41. The practice of remediating, insofar as is possible, the effects of sexual abuse is today, one of the strongly held practices for when sexual abuse is known to have occurred. The development of this practice necessitated information in the following areas: a) that sexual contact between adults and children or adolescents is always sexual abuse, not just when there is violence, physical coercion, or physical injury, b) that sexual abuse may cause emotional or psychological harm, c) that harm may be remediated through treatment, and d) the particular forms of treatment that may be utilized to address sexual abuse trauma. Prior to 1975, the professional literature was not supportive of either of the first two necessary components for this standard to develop. By the late 1970's, professionals were beginning to shift their thinking from the psychoanalytic model of understanding incest abuse and moving more towards family systems therapy. The family treatment model focused on preventing further incidents by addressing the family-system dynamics that contributed to their occurrence. Most significant in this movement was the creation of treatment programs both for child victims and adults who were molested as children.

42. **Development of a model program to address incest sexual abuse.** California became the first state to develop significant programs for victims of sexual abuse, with a model program called the Santa Clara County Child Sexual Abuse Treatment Program which began informally in 1971 with a pilot program, treated 32 families in 1973 and secured regular funding by the state in 1976. The program focused on incest offending and its objectives were to provide immediate counseling and practical assistance to families, but especially to victims of sexual abuse. Proponents of this program believed that child victims and adults who were victimized as children need therapeutic help for successful adjustment and positive self-concept (Davis, 2005).

43. **Development of treatment protocols.** In 1982, Suzanne Sgroi edited the Handbook of Clinical Intervention in Child Sexual Abuse. In this volume, Dr. Sgroi reported that there were only a "handful" of treatment providers for sexual abuse intervention in the United States and that …the field is too new and the body of accumulated knowledge and skills is too small and inadequately tested for anyone to claim that he or she has the answers. We are many years away from evolving

an intervention methodology that has stood the test of time (Sgroi, 1982, p.6). The book goes on to provide a practical guide to clinicians regarding the areas that should be addressed to treat child sexual abuse as well as specific recommendations for individual, group and family therapy. While extra-familial abuse and sexual abuse of boys are acknowledged in the text, clinical interventions in cases of incest offending clearly have the more prominent role and receive the practical advice within the content. Sgroi's guidebook, while not the only resource from this era, was a useful compilation of knowledge and strategies about what could be done to address harm to victims and 1982 marked the beginning of providing therapy as a practice standard for addressing child sexual abuse.

Conclusions

44. At no time during 1970 and 1971 could Sacred Heart School or the Diocese of Charleston have been in violation of community standards for prevention or detection of sexual abuse by a teacher or teachers because those standards had not yet been established during the timeframe (See Appendix C). As there is no evidence or suggestion that a contemporaneous report was made, there is no basis upon which to evaluate the response of these entities against prevailing community standards.

45. If I am asked to provide additional opinions, I will review the relevant materials and provide any modifications or additions to my opinions as soon as possible.

FURTHER AFFIANT SAYETH NOT.

M. Applewhite

Dr. Monica Applewhite

Sworn to and subscribed before me this
the 6 day of November, 2019.

Notary Public for State of Texas

My commission expires: 4/5/2023

6 November, 2019

PETER WOOD
Notary Public, State of Texas
Comm. Expires 04-05-2023
Notary ID 131961983

STATE OF SOUTH CAROLINA
COUNTY OF CHARLESTON

IN THE COURT OF COMMON PLEAS
CIVIL ACTION NO.: 2018-CP-10-03929

John Doe,

Plaintiff,

v.

The Diocese of Charleston, a Corporation Sole, and the Bishop of the Diocese of Charleston, in his official capacity,

Defendants.

CERTIFICATE OF SERVICE

I hereby certify that this _____ day of April, 2019, a copy of _____

_____ has been served upon other counsel of record by placing same in the United States Mail, postage prepaid, to:

Lawrence E. Richter, Jr.
Jennifer S. Ivey
The Richter Firm, LLC
622 Johnnie Dodds Blvd.
Mt. Pleasant, SC 29464

Attorneys for Plaintiff

_____
April D. Hager

Appendix A. Applewhite CV and List of Clients

MONICA APPLEWHITE, PH.D.

CURRICULUM VITAE

EDUCATIONAL BACKGROUND AND WORK EXPERIENCE

EDUCATION

The University of Texas at Arlington
Arlington, Texas
Ph.D. in Social Work – Clinical Track (1995).
Dissertation: "A Logistical Regression Model of the Decision Making Process of Women in Abusive Relationships."
Advisor: Dr. Charles Mindel

The University of Texas at Arlington
Arlington, Texas
Master's of Science in Social Work (1992).

Texas Christian University
Fort Worth, Texas
Bachelor's of Science in Social Work (1990).

WORK EXPERIENCE

Confianza, LLC - Independent consultant
September 2007 to the present
Austin, Texas

- *September 2007 to the Present – Programs for Religious Organizations, Schools and Social Service Agencies*
    - *Developed and delivered educational programs for faith-based organizations, religious and independent schools, social welfare and university systems in various locations throughout the United States, Ireland, Italy, South Pacific Island Region, South America, New Zealand, and Australia.*
    - *Conducted comprehensive risk assessment and supported implementation of risk reduction strategies for Milton Hershey School in Hershey, Pennsylvania.*
    - *Provided educational programs and policy develop for multiple independent schools in the United States.*
    - *Facilitated the review of Accreditation Standards for Men's Religious Institutes in the United States. Reviewed standards for pastoral care of victims, incident investigation and supervision of those who have sexually abused minors.*
    - *Conducted workshops for supervisors of sexual offenders. Addressed current monitoring procedures, the use of static and dynamic variables in risk assessment, internal investigations and the use of community support for secondary prevention.*

- *Delivered educational programs for Jesuit Superiors, Congregation for the Mission, Eastern and Mid-West Provinces, and numerous other programs for Religious Men.*
- *Conducted educational program for the Bishops of English-speaking countries entitled, "Monitoring the Accused and Safety Planning: Toward a Holistic Approach."*
- *Conducted educational programs for the USCCB regarding supervision of priests who have sexually offended against minors.*
- *Developed individualized programs of support and accountability for priests and religious who have sexually offended against minors and/or adults in ministry environments.*
- *Presentations for the National Safe Environments and Victim Assistance Leadership Conferences in 2009, 2010 and 2017.*
- *Conducted educational programs and institutional risk assessment for educational and residential care facilities.*
- *On-site consultation and education for University Systems and campus ministries.*
- *Provided outreach and support to victims of sexual abuse on behalf of organizations in which the abuse had occurred.*
- *Investigated historical reports of abuse and allegations of misconduct that fall short of criminal behavior.*

- *September 2007 to the Present – Research on Historical and Current Standards of Care*
  - *Reviewed and documented the professional literature regarding the development of standards of care in schools and educational institutions in the United States and internationally.*
  - *Reviewed and documented the professional literature regarding standards of care for children, youths and vulnerable adults in out of home care, including residential treatment facilities, emergency shelters, juvenile detention centers, foster care, day care centers, group homes and respite care.*
  - *Reviewed and documented technical literature regarding the knowledge base surrounding sexual abuse of minors, the treatment of sexual offenders, known prevention methods and institutional response systems from the early 1900's to the present.*
  - *Researched and documented the development of criminal statutes, sexual offender registries, punishments and parole requirements for sexual offenders throughout the history of the United States.*
  - *Reviewed and summarized the professional literature regarding the historic understandings of victims of sexual abuse, the short-term and long-term effects of abuse on children and youth, and the evolution of treatment for victims of abuse.*

Park Dietz & Associates
Expert Consultant
2008 to the present

Praesidium, Inc.
Partner, President of Religious Services (1998 – 2007)
Arlington, Texas

- *1998 to 2007 Work with Organizations that Serve Children, Youths and Vulnerable Adults*

- *Conducted numerous on-site risk assessments of organizations that serve minors and vulnerable adults.*
- *Activities included policy review, face to face interviews with staff and participants, review of records and incidents, and observations of programs.*
- *Conducted investigations of boundary violations, policy violations and other non-criminal behaviors with children, youth and vulnerable adults.*
- *Organizations included resident camps; water parks; dry parks; municipal pools; youth development organizations; public, private and charter schools; child care facilities, foster care organizations, Autism treatment facilities, residential treatment facilities, emergency shelters, juvenile corrections facilities and programs to address the needs of vulnerable adults.*
- *Developed individualized strategies to address risks identified in assessments.*
- *Developed policies and procedures to prevent and respond to physical, sexual and emotional abuse.*
- *Conducted several hundred educational workshops and seminars to address screening and selection, internal feedback systems, policy development, monitoring and supervision, consumer awareness and incident investigation.*

- *2002 to 2007 Programs for the Conference of Major Superiors of Men*
  - Addressed the major superiors of Catholic Religious Institutes in the United States. Program was entitled, "*From Compliance to Commitment: Large Scale Organizational Change to Protect Children and Young People*".
  - *Conducted 12-part Educational Program for Major Superiors entitled, "Instruments of Hope and Healing: Prevention and Response to Sexual Abuse of Minors." Educational program included sessions regarding internal investigations, responding to those who have experienced abuse,*
  - *Worked with a committee of priests, monks and brothers to develop "Accreditation for Religious Institutes," a program of accountability. The Accreditation Standards consisted of 28 requirements for prevention and response to sexual abuse, including standards for the supervision of priests and brothers who have sexually offended children and youths.*
  - *Conducted site visits of more than 400 individual religious communities to ensure adherence to accreditation standards.*
  - *Conducted numerous educational programs (60+) with individual Religious Institutes, combining research findings, investigation experiences and current industry expectations to increase the knowledge and skills for prevention among priests and brothers.*

- *2003 to 2004 Programs for the Episcopal Church and the Salvation Army*
  - *Addressed the Episcopal House of Bishops in a program entitled, "Policies and Standards for the Protection of Children" which outlined a five-step process for prevention and response to sexual abuse in religious organizations. The five-step process was accepted by the bishops and formalized in a resolution of the 74th General Convention of the Episcopal Church. The resolution adopted the standards for prevention and response to sexual abuse for all Episcopal Churches in the United States.*
  - *Developed National Model Policies for the Episcopal Church in the United States,*
  - *Developed and trained national program of prevention and response for the Episcopal Church in the United States and the Salvation Army Western Territory.*

- *1998 to 2007 Work with Religious Organizations*

    - *Conducted risk assessments of faith-based organizations, including churches, religious schools, religious camps and youth ministry programs. Developed policies, supporting forms for documentation and procedures for managing risks of abuse that are unique to these environments.*
    - *Conducted investigations of sexual misconduct in religious organizations. Investigations of misconduct included Roman Catholic and Episcopal Priests, Religious brothers and monks, Jewish rabbis, Baptist Ministers, non-denominational protestant ministers, youth ministers, camp counselors, swimming instructors and school teachers of multiple religious traditions.*
    - *Developed individualized supervision protocols for members of the clergy and others in positions of trust who have sexually abused minors, violated boundaries with adults and failed to adhere to organizational policies with respect to boundaries and the ethics of ministry.*

- *1998 to 2003 Programs for the United States Catholic Dioceses*

    - *Developed A Time to Protect God's Children and A Plan to Protect God's Children, video-based training designed to teach warning signs of child molestation and strategies for preventing and responding to abuse. Piloted program, trained trainers in 11 states and presented workshop to more than 30,000 Catholic laypeople, religious men and women, and members of the clergy.*
    - *Developed the Control Access Toolkit, a set of protocols and instruments for use in screening and selecting adults to work and volunteer in positions of trust with minors. The toolkit included interview questions, reference forms and follow-up questions, protocols for criminal background checks and a checklist for decision-making.*
    - *Reviewed 21 Roman Catholic Diocesan Policies and developed model Diocesan Policies for prevention and response to sexual abuse.*
    - *Developed a Self-Audit Toolkit for institutions to review their own policies and procedures to determine whether addition protocols may aid in the prevention and response to warning signs and incidents of abuse.*

Praesidium, Inc.
Partner, Vice-President of Risk Management Technology (1994 – 1998)
Arlington, Texas

- *1994 to 1998 Programs for YMCA's and Youth Development Organizations*

    - *Conducted risk assessment of YMCA programs, including child care, sports, Indian Guides & Princesses, resident camps, day-camps, afterschool programs and swim instruction.*
    - *Developed screening protocols for staff and volunteers, screening and selection tools, parent information materials, and incident response protocols.*
    - *Conducted numerous educational programs for YMCA's and Youth Development programs throughout the United States, including Seattle, Detroit, San Francisco and Dallas.*

- *1994 to 1998 Programs for Residential Treatment Facilities and Emergency Shelters*

    - *Conducted risk assessments for residential treatment facilities for children and youth with behavioral and emotional disturbances, including specialized programs for children and*

youth with chemical dependency, histories of sexual offending, oppositional-defiant disorders, conduct disorders, physical and sexual abuse histories and developmental delays.

- *Conducted root cause analysis of cases of adult to child abuse, child to child abuse, and incidents of sexual conduct among program participants.*
- *Developed policies and educational programs for the Association of Licensed Care Facilities in Texas.*
- *Developed protocols and implementation strategies for managing juvenile sexual offenders in residential treatment facilities.*

- *1994 to 1998 Programs for Foster Care*
  - *Conducted risk assessment foster care organizations and foster homes.*
  - *Developed screening and selection system for foster families, including protocols for home visits, a self-assessment for potential foster parents, behavioral interviews, reference check questions and protocols for decision-making.*
  - *Developed case management protocols for ongoing supervision and monitoring of foster homes. Included standard interviews with children and youth and procedures for direct observations of interactions.*
  - *Conducted training for foster parents, case managers, supervisors and administrators regarding abuse prevention and response in foster care environments.*

Child Safe Environments, Inc. (later became Praesidium, Inc.)
Consulting Firm for Organizations, specializing in prevention and response to sexual abuse.
Co-Founder (1992-1994)
Arlington, Texas

- *In preparation for consulting with organizations serving children and vulnerable adults, the following activities were completed:*
  - *Conducted complete literature review of sexual abuse, with focus on organizational abuse, disclosure, characteristics of targeted victims, prevention methods and standards for response upon disclosure.*
  - *Reviewed all empirical research that was available regarding physical and sexual abuse in organizations. Reviewed and analyzed cases of "institutional physical and sexual abuse."*
  - *Utilized a "root cause analysis" methodology to identify root causes of abuse in organizations that serve children and youth.*
  - *Reviewed legal definitions and child abuse reporting laws to develop educational materials for organizations that serve children.*
  - *Reviewed prosecuted cases and all other publically available cases to identify patterns of abuse, disclosure and investigation in organizational abuse.*
  - *Reviewed current research on sexual offenders and patterns of "extra-familial" abuse.*

PUBLICATIONS

Putting Abuse in Context, America Magazine, September 25, 2006

Understanding Infatuation and Devotion, Human Development Magazine, Winter, 2005

PROFESSIONAL AFFILIATIONS

National Association of Social Workers (NASW)

Association for the Treatment of Sexual Abusers (ATSA)

National Organization for the Treatment of Sexual Abusers (NOTA)

DEPOSITIONS AND COURT TESTIMONY

Ames v. The Latter-day Saints. State of New Jersey. No. 06-3441 (2008)

Roe v. The John Swett Unified School District. State of California. No. C 08-00422 (2009)

John Doe v. The Latter-day Saints State of California. No. BC417684 (2011)

Tim Doe v. Saint Francis Hospital. State of Connecticut. No. CV - 08-5008551 – S (2011)

Dorman v Does 1-4. State of California. No. 37-2010-000092450-CU-PO-CTL (2012)

Jane Doe v. Watchtower. State of California. No. HG11558324 (2012)

Carter v. Lewis. United States District Court. District of New Jersey. No. 08-1301 (2012)

Juan Doe 1 v. Lutheran Church Missouri Synod. State of California. No. BC450976 (2013)

Torres v. USA. United States District Court. District of New Mexico No.1:12-cv-00018 MV-RHS (2013)

Boys 2 and 3 v. Boy Scouts of America. United States District Court. Western District of Washington at Seattle No. C10-1912 RSM (2013)

Lopez v. Watchtower. Superior Court of the State of California for the County of San Diego, Central Division. No. 37-2012-00099849. CU-PO-CTL (2013)

Baker v. Watchtower. High Court of London. Trial Testimony. (2015)

Hamrick v. DSHS. State of Washington. Trial testimony. (2015)

John Doe CN v AYSO. Superior Court of the State of California. No. BC 546 652 (2017)

Does 1-4 v AYSO. Superior Court of the State of California. No. BC574025 (2018)

Pegasus v Agave Health et al. State of New Mexico. No. D-101-CV-2016-02760 (2019)

Specific Client Organizations

Camps

- Camp Carter, Fort Worth
- Camp Colman, Washington State
- Camp Grady Spruce, Dallas
- Camp Jones Gulch, San Francisco
- Camp Nissokone, Michigan
- Camp Olympia, Texas
- Camp Orkila, San Juan Islands
- Pine Cove Christian Camps
- Woodmen of the World

Child care and Social Service Organizations

- All Church Home for Children (adoption, emergency shelter, foster care, residential)
- Autistic Treatment Centers, Dallas and San Antonio
- Bair Foundation (adoption, foster care, kinship care, family services)
- Baltimore Catholic Charities (adoption, foster care, residential treatment)
- Bridge Emergency Shelter for Children and Youths
- Buckner Children's and Family Services (adoption, foster care, family services)
- Cal Farley's Boy's Ranch (residential and transitional programs for children & youth)
- Casey Family Programs (adoption, foster care, family services)
- CentaCare Social Services, Queensland, Australia
- Clinicare Corporation (Residential Treatment Centers)
- Covenant Kids, Inc. (adoption, foster care, family services)
- DePelchin Children's Center (foster care, adoption, mental health)
- D&S Residential (care for individuals with intellectual and developmental disabilities)
- Eckerd Youth Alternatives (services for children and youth w/complex mental, emotional and behavioral needs)
- Fort Worth Catholic Charities (children, refugee and family services and foster care)
- La Petite Academy (educational and child care)
- Lee and Beluah Moor's Children's Home (adoption, foster care and residential care)
- Lena Pope Home (counseling, family services and intensive treatment programs)
- Lutheran Social Services of the South (adoption, foster care, kinship care and residential)
- Marywood Child and Family Services (services for pregnant and parenting teens)
- Masonic Homes (counseling and family services)
- Methodist Children's Home (foster care, residential treatment, family services)
- Mentor Clinical Care (therapeutic & medically complex foster care, adults, adoption)
- New Horizon Academy Child care (educational and child care)
- New Jersey Department of Children and Families
- New York Foundling Hospital (adoption, foster care, adults, family services)
- North American Family Institute (juvenile justice, behavioral health, adult services)

- Presbyterian Children's Home (adoption, foster care, residential, family services)
- Rancho Valmora Treatment Center (residential treatment for adolescents)
- Safe Havens of Kornerstone (adoption, foster care, family services)
- Seguin Services, Inc. (adoption, foster care, adult services)
- Social Services of Auckland, New Zealand (foster care, kinship care, family services)
- St. Dominic's Home (family foster care, therapeutic pre-school, mental health services)
- Texas Association of Children's and Family Services (TACFS)
- Texas Department of Protective and Regulatory Services
- Texas Baptist Children's Home (residential treatment, family services)
- Wisconsin Association of Family and Children
- Wisconsin Bureau of Regulation and Licensing
- Wyoming Department of Family Services

Parks and Recreation

- Ellis and Associates
- Illinois Parks and Recreation
- Six Flags Hurricane Harbor
- World Waterpark Association

Religious Organizations

- Abbey of Gethsemani
- American Cassinese Congregation
- Anglophone Conference of Bishops
- Australian Office of Professional Standards
- Benedictine College
- Broadway Baptist Church
- Brothers of the Sacred Heart
- Capuchin Friars
- Catholic Charities of Baltimore
- Catholic Charities of Fort Worth
- Christ Chapel Bible Church
- Christian Life Movement – Ecuador, Colombia, & Peru
- Church of Jesus Christ of Latter-Day Saints
- Church of the Hills
- Conference of Major Superiors of Men
- Congregation for Institutes of Consecrated Life and Societies of Apostolic Life
- Congregation of Alexian Brothers
- Congregation of Christian Brothers
- Congregation of the Holy Spirit
- Congregation of the Passion
- Consolata Missionaries

- Conventual Franciscan Friars
- CRU – Campus Crusade for Christ
- Divine Word Missionaries
- Dominican Friars – Eastern Province
- Dominican Friars – Western Province
- Episcopal Diocese of Atlanta
- Episcopal Diocese of Indianapolis
- Episcopal Diocese of Texas
- Episcopal House of Bishops
- Episcopal Theological Seminary of the Southwest
- Glenmary Home Missioners
- Holy Cross Brothers and Fathers – Worldwide policy and education
- Hospitaller Brother of St. John of God
- International Church of the Foursquare Gospel
- Irish Catholic Bishops Conference
- Irish Missionary Union
- Josephite Fathers
- Knights of Columbus
- Legionaries of Christ
- LifeTeen International
- Maryknoll Fathers and Brothers
- Marian Sisters of Reconciliation – Peru, Ecuador, Chile, Australia, US and UK
- Marist Brothers and Fathers of New Zealand
- Marist Brothers of the Schools
- McKinney Memorial Bible Church
- Mepkin Abbey
- Mission Personnel – Episcopal Church
- Missionaries of the Sacred Heart – Prevention and response in 23 countries
- Missionaries of the Precious Blood
- Missionary Society of St. Columban
- Monastery of Christ in the Desert
- Montclair Cooperative School
- Montfort Missionaries – Global prevention and response initiative
- Mount Angel Abbey and Seminary
- National Conference of Synagogue Youth
- National Religious Vocation Directors Conference
- National Safe as Church Conference, Australia
- New Melleray Abbey
- Norbertines, St. Norbert Abbey
- Oblates of Mary Immaculate
- Office of Professional Standards for New Zealand
- Order of St. Augustine - Villanova
- Order of Friars Minor

- Order of the Most Holy Trinity
- New Jersey Catholic Conference
- Park Cities Baptist Church
- Polish Catholic Bishop's Conference
- Presbyterian Church of the USA
- Rabbinical Council of America
- Roman Catholic Archdiocese of Atlanta
- Roman Catholic Archdiocese of Baltimore
- Roman Catholic Archdiocese of Brisbane
- Roman Catholic Archdiocese of Chicago
- Roman Catholic Archdiocese of Denver
- Roman Catholic Archdiocese of Los Angeles
- Roman Catholic Archdiocese of Newark
- Roman Catholic Archdiocese of New Orleans
- Roman Catholic Archdiocese of New York
- Roman Catholic Archdiocese of Philadelphia
- Roman Catholic Archdiocese of Seattle
- Roman Catholic Diocese of Adelaide
- Roman Catholic Diocese of Anchorage
- Roman Catholic Diocese of Austin
- Roman Catholic Diocese of Brownsville
- Roman Catholic Diocese of Cairns, Queensland Australia
- Roman Catholic Diocese of Charlotte
- Roman Catholic Diocese of Dallas
- Roman Catholic Diocese of Fairbanks
- Roman Catholic Diocese of Fort Worth
- Roman Catholic Diocese of Lubbock
- Roman Catholic Diocese of Manchester, NH
- Roman Catholic Diocese of Norwich, CT
- Roman Catholic Diocese of Phoenix
- Roman Catholic Diocese of Portland, ME
- Roman Catholic Diocese of Portland, OR
- Roman Catholic Diocese of San Angelo
- Roman Catholic Diocese of Springfield
- Safe Environment Conference of the United States
- Society of Jesus, California Province
- Society of Jesus, Chicago Province
- Society of Jesus, Missouri Province
- Society of Jesus, New York Province
- Society of Jesus, Oregon Province
- Sodalitium Christianae Vitae – Worldwide
- St. Joseph's Abbey
- Sulpicians

- Texas Catholic Conference
- The Salvation Army, United Kingdom with the Republic of Ireland
- The Salvation Army USA Western Territory (Denver to Guam)
- United States Conference of Catholic Bishops
- United States Jesuit Conference
- Vincentians – Eastern Province
- Vincentians – Midwest Province
- Windsor Village United Methodist Church
- Xaverian Brothers
- Young Life
- Youth for Christ

Residential Care Facilities for Clergy and Other Ministers

- Recon, Inc.
- Shalom Center, Inc.
- St. Luke Institute
- St. Michael's Community
- The Southdown Institute, Toronto Canada
- Vianney Renewal Center

Universities, Schools, and Educators

- Ambassador Programs
- Archer School for Girls
- Arrupe Jesuit High School
- Beggs Independent School District
- Board of Education, City of Chicago
- Brother Rice High School
- Buckingham, Browne and Nichols School
- Catholic Education Office - Sydney, New South Wales
- Catholic Education Office - Toowoomba, Queensland
- Concord Academy
- DeMatha Catholic High School
- Edison Schools (Nationwide)
- Fordham Preparatory School
- Hackley School
- Gonzaga University
- Little Red Schoolhouse and Elisabeth Irwin High School
- Madill School District
- Marist School, Atlanta Georgia
- Marlborough School for Girls
- Milton Hershey School

- Montessori Schools
- National Deaf Academy
- Newton Learning Home Field Adventure
- Nightingale-Bamford School
- Regis High School, New York
- San Juan Diego High School
- Schools Excess Liability Fund
- St. Augustine Catholic School
- St. Ignatius College Preparatory School, Chicago
- St. John's College, Belize City
- St. John's University, Collegeville, MN
- St. John's University, New York City
- St. Joseph's Preparatory School, Philadelphia
- St. Mark's School, Southborough, MA
- The Fessenden School
- The Imani School
- The Winsor School
- Ventura County Schools Self- Funding Authority
- Wyoming School Board
- Wyoming Seminary Academy

Youth Development Organizations

- Baden-Powell Scout's Association
- Heritage YMCA Group
- H.O.P.E. Farm
- Junior Achievement, Inc.
- Old Colony YMCA
- Pacific Science Center
- Sierra Club
- YMCA of Fort Worth
- YMCA of Greater Kansas City
- YMCA of Greater New York
- YMCA of Greater Seattle
- YMCA of Greater St. Paul
- YMCA of Metropolitan Dallas
- YMCA of Metropolitan Detroit
- YMCA of Metropolitan Minneapolis
- YMCA of Newport County
- YMCA of Pittsburgh
- YMCA of San Diego County
- YMCA of San Francisco
- YMCA of the Treasure Coast
- YMCA of the USA

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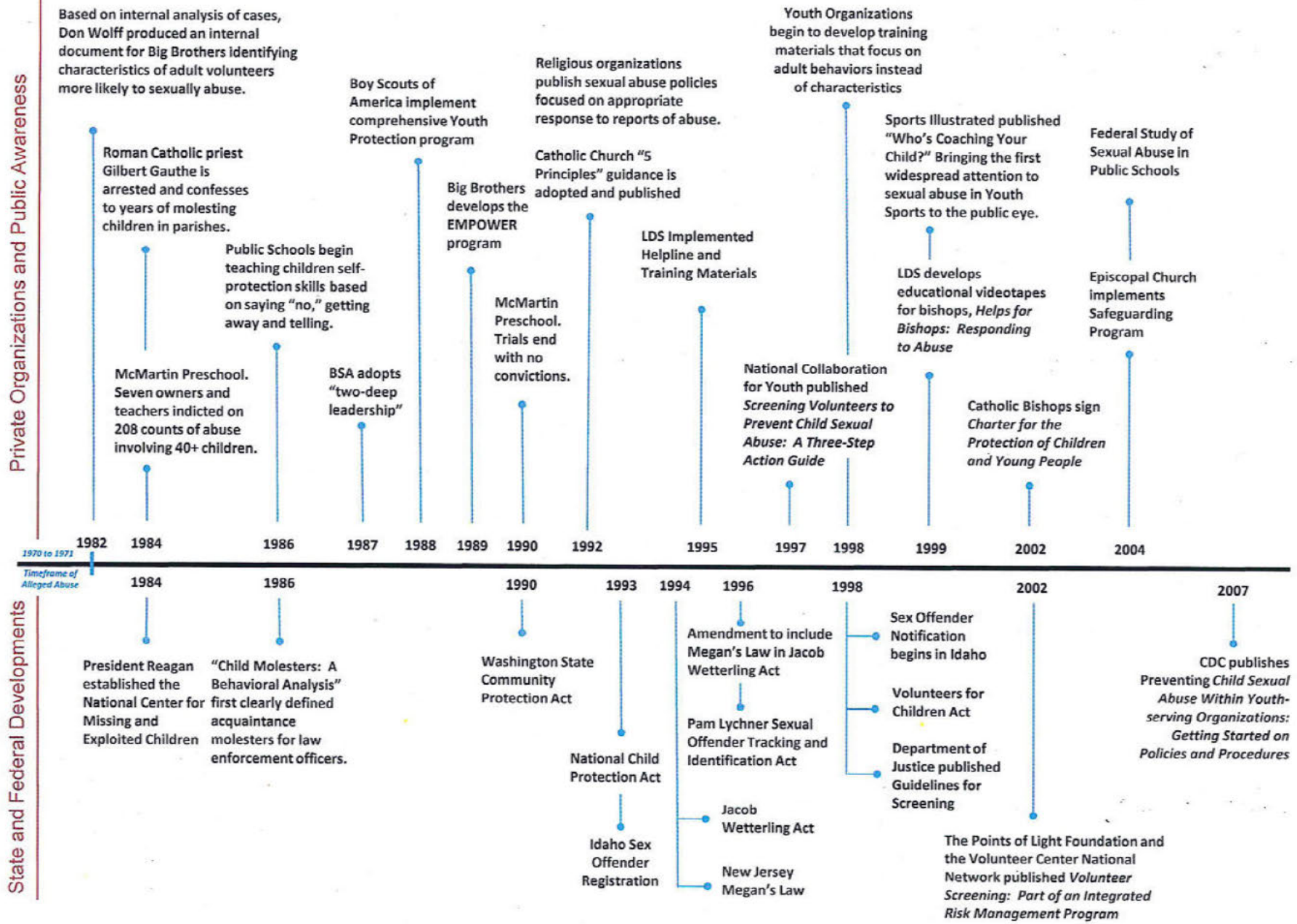
Appendix C. Timeline of Major Events Relating to Sexual Abuse in Organizations



Washington State Community Protection Act – 1990

In 1990, Washington State passed the "Community Protection Act" which created the term "sexually violent predator" to distinguish sexual offenders who were eligible for civil commitment. The definition of the sexually violent predator is a person who has committed a crime of sexual violence, suffers from a mental abnormality or personality disorder which makes the person likely to engage in predatory acts of violence and who is a stranger to the victim or cultivated the relationship for the primary purpose of victimization.

In addition to the provision for civil commitment, The Community Protection Act contained additional strategies for community safety, including longer sentences, mandatory registration of sexual offenders who are convicted, and most ground-breakingly, community notification. The Washington law became the model for similar legislation which was passed in Kansas, Arizona, California, Wisconsin, Illinois, and North Dakota (Matson & Lieb, 1997). The community notification dimension of Washington's law represented the first effort to use sexual offender registries to inform the public of a potential threat by a sexual offender. Prior uses of the registries were limited to law enforcement and the information was considered private and confidential. The Community Protection Act authorized the release of information to the public about offenders who were judged to be "high-risk" to re-offend.

National Child Protection Act – 1993

The National Child Protection Act was also called the "Oprah Winfrey Act." This legislation allowed individual states with the opportunity to pass legislation that would allow entities within their own states to access national criminal records through the FBI finger-print based repository. States were not required to pass their own laws in this regard, but the opportunity was available to them. However, most states did not quickly pass their own statues and in the absence of the state law, organizations still did not have access to the FBI criminal records.

New Jersey Megan's Law - 1994

In 1994, a seven year old girl named Megan Kanka was raped and murdered by a twice-convicted sexual offender who had moved down the street from her family. Lawmakers honored her memory by naming the New Jersey Community Notification statute, "Megan's Law." (Glaberson, 1996). Within the year, community notification and sexual offender registry laws throughout the country were called Megan's Law.

Jacob Wetterling Act – 1994

In 1994, Congress passed the *Jacob Wetterling Act* (42 U.S.C. 14071) requiring all states to create registration for violent sexual offenders and offenders who are convicted of sexual crimes against children. The Act also required more rigorous tracking of all sexual offenders, but particularly "sexually violent predators." All states were given until September of 1997 to comply with these new Federal requirements (U.S. Department of Justice, 1997).

Amendment to include Megan's Law - May of 1996

From 1994 to 1996, it was left to the discretion of individual states to determine whether relevant information from the sexual offender registries would be made available to the public. In May of 1996, Congress amended the Act to include "Megan's Law" and required all states to "release relevant information that is necessary to protect the public concerning a specific person required to register."

Pam Lychner Sexual Offender Tracking and Identification Act - October of 1996

In October of 1996, the *Pam Lychner Sexual Offender Tracking and Identification Act* was passed, directing the FBI to establish a national database of sexual offenders to assist law enforcement in tracking sexual offenders who move from state to state.

Volunteers for Children Act – October of 1998

When President Clinton signed this bill into law it amended the National Child Protection Act of 1993 (42 U.S.C. Sec. 5119). In so doing, for the first time, this allowed any "Qualified Entity:" public or private; for-profit or non-profit to access the FBI database of criminal records. Qualified Entities are those which provide care, treatment, education, training, instruction, supervision or recreation to children, the elderly or individuals with disabilities to request fingerprint-based national criminal history background checks the FBI for the purpose of screening and selecting volunteers or employees.

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF CHARLESTON	)	Civil Action No.: 2018-CP-10-3929

John Doe,

Plaintiff,

vs.

Bishop of Charleston, a Corporation Sole, and The Bishop of the Diocese of Charleston, in his official capacity,

Defendants.

DEFENDANTS' MEMORANDUM REGARDING INADMISSIBILITY OF EXPERT TESTIMONY UNDER RULE 702

Defendants Bishop of Charleston, a Corporation Sole, and the incorrectly and improperly named Bishop of the Diocese of Charleston, in his official capacity (hereinafter "Defendants") hereby submit the following memorandum of law in support of their pending motions for summary judgment involving the lack of any admissible evidence regarding repressed memory syndrome. Plaintiffs have failed to provide expert testimony sufficient to maintain any action based on repressed memory syndrome. Under South Carolina law, application of the discovery rule based on alleged repressed memory syndrome requires expert testimony to prove the abuse occurred as well as to prove that the memories of the alleged abuse were repressed. In order to present opinions to a factfinder, two factors must be established: (1) the expert must be qualified to provide that opinion by education, experience, or some special knowledge; and (2) the opinion must be based on science that is reliable. Plaintiff's experts are not qualified to provide testimony about repressed memory syndrome, and, given the dearth of science supporting opinions regarding the hypothesis of repressed memory are not reliable. On that basis, Plaintiff's proffered expert testimony must be excluded.

Critically, South Carolina law also requires that expert testimony must be reliable in order to be admitted into evidence under Rule 702.[1] Plaintiff's experts cannot satisfy this reliability requirement with regard to repressed memory syndrome. As the South Carolina Supreme Court, the Court of Appeals, plaintiff's own expert witness, and the defense experts all agree, repressed memory syndrome is a highly controversial topic in the field of psychology and psychiatry, with major professional associations denying its very existence.[2] Plaintiff's experts can point to no study, research, or publication they have either conducted or relied upon that can show any form of test to diagnose whether someone has repressed memory syndrome. They can present no proof of the existence of any method to determine whether a repressed memory is truthful. They can provide no scientific basis to show what error rate there is in reports of repressed memory. Their sole source of diagnostic information is self-reporting of the Plaintiff, which is an inherently unreliable source. In the absence of any scientific basis for their opinions, the reliability requirement for the admissibility of the expert opinion cannot be met.

FACTS

This case arises out of a claim that the Plaintiff suffered sexual abuse as a child. The Plaintiff further claims that he repressed the memories of those alleged acts of abuse, only for them to reemerge later in adulthood. In his Complaint, Plaintiff states "other litigation, news reports, and other occurrences have led to Plaintiff now becoming so aware [of the alleged abuse], and Plaintiff could not have so known or learned previously. His memory was repressed." Given the age of the Plaintiff at the time of the alleged abuse (and the time since Plaintiff had reached the age of majority), the statute of limitations had long since run on any

[1] *Watson v. Ford Motor Co.*, 389 S.C. 434, 699 S.E.2d 169 (2010).
[2] Depo. Tr. of Sally Duffy, Ph.D., Nov. 26, 2019, p.63.

causes of action related to Plaintiff's childhood sexual abuse claims by the time Plaintiff filed this claim.

In order to attempt to prove both the fact of the abuse and the repression of the memories, Plaintiff has named two experts in this litigation: Sally Duffy, Ph.D. and Dorothy Whalen. Dr. Duffy is a licensed psychiatrist with a Ph.D. Ms. Whalen is a clinical social worker.

Defendants have named James I. Hudson, M.D., Sc.D.; Janine Shelby, Ph.D.; and, Elizabeth Loftus, Ph.D. as experts for the purposes of repressed memory syndrome. Dr. Hudson is a professor of Psychiatry at Harvard Medical School and Director of the Biological Psychiatry Laboratory at McLean Hospital, which is Harvard's principal psychiatric teaching hospital. Dr. Hudson opined that the theory of "repressed memory" is not scientifically valid. In his words, from Exhibit A of his affidavit: "Repressed memory is not generally accepted in the relevant scientific community; it has never been demonstrated to occur in a methodologically sound peer-reviewed published study; and it is not subject to an ascertainable error rate."[3] His report notes that the hypothesis of repressed memory syndrome has been described as "a piece of psychiatric folklore, . . . a fairy tale belief, and a clinician's cold fusion." He opines that the theory of repressed memory "has not even remotely achieved 'general acceptance' in the relevant scientific community."

Dr. Shelby is a licensed psychologist specializing in trauma who serves as an Associate Clinical Professor in the Geffen School of Medicine at the University of California, Los Angeles. In her affidavit, Dr. Shelby opined in part,

> "A central issue of this case is the degree to which Mr. John Doe is able to accurately report on abuse he claimed to recall after a delay of several decades. Such memories are implicitly subject to distortion and bias. There are many

[3] Affidavit and Appendix A of Hudson Report, p. 6.

factors that shape memory. Mr. Doe's LSD and other substance use around the same time as the abuse described in this claim may have influenced his perception of events."[4]

Finally, Dr. Loftus is Distinguished Professor at the University of California, Irvine where she is the director of the Center for Psychology & Law. Dr. Loftus holds a Ph.D. in Psychology from Stanford University. Dr. Loftus has authored more than 600 published papers, the majority of which concern the topic of human memory. Dr. Loftus opines the following in her affidavit:

"Briefly, the idea that one can repress horrible brutalization into the unconscious and reliably recover the experiences later has received virtually no credible scientific support. The notion is best described as folklore that continues to be advanced by some mental health professionals who uncritically accept abuse reports, no matter how dubious, and claims of repression, no matter the lack of scientific support."[5] (emphasis added).

ARGUMENT

The Court, in its function as gatekeeper for the admissibility of expert testimony, must exclude the reports and testimony of Plaintiff's experts. Neither witnesses are qualified to testify as to repressed memory syndrome given their lack of research and education in the field. Further, and most critically, neither witness can satisfy the reliability requirement of Rule 702 because (1) repressed memory syndrome has no credible scientific basis as a theory or diagnosis and (2) as a result, the testimony of the Plaintiff (itself unreliable as will be shown) is the only basis for the expert opinion that Plaintiff has repressed memories.

[4] Affidavit and report of Shelby, p. 14.
[5] Affidavit and Report of Loftus, paragraph 9.

In *Moriarty v. Garden Sanctuary Church of God*, the Court of Appeals explicitly held that expert testimony, proving that (1) sexual abuse occurred and that (2) the plaintiff repressed memories of the abuse, is a requirement in order to proceed with a cause of action based on repressed memory syndrome.[6] This evidence is required at both the summary judgment stage and the trial stage.[7] If particular subject matter requires expert testimony, then the expert must meet the qualifications necessary to give opinion testimony. In *Moriarty*, Judge Anderson wrote that the trial judge must qualify any expert in repressed memory syndrome under Rule 702, SCRE.[8] However, a careful analysis under Rule 702 precludes any such expert testimony from being admitted into evidence or considered by the Court.

The admission of expert testimony in South Carolina is governed by Rule 702, SCRE, which provides:

> If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise.

Expert evidence is required where a factual issue must be resolved with scientific, technical, or any other specialized knowledge.[9] Unlike lay testimony, in which a witness may not provide opinion testimony requiring specialized knowledge, expert witnesses are allowed to provide testimony of their opinions as long as such testimony is based on the types of evidence relied upon in the particular expert's field.[10]

Because of this heightened standard for the admission of expert opinion, the Court plays a critical role as the gatekeeper for admissibility of such testimony. To be admitted into

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[6] *Moriarty v. Garden Sanctuary Church of God*, 334 S.C. 150, 511 S.E.2d 699 (Ct. Appeals 1999).
[7] *Id*.
[8] *Id*.
[9] *Watson v. Ford Motor Co.*, 389 S.C. 434, 699 S.E.2d 169 (2010).
[10] *Id*.

evidence, expert testimony must pass the trial court's affirmative and meaningful gatekeeping duty.[11] This gatekeeping function includes preventing the introduction of "junk science" and pseudoscience into evidence. Such testimony faces "additional scrutiny relative to other evidentiary decisions,"[12] requiring three "key" preliminary findings "which are fundamental to Rule 702" before a jury (or Court at summary judgment) may hear and consider expert testimony:

(1) The trial court must find that the subject matter is beyond the ordinary knowledge of the jury, thus requiring an expert to explain the matter to the jury.

(2) The trial court must find that the proffered expert has acquired the requisite knowledge and skill to qualify as an expert in the particular subject matter.

(3) The trial court must evaluate the substance of the testimony and determine whether it is reliable.[13]

To be clear, the above requirements must be met as a threshold matter of admissibility.

These are not factors for a jury to consider in weighing the credibility of the testimony. The Supreme Court stated this truism powerfully:

> The familiar tenet of evidence law that a continuing challenge to evidence goes to "weight, not admissibility" has never been intended to supplant the gatekeeping role of the trial court in the first instance in assessing the admissibility of expert testimony, including the threshold determination of reliability."[14]

If these factors are not satisfied, the opinions must be excluded from the evidence before the Court. Expert testimony is not admissible unless it satisfies all three of the above requirements regarding subject matter, expert qualifications, and reliability. In short, "only after the trial court has found that expert testimony is necessary to assist the jury in resolving factual questions, the

[11] *State v. White*, 382 S.C. 265, 676 S.E.2d 684 (2009)(clarifying that Rule 702 requirements must be met whether the evidence is "scientific" or "non-scientific").
[12] *Watson*, 389 S.C. at 445-446, 699 S.E.2d at 174-175 (internal citations omitted).
[13] *Id*.
[14] *White*, 382 S.C. at 273, 676 S.E.2d at 688 (2009).

expert is qualified in the particular area, and the testimony is reliable, may the trial court admit the evidence and permit the jury to assign it such weight as it deems appropriate."[15]

The opinions of Plaintiff's experts must be excluded and must not be considered for purposes of summary judgment because of the complete lack of reliability of the testimony under Rule 702 as well as their lack of qualification. The exclusion of the testimony under Rule 702, SCRE leads inevitably to the result that Plaintiff cannot provide admissible expert evidence that can satisfy the requirements of *Moriarty*. Furthermore, without expert testimony regarding the theory of repressed memory, Plaintiff may not testify regarding his own recovered memories.

I. The Plaintiff's experts cannot satisfy the "reliability" requirement of the Rule 702 admissibility analysis.

a. The theory of repressed memory syndrome is inherently unreliable, unproven, unsound, and by no means generally accepted in the scientific community.

Reliability is a "central feature of Rule 702 admissibility."[16] Regardless of whether it is scientific, technical, or testimony that requires special knowledge, expert testimony must satisfy the Rule 702 criteria, and that includes the trial court's gatekeeping function in ensuring the proposed expert testimony meets a reliability threshold for the jury's ultimate consideration.[17] The admissibility of scientific evidence is "dependent on the degree to which the trier of fact must accept, on faith, scientific hypotheses not capable of proof or disproof in court and not even generally accepted outside the courtroom."[18] There are several factors the court must consider when analyzing whether an expert's scientific opinion testimony is reliable, such as:

(1) the publications and peer review of the technique;

(2) prior application of the method to the type of evidence involved in the case;

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[15] *Id*.
[16] *State v. White*, 382 S.C. 265, 676 S.E.2d 684 (2009)
[17] *Id*.
[18] *State v. Jones*, 273 S.C. 723, 259 S.E.2d 120 (1979).

(3) the quality control procedures used to ensure reliability; and

(4) the consistency of the method with recognized scientific laws and procedures.[19]

Plaintiff's experts cannot satisfy any of the above requirements for a reliability analysis.

i. Publications and peer review

There are no peer reviewed studies, articles, or publications supporting the theory of repressed memory. By their own admission, neither Dr. Duffy nor Ms. Whalen relied on any reliable scientific studies or papers on which any of their opinions regarding repressed memory syndrome were based. Dr. Duffy submitted an 8-page report of her "Documentation Review and Psychological Evaluation" in which she discusses Plaintiff's alleged repression of memories. The report is devoid of any sources or citations upon which Dr. Duffy bases her opinions and contains no bibliography or table of authorities to show any such foundation. Dr. Duffy has not authored any scientific, peer-reviewed studies of the theory of repressed memory, nor has she participated in any such studies. The same holds for Mrs. Whalen – who said she might have read an article about repressed memory years ago.

In stark contrast, Dr. Hudson's report and Appendix A, as contained in his affidavit, show that, since 2000, repressed memory has been rejected by the scientific community as little more than a myth. He informs that "repressed memory" hypothesis has been rejected by the scientific community on two grounds: (1) it has not been proven and (2) because proponents of repressed memory rely upon studies with substantial and

[19] *State v. Council*, 335 S.C. 1, 515 S.E.2d 508 (1999).

obvious flaws that do not meet basic scientific standards.[20] He describes the studies purporting to "prove" or "support" the theory of repressed memories as "scientifically almost valueless."[21] In contrast to Plaintiff's proffered experts, Dr. Hudson has authored hundreds of articles that have been published in peer reviewed journals and publications, and is the co-author of a treatise on memory.

Dr. Elizabeth F. Loftus, Ph.D.'s affidavit comes to similar conclusions regarding any peer-reviewed studies relied upon by mental health professionals as "evidence" that repressed memory syndrome is a valid scientific concept. Dr. Loftus is one of the 100 Most Eminent Psychologists of the 20th Century; Distinguished Professor at the University of California, Irvine; prolific author; recipient of over $1 million grants; member and past president of the Association for Psychological Science; and, inductee to the National Academy of Sciences. She has not only reviewed studies regarding memory but also conducted such studies herself. She notes that the studies typically relied upon by mental health professionals[22] are highly controversial and questionable.[23] She and others having carefully analyzed the studies, they have reached the conclusion that it is "misleading to use [those studies] as proof of amnesia."

What *has* been demonstrated by peer-reviewed scientific studies is that memory "does not work like a video recording device."[24] Humans do not simply record events and then play them back later. According to Dr. Loftus, the process is much more complex and involves

[20] Affidavit and Appendix A of Hudson Report, p. 29 – 30.
[21] *Id*.
[22] As distinguished from scientists
[23] Affidavit of Elizabeth Loftus, Ph.D., paragraph 12.
[24] Affidavit of Elizabeth Loftus, Ph.D., paragraph 5.

combing traces from an original experience with other bits and pieces of information that are acquired from other sources.[25]

It is worth noting the conclusions of Harvard University clinical psychologist and tenured faculty member Richard McNally, whose work "Remembering Trauma" Dr. Loftus cites in her affidavit:

> ii. The evidence points to three conclusions. First, people remember horrific experiences all too well. Victims are seldom incapable of remembering their trauma. Second, people sometimes do not think about disturbing events for long periods of time, only to be reminded of them later. However, events that are experienced as overwhelmingly traumatic at the time of their occurrence rarely slip from awareness. Third, there is no reason to postulate a special mechanism of repression or dissociation to explain why people may not think about disturbing events for long periods. A failure to think about something does not entail an inability to remember it (amnesia).[26]

ii. Prior application of the method to the type of evidence in the case

A foundational barrier for Plaintiff's experts in the "reliability" analysis is the fact that there is no "method" by which they arrived at their opinions that Plaintiff has repressed memory syndrome. Dr. Duffy explained multiple times in her deposition testimony that there is no "test" or objective tool that can be used to determine whether an individual has repressed memories. This would include anything from standard questionnaires and interview questions to radiographic diagnostic tools such as CT scans. Her report and testimony do not show any methodology whatsoever for how she arrived at her opinion that Plaintiff suffers from "repressed memory syndrome." Simply put, and as Dr. Duffy readily admits, there is no "method" for determining whether a person has repressed memories. There are no neuropsychiatric tests. There is no objective method

[25] Affidavit of Elizabeth Loftus, Ph.D., paragraph 5.
[26] Affidavit of Loftus, paragraph 11(ii).

by which the fact of memory repression can be analyzed. It cannot be determined by an MRI or a CT scan. None of plaintiff's experts have conducted multi-modal, multi-source forensic examinations. There is just no reliable evidence for the Court to consider as to the prior application of such a method to this type of evidence. Dr. Duffy's conclusory statements that Plaintiff suffers from "repressed memory syndrome" do not satisfy the burden of proving a reliable method used to arrive at that conclusion.

iii. Quality control put in place to ensure reliability

Plaintiff's experts have not and cannot point to any quality control measures put in place to ensure the reliability of the expert testimony and opinions. This is likely at least partly to do with the fact that studies attempting to prove repressed memory have no error rates, controls, or standardization.[27] In fact, in reviewing typically relied-upon studies attempting to prove "repressed memory syndrome," Dr. Hudson puts the error rates of most retrospective and prospective studies of "repressed memories" at or near 100% due to fundamental scientific flaws in the manner in which those studies were constructed and carried out.[28]

True scientific error rates (beyond the 100% Dr. Hudson estimates based on the form of the studies) and controls do not exist with regard to the studies attempting to prove the theory. There are no generally accepted quality controls relating to any "method" utilized by Plaintiff's experts in attempting to show Plaintiff has repressed memories. Again, this is primarily the result of the fact that there is no established methodology for determining whether a given person has repressed memories. There is no scientifically sound guideline or test for determining whether a patient is "repressing"

[27] Affidavit and Appendix A of Hudson Report, p. 41.
[28] *Id.*

memories, so no quality control or error analysis can be done with regard to Plaintiff's expert's opinions in this case.

iv. Consistency of the method with recognized scientific laws and procedures

Plaintiff bears the burden of proving that the expert's methods are consistent with recognized scientific laws and procedures. There has been no testimony or evidence from Plaintiff's experts of any method utilized to form the opinion that Plaintiff has repressed memory syndrome. Even if one reads Dr. Duffy's testimony and report of reviewing documentation and interviewing Plaintiff once as a "method" of arriving at such an opinion, the overwhelming evidence shows that the theory of repressed memory itself is not consistent with recognized laws and scientific procedures.

In his affidavit, Dr. Hudson goes into great detail about the fact that studies regarding repressed memories are so fundamentally flawed in their design and application as to be essentially worthless.[29] His analysis of the few commonly cited research studies, both retrospective and prospective, show a failure by the studies' curators to ask routine follow-up questions such as why they did not mention past memories when interviewed (i.e. had they chosen not to mention them, had they simply forgotten them?).[30] Such failures lead to astronomical estimated error rates and a deviation from scientific procedures.[31]

Putting aside the fact that the theory of repressed memory itself has not been scientifically proven, there is no scientifically supported method for evaluating a patient for repressed memory syndrome. As such, there is no consistent, scientific method by

[29] Affidavit and Appendix A of Hudson Report, p. 29 – 30.
[30] Affidavit and Appendix A of Hudson Report, p. 30 -31.
[31] Affidavit and Appendix A of Hudson Report, p. 41.

which to establish the consistency necessary to satisfy this factor of the reliability analysis.

b. As Plaintiff's expert witnesses concede, there are no scientifically validated methods to test the veracity of a claimed repressed memory, nor is there any way to test the reliability and accuracy of a claimed recovered memory.

In her deposition, Dr. Duffy stated that there is no scientific ability or technological process to prove that repressed memories exist.[32] Dr. Duffy agrees that that repressed memory syndrome is highly controversial among psychologists.[33] She also testified that memory is not always consistent.[34]

Dr. Duffy conceded in her deposition that the American Psychological Association as well as similar associations in England, Australia, and Canada confirmed as recently as 2012 that there was no general acceptance of repressed memory syndrome.[35] Dr. Duffy speculates in her deposition that there may be a way to scientifically prove repressed memory syndrome "within the next five to ten years."[36] No test currently exists to prove repressed memory syndrome, and, although Dr. Duffy does neuropsychological testing on some of her patients, she has not used it on repressed memory patients.[37] Dr. Duffy testified in her deposition that that it is not currently known how the psyche represses a memory from physiological standpoint.[38] Critically, Dr. Duffy provided the following testimony:

> A. Because, you know, I mean, testing is -- psychologists, we like our tests. Because we -- because they are -- especially verifiable tests that have been around for a long time and they've had lots of studies to prove

[32] Depo. Tr. of Sally Duffy, Ph.D., Nov. 26, 2019, p. 24 - 25.
[33] *Id* at 50.
[34] *Id* at 53.
[35] Depo. Tr. of Sally Duffy, Ph.D., Nov. 26, 2019, p.63.
[36] *Id* at 64.
[37] *Id* at 68.
[38] *Id* at 78 – 79.

> they're -- to prove -- to prove their validity and to prove that they actually -- you've got to look at validity and reliability. You know, are they valid in terms of testing what they say they're valid? And are they reliable for -- in terms of result from person to person?
>
> Q. And we don't have either of those for repressed memory?
>
> A. Not yet. We're coming close.
>
> Q. Okay.
>
> A. I -- I hope.[39]

As a result, according to Dr. Duffy, she can only rely on the reporting of her patient with regard to the alleged repressed memories.[40] Further complicating matters, there is no way to determine whether the patient is being honest with the treating provider.[41] Dr. Duffy agrees that memory is malleable and can be changed based on implanted memories or suggestion.[42] During her testimony, Dr. Duffy admits that she has no way of differentiating whether Plaintiff is choosing not to report a past event or instead is suffering from repressed memory syndrome because her evaluation was "a one-shot deal."[43]

Further, Dr. Duffy was unable to envision how a prospective test could even be set up to determine how many victims of sexual abuse would suffer from repressed memory syndrome.[44] Dr. Duffy agreed that sometimes a so-called "recovered memory" simply is not true.[45] There is

[39] *Id* at 72 – 73.
[40] Depo. Tr. of Sally Duffy, Ph.D., Nov. 26, 2019, p. 74.
[41] *Id*.
[42] *Id* at 75- 76.
[43] *Id* at 86 – 87.
[44] *Id* at 95 – 96.
[45] *Id* at 101.

no way to test whether a memory that is recovered is part of another memory disorder, such as dementia or simply forgetting as opposed to repressed memory syndrome.[46]

c. Plaintiff's experts rely solely on the testimony of Plaintiff, which they admit is unreliable.

Dr. Duffy states that it is her opinion that Plaintiff began repressing memories when he was in seventh grade.[47] However, Dr. Duffy cannot say when Plaintiff began to remember these alleged repressed memories.[48] Dr. Duffy acknowledges there are inconsistencies in the memories Plaintiff does and does not have from the time period in question.[49] Dr. Duffy described Plaintiff's deposition testimony as "very hard to read" and "full of inconsistencies."[50] She "could not make heads or tails of some of that stuff."[51]

According to Dr. Loftus, "it is virtually impossible to tell the difference between a true memory and a false one without independent corroboration."[52] Such memories are susceptible to distortion from suggestions, even for those with otherwise extraordinarily good memories.[53] Dr. Loftus cites studies showing that people, who are not purposely lying, have become convinced that something occurred to them that is false.[54] Such evidence creates incredible gaps in reliability of victim testimony that cannot be overcome by any known method.

d. There is no corroborating evidence

Both *Moriarty* decisions express deep concerns from the respective courts about "repressed memory syndrome." In addition to noting its divisive position in the psychiatric and psychological communities, both courts acknowledged "the horrific possibility of false

[46] *Id* at 103 – 104.
[47] *Id*.
[48] *Id* at 107.
[49] *Id* at 112 – 113
[50] *Id* at 120.
[51] Depo. Tr. of Sally Duffy, Ph.D., Nov. 26, 2019, p. 102.
[52] Affidavit of Loftus, paragraph 7.
[53] *Id*.
[54] *Id* (citing Loftus & Ketcham, 1994; Pendergrast, 1999).

accusations" and acknowledged that, in addition to expert evidence, corroborating evidence is required because of "the disagreement among the psychological and medical communities about the validity of repressed memory syndrome, the danger a plaintiff's memories could be faked or implanted during therapy, and the desire that a plaintiff not have the ability to control the running of the statute of limitations solely by allegations whose only support is contained within the plaintiff's mind."[55]

As a prerequisite for application of the discovery rule to toll the statute of limitations, the Moriarty Court held that objective verifiability may be satisfied by corroborating evidence such as: (1) an admission by the abuser; (2) a criminal conviction; (3) documented medical history of childhood sexual abuse; (4) contemporaneous records or written statements of the abuser, such as diaries or letters; (5) photographs or recordings of the abuse; (6) an objective eyewitness's account; (7) evidence the abuser had sexually abused others; or (8) proof of a chain of facts and circumstances having sufficient probative force to produce a reasonable and probable conclusion that sexual abuse occurred.[56]

Plaintiff has failed to provide any admissible evidence falling within any of the above eight categories of objectively verifiable evidence of Plaintiff's being sexually abused. He testified that he did not report the abuse to anyone. He did not see a doctor or any other health care provider. Neither accused teacher was convicted, nor did either ever confess to abusing this Plaintiff. There is a complete lack of contemporaneous circumstantial evidence that this plaintiff was abused. As a result, the admission of expert testimony as to repressed memory syndrome in this case would realize the worst fears of the *Moriarty* courts, which is a Plaintiff having "the

[55] *Moriarty v. Garden Sanctuary Church of God*, 334 S.C. 150, 511 S.E.2d 699 (Ct. Appeals 1999).
[56] *Id*.

ability to control the running of the statute of limitations solely by allegations whose only support is contained within the plaintiff's mind."

e. The presence of "dissociative amnesia" in the DSM 5 does not indicate reliability.

The *DSM-5* is the most recent edition of the official diagnostic manual of the American Psychiatric Association. "Dissociative amnesia" is a broad term embracing "both scientifically legitimate and accepted memory phenomena…together with the dubious and highly controversial phenomenon of "repressed memory."[57] According to Dr. Hudson, the inclusion of the broad category of "dissociative amnesia" in the *DSM-5* is in no way indicative of general acceptance of "repressed memory." Rather, he analogizes such a proposition to a zoological text recognizing the category of "equine mammals," which would include subcategories such as horses and zebras, as thereby also recognizing fantastical and fictional equines, such as unicorns.[58]

The United States Supreme Court was skeptical about the DSM's utility in a legal setting because a diagnosis that is present in the DSM "may mask vigorous debate within the profession."[59] Even the DSM itself contains strict caution against the use of psychiatric diagnoses in forensic settings, stating in its introduction:

> "When the DSM-UV categories, criteria, and textual descriptions are employed for forensic purposes, there are significant risks that diagnostic information will be misused or misunderstood. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and information contained in a clinical diagnosis."[60]

Therefore, the inclusion of dissociative amnesia should not be read as in any way endorsing or validating the subcategory of "repressed memory."

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[57] Affidavit and Appendix A of Hudson Report, p. 41.
[58] *Id*.
[59] *Clark v. Arizona*, 548 U.S. 735, 774, 126 S. Ct 2709, 2734 (2006).
[60] *Id* (citing Introduction to DSM-IV-TR at xxxii-xxxiii).

II. Plaintiff's experts lack the necessary qualifications to provide opinion testimony regarding repressed memory syndrome.

a. Debra Whalen

Debra Whalen is a clinical social worker who provided counseling to Plaintiff after his allegations of resurfacing memories of childhood abuse at the hands of teachers from Sacred Heart. Ms. Whalen, who has not made a diagnosis of repressed memory syndrome, is also not qualified to present opinion testimony as to repressed memory syndrome. According to Ms. Whalen's deposition testimony, Ms. Whalen has never written any articles or conducted any studies on repressed memory syndrome.[61] She testified she had "done some reading" about it "a number of years ago."[62] She acknowledged that there "has been controversy about repressed memories" and agreed that there are many psychologists who do not think it is a viable scientific theory.[63] Ms. Whalen does not possess any specialized knowledge about repressed memory syndrome, and cannot be qualified as an expert in that field given her lack of education, training, or experience in the field of repressed memories.

b. Sally Duffy, Ph.D.

Dr. Duffy has never been qualified by a court of any jurisdiction as an expert in the field of repressed memory syndrome.[64] Dr. Duffy has only been published, by her recollection, twice in a peer-reviewed journal, which was during her education. Neither of the articles was related to repressed memory syndrome, a topic on which she has never been published.[65] Dr. Duffy could not point to any specific study that establishes that the theory of repressed memory syndrome has

[61] Depo. Tr. of Dorothy Whalen, Sept. 19, 2019, p. 64.
[62] *Id*.
[63] *Id*.
[64] Depo. Tr. of Sally Duffy, Ph.D., Nov. 26, 2019, p. 35 – 37.
[65] *Id at* 55 – 57.

been proven to be scientifically valid.[66] Dr. Duffy cannot identify studies examining the rate of patients who suffer the normal act of forgetting as opposed to repressing memories.[67]

In contrast, Defendant's experts are highly qualified scientists on the leading edge of memory studies and have participated in research studies and reviews in order to form their opinions of repressed memory syndrome. Like any hypothesis, the theory must be tested and proven to be accurate before the theory can be deemed reliable. As Dr. Duffy stated regarding the unconscious mind – she did not believe in the theory until a scientific test was developed that proved its existence. Repressed memories cannot be tested scientifically, the fact of the repression cannot be verified, and the truth of the recovered memory cannot be ascertained.

III. Plaintiff's experts cannot provide admissible testimony because of the risk that the experts will "vouch" for Plaintiff's credibility.

Dr. Duffy testified in her deposition that she "believes" Plaintiff regarding the allegations of abuse and repression of the memories.[68] This statement creates substantial problems for Dr. Duffy's ability to provide admissible evidence as recently discussed by the Court of Appeals. In *Makins*, the trial court allowed a therapist to testify as both an expert in child sexual abuse trauma and as a fact witness regarding the child victim's allegations of sexual abuse. The Court agreed that allowing such dual testimony was error, as allowing the person who examined the victim to opine as to the allegations themselves "runs the risk that the expert will vouch for the alleged victim's credibility."[69]

The Court found this danger present whether the bolstering of the victim's credibility was direct or indirect. They cited with approval the case of *State v. Dawkins*, 297 S.C. 386 377 S.E.2d 298 (1989), which held that a treating psychiatrist improperly bolstered the credibility of

[66] *Id at 61*.
[67] *Id at* 92.
[68] *State v. Makins*, 2019 S.C. App. LEXIS 79, 2019 WL 4180050 (Ct. App. September 4, 2019).
[69] *Id*.

the victim when "the solicitor posed the following question - 'Based on your examination and your observations of Pamela, are you of the impression that her symptoms are genuine?,' to which the doctor answered, 'yes.'"[70] The impermissible harm from improper bolstering "is compounded' when the witness is 'qualified as an expert"[71] because fact witness testimony is often improperly given more weight when offered by an expert. As a result of Plaintiff's experts' treatment of Plaintiff, they cannot provide admissible testimony as to whether the abuse actually occurred as such would do irreparable harm to the case of Defendants by improperly bolstering Plaintiff's testimony.

CONCLUSION

Plaintiff must produce admissible expert testimony to prove the fact of his abuse and the fact of his repression of memories of that abuse. Plaintiff can produce neither. Neither Sally Duffy nor Dorothy Whalen qualify as experts in the field of repressed memory syndrome by education, knowledge, or experience. As importantly, neither expert can satisfy the reliability requirement for admission of expert testimony under Rule 702, SCRE. The theory of repressed memory syndrome is largely discredited in the scientific community, and the proposed experts did not utilize or show any scientifically accepted methods for arriving at a conclusion that Plaintiff suffers from repressed memory syndrome. All that is left is the self-reporting of the Plaintiff, with nothing more to substantiate these serious allegations. As a result of the lack of admissible expert evidence, Plaintiff has failed to satisfy the expert evidence requirement of *Moriarty* and summary judgment must be granted in favor of Defendants.

[Signatures on next page]

[70] *State v. Dawkins*, 297 S.C. 386, 377 S.E.2d 298 (1989).
[71] *Briggs v. State*, 421 S.C. 316, 324, 806 S.E.2d 713, 717 (2017).

Respectfully submitted,

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Larkin Hegler

From: Dukes, Richard S. <RDukes@TurnerPadget.com>
Sent: Tuesday, December 17, 2019 12:54 PM
To: Price, Bentley Law Clerk (Juliana Beeks)
Cc: Larry Richter; Robert Sumner; Larkin Hegler; Price, Bentley Secretary (Tamara Walters); Jones, Alan; Michelle Stith; Dillard, Cynthia W; Jones, Kari A
Subject: RE: Doe/Roe/Doe 432 v. The Bishop of Charleston, et al cases
Attachments: John Doe (888) v. Doe_BOC (18-3929) - Defendant_s proposed order grantin....docx

Dear Judge Price:

As requested, attached is a proposed order granting the Diocese's motion for summary judgment on charitable immunity. In drafting this, I drew heavily on the order entered by Judge Jefferson that was an exhibit to our motion.

Please feel free to contact us with any concerns.

With warm regards,

Rich Dukes

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-----Original Message-----
From: Price, Bentley Law Clerk (Juliana Beeks) [mailto:bpricelc@sccourts.org]
Sent: Monday, December 16, 2019 2:35 PM
To: Dukes, Richard S.
Cc: Larry Richter; Robert Sumner; Larkin Hegler; Price, Bentley Secretary (Tamara Walters); Jones, Alan; Michelle Stith; Dillard, Cynthia W; Jones, Kari A; Jackie Williamson
Subject: Re: Doe/Roe/Doe 432 v. The Bishop of Charleston, et al cases

Good afternoon everyone,

Judge Price asked if both sides would send over proposed orders for the motion for Summary judgment based on the common law doctrine of charitable immunity in effect at the of the alleged abuse. He also asked that I ask how long it would take for you to send them to us.

Let us know!

Thanks,

Julie

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF CHARLESTON	)	Civil Action No.: 2018-CP-10-3929

John Doe,

Plaintiff,

vs.

Bishop of Charleston, a Corporation Sole, and The Bishop of the Diocese of Charleston, in his official capacity,

Defendants.

ORDER

THIS MATTER came before the Court on separate motions for summary judgment on all causes of action: (1) Defendants' Motion for Summary Judgment based upon the common law Doctrine of Charitable Immunity; (2) Motion for Summary Judgment on the Statute of Limitations / lack of admissible evidence of repressed memory syndrome; and (3) Motion for Summary Judgment based upon the *res judicata* effect of a 2007 class action settlement. Having analyzed the briefing submitted by the Defendants (Plaintiff did not submit a brief in opposition) and the oral arguments heard on December 12, 2019, the Court orders that the Defendants' Motion for Summary Judgment based on Charitable Immunity is hereby **GRANTED**. Having reached this conclusion, the Court does not rule on the other two dispositive motions before it.

UNDISPUTED FACTS

Plaintiff John Doe alleges he was sexually abused by two teachers at Sacred Heart School, Chris Hartnett and Hal Brooks, during the school year he was in 7th grade – 1970 – 1971. Sacred Heart School is listed in the *Official Catholic Directory* as part of the Roman

Catholic Diocese of Charleston.[1] The record reflects that Hal Brooks taught at Sacred Heart for the Fall semester of 1970 only.[2] Brooks denies engaging in any sexual abuse of Plaintiff Doe.

The Bishop of Charleston, a Corporation Sole, (referred to alternately as "the Diocese") is a charitable entity, and has been since Bishop of Charleston, a Corporation Sole was created by the General Assembly in 1880.[3] Since 1946, the federal government has recognized the United States Conference of Catholic Bishops as having a group designation as a charitable organization and has determined that all agencies and instrumentalities, and the educational, charitable, and religious institutions listed in the *Official Catholic Directory* qualify for charitable status. The record contains the I.R.S. determination from 1970 establishing the charitable status of both the Diocese and Sacred Heart School. Additionally, the Diocese submitted the affidavit of John Barker, Chief Financial Officer of the Diocese, attesting that the Corporation Sole, from its inception until the present, has been a charitable entity.

STANDARD FOR SUMMARY JUDGMENT

Rule 56 of the South Carolina Rules of Civil Procedure provides that a party may move, with or without supporting affidavits, for summary judgment in his favor as to all or part of a claim.[4] The trial court must grant the motion "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a

[1] The Diocese of Charleston's *Official Catholic Directory* listing for 1970 – 1971 is in the record before this Court.
[2] *See Affidavit of Harold Brooks*.
[3] *See* Affidavit of John Barker and Act of the General Assembly, December 13, 1880.
[4] Rule 56(a), SCRCP.

judgment as a matter of law."[5] In situations where the plaintiff bears the burden of proof, a defendant may satisfy its initial burden by "showing"--that is, pointing out to the [trial] court--that there is an absence of evidence to support the plaintiff's case.[6] Once the defendant has carried its initial burden, plaintiff must come forward with admissible evidence to show that there is a genuine issue of fact remaining for trial.[7] The plaintiff must "do more than show that there is some metaphysical doubt as to the material facts," and must show that there is a genuine issue for trial.[8] The plaintiff may not rest upon the mere allegations of his pleadings.[9]

1. There is no genuine issue of material fact that the Diocese of Charleston is, and was in 1970, a charitable entity.

It is clear from the record before this Court that the Roman Catholic Diocese of Charleston was and remains a charity. This includes Sacred Heart School, which is listed in the 1970 *Official Catholic Directory*. All of the officers, directors, employees, and agents of the Diocese or Sacred Heart would, therefore, have been personnel of a charitable organization. All of the school's activities relevant to this case were within the scope of the school's role as a charitable entity. There is no evidence in the record that the injuries in this case arise from any for-profit activities on the part of the Diocese or Sacred Heart School. Likewise, there is no evidence in the record establishing that the Diocese *is not* a charitable entity.[10]

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[5] *Id.* Rule 56(c).
[6] *Id*. (alteration in original) (quoting Celotex Corp. v. Catrett, 477 U.S. 317, 325, 91 L. Ed. 2d 265, 106 S. Ct. 2548 (1986)).
[7] Baughman, 306 S.C. at 115, 410 S.E.2d at 545.
[8] *Id.*
[9] *Id.*
[10] It is worthy of note that 26 U.S.C. § 7611 contains specific restrictions on efforts to inquire into a church's tax exempt charitable status – that inquiry may only be commenced by the Secretary of the Treasury or another appropriate high-level Treasury official; the inquiry must

Further, while not determinative of this case, several judges in this Circuit have recognized the Diocese's charitable status and have granted summary judgment based upon common law charitable immunity for claims arising before 1981. Notably, Judge Deadra Jefferson granted summary judgment to the Diocese in *Doe v. The Diocese of Charleston*, Civil Action No. 02-CP-10-0770, in which she held that Sacred Heart School and the Diocese were charitable entities and were immune from suit arising from allegations of sexual abuse that occurred in 1960. Likewise, Judge J.C. Nicholson granted the Diocese's summary judgment motions in several cases in 2017. Judge Jefferson's Order is part of the record before this Court, as is one of Judge Nicholson's Orders from 2017.

2. The Doctrine of Charitable Immunity.

For nearly all of the 20th Century, the law in South Carolina was that charities were immune from suit in tort. The Doctrine of Charitable Immunity was espoused in South Carolina in *Linder v. Columbia Hospital of Richmond County*, in which the Supreme Court held "a charitable corporation is not liable [for] injuries resulting from the negligent or tortious acts of a servant, in the course of his employment [if] such corporation has exercised due care in his selection."[11] In *Vermillion v. Williams College of Due West*, the Supreme Court went further:

> [T]he exemption of public charities from liability and actions for damages for tort rests not upon the relation of the injured party to the charity, but upon grounds of public policy, which forbids the crippling or destruction of charities which are

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begin within 3 years; and suit over the charitable status may only be brought by the government in the United States District Court for the District of Columbia.

[11] *Linder*, 98 S.C. 25, 81 S.E. 512, 512-14 (1914). Notably, the record contains the Affidavit of Dr. Monica Applewhite, the Diocese's expert witness, affirming that the Diocese complied with the standard of care in hiring the two teachers at the time they were hired in around 1970. She detailed the fact that the teachers were very recent college graduates who had no report of predilections toward sexually abusing minors prior to their being hired. Dr. Applewhite also discussed the very limited means available to a school to check the backgrounds of applicants at that time.

> established for the benefit of the whole public to compensate one or more individual members of the public for injuries inflicted by the negligence of the corporation itself or of its superior officers, or agents, or of its servants or employees. The principle is that in a organized society, the rights of the individual must, in some instances, be subordinated to the public good . . . that being so, what difference can it make whether the tort is out of the corporation itself or its superior officers and agents or that of its servants, liability for the one would effectually embarrass or sweep away the charity as the other. It would therefore be illogical to admit liability for one and deny it for the other. [12]

The *Vermillion* Court held that charitable institutions were exempt from liability for the torts of their agents whether they were selected with or without due care.[13]

In 1959, the South Carolina Supreme Court reaffirmed the defense of charitable immunity in *Eiserhardt v. State Agricultural and Mechanical Society of South Carolina*. As before, the Supreme Court held that charitable entities were immune from suit in tort for activities within the scope of the charity's charitable mission. [14] As Judge Jefferson held, Catholic Schools are very much part of the charitable mission of the Roman Catholic Church.

In 1966, the Supreme Court again specifically reiterated the doctrine of absolute charitable immunity and applied it to a tort claim against the Diocese and declared the Church to be a true charity entitled to immunity from suit altogether.[15] The Court further held that a charity's immunity from suit is unaffected by the fact that the charity procured liability insurance that would cover the loss.[16] Rather, the Diocese was immune from suit in tort. The *Decker* Court affirmed the dismissal of a negligence suit on the Diocese's demurrer.

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[12] *Vermillion v. Williams College of Due West*, 104 S.C. 197, 88 S.E. 649, 650 (1916); *Lindler v. Columbia Hospital*, 81 S.C. 25, 81 S.E. 512 (1914).
[13] *Vermillion*, at *Id.*
[14] *Eiserhardt v. State Agricultural and Mechanical Society of South Carolina*, 235 S.C. 305, 111 S.E.2d 568 (1959) and again in *Decker v. Bishop of Charleston*, 247 S.C. 317, 147 S.E.2d 264, 268 (1966).
[15] *Decker v. Bishop of Charleston*, at 268.
[16] *Id.* at 269.

In 1981, the South Carolina Supreme Court abrogated the doctrine of charitable immunity.[17] However, the Court only did away with charitable immunity going forward – the abrogation could not be applied retrospectively.[18] Thus, a Court must apply charitable immunity as it existed at the time of the allegedly tortious activity.[19]

As late as 1979, in *Douglass v. Florence Gen'l. Hosp.*, the Supreme Court reaffirmed the doctrine of charitable immunity for torts that occurred while the doctrine remained effective.[20] The plaintiff in that case filed suit prior to the Supreme Court's decision in *Brown v. Anderson Cty. Hosp.*, although the case was pending when the *Brown* decision was issued. The trial court dismissed plaintiff's complaint based upon charitable immunity and determined that *Brown* applied only prospectively and could not give life to plaintiff's complaint. The Supreme Court affirmed that decision because *Brown* created liability where, before, there had been none. Florence General Hospital was immune from suit for its employees' negligence, even if heedless or reckless.[21]

There is no question based upon the record before this Court that the Doctrine of Charitable Immunity was in full force and effect during the entire time Hartnett and Brooks are alleged to have abused the Plaintiff. The events that gave rise to the injuries sustained by the Plaintiff occurred at the time the Doctrine of Charitable Immunity was the law in South

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[17] *Fitzer v. Greater Greenville South Carolina YMCA*, 277 S.C. 1, 282 S.E.2d 230 (1981).
[18] *See Hupman v. Erskine College*, 281 S.C. 43, 44, 314 S.E.2d 314, 315 (1984), *Hasell v. Medical Society of S.C.* 288 S.C. 318, 342 S.E. 594, 595 (1986) *see also Brown v. Anderson Cty. Hosp.*, 234 S.E.2d 873 (S.C. 1977) (modifying charitable immunity as to hospitals only to render them liable for heedless and reckless acts and prospectively only).
[19] *See Laughridge v. Parkinson*, 403 S.E.2d 120, 120 (1991) (holding that charitable immunity law in existence at the time of tortious conduct in 1979 must be applied).
[20] *Douglass v. Florence Gen'l. Hosp.*, 259 S.E.2d 117 (S.C. 1979),
[21] *Douglass*, 259 S.E.2d at 118.

Carolina. It is an absolute defense to a claim which arose from the actions complained of by the Plaintiff against the Defendants.

3. Application of the Doctrine of Charitable Immunity.

Applying these principles, it is clear that Plaintiff's claims are barred by the Doctrine of Charitable Immunity. The record before the Court contains no evidence establishing that there is any factual issue that the Bishop of Charleston, a Corporation Sole is a charitable institution, and the now-shuttered Sacred Heart School, its officers, agents, and employees are all part of a charitable organization. There can be no dispute that the Corporation Sole and Sacred Heart School were "charities" under the law of South Carolina. The events in question happened some eleven years before the Supreme Court abrogated common law charitable immunity in 1981. Accordingly, at the time of the events in question, it was the law of this State that charities were immune from all tort liability.

The Diocese is, and has been, a charity entitled to common law charitable immunity as the law established at the time of any actions alleged in this case. It is without question that both South Carolina and federal authorities have long-determined the Diocese to be a charitable institution.[22] South Carolina law does not permit the courts of this state to substitute its judgment for the judgment of an agency.[23] Unlike the legislatively created limitation on liability

[22] In addition to the affidavit of John Barker establishing the Catholic Church's charitable status, the Court can take judicial notice of the *fact* that, since 1946, the federal government has recognized the United States Conference of Catholic Bishops as having a group designation as a charitable organization and has determined that all agencies and instrumentalities, and the educational, charitable, and religious institutions listed in the *Official Catholic Directory* qualify for charitable status. *See Internal Revenue Service Group Determination Letter*, attached as ***Exhibit C*** and ***Exhibit D*****,** Official Catholic Directory, 1971.

[23] *See e.g.* S.C. Code Ann. § 1-23-380(6).

for charities, immunity from suit is *not* an issue to be applied after a jury verdict. Rather, pre-1981 charitable immunity shields charities from suit altogether.

It is important to note that charitable organizations are recognized as such by the federal government – whose rules, regulations, and enforcement govern whether an organization can be considered a charity and exempt for state and federal taxes. When the General Assembly codified the common law doctrine of charitable immunity, it specifically premised charitable status on the Internal Revenue Service's determination.[24] That is a determination of the federal government that the state is required to honor by the Supremacy Clause of the Constitution. In addition, the federal code contains a specific provision regarding the procedure to review and revoke a charity's status – that can only be done by the Department of the Treasury and for very specific reasons.[25] Federal law affords no private right of action to challenge a church's charitable status.

CONCLUSION

As the Courts of this State have consistently and repeatedly held, Plaintiff's claims are barred by the common law Doctrine of Charitable Immunity. The Corporation Sole, and all its ministries, schools, and affiliates listed in the *Official Catholic Directory* are in fact charities and no amount of pleading or argument can change that. Nor can it change the Internal Revenue Service's determination – not just for the Diocese of Charleston, but for the entirety of the American church – that the Church is a charitable institution. There is no genuine issue of

[24] *See* S.C. Code Ann. § 33-56-20.

[25] 26 U.S.C. § 7611 contains specific restrictions on efforts to inquire into a church's tax exempt charitable status – that inquiry may only be commenced by the Secretary of the Treasury or another appropriate high-level Treasury official; the inquiry must begin within 3 years; and suit over the charitable status may only be brought by the government in the United States District Court for the District of Columbia.

material fact regarding the Church's status as a charitable organization and there is no admissible evidence to the contrary. The Court must apply charitable immunity as it existed in 1971, and, on that basis, Defendants' Motion for Summary Judgment is hereby **GRANTED** and all claims and causes of action of Plaintiff in this case are hereby **DISMISSED WITH PREJUDICE**.

Based upon the foregoing, the Court need not reach the separate motions regarding the statute of limitations or *res judicata*.

IT IS SO ORDERED.

_____
Hon. Bentley D. Price
Circuit Court Judge

_____ day of _____, 2019
Charleston, South Carolina

Larkin Hegler

From: Larry Richter <LRichter@RichterFirm.com>
Sent: Monday, December 23, 2019 3:19 PM
To: 'Price, Bentley Law Clerk (Juliana Beeks)'; 'Dukes, Richard S.'
Cc: 'Robert Sumner'; 'Larkin Hegler'; 'Price, Bentley Secretary (Tamara Walters)'; 'Jones, Alan'; 'Michelle Stith'; 'Dillard, Cynthia W'; 'Jones, Kari A'; 'Jackie Williamson'
Subject: RE: Doe/Roe/Doe 432 v. The Bishop of Charleston, et al cases
Attachments: Proposed Order (DOE).docx

Ms. Beeks,

Pursuant to Judge Price's instruction here is our proposed order dealing with the issue of charitable immunity in the Doe matter. Thank you for giving us some time consideration. We were under water at the time we heard from you.

Merry Christmas to all of you and best wishes for a happy New Year. We hope to hear from you soon.

Lawrence E. Richter, Jr.
The Richter Firm, LLC
622 Johnnie Dodds Blvd.
Mt. Pleasant, SC 29464
843-849-6000
843-881-1400 fax

PLEASE NOTE MY NEW EMAIL ADDRESS IS LRichter@RichterFirm.com

-----Original Message-----
From: Price, Bentley Law Clerk (Juliana Beeks) [mailto:bpricelc@sccourts.org]
Sent: Monday, December 16, 2019 2:35 PM
To: Dukes, Richard S. <RDukes@turnerpadget.com>
Cc: Larry Richter <LRichter@richterfirm.com>; Robert Sumner <Robert.Sumner@butlersnow.com>; Larkin Hegler <Larkin@richterfirm.com>; Price, Bentley Secretary (Tamara Walters) <bpricesc@sccourts.org>; Jones, Alan <AGJones@turnerpadget.com>; Michelle Stith <Michelle@richterfirm.com>; Dillard, Cynthia W <CDillard@turnerpadget.com>; Jones, Kari A <KJones@turnerpadget.com>; Jackie Williamson <jackie.williamson@berkeleycountysc.gov>
Subject: Re: Doe/Roe/Doe 432 v. The Bishop of Charleston, et al cases

Good afternoon everyone,

Judge Price asked if both sides would send over proposed orders for the motion for Summary judgment based on the common law doctrine of charitable immunity in effect at the of the alleged abuse. He also asked that I ask how long it would take for you to send them to us.

Let us know!

Thanks,

Julie

STATE OF SOUTH CAROLINA | IN THE COURT OF COMMON PLEAS

COUNTY OF CHARLESTON | CIVIL ACTION NO.: 2018-CP-10-03929

John Doe,

Plaintiff,

v.

The Bishop of Charleston, a Corporation Sole, and the Bishop of the Diocese of Charleston, in his official capacity,

Defendants.

ORDER

This matter came before the Court for hearing on three separate motions for summary judgment on all of the Plaintiff's causes of action: (1) Defendants' Motion for Summary Judgment based on the common law Doctrine of Charitable Immunity; (2) Defendants' Motion for Summary Judgment based on the Statute of Limitations /claimed lack of admissible evidence of repressed memory syndrome; and (3) Defendants' Motion for Summary Judgment based on the *res judicata* effect of a 2007 class action settlement Subsequent to the hearing the Court requested proposed orders relating to the charitable immunity issue from both the Defendants and the Plaintiff. For the reasons set out hereafter, the Defendants' Motion for Summary Judgment based on the common law Doctrine of Charitable Immunity is **DENIED**.

STANDARD FOR SUMMARY JUDGMENT

Summary judgment is properly granted when, viewing the evidence and inferences to be drawn therefrom in a light most favorable to the nonmoving party, the pleadings, depositions,

answers to interrogatories, admissions, and affidavits, if any, show that there is no genuine issue of material fact and the moving party is entitled to a judgment as a matter of law. Rule 56(c), SCRCP; *Woodson v. DLI Props., LLC,* 406 S.C. 517, 528, 753 S.E.2d 428, 434 (2014). "In determining whether any triable issues of fact exist for summary judgment purposes, the evidence and all the inferences [that] can be reasonably drawn from the evidence must be viewed in the light most favorable to the nonmoving party" who can rely on even "a mere scintilla of evidence in order to withstand a motion for summary judgment." *Hancock v. Mid-S. Mgmt.*, 381 S.C. 326, 329B31, 673 S.E.2d 801, 802B03 (2009).

THE OPERATIVE ALLEGATIONS IN THE PLAINTIFF'S COMPLAINT

As alleged in his Amended Complaint, the Plaintiff was born in 1957 and around the ages of 12 to 14 (*i.e.*, around 1969 to 1971) he was sexually molested by Chris Hartnett and Hal Brooks, teachers at the Sacred Heart Catholic School. The Plaintiff further alleges that the Defendants encouraged him to trust, revere, obey, and confide in Hartnett and Brooks, and that the Defendants not only knew or should have known of the sexual abuse but also tried to conceal it. The Plaintiff further alleges that his memory of these events had been repressed and he learned only within the past two years of the causal relationship between his injuries and the sexual abuse, the Defendants' knowledge of the abuse, and the Defendants' concealment of the abuse. He has offered sworn testimony by his deposition supporting his claims. Based on these facts the Plaintiff has asserted claims for relief based on Outrage, Negligence/Gross Negligence, Breach of Fiduciary Duty, Intentional Infliction of Emotional Distress, Fraudulent Concealment, Civil Conspiracy, Negligent Retention or Supervision, Breach of Contract, and Breach of Contact Accompanied by a Fraudulent Act.

THE DEFENDANTS' ARGUMENT

The Defendants' charitable immunity argument is summed up in the following paragraph in their motion:

> In 1981, the South Carolina Supreme Court abrogated the doctrine of charitable immunity. [*citing Fitzer v. Greater Greenville South Carolina YMCA*, 277 S.C. 1, 282 S.E.2d 230 (1981).] However, the Court only did away with charitable immunity going forward -- the abrogation could not be applied retrospectively. [*citing Hupman v. Erskine College*, 281 S.C. 43,314 S.E.2d 34 (1984), *Hasell v. Medical Society of S.C.*, 288 S.C.318, 342 S.E.2s 594 (1986), and *Brown v. Anderson Cty. Hosp*., 234 S.E.2d 873 (1977).] Thus, a Court must apply charitable immunity as it existed at the time of the allegedly tortious activity. [*citing Laughridge v. Parkinson*, 403 S.E.2d 120 (1991).]

Stated otherwise, the Defendants assert the Plaintiff's cause of action accrued no later than 1971, 10 years before charitable immunity was prospectively abolished by the Supreme Court in 1981. The Defendants further assert that charitable immunity affords them a complete defense, warranting summary judgment in their favor on all causes of action.

ANALYSIS

First, the Court concludes that the Plaintiff's causes of action accrued no later than 1971 and that the doctrine of charitable immunity then in effect applies regardless of whether the statute of limitations was tolled by the Plaintiff's repressed memory.

1. **Tolling of the statute of limitations due to repressed memory.**

South Carolina recognizes repressed memory of childhood sexual abuse as a basis for tolling the statute of limitations: "We affirm without extensive discussion the Court of Appeals' holding that repressed memories of sexual abuse can exist and a plaintiff may attempt to recover damages when those memories are triggered and remembered. The condition is known as

dissociative amnesia. A cause of action based on such a theory is valid in South Carolina for the reasons set forth by the Court of Appeals." *Moriarty v. Garden Sanctuary Church*, 341 S.C. 320, 534 S.E.2d 672 (2000). Public records indicate the Defendants have settled claims arising from sexual abuse of minors by the Diocese's clergy, employees, going back as early as 1943, and have had occurrence-based insurance policies for such claims since 1962. *See Bishop of Charleston v. Century Indem. Co.*, 225 F.Supp.3d 554, 558 (D. S.C. 2016):

> Plaintiffs the Bishop of Charleston as a corporation sole and the Bishop of the Diocese of Charleston in his official capacity (together, the "Diocese") seek reimbursement from Century for $11.5 million paid to settle claims arising from sexual abuse of minors by the Diocese's clergy. The abuse at issue occurred over the approximate period 1943 to 1986. (Am. Compl. Ex. 1, Dkt. No. 1-1 at 18-22.) The settlements of claims arising from that abuse occurred between 1994 and the present, including a multimillion-dollar settlement of three class actions (which also settled three individual actions), executed on January 12, 2007. (*Id.*; Settlement and Arbitration Agreement, Dkt. No. 71-1.)
>
> The parties agree that Century's predecessor-in-interest, Insurance Company of North America, issued the Diocese occurrence-based insurance policies covering the periods May 6, 1965 to May 6, 1968 (policy CP2831), May 6, 1968 to May 6, 1971 (policy CP10065), and May 6, 1971 to May 6, 1979 (policy CP044874). (Am. Compl. & 5, Dkt. No. 1-1 at 15; Answer ¶ 5, Apr. 14, 2014, Dkt. No. 4 at 1-2.) The Diocese alleges that an additional policy, CGL132981, covered the period May 6, 1962 to May 6, 1965. (Am. Compl. ¶ 5, Dkt. No. 1-1 at 15.) Century denies the existence of CGL 132981. (Answer ¶ 5, Dkt. No. 4 at 1-2.) There is no claim of coverage before May 6, 1962.

2. **Accrual date of the Plaintiff's causes of action.**

The Court concludes that the Plaintiff's causes of action accrued no later than 1971, regardless of any future increase in damages or the fact the statute of limitations was tolled due to

his repressed memory. *See Bergstrom v. Palmetto Health Alliance*, 358 S.C. 388, 596 S.E.2d 42 (S.C. 2004):

> A cause of action accrues at the moment when the plaintiff has a legal right to sue on it. The law presumes at least nominal damages at that point. The fact that substantial damages did not occur until later is immaterial to determining when the action accrued or arose." *Stephens v. Draffin*, 327 S.C. 1, 5, 488 S.E.2d 307, 309 (1997) (tort claims of patient who had been treated for years by his physician, and claims of patient's wife, accrued before the date contributory negligence was abrogated; thus their claims were controlled by doctrine of contributory negligence as that rule was in effect when their claims first accrued).
>
> In South Carolina, the law in effect at the time the cause of action accrued controls the parties' legal relationships and rights." *Id*.; *see also Tilley v. Pacesetter Corp.*, 355 S.C. 361, 371, 585 S.E.2d 292, 297 (2003) (plaintiffs' claims accrued prior to filing of class action lawsuit; therefore, version of consumer protection statute in effect when plaintiffs filed the lawsuit and court granted summary judgment was controlling); *Murphy v. Owens-Corning Fiberglas Corp.*, 356 S.C. 592, 590 S.E.2d 479, 482-484 (2003) (cause of action ordinarily accrues when facts relating to negligence and damages exist which authorize one party to maintain an action against another); *Swindler v. Swindler*, 355 S.C. 245, 247 n. 1, 584 S.E.2d 438, 439 n. 1 (Ct. App. 2003) (applying provisions of Uniform Commercial Code in effect when cause of action accrued).

3. **Scope of the charitable immunity defense in 1971.**

The Court disagrees with the Defendants' argument that the charitable immunity defense as it existed in 1971 provided a complete defense to the types of claims asserted by the Plaintiff in this case. The Plaintiff asserts that the Defendants concealed claims such as this for many years and there are no reported decisions from that time asserting the types of claims asserted in this case. Accordingly, we can only speculate as to how our appellate courts would have treated such claims had they come to light in 1971. What is clear from the reported decisions from that era is

that the doctrine of charitable immunity was long out of favor with our appellate courts before it was finally extirpated by the Supreme Court in *Fitzer v. Greater Greenville South Carolina YMCA*, 277 S.C. 1, 282 S.E.2d 230 (1981). For example, in *Eiserhardt v. State A. & M. Society of South Carolina*, 235 S.C. 305, 111 S.E.2d 568 (1959), the Supreme Court stated that the applicability of the charitable immunity doctrine depends on the facts of the particular case and held that it did not extend to a commercial venture conducted by a charitable corporation, saying:

> And we do not think immunity should be extended to a situation where the activity out of which the alleged liability arose is primarily commercial in character and wholly unconnected with the charitable purpose for which the corporation was organized. This view is supported by the overwhelming weight of authority. Annotation 25 A.L.R.2d at page 130.

The first full assault on the doctrine of charitable immunity occurred in 1966 in *Decker v. Bishop of Charleston*, 247 S.C. 317, 147 S.E.2d 264 (1966), where the plaintiff was granted permission to argue against precedent that the doctrine should be totally abolished. The plaintiff's claim in that case was based on simple negligence involving a six-inch fall to the church floor during church service:

> It is alleged in the complaint that on April 8, 1963, Carolyn Gohl Schmidt entered The Cathedral of St. John The Baptist and proceeded up the center aisle to the altar rail in order to say her prayers. When she had finished, she turned from the altar rail and walked back toward the center aisle and at a point near the front-most pew she fell off the platform onto the main church floor, a distance of approximately six inches, seriously injuring herself. She alleges that her injuries were proximately caused by the negligence of the respondent.

The Supreme Court declined to abolish charitable immunity outright at that time based on the particular facts of that case, noting:

> It is our conclusion that the doctrine of charitable immunity should not be overruled. The doctrine is particularly applicable in this case. Here, we have a true charity, the church, engaged in conducting a religious service and, in which, Carolyn Gohl Schmidt was participating at the time of her injury.

However, by 1973 the Supreme Court had drastically limited the scope of the charitable immunity doctrine in *Jeffcoat v. Caine*, 261 S.C. 75, 198 S.E.2d 258 (1973), a case involving false imprisonment. The Court extensively reviewed the doctrine from its origins and determined that, despite some statements in *dicta* suggesting the contrary, "the rule of charitable immunity has never been extended by our decisions beyond the facts in *Lindler*, *Vermillion*, and *Decker*":

> The doctrine of charitable immunity was apparently first recognized in this State in *Lindler v. Columbia Hospital*, 98 S.C. 25, 81 S.E. 512. The action in that case was by a patient for damages alleged to have been sustained through the negligence of a nurse employed by the hospital, a charitable institution. The Court, in exempting the hospital from liability, stated the applicable rule and its basis as follows:
>
> The true ground upon which to rest the exemption from liability is that it would be against public policy to hold a charitable institution responsible for the negligence of its servants, selected with due care.
>
> It is evident that the Court, in *Lindler*, did not intend to fashion a rule of complete exemption from tort liability; for it was careful to point out that the question of whether a charitable institution 'would be liable for negligence in the selection of its servants without due care is not before the court for consideration.'
>
> The Court next considered the doctrine of charitable immunity in the case of *Vermillion v. Woman's College of Due West*, 104 S.C. 197, 88 S.E. 649. Plaintiff was injured when the balcony of defendant's auditorium fell during the progress of an entertainment. Action was brought on the theory that the balcony fell because of negligence in construction. The decision in this case affirmed the holding in *Lindler* that charitable institutions were exempt from

liability for the negligent conduct of their agents and, in addition, held that such exemption from liability for the acts of their agents applied 'whether these be selected with or without due care.' The case was remanded, however, for a new trial and, upon appeal after a retrial, judgment for defendant was affirmed. 111 S.C. 156, 97 S.E. 619.

Subsequently, in *Peden v. Furman University*, 155 S.C. 1, 151 S.E. 907, the Court refused to extend the immunity doctrine so as to exempt a charitable institution from liability for trespass and nuisance arising out of the activity of a lessee.

The Court also refused to extend immunity to the commercial activities of a charity in *Eiserhardt v. State Agricultural and Mechanical Society of South Carolina*, 235 S.C. 305, 111 S.E.2d 568. That was an action for damages allegedly sustained as a result of stepping into a hole in a parking lot controlled and operated by the defendant. The operation of the parking lot was a commercial venture and the Court held that immunity should not be extended 'to a situation where the activity out of which the alleged liability arose is primarily commercial in character and wholly unconnected with the charitable purpose for which the corporation was organized,' even though the commercial activity was for the purpose of increasing the fund to be used for the charity.

We applied the rule adopted in *Lindler* and *Vermillion* to exempt a church from liability for negligence in *Decker v. Bishop of Charleston*, 247 S.C. 317, 147 S.E.2d 264.

The foregoing are the prior decisions of this Court, which are relevant to the present inquiry. There can be no doubt that the decisions in *Lindler*, *Vermillion*, and *Decker* contain broad general expressions to the effect that charitable institutions are exempt from all tort liability. However, the broad statement of a rule of complete exemption from tort liability was unnecessary to a decision in those cases, and the rule of charitable immunity has never been extended by our decisions beyond the facts in *Lindler*, *Vermillion*, and *Decker*. In fact, in *Eiserhardt* the immunity doctrine did not exempt the charity from liability for the negligent operation of a commercial enterprise and in *Peden*, liability was placed upon the charity for trespass and the creation of a nuisance.

> These decisions point up the fact that this Court, while adhering in the past to the rule that charitable institutions are exempt from liability for mere negligence, has in every instance refused to further extend the rule. Therefore, the application of the immunity doctrine in a case of intentional tort is not required by precedent, nor, we conclude, by reason or justice.
>
> A long discussion of the charitable immunity doctrine is unnecessary. It is sufficient to point out that it has been subject to much criticism in recent years and considered by an increasing number of courts and writers as unsupportable under modern conditions. *See*: 7 S.C.L.Q. 443; 19 S.C.L.Q. L.Q. 191; 20 S.C.L.Q. 2; Prosser, *Law of Torts*, 4th ed., *Section* 133, p. 992; Annotation 25 A.L.R.2d 29.
>
> Regardless of the public policy support, if there now be such, for a rule exempting a charity from liability for simple negligence, we know of no public policy, and none has been suggested, which would require the exemption of the charity from liability for an intentional tort; and we refuse to so extend the charitable immunity doctrine. (Emphasis added.)

From the foregoing decisions this Court concludes that the doctrine of charitable immunity as it existed in 1971 would not have afforded the Defendants exemption from liability for the causes of action alleged in the Plaintiff's Amended Complaint. Defendants' Motion is **DENIED**.

IT IS SO ORDERED.

_____
Hon. Bentley D. Price
Circuit Court Judge

_____ day of _____, 2019
Charleston, South Carolina

STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

IN THE COURT OF COMMON PLEAS

CIVIL ACTION NO.: 2018-CP-10-03929

John Doe,

Plaintiff,

v.

The Bishop of Charleston, a Corporation Sole, and the Bishop of the Diocese of Charleston, in his official capacity,

Defendants.

PLAINTIFF'S MOTION TO ALTER OR AMEND

Plaintiff John Doe hereby moves this Honorable Court pursuant to Rule 59(e), SCRCP, to alter or amend its order entered herein on January 9, 2020, which granted the Defendants' Motion for Summary Judgment as to all of Plaintiff's claims based on the common law Doctrine of Charitable Immunity, by vacating the aforesaid order and entering an order in the form attached hereto as Exhibit A, and in support hereof Plaintiff would show the Court as follows:

1. As alleged in his Amended Complaint, and testified to in his deposition, the Plaintiff was born in 1957, and around the ages of 12 to 14 (*i.e.*, around 1969 to 1971) he was sexually molested by Chris Hartnett and Hal Brooks, two teachers at Sacred Heart Catholic School. The Plaintiff further alleges that the Defendants encouraged him to trust, revere, obey, and confide in Hartnett and Brooks, and that the Defendants not only knew or should have known of the sexual abuse but also tried to conceal it. The Plaintiff further alleges that his memory of these events had been repressed and he learned only within the past two years of the causal relationship between his injuries and the sexual abuse, the Defendants' knowledge of the abuse, and the Defendants'

concealment of the abuse. Based on these facts the Plaintiff has asserted claims for relief based on Outrage, Negligence/Gross Negligence, Breach of Fiduciary Duty, Intentional Infliction of Emotional Distress, Fraudulent Concealment, Civil Conspiracy, Negligent Retention or Supervision, Breach of Contract, and Breach of Contract Accompanied by a Fraudulent Act.

2. As set forth in Exhibit A, Plaintiff agrees that his causes of action arose no later than 1971, and that the South Carolina Supreme Court did not fully abolish the Doctrine of Charitable Immunity until 1981, and then only prospectively, in *Fitzer v. Greater Greenville South Carolina YMCA*, 277 S.C. 1, 282 S.E.2d 230 (1981). Thus, a Court must apply charitable immunity as it existed at the time of the allegedly tortious activity. *Laughridge v. Parkinson*, 403 S.E.2d 120 (1991).

3. Although the Defendants have raised a strawman argument that Plaintiff contests the applicability of the Doctrine of Charitable Immunity to the Defendants by contending that it is not a charitable organization, that is not Plaintiff's argument at all. Plaintiff's argument is that the scope of the Doctrine of Charitable Immunity in 1971 would not have afforded the Defendants exemption from liability for the claims set out in Plaintiff's Amended Complaint.

4. As further set forth in Exhibit A, in *Eiserhardt v. State A. & M. Society of South Carolina*, 235 S.C. 305, 111 S.E.2d 568 (1959), the Supreme Court stated that the applicability of the charitable immunity doctrine depends on the facts of the particular case. Plaintiff contends that the extent of the scope of the Doctrine of Charitable Immunity in 1971 was never tested in claims such as Plaintiff's, which are based on sexual abuse of children, because the Defendants wrongfully concealed such claims for many years.

5. As further set forth in Exhibit A, in *Jeffcoat v.Caine*, 261 S.C. 75, 198 S.E.2d 258 (1973), the unanimous South Carolina Supreme Court explained that, despite some dicta in earlier

decisions, the scope of the Doctrine of Charitable Immunity had always been limited to tort claims based on simple negligence. Thus, it had never applied to tort claims based on gross negligence, or to intentional torts, or to contract or other non-tort claims. As the Supreme Court stated in reviewing its earlier decisions: "These decisions point up the fact that this Court, while adhering in the past to the rule that charitable institutions are exempt from liability for mere negligence, has in every instance refused to further extend the rule."

6. The Defendants' reliance on the Circuit Court orders of Judge Jefferson and Judge Nicholson granting summary judgment in actions against the Defendants based on sexual abuse of children is misplaced. Those actions were not appealed, apparently for tactical reasons, and the orders contained no analysis of the causes of action that had been plead or the extent of the scope of the Doctrine of Charitable Immunity prior to 1981. Accordingly, they have no predictive value as to how our present appellate courts would view the scope of the Doctrine of Charitable Immunity as it existed in 1971. In the subject order of Judge Nicholson, Defendants' charitable immunity arguments were agreed to by the Plaintiff therein, as is shown in the transcript of the relevant hearing, an open record of a public proceeding.

7. In *Fitzer v. Greater Greenville South Carolina YMCA*, 277 S.C. 1, 282 S.E.2d 230 (1981), the case that finally abolished the Doctrine of Charitable Immunity, the claim was that in a camp operated by the YMCA a camper was injured by a rock thrown by another camper. In abolishing the Doctrine, the Supreme Court delivered this blistering critique:

> Public policy is a dynamic not static concept, and what was valid in the past is not necessarily a valid policy today. Moreover, when the reason for a declared public policy no longer exists, we should not hesitate to abolish it and the rules which are supported by the policy.

> The rationale for abrogating the doctrine of charitable immunity can be stated no clearer than in *Geiger v. Simpson Methodist-Episcopal Church of Minneapolis*, 174 Minn. 389, 219 N.W. 463, 465 (1928), which held:
>
> "It is a trite saying that charity begins at home... Men and corporations alike are required to be just before being charitable... We do not think it would be good public policy to relieve them from liability for torts or negligence. Where innocent persons suffer through their fault, they should not be exempted. That rule, in the long run, will tend to increased efficiency and benefit them and the public, as well as persons so injured. It is almost contradictory to hold that an institution organized to dispense charity shall be charitable and extend aid to others, but shall not compensate or aid those injured by it in carrying on its activities."
>
> A rule which no longer serves a legitimate purpose should not be followed solely because of a dogged adherence to *stare decisis*. *Stare decisis* should be used to foster stability and certainty in the law, but, not to perpetuate error and injustice.
>
> Furthermore, the general availability of liability insurance, which had been obtained in this case, underscores the unreasonableness of our continued adherence to this archaic doctrine. *Brown*, *supra*, 268 S.C. at 491, 234 S.E.2d 873.
>
> The doctrine of charitable immunity has no place in today's society. We hold a charitable institution is subject to liability for its tortious conduct the same as any other person or corporation. The doctrine of charitable immunity is abolished in its entirety and the case is reversed and remanded for trial.

Id. at 4-5, 282 S.E.2d at 231.

8. Although we can only speculate as to how our Supreme Court would have reacted ten years earlier in 1971 had it been presented with a tort claim against these Defendants involving the sexual abuse of children, facts considerably more horrendous than the rock throwing claim in *Fitzer*, it seems more than likely that it would have held at that time that the Defendants could not hide behind the Doctrine of Charitable Immunity even for simple negligence. As the Supreme

Court aptly noted in *Fitzer*, "It is almost contradictory to hold that an institution organized to dispense charity shall be charitable and extend aid to others, but shall not compensate or aid those injured by it in carrying on its activities."

For the foregoing reasons, Plaintiff respectfully moves the Court to alter or amend its prior order pursuant to Rule 59(e), SCRCP, by vacating that order and entering an order in the form attached hereto as Exhibit A.

Respectfully submitted,

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ATTORNEYS FOR PLAINTIFF

16th day of January, 2020
Mount Pleasant, South Carolina

STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

IN THE COURT OF COMMON PLEAS

CIVIL ACTION NO.: 2018-CP-10-03929

John Doe,

Plaintiff,

v.

The Bishop of Charleston, a Corporation Sole, and the Bishop of the Diocese of Charleston, in his official capacity,

Defendants.

ORDER

This matter previously came before the Court for hearing on three separate motions for summary judgment on all of the Plaintiff's causes of action: (1) Defendants' Motion for Summary Judgment based on the common law Doctrine of Charitable Immunity; (2) Defendants' Motion for Summary Judgment based on the Statute of Limitations / lack of admissible evidence of repressed memory syndrome; and (3) Defendants' Motion for Summary Judgment based on the *res judicata* effect of a 2007 class action settlement At the conclusion of the hearing the Court requested proposed orders from both the Defendants and the Plaintiff. The Parties each submitted proposed orders and the Court issued an order which granted only the Defendants' Motion for Summary Judgment based on the common law Doctrine of Charitable Immunity and provided that, "Having reached this conclusion, the Court does not rule on the other two dispositive motions before it." The Court finds that the Defendants have thereby abandoned reliance on their Motion for Summary Judgment based on the Statute of Limitations / lack of admissible evidence of repressed memory

syndrome and on their Motion for Summary Judgment based on the *res judicata* effect of a 2007 class action settlement.

On January 9, 2020, the Court entered an Order granting the Defendants' Motion for Summary Judgment based on the common law Doctrine of Charitable Immunity. The Court has now considered the Plaintiff's Rule 59(e) Motion to Alter or Amend that Judgment and hereby vacates its previous Order and denies the Defendants' Motion.

STANDARD FOR SUMMARY JUDGMENT

Summary judgment is properly granted when, viewing the evidence and inferences to be drawn therefrom in a light most favorable to the nonmoving party, the pleadings, depositions, answers to interrogatories, admissions, and affidavits, if any, show that there is no genuine issue of material fact and the moving party is entitled to a judgment as a matter of law. Rule 56(c), SCRCP; *Woodson v. DLI Props., LLC* , 406 S.C. 517, 528, 753 S.E.2d 428, 434 (2014). "In determining whether any triable issues of fact exist for summary judgment purposes, the evidence and all the inferences [that] can be reasonably drawn from the evidence must be viewed in the light most favorable to the nonmoving party ... [who] is only required to submit a mere scintilla of evidence in order to withstand a motion for summary judgment." *Hancock v. Mid-S. Mgmt.*, 381 S.C. 326, 329B31, 673 S.E.2d 801, 802B03 (2009).

THE OPERATIVE ALLEGATIONS IN THE PLAINTIFF'S COMPLAINT

As alleged in his Amended Complaint, the Plaintiff was born in 1957 and around the ages of 12 to 14 (*i.e.*, around 1969 to 1971) he was sexually molested by Chris Hartnett and Hal Brooks, two teachers at the Charleston Catholic School. The Plaintiff further alleges that the Defendants encouraged him to trust, revere, obey, and confide in Hartnett and Brooks, and that the Defendants

not only knew or should have known of the sexual abuse but also tried to conceal it. The Plaintiff further alleges that his memory of these events had been repressed and he learned only within the past two years of the causal relationship between his injuries and the sexual abuse, the Defendants' knowledge of the abuse, and the Defendants' concealment of the abuse. He has offered sworn testimony by his deposition supporting his claims. Based on these facts the Plaintiff has asserted claims for relief based on Outrage, Negligence/Gross Negligence, Breach of Fiduciary Duty, Intentional Infliction of Emotional Distress, Fraudulent Concealment, Civil Conspiracy, Negligent Retention or Supervision, Breach of Contract, and Breach of Contract Accompanied by a Fraudulent Act.

THE DEFENDANTS' ARGUMENT

The Defendants' charitable immunity argument is summed up in the following paragraph in their motion:

> In 1981, the South Carolina Supreme Court abrogated the doctrine of charitable immunity. [*citing Fitzer v. Greater Greenville South Carolina YMCA*, 277 S.C. 1, 282 S.E.2d 230 (1981).] However, the Court only did away with charitable immunity going forward -- the abrogation could not be applied retrospectively. [*citing Hupman v. Erskine College*, 281 S.C. 43,314 S.E.2d 34 (1984), *Hasell v. Medical Society of S.C.*, 288 S.C.318, 342 S.E.2s 594 (1986), and *Brown v. Anderson Cty. Hosp.*, 234 S.E.2d 873 (1977).] Thus, a Court must apply charitable immunity as it existed at the time of the allegedly tortious activity. [*citing Laughridge v. Parkinson*, 403 S.E.2d 120 (1991).]

Stated otherwise, the Defendants assert the Plaintiff's cause of action accrued no later than 1971, 10 years before charitable immunity was prospectively abolished by the Supreme Court in 1981. The Defendants further assert that charitable immunity affords them a complete defense, warranting summary judgment in their favor on all causes of action.

ANALYSIS

First, the Court concludes that the Plaintiff's causes of action accrued no later than 1971 and that the doctrine of charitable immunity then in effect applies regardless of whether the statute of limitations was tolled by the Plaintiff's repressed memory.

1. **Tolling of the statute of limitations due to repressed memory.**

South Carolina recognizes repressed memory of childhood sexual abuse as a basis for tolling the statute of limitations: "We affirm without extensive discussion the Court of Appeals' holding that repressed memories of sexual abuse can exist and a plaintiff may attempt to recover damages when those memories are triggered and remembered. The condition is known as dissociative amnesia. A cause of action based on such a theory is valid in South Carolina for the reasons set forth by the Court of Appeals." *Moriarty v. Garden Sanctuary Church*, 341 S.C. 320, 534 S.E.2d 672 (2000). Public records indicate the Defendants have settled claims arising from sexual abuse of minors by the Diocese's clergy going back as early as 1943, and have had occurrence-based insurance policies for such claims since 1962. *See Bishop of Charleston v. Century Indem. Co.*, 225 F.Supp.3d 554, 558 (D. S.C. 2016):

> Plaintiffs the Bishop of Charleston as a corporation sole and the Bishop of the Diocese of Charleston in his official capacity (together, the "Diocese") seek reimbursement from Century for $11.5 million paid to settle claims arising from sexual abuse of minors by the Diocese's clergy. The abuse at issue occurred over the approximate period 1943 to 1986. (Am. Compl. Ex. 1, Dkt. No. 1-1 at 18-22.) The settlements of claims arising from that abuse occurred between 1994 and the present, including a multimillion-dollar settlement of three class actions (which also settled three individual actions), executed on January 12, 2007. (*Id.*; Settlement and Arbitration Agreement, Dkt. No. 71-1.)
>
> The parties agree that Century's predecessor-in-interest, Insurance Company of North America, issued the Diocese

> occurrence-based insurance policies covering the periods May 6, 1965 to May 6, 1968 (policy CP2831), May 6, 1968 to May 6, 1971 (policy CP10065), and May 6, 1971 to May 6, 1979 (policy CP044874). (Am. Compl. & 5, Dkt. No. 1-1 at 15; Answer & 5, Apr. 14, 2014, Dkt. No. 4 at 1-2.) The Diocese alleges that an additional policy, CGL132981, covered the period May 6, 1962 to May 6, 1965. (Am. Compl. & 5, Dkt. No. 1-1 at 15.) Century denies the existence of CGL 132981. (Answer & 5, Dkt. No. 4 at 1-2.) There is no claim of coverage before May 6, 1962.

In any event, as previously noted, the Defendants have abandoned their statute of limitations argument.

2. **Accrual date of the Plaintiff's causes of action.**

The Court concludes that the Plaintiff's causes of action accrued no later than 1971, regardless of any future increase in damages or the fact the statute of limitations was tolled due to his repressed memory. *See Bergstrom v. Palmetto Health Alliance*, 358 S.C. 388, 596 S.E.2d 42 (S.C. 2004):

> A cause of action accrues at the moment when the plaintiff has a legal right to sue on it. The law presumes at least nominal damages at that point. The fact that substantial damages did not occur until later is immaterial to determining when the action accrued or arose." *Stephens v. Draffin*, 327 S.C. 1, 5, 488 S.E.2d 307, 309 (1997) (tort claims of patient who had been treated for years by his physician, and claims of patient's wife, accrued before the date contributory negligence was abrogated; thus their claims were controlled by doctrine of contributory negligence as that rule was in effect when their claims first accrued).
>
> In South Carolina, the law in effect at the time the cause of action accrued controls the parties' legal relationships and rights." *Id.*; *see also Tilley v. Pacesetter Corp.*, 355 S.C. 361, 371, 585 S.E.2d 292, 297 (2003) (plaintiffs' claims accrued prior to filing of class action lawsuit; therefore, version of consumer protection statute in effect when plaintiffs filed the lawsuit and court granted summary judgment was controlling); *Murphy v. Owens-Corning Fiberglas Corp.*, 356 S.C. 592, 590 S.E.2d 479, 482-484 (2003) (cause of action ordinarily accrues when facts relating to negligence

> and damages exist which authorize one party to maintain an action against another); *Swindler v. Swindler*, 355 S.C. 245, 247 n. 1, 584 S.E.2d 438, 439 n. 1 (Ct. App. 2003) (applying provisions of Uniform Commercial Code in effect when cause of action accrued).

3. **Scope of the charitable immunity defense in 1971.**

The Court disagrees with the Defendants' argument that the charitable immunity defense as it existed in 1971 provided a complete defense to the types of claims asserted by the Plaintiff in this case. The Plaintiff asserts that the Defendants concealed claims such as this for many years and there are no reported decisions from that time asserting the types of claims asserted in this case. Accordingly, we can only speculate as to how our appellate courts would have treated such claims had they come to light in 1971. What is clear from the reported decisions from that era is that the doctrine of charitable immunity was long out of favor with our appellate courts before it was finally extirpated by the Supreme Court in *Fitzer v. Greater Greenville South Carolina YMCA*, 277 S.C. 1, 282 S.E.2d 230 (1981). For example, in *Eiserhardt v. State A. & M. Society of South Carolina*, 235 S.C. 305, 111 S.E.2d 568 (1959), the Supreme Court stated that the applicability of the charitable immunity doctrine depends on the facts of the particular case and held that it did not extend to a commercial venture conducted by a charitable corporation, saying:

> And we do not think immunity should be extended to a situation where the activity out of which the alleged liability arose is primarily commercial in character and wholly unconnected with the charitable purpose for which the corporation was organized. This view is supported by the overwhelming weight of authority. Annotation 25 A.L.R.2d at page 130.

The first full assault on the doctrine of charitable immunity occurred in 1966 in *Decker v. Bishop of Charleston*, 247 S.C. 317, 147 S.E.2d 264 (1966), where the plaintiff was granted

permission to argue against precedent that the doctrine should be totally abolished. The plaintiff's claim in that case was based on simple negligence involving a six inch fall to the church floor during church service:

> It is alleged in the complaint that on April 8, 1963, Carolyn Gohl Schmidt entered The Cathedral of St. John The Baptist and proceeded up the center aisle to the altar rail in order to say her prayers. When she had finished, she turned from the altar rail and walked back toward the center aisle and at a point near the front-most pew she fell off the platform onto the main church floor, a distance of approximately six inches, seriously injuring herself. She alleges that her injuries were proximately caused by the negligence of the respondent.

The Supreme Court declined to abolish charitable immunity outright at that time based on the particular facts of that case, noting:

> It is our conclusion that the doctrine of charitable immunity should not be overruled. The doctrine is particularly applicable in this case. Here, we have a true charity, the church, engaged in conducting a religious service and, in which, Carolyn Gohl Schmidt was participating at the time of her injury.

However, by 1973 the Supreme Court had drastically limited the scope of the charitable immunity doctrine in *Jeffcoat v. Caine*, 261 S.C. 75, 198 S.E.2d 258 (1973), a case involving false imprisonment. The Court extensively reviewed the doctrine from its origins and determined that, despite some statements in *dicta* suggesting the contrary, "the rule of charitable immunity has never been extended by our decisions beyond the facts in *Linder*, *Vermillion*, and *Decker*":

> The doctrine of charitable immunity was apparently first recognized in this State in *Lindler v. Columbia Hospital*, 98 S.C. 25, 81 S.E. 512. The action in that case was by a patient for damages alleged to have been sustained through the negligence of a nurse employed by the hospital, a charitable institution. The Court, in exempting the hospital from liability, stated the applicable rule and its basis as follows:

'The true ground upon which to rest the exemption from liability is that it would be against public policy to hold a charitable institution responsible for the negligence of its servants, selected with due care.'

It is evident that the Court, in *Lindler*, did not intend to fashion a rule of complete exemption from tort liability; for it was careful to point out that the question of whether a charitable institution 'would be liable for negligence in the selection of its servants without due care is not before the court for consideration.'

The Court next considered the doctrine of charitable immunity in the case of *Vermillion v. Woman's College of Due West*, 104 S.C. 197, 88 S.E. 649. Plaintiff was injured when the balcony of defendant's auditorium fell during the progress of an entertainment. Action was brought on the theory that the balcony fell because of negligence in construction. The decision in this case affirmed the holding in *Lindler* that charitable institutions were exempt from liability for the negligent conduct of their agents and, in addition, held that such exemption from liability for the acts of their agents applied 'whether these be selected with or without due care.' The case was remanded, however, for a new trial and, upon appeal after a retrial, judgment for defendant was affirmed. 111 S.C. 156, 97 S.E. 619.

Subsequently, in *Peden v. Furman University*, 155 S.C. 1, 151 S.E. 907, the Court refused to extend the immunity doctrine so as to exempt a charitable institution from liability for trespass and nuisance arising out of the activity of a lessee.

The Court also refused to extend immunity to the commercial activities of a charity in *Eiserhardt v. State Agricultural and Mechanical Society of South Carolina*, 235 S.C. 305, 111 S.E.2d 568. That was an action for damages allegedly sustained as a result of stepping into a hole in a parking lot controlled and operated by the defendant. The operation of the parking lot was a commercial venture and the Court held that immunity should not be extended 'to a situation where the activity out of which the alleged liability arose is primarily commercial in character and wholly unconnected with the charitable purpose for which the corporation was organized,' even though the commercial activity was for the purpose of increasing the fund to be used for the charity.

> We applied the rule adopted in *Lindler* and *Vermillion* to exempt a church from liability for negligence in *Decker v. Bishop of Charleston*, 247 S.C. 317, 147 S.E.2d 264.
>
> The foregoing are the prior decisions of this Court, which are relevant to the present inquiry. There can be no doubt that the decisions in *Lindler*, *Vermillion*, and *Decker* contain broad general expressions to the effect that charitable institutions are exempt from all tort liability. However, the broad statement of a rule of complete exemption from tort liability was unnecessary to a decision in those cases, and the rule of charitable immunity has never been extended by our decisions beyond the facts in *Lindler*, *Vermillion*, and *Decker*. In fact, in *Eiserhardt* the immunity doctrine did not exempt the charity from liability for the negligent operation of a commercial enterprise and in *Peden*, liability was placed upon the charity for trespass and the creation of a nuisance.
>
> These decisions point up the fact that this Court, while adhering in the past to the rule that charitable institutions are exempt from liability for mere negligence, has in every instance refused to further extend the rule. Therefore, the application of the immunity doctrine in a case of intentional tort is not required by precedent, nor, we conclude, by reason or justice.
>
> A long discussion of the charitable immunity doctrine is unnecessary. It is sufficient to point out that it has been subject to much criticism in recent years and considered by an increasing number of courts and writers as unsupportable under modern conditions. *See*: 7 S.C.L.Q. 443; 19 S.C.L.Q. L.Q. 191; 20 S.C.L.Q. 2; Prosser, *Law of Torts*, 4th ed., *Section* 133, p. 992; Annotation 25 A.L.R.2d 29.
>
> Regardless of the public policy support, if there now be such, for a rule exempting a charity from liability for simple negligence, we know of no public policy, and none has been suggested, which would require the exemption of the charity from liability for an intentional tort; and we refuse to so extend the charitable immunity doctrine. (Emphasis added.)

From the foregoing decisions the Court concludes that the doctrine of charitable immunity as it existed in 1971 would not have afforded the Defendants exemption from liability for the

causes of action alleged in the Plaintiff's Amended Complaint and therefor the Defendants' Motion is **DENIED**.

IT IS SO ORDERED.

_____
Hon. Bentley D. Price
Circuit Court Judge

_____ day of _____, 2020
Charleston, South Carolina

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

RECEIVED
Jan 20 2021
SC Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

Bentley D. Price, Circuit Court Judge

Appellate Case No. 2020-000804

John Doe, ...Appellant,

v.

Bishop of Charleston, a Corporation Sole, and The Bishop of the Diocese of Charleston, in his official capacity.....Respondents.

CERTIFICATE OF COUNSEL

The undersigned hereby certifies that the Amended Record on Appeal contains all material proposed to be included by any of the parties and not any other material.

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January 20, 2021
Mt. Pleasant, South Carolina

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM CHARLESTON COUNTY
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Bentley D. Price, Circuit Court Judge

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CERTIFICATE OF COMPLIANCE

The undersigned hereby certifies that the Amended Record on Appeal complies with the Supreme Court Order dated April 15, 2014 regarding personal identifiers and sensitive information.

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