British False Memory Society

NEWSLETTER

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Dear Friends,

The first months of my new position as director have flown by. It is proving a hard task to follow in Roger Scotford's footsteps because so much was achieved in the first five years with Roger at the helm. However, we are delighted to report that he has agreed to act as a consultant to the Society now he has retired.

I hope though, that we can all work together to take the Society into the future with the aim of ensuring that parents will never again have to endure the devastation that "false memories" wreak upon families. With unscientific beliefs still much in evidence among some mental health professionals we have a long struggle on our hands! Only a few weeks ago, a full-page article was published in the Daily Mail about a young woman who was diagnosed through a helpline counsellor as having Multiple Personality Disorder, as the Mail called it. In the United States, the diagnosis of Dissociative Identity Disorder, which MPD has now been renamed, has caused very serious concerns. Many mental health practitioners believe that the diagnosis comes from the therapists' beliefs and not from the patients' symptoms. We do not want to see an epidemic of these cases – which are predicated on the belief that there was early sexual abuse which the patient repressed – come over here.

For some families life is beginning to show signs of improvement. This year, more families than ever before, have rung to tell us that their son or daughter is slowly returning to the fold. Of course, it does not always follow that family relationships are fully restored but for a small number complete reconciliation has been possible. Pamela Freyd of the False Memory Syndrome Foundation in Philadelphia spoke at our Annual General Meeting in May, about the process of picking up the pieces in family reconciliation. For more information see page 2.

The process of retraction has also been of interest to a PhD Researcher at Portsmouth University. James Ost has conducted research into retractors' experiences of recovering and then retracting abuse memories. He has found that the process of retraction takes substantially longer than the original recovery of the "memories" and strikingly there was much less social pressure to retract them than there was to "remember" them in the first place. See James Ost's article on Retractors' Experiences.

Some retractors, who are now struggling to rebuild their lives after realising what has happened to them, have decided to seek redress through the legal system. The procedure is long and arduous, often starting with a formal complaint to the therapist's or clinician's professional body, possibly to the General Medical Council or the Health Ombudsman and ultimately, if there is no satisfaction, to the courts. In this issue we learn of the progress of one retractor's pursuit of legal redress and a mother's research into how to approach the Health Ombudsman.

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It is not only the retractors who face a long legal process. Many parents too, want to seek redress for the indignities they have suffered through false accusations being stated as fact and recorded against them, often without a single opportunity to counter these claims. Parents fall into the category of third party individuals who are nonetheless drawn into this mire by implication and uncorroborated accusations. They must be given the right to protect and defend their integrity and innocence. Until now, the mental health professions have been reluctant to acknowledge their duty of care to third parties. The Americans show the way forward in the case heard before the Supreme Court of New Hampshire, see page 17.

In the UK, the British Medical Association has stated that even where a doctor has not explicitly accepted a duty of care for several people, there is a general ethical obligation to respect the rights of non-patients and avoid foreseeable harm to them.

The General Medical Council is currently investigating practitioners following complaints by third parties. Professor Brandon and his colleagues on the Royal College of Psychiatrists' Working Party, state in the College's recommendations for good practice, "Once an accusation is taken outside the consulting room, especially where any question of confrontation or public accusation arises, there is rarely any justification for refusal to allow a member of the therapeutic team to meet family members." How often does this opportunity occur? If it has been offered to you please let us know. Or, if you are keen to take your complaint further but do not know what steps to take next, we would like to hear from you.

To everyone who kindly sent me cards and messages of support and encouragement I send my thanks. I greatly value contact with members and hope that you will continue to keep us up-to-date with any developments in your family and to contact us with your ideas and questions.

Madeline Greenhalgh

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Did you miss the AGM?

The BFMS Annual General Meeting was held on Saturday 8th May 1999 at the Royal Aeronautical Society.

There was a strong legal emphasis with informative talks from Dr Christopher Barden, practising lawyer and psychologist from the United States of America and Alan Gold, a barrister from Canada. Pamela Freyd, Executive Director of the False Memory Syndrome Foundation in Philadelphia gave some tips on family reconciliation based on the American experience. If you missed this event you can catch up on the afternoon lecture sessions by purchasing a video of the proceedings. Transcripts of the talks are also available.

Copies are available from the BFMS office at £12 for the video (inclusive of postage and packing) or £5 for a copy of the transcripts of the three talks.

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Retractors' Experiences: A comparison of social pressure and time course in the recovery and retraction of abuse memories

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Note: This article is a brief summary of an ongoing programme of research

Acknowledgements: The authors would like to thank the three anonymous retractors for insightful feedback on the early versions of the questionnaire, the British False Memory Society (BFMS) and the False Memory Syndrome Foundation (FMSF) for informing people of the opportunity to take part in this study and all the respondents who were willing to devote time and effort to completing the questionnaire. Comments made in this paper represent the views of the authors, not any organisation.

Introduction

Recent studies of retractors' experiences have highlighted several factors that appear to characterise their accounts of recovering memories of alleged abuse. These include: a positive dependent transference on the therapist; the client's need to make sense of his or her own mental and emotional disturbances (de Rivera, 1997; Lief & Fetkewicz, 1995), the pressure experienced by retractors to recover so-called abuse 'memories' (Goldstein & Farmer, 1993) and the influence of support groups and group contagion on the development of such memories (Nelson & Simpson, 1994).

Whilst retractors might seem to provide the ideal solution to the study of the creation of 'false', or pseudo-memories, since they themselves now confirm

that their earlier claims were indeed false, not all researchers are convinced that their accounts are reliable (Singer, 1997; Kassin, 1997). Furthermore, unsubstantiated claims have been made regarding the processes of recovery and retraction, and of retractors themselves. Blume (1995), for example, argues that retractors may simply be highly suggestible individuals, who have been first 'talked into' believing that they were abused and have now been 'talked out' of making a retraction. Similarly, Singer (1997) suggests that the pressure from an individual's family to retract claims of childhood sexual abuse may be as great as the pressures an individual may feel in therapy to produce a narrative of having been abused. Reviere (1997) goes further and argues that group pressures to retract may be *even stronger* than those to accuse one's own family.

> "The more I co-operated, the more the pressure was to remember more memories."

The present study was conducted primarily to address such unsubstantiated claims concerning the alleged symmetry of the processes of recovery and retraction. This article summarises just two of the findings from this research, concerning the pressure to recover abuse memories compared to the pressure to retract and the differences in time course between recovery and retraction?

Method

A questionnaire was developed consisting of 62 open and closed questions relating to the initial recovery and subsequent retraction, and was distributed either by e-mail or letter via the BFMS and the FMSF. The respondents, who were anonymous, replied directly to the first author. None of the questions involved a direct comparison between recovery and retraction, and every care was taken to ensure that the questions, although phrased in such a way as to cause minimum offence or distress, were not leading in any way. Responses were sought from retractors who had earlier made accusations or claims of childhood sexual abuse, as a result of some form of therapy. A total of 20 retractors (two male respondents and 18 female respondents) completed and returned the questionnaire.

Analysis

Pressure to 'recover memories': Respondents were asked 'Did you experience any pressure that encouraged you to remember abuse and/or 'recover memories of abuse'? Of the 19 participants who responded, 16 (84.5%) claimed that they had experienced some pressure to 'recover' memories of childhood sexual abuse and three participants (15.5%) stated that they did not experience any pressure to 'recover' memories. The mean rating of the amount of 'pressure to recover' experienced was 3.74 on a 6 point scale (where a score of zero means 'no pressure' and a score of 5 means 'forceful').

Pressure to retract: Of the 19 participants who responded to this item, three (15.5%) claimed that they had experienced some pressure to retract the recovered memories, whilst the remaining 16 participants (84.5%) claimed that they did not experience any pressure to retract the recovered memories. The mean rating of the amount of 'pressure to retract' was 0.47 on a 6-point scale (where a score of zero means 'no pressure' and a score of 5 means 'forceful').

Statistical comparison indicated that the majority of respondents felt under greater pressure to recover their initial memories than to retract their abuse memories (Wilcoxon matched pairs test, $p = .0009$). Sixteen respondents also gave details of the source and type of pressure that they experienced. The pressure they described ranged from group and peer pressure (e.g. "some pressure to fit in with the group and have an abuse history" q20, r1), to more detailed accounts, such as:

> "He [therapist] kept pressuring me by telling me that if I wanted to recover from my depression at that point and become a better mother, then I better look at these memories and do some work with them. He also thought if I left my children with their grandparents, they might be in danger. He kept insisting that I had all of the symptoms and I might as well admit it. He acted like he could see right through me and that he knew my story better than I did" (q20, r19)

and:

> "The more I co-operated, the more the pressure was to remember more memories. It went on and on. When I was in a dissociative disorder outpatient clinic and I was at the point of nearly going insane with the amount of memories and sitting and listening to everyone else's, I

decided I was going to quit. They were very upset and told me I would be back, or I would end up dead" (q20b, r10).

Time course of recovery: Sixteen participants (80%) responded to the item "If you recovered 'memories' SOLELY in therapy please estimate how long you were in therapy BEFORE you recovered your first 'memory' of abuse?". Of these, 14 provided estimates that could be used for statistical comparison. For the majority of these respondents, the recovery process was reported to be relatively rapid, the average time taken to recover the first memory being 8.6 weeks (median 6 weeks).

Time course of retraction: Seventeen participants (85%) responded to the item about the length of time they had taken to become convinced the memories were not true. Fifteen respondents reported that the average time taken by respondents to become convinced that the memories were not true was 4.5 years (median 4 years).

Eleven respondents provided an exact time estimate of the processes of *both* recovery and retraction. Statistical analysis indicated that the time taken for these respondents to recover abuse memories were significantly shorter than the time before they became convinced the memories were not true (Wilcoxon matched pairs test, $p = .035$).

General discussion

This research was conducted primarily to address unsubstantiated claims that have been made regarding the possible symmetries, or asymmetries, between the processes of recovery and retraction and, therefore, the reliability of retractors' accounts. Is it the case, as Blume (1995), Singer (1997), and Reviere (1997), have suggested that retractors are simply individuals who are being swayed first one way (to believe that they were sexually abused as children) and then the other (that they were not sexually abused as children) and that the pressure to retract is equal to, or greater then, the pressure to recover abuse memories?

Our data suggests that this is not the case. Our sample of retractors reported experiencing greater pressure to recover memories than to retract them. This does not support the hypothesis put forward by Reviere (1997) that 'group norms' to retract abuse memories may be greater than the pressure to recover abuse memories, but rather the reverse. Not only did the majority of the respondents report less pressure to retract than to recover memories of abuse, but they also claimed that the pressure to retract was minimal.

Recovering abuse memories was also reported to have taken significantly less time than retracting them. Retraction appears to have been a relatively slow process of realisation, typically taking years. Retractors, according to our evidence, should not therefore be characterised as people "most vulnerable to changing [their] beliefs when the winds of social influence blow in a different direction" (Hammond, 1995, p. 112). Unsubstantiated claims about the unreliability of retractors' accounts remain, at the very least, 'not proven'.

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BOOK REVIEW

Dangerous game of MPD by Campbell Perry

Making of An Illness: My Experience with Multiple Personality Disorder, Gail Macdonald

Laurentian University Press
ISBN 0-88667-045-4, 129 pages,
CD$9.95 plus $2.20 for shipping OR £6.25 including postage via BFMS office

Gail Macdonald is a courageous woman who has been through a nightmarish ordeal that would have completely destroyed a lesser person.

In the early 90's, the Ontario Government sponsored the training of therapists in recognising and treating "multiple personality disorder" (MPD). The number of therapists estimated to be trained vary widely, from several hundred to a couple of thousand. One of the trainees was a social worker from California, who settled in a small Ontario town. Gail, a recovering drug and alcohol addict, had been his client before he took his MPD training, and she was well on her way to regaining her long-lost self-esteem. After the indoctrination in spotting MPD, her therapist's modus operandi changed drastically. Soon after, most of his clients started to exhibit signs of MPD. In her memoir, *Making of an Illness*, Gail describes how she and her therapist engaged in a tragic and dangerous game of deceit and self-deception that almost cost her her life. She writes about horrible episodes of self-mutilation, about voices in her head, and about incidents of vivid hallucinations. In *Making of an Illness*, Gail presents entries from her journal, written or drawn by different "alters", and the narrative is supported by quotations from her therapy records .

…….she and her therapist engaged in a tragic and dangerous game of deceit and self-deception that almost cost her her life.

Ultimately, her story has a happy ending. As a result of the intervention by a friend, Gail started having doubts about both her diagnosis and her treatment, and finally she and two other women left therapy. Gradually, her mental state improved. She decided to sue her therapist and his supervisors, and she settled out of court in the fall of 1996, in what is believed to be the first settlement of this sort in Canada. Today she lives on a farm with her three children, and is employed at a job she likes. She is on good terms with her parents and visits them regularly.

Gail gives voice to the many people who have been hurt by irresponsible treatment at the hands of MPD believers. *Making of an Illness* may serve as a timely and potent antidote to false beliefs and harmful procedures that are still being used, with impunity, by some mental health care providers.

Making of an Illness is an eloquent account of how utilising a "disguised" hypnotic procedure can make patients function even more poorly. The book is distressing at times, but has a happy ending.

Campbell Perry, Professor Emeritus of Psychology, Concordia University, Montreal

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Freudian Tales of Seduction

by Allen Esterson

Once upon a time, when Freud's reputation for probity was virtually unchallenged, everyone knew that in the early days of his medical practice almost all his female patients told him they had been sexually abused in childhood. At first Freud believed them, and thought he had discovered the cause of hysteria, but soon he realised that some of the women's accounts were fantasies. This led to the discovery of infantile sexual fantasies and Oedipal desires, the true origins of the reports of many of the patients. On the foundation of this discovery Freud built his influential theories of childhood psychosexual development. Then in the 1970's some feminist writers concerned about the sexual abuse of female children reinterpreted the traditional story: Freud had not discovered infantile fantasies at all, he had capitulated to the opposition of his professional colleagues, who were outraged by his claims of widespread sexual abuse by fathers in their community, and effectively abandoned his abused women patients. Thanks to Freud's theory that most of the memories of childhood sexual abuse originated from Oedipal fantasies, generations of psychoanalysts had disbelieved their women patients when they reported such abuse by their fathers. Finally, Jeffrey Masson took this new view a stage further, purportedly giving it a more scholarly basis. During the 1970's, when he

was a psychoanalyst, he was influenced by the writings of Robert Fliess, who claimed that his analyses showed that virtually all his patients had been abused by a parent. When he was appointed Projects Director of the Freud Archives in 1980 Masson gained access to other material which convinced him that the feminist interpretation of the seduction theory episode was correct, and published his conclusions in his highly influential book *The Assault on Truth*. It would not be far from the truth to say that for many people Masson's account displaced the Freudian version as the received history of the seduction theory.

There is one more strand to this story. In 1974 the philosopher Frank Cioffi gave a talk on Radio 3 entitled "Was Freud a Liar?". In this talk (which was published in *The Listener*), Cioffi drew attention to serious discrepancies between Freud's retrospective accounts of the seduction theory episode and what he had written in his 1896 seduction theory papers. He showed that these papers indicated that the patients had *not* told Freud they had been sexually molested in early childhood. On the contrary, it was Freud himself who insisted that he had uncovered repressed memories of such events, in the face of the resistance of his patients. In other words, he had foisted his own preconceived analytic "reconstructions" onto his patients, and claimed he had analytically 'corroborated' his theory by inducing them to "reproduce" the supposed "sexual scenes". However, although no one actually refuted Cioffi's arguments, his revelations were either derided or ignored.

During the 1980's, while the dispute raged between the feminists and the Freudians, a few other researchers were arriving at essentially the same conclusions as Cioffi. This development was highlighted by Frederick Crews in an article in the *New York Review of Books* in 1993, but for the most part the revelation that neither the psychoanalytic, nor Masson's, accounts were compatible with what Freud wrote in the original papers was dismissed, generally by people who had clearly not bothered to actually examine the evidence.

That Freud's accounts of the episode, repeated by numerous scholars and commentators for much of this century, are grossly misleading can be seen by examining the original papers with a modicum of care. But it seems that the vividness of Freud's historical accounts, and his mastery of persuasive rhetoric, have cast a spell over a multitude of readers, for whom the appeal of an enthralling story has counted for more than a dispassionate appraisal of the evidence based on an examination of the original documents. Here are some of the well know 'facts' that turn out to be false: Freud propounded the seduction theory because of numerous reports from his female patients when they came to him for treatment; he naively believed these reports until he discovered that some of them were actually wishfulfilling fantasies of "seduction"; fathers were predominantly the culprits implicated at that time; Freud's colleagues were outraged by his claims of widespread childhood sexual abuse; he was ostracised by his professional colleagues after the "Aetiology of Hysteria" lecture in 1896. None of these is true, but who wants to spoil a good story?

> ……contrary to the received story, it was Freud himself who insisted, on the basis of preconceived theory, that the patients had been sexually molested in infancy, while the patients did not believe it!

The basic facts are as follows. In the early 1890's Freud sought the origins of hysteria (disorders for which there was no apparent physical cause) in repressed memories of traumatic incidents. He was convinced that these were sexual in nature, but had yet to posit that they necessarily occurred in childhood. He was already convinced that by treating the physical symptoms as symbolic representations he could uncover the supposed traumas. At the same time he developed a procedure by means of which he endeavoured to induce his patients to "reproduce" the forgotten incident, with the idea that they would discharge the energy associated with the trauma and be relieved of the symptom. He encouraged the patients to talk about anything which came to mind in connection with a specific symptom, and when nothing was forthcoming he pressed his hand on their forehead and insisted that there was something in their mind. In this way he tried to set up a train of thoughts or images which he hoped would lead to the origins of the symptom. In *Studies on Hysteria*, published in 1895, he described this "pressure technique" in terms which show that he frequently arrived at his conclusions prior to eliciting what he believed was corroborative evidence from his patients, and even told them in advance what the supposed incident was.

At this time he had yet to claim a single case involving sexual abuse in infancy. Then in early

October 1895 he wrote to his confidant Wilhelm Fliess that he had discovered the solution to the origins of hysteria: repressed memories of sexual excitations in infancy. Freud's idea was that the effect of a sexual trauma in early childhood would remain unexpressed until after puberty, when the development of a person's sexual faculties enabled the unconscious memory, once triggered, to manifest itself in the form of hysterical symptoms. Within five months Freud had written a paper in which he claimed that he had uncovered in every one of his patients forgotten "sexual scenes" of molestations in infancy which accounted for their symptoms. The assailants, he wrote, were nursemaids, governesses, servants, teachers and, in several cases, slightly older brothers. In a lecture he delivered in April 1896 he added adult strangers and close relatives to the list. He claimed that the patients had all "reproduced" the sexual scenes, though precisely what he meant by this remained obscure. That he was using an extraordinarily coercive procedure is apparent from his own words: "Before they come for analysis the patients know nothing of these scenes. They are indignant as a rule if we warn them such scenes are going to emerge. Only the strongest compulsion of the treatment can induce them to embark on a reproduction of them." The notion that the patients reported to Freud that they had been sexually abused in early childhood, as the traditional story has it, is contradicted by the fact that he reported that the patients "have no feeling of remembering the scenes" and "assure me... emphatically of their unbelief". In other words, contrary to the received story, it was Freud himself who insisted, on the basis of preconceived theory, that the patients had been sexually molested in infancy, while the patients did not believe it!

> ……..such is the power of the Freud Myth……

Since Freud never published clinical details, his actual evidence for the alleged 'corroborations' remains unknown. But he soon decided that the theory that every case of hysteria was caused by repressed memories of infantile sexual abuse was not sustainable, though the reasons he gave at various times for reaching this conclusion were not consistent. But, after keeping quiet about his 1896 claims for some years, rather than acknowledge (even to himself) that his analytic technique of interpretation had produced spurious findings he asserted that what he had allegedly uncovered were unconscious fantasies which covered up memories of infantile masturbation and (in the final version of his story) Oedipal incestuous desires. In order to make this account plausible he had to retrospectively modify his original claims, a process which can be followed through the four accounts he gave over the years. Eventually, in accord with his Oedipus theory that infant girls experience sexual desires for their father, he asserted that almost all his early women patients had told him they had been "seduced" by their father, an account manifestly at odds with what he had claimed in the 1896 papers.

In summary, in the period 1895-97 Freud effectively foisted a preconceived theory onto his patients, and over the years published a series of accounts which served to obscure what actually happened at that time. In this way he not only evaded having to acknowledge that his analytic technique had produced spurious clinical findings, he was able to claim that these same findings (suitably doctored) led him to discover infantile fantasy life, thus paving the way to his influential theories of human psychosexual development (invariably described as clinical "findings"). Perhaps the most extraordinary part of this story is that the discrepancies between the traditional story and Freud's original claims are there for anyone to see; yet, such is the power of the Freud myth, many commentators still dismiss those who point out these discrepancies as "Freud-bashers", and misconstrue the nature of the challenge to the traditional story. For those who have fondly believed in Freud's heart-warming account of how his momentous discovery of the existence of infantile sexual fantasies arose out of error, the revelation that the story is phoney is a hard pill to swallow.

For more details, see: "Jeffrey Masson and Freud's Seduction Theory: A New Fable Based on Old Myths", History of the Human Sciences, vol. 11, no. 1, February 1999, pp. 1-21.

Information about the seduction theory can be found on the Seduction Theory web site:
http://www.shef.ac.uk/uni/projects/gpp/aesterson.html

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Stop Bad Therapy & FMSF Websites

http://www.StopBadTherapy.com is an internet website containing useful information and advice on false accusations of abuse (US-based).

All the FMSF past newsletters can be read on:
http://www.FMSFonline.org

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Recovered Memory Therapy Side-lined as *Fragments* Disintegrates

In the last newsletter we reviewed the controversy surrounding the Wilkomirski 'recovered memory memoir' of the Holocaust[1]. The award-winning book *Fragments*[2] is now widely accepted as a fake with additional research by Elena Lappin in *Granta*[3], and Philip Gourevitch in the *New Yorker*[4] throwing further light on the genesis of his new-found identity as a child survivor of Majdenek and Auschwitz.

However, the extent to which Wilkomirski, the former Bruno Dössekker, genuinely believes his adopted identity and if so whether therapy might be responsible, remains unresolved. The case is important because it has obvious parallels with spurious sexual abuse survivor stories and the question of 'false memory'.

Elena Lappin had the good fortune to meet with Wilkomirski both before and after the exposé by Swiss writer David Ganzfried. She provides an insightful account of the character of Wilkomirski including telling traces of the different personae he has developed. When refusing to show her his personal Holocaust archive he switches into 'a young boy's soprano, a little on the feeble side. It occurred to me [Lappin] that it was much easier to tell the story of a traumatic childhood in that delivery, rather than in adult baritone. It was a child's voice…'. However, there is no inquiry as to whether this mode of being, suggestive of the MPD 'child alter', and the story itself, has evolved through therapy and his therapist, Monika Matta, is neither named nor interviewed.

…….subsequent researches and meetings with Wilkomirski reveal how the Swiss musician reinvented himself……

The former editor of the *Jewish Quarterly,* Lappin first met Wilkomirski/Dössekker when presenting him with an award for non-fiction. That was in early 1997 when his powerful 'child's eye' view of the ultimate horror of the 20th century had captured the imagination of the literary world. Lappin's subsequent researches and meetings with Wilkomirski reveal how the Swiss musician reinvented himself according to make believe, absorbing the material that he had seen and read as if it was his own history.

Mark Pendergrast, author of *Victims of Memory* was one of the first to question the authenticity of *Fragments*, when he recognised the hallmarks of the confabulated narrative reminiscent of the uncorroborated retrospective 'adult survivor' stories. He takes the view, in contrast to some of the other sceptics, that Wilkomirski/Dössekker truly believes his new identity[5].

Once exposed, Wilkomirski/Dössekker went into hiding, but through intermediaries, including his psychologist mentor, Elitsur Bernstein, denied the 'recovered memory' provenance. He claimed always to have remembered the camp experiences. His therapy, undergone prior to the book being written, had merely clarified the details in his mind, he claimed.

Both Lappin and Gourevitch accept this denial at face value because there is evidence that Wilkomirski had a history of obsessive interest in the Holocaust and a reputation as a fantasist. However, denial of the importance of therapy and the post-therapeutic assertion of having 'always remembered' alleged contradictory events is a familiar ploy of those whose box of tricks has been outed. As Mark Pendergrast observes: 'Why would he stress the fragmentary, chaotic nature of his 'memories' writing about how 'the first pictures surface one by one, like upbeats'? Why would he have referred to recovered memories in speeches. In November 1997, Wilkomirski/ Dössekker spoke at a Holocaust conference in Vienna, along with Israeli psychologist Elitsur Bernstein, on the Problematics of Identity of Surviving Children of the Holocaust: A Proposal for the Interdisciplinary co-operation between Therapists and Histories.' They asserted that, using their method, even pre-verbal memories could be recovered accurately fifty years later.'

For Lappin and Gourevitch, Wilkomirski is a psychological oddity: rare if not unique unless a hoaxer. Pendergrast embeds him within the context of the belief system underpinning the recovered memory epidemic and thus a victim of memory on a far wider scale. 'The similarities are quite glaring,' he says in an exchange of letters with Gourevitch 'including the methodology, the mindset of victimology, the horror-quality stories, the demand for attention and sympathy, the disdain for truth, the avoidance of science and logic, and the involvement of memory-altering therapy. …[t]his kind of false memory is not particularly unusual or surprising in the late 20th century. It's all part of a kind of post-modernist therapy that helps people to rewrite their

pasts in order to become victims, when in reality they were not.'

Imitation may be the sincerest form of flattery but there is a natural repugnance felt towards people discovered to have faked suffering. The scorn likely to be poured on Wilkomirski as a fraudster will be proportionate to the magnitude of the genuine crime of the Holocaust. Yet it seems clear that Wilkomirski, like so many of the 'recovered memory' survivors, turned a penchant for fantasy into a richly woven narrative identity through the theory and practice of recovered memory therapy. At some point the meaning of his life merged with the investment in the new identity. Since he was encouraged to believe fantasies could be the truth 'revealed' why shouldn't he believe that somebody called 'Benjamin Wilkomirski' - a name he purloined variously from a violinist he admired in his youth and the home town of his mentor, Bernstein – might have existed out there for him to discover on the roll call of concentration camp victims and that this same phantom existence was, as if by magic, identical to himself!

Such distorted thinking is the hallmark of the trance logic of 'recovered memory' where *saying* is *believing* is *being*. But we may eventually be grateful for the Wilkomirski fiasco as an object lesson in truth. Grotesque as it is for an artefact of therapy to be passed off as relic of mass inhumanity, it is the very reality of the latter that gives the lie to the former. It would add insult to injury to claim that Wilkomirski discovered a 'narrative truth' so that he might be numbered indiscriminately with genuine survivors simply to protect his feelings. Precisely because we know the reality, it would be an abomination both to him and camp survivors to adopt this sentimental preciosity. It is doubtful too whether even he would wish to cling on to a 'meaning' so publicly, and shamefully, debased. As Raul Hilberg, a leading authority on the Holocaust, said of *Fragments*: 'If you get rid of all the inaccuracies, what remains?'

Yet therapists hide behind the fiction of 'narrative truth' when parents and others are accused of the most grotesque sexual crimes against children that, if true, would rank with the cruelty meted out to the survivors of the death camps. Insulating their protégées like coddled eggs, they are seemingly oblivious to the blistering implications - *the real meaning* - of the narratives if they are true, and the indelible damaging effect on both the client and the accused if they are false.

Nor should it be assumed that the fictional narrative corresponds to similar facts in the author's experience. Whilst almost anything can be shown to have some form of symbolic meaning with false memories pinned to aspects of truth, the suggestion that the Wilkomirski fantasy veiled an abusive childhood - a theme touched on by Lappin - is as unreliable a thesis as is the literal interpretation of the book. As this sorry tale demonstrates nothing concerning memory substitutes for independent corroboration.

At the end of the day, the Wilkomirski saga is merely an embarrassment. The damage inflicted on others is slight, the chief casualty, by his own hand, being Wilkomirski. No one has ended up in jail on false charges; nobody has had his family ripped apart. That is why its chief importance is not in its own apparent domain – Holocaust history – but as an object lesson in the still unfolding witchhunt against the innocent accused of sexual abuse.

Margaret Jervis

1 *Recovered Memories of the Death Camps* Vol. 6 No. 1 p.19
2 *Fragments – Memories from Childhood 1939-1948* Picador
3 The Man with Two Heads, *Granta* 66, Truth & Lies p.7
4 The Memory Thief, *New Yorker*, June 14 1999
5 Holocaust Hoax? *LM* 118, March 1999

See also http://www.StopBadTherapy.com

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MEMBERS' FORUM

Victim Is as Victim Does

It takes more than a false memory to produce a case of false memory syndrome. FMS involves not just recovering supposed memories but making them the central feature in one's life, the basis of a new identity. The rewards can be substantial: attention and sympathy; status as a survivor (very fashionable in some circles); the companionship of fellow-sufferers; above all, the comfort of knowing that, whatever one's past or present problems, somebody else was to blame.

We have seen our accusing children reject anyone who doubts their allegations, rush to join support groups, pore over the self-help literature - in short, turn themselves into full-blown, single-minded victims of child abuse. We, for our part, regard them as victims of irresponsible therapy, often allied to a dubious ideology. From either point of view, it's a self-reinforcing process that offers no way out. On the contrary, it usually intensifies and prolongs their suffering.

But what about us, the accused parents? Are we not also victims? My concern is that we face exactly the same temptations as our children. When the blow falls we feel shock, horror, perhaps bewilderment. We want to make sense of what has happened to us, so we read books about false memory, we go to BFMS meetings and we talk to others in the same situation.

Then what? Does being an accused parent become a full-time occupation? Do we dedicate our lives to grieving over our misfortune? Do we even take the offensive, launching lawsuits or battling with therapists and health authorities? Of course, we all develop our own ways of coping. But what if the effect is to intensify and prolong our suffering?

> "We are not bound to mirror the behaviour of our children."

Some accused parents are forced into action - I think of those threatened with court proceedings. For most of us, though, there is a choice. We are not bound to mirror the behaviour of our children. We do not need to identify with our status as accused or to insist on our victimhood. After all, there are other roles for us to perform and more productive uses for our energy. We may be husbands, wives, grandparents. We may be active in our local community or a voluntary organisation. We may have a sport we enjoy playing or a hobby that gives us satisfaction. We may even have to work for a living!

Isn't there a tightrope to be walked, a balance to be struck between equipping ourselves to contend with false accusations and allowing them to dominate our lives? We cannot forget what has taken place, nor do we wish to do so. But by putting it into some kind of perspective we can diminish its power over us.

Obsession is never a healthy state. How sad it would be to create an accused parent syndrome and fall victim to that too!

Malcolm Stern
Trustee

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The Health Service Ombudsman Complaint Information

The Ombudsman is now called the Commissioner and the department is the Office of the Health Service Commissioner for England (HSC).

The HSC will only look at a complaint if it has not been resolved by complaining to the relevant NHS Trust, so that avenue has to be explored first.

The HSC is completely independent and is publicly funded. The HSC will not investigate unless he thinks there is a good chance of proving the complaint is justified. He will not investigate unless he thinks something will be achieved by proving that something is wrong. Well worth remembering when you send in your complaint - make sure you know what it is you want your complaint to achieve.

The HSC's primary role is to investigate NHS Trusts, but, if the event(s) took place after 31 March 1996, he may also investigate a particular doctor or other trained professional. When a Trust is investigated, the relevant doctor(s) will also be investigated.

The investigation procedure is confidential. Expect an investigation to take months rather than weeks.

The HSC will not investigate problems with Social Services. Social Services has its own Local Government Ombudsman. The HSC and the Local Government Ombudsman will work together (the HSC and the GMC do not).

The HSC is concerned to establish "reasonable" treatment by a Trust and its doctor(s) and if the doctor has adhered to current guidelines. They will not determine negligence - that is for a court to decide. The HSC will also investigate the possible harm or injustice suffered as a result of the Trust's actions or the doctor's treatment.

The HSC will not investigate a complaint about a complaint.

Although there are time limits, nominally one year from becoming aware there is a problem (so the earlier the complaint is submitted the better) the HSC is approachable and will consider 'late' complaints if it can be proved that there was a reason. For example other complaint(s) took longer than expected thus delaying an application to the HSC.

The HSC publishes a free leaflet which explains how the system works. It also provides useful information and helps with formulating a complaint. It can be obtained from:

Office of the Health Service Commissioner for England:- Millbank Tower, Millbank, London SW1P 4QP, Tel: (020) 7217 4051
The current Commissioner is Mr Michael Buckley.

The office of the HSC has investigators, legal and medical advisors and has recently appointed a part-time psychiatric advisor. All the investigators are helpful and approachable. Submitting a complaint is not a daunting prospect. The investigators try their hardest to help and are used to people writing emotional, complex letters. They are also used to people not expressing themselves clearly. The Commissioner realises that he is dealing with people who have had, or feel they have had, something go terribly wrong and have had the added frustration of being dissatisfied with the NHS complaints procedure.

> The Health Service Commissioner will investigate third-party complaints.

The HSC will investigate third-party complaints. He will also investigate a complaint by parents on behalf of a child who is deemed educationally unfit to complain on it's own behalf.

Do not give up if the Commissioner initially turns down the complaint. He has been known to reverse the decision not to investigate when sent yet another letter. Persistence can pay off. Further information about the complaint can be submitted at a later date if needs be.

To launch a complaint to the HSC:-

- Write down what happened as clearly as possible and send copies of all relevant letters
- Try to state what you feel happened, what you are unhappy about (stick to the facts), and say what you want the HSC to investigate and what you would like the complaint to achieve.

To summarise, it is well worth complaining to the HSC. The complaint will be looked at very fairly. The HSC is COMPLETELY impartial. The staff are very approachable and will take time to tell you what is happening to the complaint. They are sympathetic and you will not be made to feel you are making a nuisance of yourself.

Please contact me via the BFMS office if you would like to discuss the process further.

Eileen Berridge

Tragic Problems

Coping with false accusations of sexual abuse arising from false memories

by Barnabas, 1999

How do you cope when faced with devastating false allegations of the most evil things imaginable? Barnabas has collated some helpful ideas on dealing with the effects such accusations can wreak on all aspects of your life.

From the initial shock; the urgent need to defend yourself and trying to grasp some understanding of what is happening to you, through to protecting your own mental health and yet managing to retain some hope, this booklet is a positive asset to anyone caught up in this nightmare.

Copies are available from the BFMS
To order please send £5 to cover photocopying costs and postage.

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BOOK REVIEW

Veiled illusions permeate therapist's beliefs by C Brooks Brenneis

Remembering Trauma: A Psycho-therapist's Guide to Memory and Illusion, Phil Mollon

John Wiley & Sons. 1998. [p. 221 + xv] Chichester

For most psychoanalysts, the 'Memory Wars' - that battle over the authenticity of memories of trauma recovered in psychotherapy - may be being fought in a distant land, between parties none of whom raise great sympathy or interest, and about matters that seem relatively far removed from everyday analytic practice. This is, I think, a mistaken perspective; for the Memory Wars, in a very basic sense, engage issues fundamental to analytic practice. At the centre of this debate lie questions about the impact of real past events on psychological development, about the reliability of memory and our capacity to discern past from present, about dissociation as a defence against trauma, and about the vulnerability of the therapeutic

process to suggestion. When a seasoned clinician with significant psychoanalytic leanings and a very broad acquaintance with the relevant scientific literature presents a careful look at this mess, it is worth paying attention to. In *Remembering Trauma*, Mollon accomplishes two ends; he reviews and critically summarises a diverse band of information relevant to the problem of recovered memories; and, based on his conclusions, he offers a series of guidelines for responsible psychoanalytic practice.

Memory and memory for trauma receive considerable attention. Mollon uses an impressively heterogeneous collection of information—clinical cases, clinical, laboratory, and biological research, and emerging theoretical models of memory—to illuminate memory's complexities, especially in response to trauma. Memory, as is now universally accepted, is a reconstructive process, shaped by the present as well as the past, and consequently responsive to a fair amount of internal and external influence. Two systems of memory exist side by side—explicit and implicit. Explicit memory is directly available to consciousness and includes the memories of personal experience that help define our conscious sense of self. Implicit memory registers outside of consciousness and may be demonstrated only in action, as in habitual and skilful behaviours, conditioned responses, and perceptual priming.

Based on his reading of the evidence, Mollon argues that the experience of trauma alters the biological and psychological context for memory. A high degree of autonomic arousal, the psychological equivalent of which may be dissociated (or divided) consciousness, interferes with or blocks the encoding of explicit memory while allowing implicit memory to register unimpeded. The result may be a state-dependent but fragmented set of memories grounded in implicit memory, dissociated from consciousness, and likely to re-emerge into consciousness only when an emotional version of the original traumatic learning situation is reinstated.

This theoretical explanation makes it seem as if the psychotherapeutic re-evocation of implicit memories of otherwise unremembered trauma and their recasting into explicit memory might be a relatively straightforward matter. Such is not the case, as Mollon points out. Hypnotic and dissociative states appear to be conceptually identical, and the literature on memory enhancement through hypnosis is far from reassuring. In fact, hypnosis often enhances individuals' confidence in their memory at the expense of its accuracy, with error introduced through the heightened suggestibility known to accompany a hypnotic state. The picture is further complicated by the mind's ubiquitous effort to construct meaning out of experience. When that experience comes across as anxiety-laden and unformulated or 'unmentalised', '*any* narrative which provides some fit with feelings of terror may be embraced simply *because* it fits and thereby provides words, a structure, and a container which greatly reduce anxiety' (p. 157-8). As any narrative of trauma is likely to offer some degree of congruence, true and false narratives may be indistinguishable.

With these complexities in mind, Mollon generates several guidelines for psychoanalytic clinicians. These guidelines enumerate ways to avoid constructing or colluding with false memories, list general treatment principles for work with borderline and dissociative personality disorders, and summarise factors that may contribute to false memories of trauma and conversely failure to recognise true residual memories of trauma. In general these guidelines are conservative and cautious. For example, Mollon specifically includes the possibility that 'imagery of sexual abuse may be a representation of abusive experiences in therapy ...' (p. 175) and the more general notion that the therapist and the patient jointly construct the patient's emerging narrative of childhood development, and thus that the therapist 'cannot *not* influence' (p. 174) that narrative. In brief, Mollon's advice to clinicians facing clinical material that includes the prospect of lost memories of trauma is sage: tolerate uncertainty, for, without external corroboration, there is no way to know what is and what is not true.

…….the therapist 'cannot *not* influence' that narrative.

As balanced as this reading of the issues seems, to this reader's mind, it contains some conceptual misunderstandings and clear-cut biases. His sometimes indignant references to the False Memory Syndrome Foundation (FMSF) strike a jarring note, as does his inclination to mention, with apparent pejorative intent, any critic's association to this group. One may get the impression that the debate about recovered memories is occurring between hard-pressed, responsible clinicians and critics who are more or less hired guns for the FMSF. Even a cursory look at current analytic literature would establish that this is hardly the case. With his statement that 'the evidence for ritual abuse is highly ambiguous—taken as a whole, the allegations are neither clearly true nor clearly untrue' (p. 182), Mollon appears to endorse the possibility that these recovered accounts may

convey some substantial degree of truth. This reflects, I think, an uncritical review of the evidence he summarises and certainly one at variance with the almost uniform discredit with which most informed observers view these reports. One wonders, if tactful questions are not raised in response to patients' initial, nascent accounts of such activities, can we not help but endorse them with our silence?

The case histories Mollon uses to illustrate the effects of trauma on memory and various therapeutic responses to suggestive but ambiguous clinical material are themselves ambiguous and tantalising. Several cases allude to external, confirmatory verification but in a fashion that makes it difficult to assess this evidence. This was particularly vexing, for example, in the case of Susan (pp. 37-9), who found corroboration for her precise implicit memory responses to consciously unremembered early abuse. If authentic, and Mollon makes clear that he feels it is, this case provides unparalleled confirmation of the theory that trauma may impair explicit memory but preserve implicit memory with exactness. Given that Mollon must appreciate the singular nature of Susan's experience, the absence of such details is disappointing and leaves one wondering if the evidence is as definitive as Mollon indicates.

At the heart of Mollon's enterprise are two powerful ideas frequently embedded in the clinical literature but which I regard as highly questionable. The notion of an implicit memory that acts as a virtual recorder for the sights, sounds, and sensations of early trauma provides an engine that may trigger and steer a search for past trauma. This notion, however, is misleading. Nowhere is there attached to the various habits, routines, and repetitive twitches of our lives a label that identifies them as responses to discrete past events. Moreover, implicit memory, if that is indeed what these responses represent, by definition contains no reflections of its origins. Consequently, one may err twice - once, in assigning to any piece of repetitive behaviour or reaction the potential label of implicit memory; and twice, in thinking that the origins of an implicit memory can be found with any reliability. We may then search where nothing is to be found and in the process create what we have been looking for.

The pairing of dissociation with trauma is, to my mind, a similarly misleading view of the evidence. While we can demonstrate a relationship between trauma and dissociation, that relationship is not nearly as close or predictable as is needed for clinical inference. The vast majority of individuals with a penchant for dissociation—the ability to segment consciousness and be totally absorbed in stimuli—have no prior experience of trauma, and therefore the prior existence of trauma cannot be inferred from dissociative tendencies. More troubling, however, is the fact that all of these individuals are exquisitely suggestible and may readily intuit the unspoken biases and theoretical expectations of important others, like therapists. Once again there is the possibility that, armed with a belief in the connection between dissociative states and trauma, we may create what we are looking for.

Mollon's efforts to acquaint readers with essential information about memory's vagaries is commendable, but to my mind biased and sometimes in error. His recommendations to clinicians are indeed thoughtful, cautious, and potentially useful. But, as his book reveals, even the most carefully wrought guidelines are porous to a therapist's implicit beliefs. That Mollon's guidelines were designed specifically to guard against suggestion in the critical area of recovered memories of trauma indicates to me how subtle, complex, and powerful implicit beliefs can be. Quite aside from the topic of recovered memories, psychoanalysis must continue its efforts to understand and examine the inevitability of our unconscious influence on our patients, their clinical material and our theories.

C. BROOKS BRENNEIS, April 1999
brenneis@facstaff.wisc.edu

Review published in IJPA, June 1999, Part 3, vol 80 ,pp614-616

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NEWS FORUM

Truth and Lies

One in ten people who lie convince themselves they are telling the truth. That is the finding of two studies of 140 people by Dr Danielle Polage from the University of Washington, USA reported in the *Independent,* June 5 1999 (American Psychological Society Conference: Study Uncovers the Truth about Lying by Cherry Norton).

While for the majority of people lying about an event reinforces their memory of the truth, for ten cent, the lie is reinforced and they subsequently deny that they were lying.

Dr Polage is reported as remarking "Lying is a form of imagination in which someone creates an alternative reality. For some people the lie becomes so incorporated into their memory that they believe the lie."

The report goes on to state: 'People who repeatedly lie about an event, and are then faced with facts that prove they are lying, cannot admit it because they believe their version of events. These people will not display any of the body or facial movements that can betray a liar'.

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Leading MPD psychiatrist facing ruin

A leading exponent of MPD is suing his insurance company for alleged premature settlement of a claim which has left his life and practice in ruins.

International notoriety engulfed psychiatrist, Dr Bennett Braun, in 1997 when a former patient won a $10.6 out of court settlement against Braun and Rush Presbyterian Hospital, Chicago. A depressed housewife, Patricia Burgus was diagnosed as MPD in 1986 and came to believe she was a high priestess in a satanic cult with 300 personalities due to childhood abuse and that her sons of 4 and 6 had been similarly abused. They were hospitalised for three years in the child psychiatric unit. Braun now risks losing his medical license through disciplinary hearings and investigations and faces further malpractice suits. An initial hearing before the Illinois Department of Professional Regulation is scheduled to begin on November 16. Also charged is Dr Roberta Sachs, another leading MPD psychiatrist.

Braun now claims that the settlement, whereby neither he nor the hospital admitted negligence, has caused him humiliation in the eyes of his peers and patients and severe emotional stress affecting his health (*Chicago Tribune* 23/6/99).

With so many of the former luminaries of MPD in the US facing 'false memory' malpractice lawsuits (including the leading conspiracy theorist Dr Colin Ross) the International Society for the Study of Dissociation is reportedly in crisis and has been shunned by other professional organisations. It may be significant therefore that the Society held an international conference in Manchester in May this year, rather than the European faction, established only in 1994, running its own. The existence of MPD or its update 'Dissociative Identity Disorder' has been viewed sceptically by the psychiatric mainstream in the UK, despite the explosion of the diagnosis in North America.

Attempts to diagnose MPD in the UK go back a number of years among recovered memory enthusiasts but have largely taken root among rape crisis and feminist groups. A survey by Dr Ray Aldridge-Morris, author of *MPD: A Study in Deception,* among psychologists in the UK in 1993 indicated only a small number of clinicians making an MPD diagnosis, but of these most had a surprisingly large number of MPD patients. Though tentative, these results echo experience elsewhere that the alleged ability to spot MPD and make it seem real is in the eye of the diagnostician.

Since then a number of MPD exponents, including Dr Colin Ross, have run training sessions in the UK. The UK faction of the ISSD has been founded and a MPD 'survivor' newsletter (*Collective Consciousness*) has been established.

The MPD 'dissociative model' of hidden child abuse is now more frequently cited by therapists than 'repression' because it apparently offers a way out of the trap of total amnesia for abuse by allowing *parts* of a patient to have always remembered the alleged abuse. With a recent plug for the condition in the Daily Mail maybe there will be a renewed attempt to regain credibility in the US through colonisation abroad.

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'Satanic Abuse' migrates to Ireland

Satanic abuse has had its heyday in the UK with the discrediting of reports from children and adult 'survivors'. But news from Ireland indicates that Rape Crisis groups are actively promoting the myth in the republic.

A report in the Irish *Sunday Times* (11/7/99) states that Rape Crisis centres have opened satanic abuse helplines there despite there being no evidence of this type of crime discovered by the police in Ireland. Fiona Neary, the national co-ordinator of the Rape Crisis centres, defended the move on the grounds that one office had dealt with five cases with 'a number reported to other counsellors'.

Helpline counsellors were to be trained by English members of the Ritual Abuse Information Network and Support (RAINS) including Sue Hutchinson of SAFE whose claims helped ignite the full-blown scare back in 1990-1 in the UK affecting families with children. Both the BFMS and criminologist Bill Thompson decried the move as a retrograde attempt to establish the credibility of Satanic Ritual Abuse. Neary countered that the purpose of the helplines was simply to be 'available for victims'.

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Terror in the Courtroom

Extracted from *How the Police Trawl the Innocent,* Richard Webster
New Statesman – 19 July 1999.

"The problem that our criminal justice system now faces is that the attitude we have adopted as a society towards allegations of sexual abuse is neither sane nor reasonable. So terrifying has the spectre of child sexual abuse become, so convinced are we that we are beset by some unspeakable evil, that the ordinary checks and balances built into our justice system have been rendered powerless.

"In recent years barristers have noticed an increasing tendency for the CPS to allow sexual cases to proceed, regardless of the quality of the evidence. At the same time both magistrates and judges seem terrified to use their powers to dismiss unsound prosecutions or to halt trials as an abuse of process. The terror that an innocent person might be found guilty, which has traditionally and rightly been the foundation on which our entire justice system has been built, has been replaced by the terror that a guilty man might go free.

"In these circumstances, in which both magistrates and judges have in effect relinquished their traditional responsibility to protect the public against ill-founded and dangerous prosecutions, it should scarcely be surprising that juries, misled by the court into believing that the evidence being presented to them is safe, should use this evidence as the basis for convicting the defendant. For juries too, are susceptible to terror. And they, too, are liable to reach a verdict of guilty not on the evidence but in response to the fear that they might acquit a guilty man. If recent rulings are any guide, even some appeal court judges appear to have succumbed to the terror.

"When you are faced by an unspeakable evil, the safest course is always to convict, whatever reasonable doubts there may be about whether the defendant has actually committed the crimes of which he or she is accused. We saw that again and again in the cases brought after the IRA terror bombings.

"In such a climate, the dispensing of justice is replaced by a witch-hunt. And, because police trawling operations have been allowed to develop virtually unchallenged over ten years, we are now in the midst of a witch-hunt of unprecedented intensity."

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Therapist's Beliefs….

Robin Balbernie of Severn NHS Trust writing in *Clinical Child Psychology and Psychiatry,* Vol 4, Issue 2, April 1999.

"In this paper I describe an example of projective identification from work with a six-year-old adopted boy, where I found myself almost completely unable to function for several sessions. A traumatic past experience belonging to my patient, which he *could have no conscious knowledge of,* (editor's italics) had been pushed out of his unconscious to lodge in mine; and then, in turn, I acted out a version of that experience."

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The Demise of PAIN

The first British charity to help parents wrongly accused of child abuse has been forced to close down. In May this year, Parents Against Injustice, set up in the mid eighties in response to the rising tide of misdiagnosis, could no longer raise sufficient funds to keep going.

Founded by former nurse Sue Amphlett, PAIN advised nearly 13,000 families over its near 15-year life-span. It also became a touchstone for legal, welfare and social work professionals concerned about the dramatic rise in unwarranted child protection intervention and misinformation. Examples of misdiagnosis ranged from doctors diagnosing non-accidental injury when a child was suffering from an organic disorder, use of the 'child abuse accommodation syndrome' to detect alleged hidden sexual abuse and latterly Munchausen's Syndrome by Proxy where parents were wrongly accused of abusing children for emotional gain.

Although originally misdiagnosis of physical abuse was the main problem identified, by the late eighties false accusations of sexual abuse gained the ascendancy. PAIN was instrumental in helping **e**xpose the Cleveland scandal in 1987 warning against the hysteria of presumptive diagnosis that became the basis of 'false memory' claims. Prior to the setting up of the BFMS in 1993, PAIN warned of the spread of false accusations through regression therapy.
Despite gaining recognition from professional organisations including the National Society for Prevention of Cruelty to Children and the National Institute for Social Work, and contributing to the rethink of child protection investigation in the Department of Health report *Messages from Research,*

PAIN was unable to surmount the crisis caused by the withdrawal of the Department of Health pump-priming funding three years ago. On closure Sue Amphlett decided that unless a three-year guarantee of funding, amounting to £250,000 could be found, PAIN would not be resurrected.

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Hillary Clinton faces London protest by falsely accused

Relatives and friends of people wrongly accused or convicted of child abuse demonstrated outside a ChildLine conference in London on May 13. The conference, chaired by Cherie Booth QC, was addressed by the Home Secretary and Hillary Clinton on the subject of children's evidence in child abuse prosecutions.

The organisers of the demonstration, Relatives and Friends of those Falsely Accused of Abuse stated their aim was not to undermine the need for child abuse prosecutions, but to draw attention to the hidden plight of the victims of miscarriages of justice. The social work magazine *Community Care* published a picture and caption on the demonstration, (20-26 May) believed to be the first of its kind in the UK.

RFFAA is an offshoot of the campaign group Action Against False Allegations of Abuse formed earlier this year following the circulation of a pamphlet alleging widespread injustice through child abuse fears.

For further information about RFFAA and AAFAA

write to PO Box 84, Leeds LS5 3XZ

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'Repressed Memory' author loses the plot

Psychologist Renee Fredrickson, author of one of the most influential recovered memory primers, has had her license restricted following complaints about her practice.

The Minnesota Board of Psychology has ordered that Fredrickson be barred from providing therapy concerning cults, ritual or satanic abuse. She will also be banned from using hypnotic techniques in therapy except under supervision until she can demonstrate competence.

The ruling followed an investigation into treatment over a ten-year period between 1987 and 1996. Three patients were encouraged to develop images of ritual satanic abuse, torture, murder and sexual abuse during therapy using a variety of visualisation and hypnotic techniques. The Board found that she failed to warn patients of the unreliability of hypnotic recall and that she practised 'when [her] objectivity and effectiveness [were] impaired'. It also noted other forms of unprofessional conduct and evidence of 'possible mental dysfunction' including false reports of stalkers.

Fredrickson's fall from grace is a benchmark in the dissolution of recovered memory therapy. Her 1992 book, *Repressed Memories: A Guide to Recovery from Sexual Abuse* came to Britain at the high water mark of the Freudian 'repressed memory' revival and furnishes methods of conjuring up the most grotesque personal histories out of thin air.

Using the robust method of memory recovery characterised as 'forceps' by Mark Pendergrast in *Victims of Memory*, Fredrickson encouraged anybody to become a repressed memory abuse survivor and provided the building blocks of an action-packed visual narrative, including suggesting that the therapist provide scene prompts to cue the sluggish 'memory'. 'Action builds, and you become deeply engaged in the process, curious to find out what your mind will picture', she promised.

Fredrickson fostered a paranoid mentality where the everyday becomes a horror movie 'Bedrooms, bathrooms, basements, and closets are common places where sexual abuse occurs, so be alert to reactions to those places or to objects in them'.

This way of thinking became *de rigueur* for a whole generation of survivors, therapists and counsellors where an alleged history of abuse became a way of experiencing the world. Now grounded, Fredrickson may find time to take a piece of her own advice. For, after urging trenchant belief in abuse and confrontation, she adds 'if months or years down the road, you find you are mistaken about details, you can always apologise and set the record straight.'

Time to own up, Renee!

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LEGAL FORUM

Third Party Lawsuits Against Therapists

Could you sue your accuser's therapist? Tempting as this may be, the likelihood is that any action will fail because it will be difficult to demonstrate that the therapist owes you a duty of care. However, as the potential consequences of allegations of sexual abuse become that much more serious and the unreliability of memory recovery techniques is widely acknowledged, third party lawsuits may take root in the UK.

……a therapist may owe a duty of care to both the adult patient and those accused of sexual abuse where harm through a negligent diagnosis is foreseeable.

In the United States, courts are beginning to recognise that the consequences of false allegations of sexual abuse encouraged by therapists are both devastating and avoidable. Because of the special nature of the diagnosis, a therapist may owe a duty of care to both the adult patient and those accused of sexual abuse where harm through a negligent diagnosis is foreseeable.

The most definitive statement of this principle in a recent decision by the Supreme Court of New Hampshire, USA. *Hungerford v Susan Jones* spelt out the gravity of the consequences of false allegations:

> It is indisputable that "being labelled a child abuser [is] one of the most loathsome labels in society" and most often results in grave physical, emotional, professional, and personal ramifications. This is particularly so where a parent has been identified as the perpetrator. Even when such an accusation is proven to be false, it is unlikely that social stigma, damage to personal relationships, and emotional turmoil can be avoided. In fact, the harm caused by misdiagnosis often extends beyond the accused parent and devastates the entire family. Society also suffers because false accusations cast doubt on true claims of abuse and thus undermine valuable efforts to identify and eradicate sexual abuse.

The court found the public interest was best served by restricting therapists' immunity:

> ….a therapist owes an accused parent a duty of care in the diagnosis and treatment of an adult patient for sexual abuse where the therapist or the patient, acting on the encouragement, recommendation, or instruction of the therapist, takes public action concerning the accusation. In such instances the social utility of detecting and punishing sexual abusers and maintaining the breadth of treatment choices for patients is outweighed by the substantial risk of severe harm to falsely accused parents, the family unit and society.

In June this year, the Wisconsin Supreme Court followed suit in *Sawyer v Midelfort* 1999 Wisc LEXIS 86, June 29, 1999. In both these cases the gravity of the potential effect of false accusations was seen to overrule the public policy considerations precluding liability as was the alleged complexity of suspected sexual abuse cases. In *Sawyer* the Court held that 'we do not believe that a therapist should be relieved from liability when his or her treatment is negligent simply because the problem he or she is treating is complex'.

Third party suits against 'recovered memory' therapists have not so far been tested in the UK but then neither has any action by a misdiagnosed adult patient run its course.

In the US the increase in third party suits has come in the wake of successful claims by former patients. In December 1998 a False Memory Syndrome Foundation legal survey noted 158 claims of malpractice by third parties for alleged encouragement of false memory.

Now the Brandon report has established the unreliability of recovered memory claims and the associated therapy there may be scope for the development of the law to cover the foreseeable harm caused by negligent statements of mental health practitioners.

(For further information on US cases and copies of the New Hampshire Supreme Court judgement in *Hungerford v Jones* (1998) contact Margaret Jervis at the BFMS)

BOOK REVIEW

Where the truth lies in expert evidence by Chris Saltrese

Analysing Witness Testimony: A Guide for Legal Practitioners & Other Professionals

Edited by Anthony Heaton-Armstrong, Eric Shepherd and David Wolchover

Blackstone Press, £31.95, 360pp

Allegations of sexual abuse have become depressingly prevalent over the past ten years in this country and whilst it should not be doubted for one moment that sexual abuse in its various forms is a very real and disturbing problem, equally it must be recognised that a great many complaints of such abuse are complete fabrications.

> Any chapter purporting to deal with complaints of sexual abuse is certainly incomplete without reference to the torrent of retrospective allegations against residential workers which currently engage the majority of polices forces in the United Kingdom…..

Sexual abuse is, of course, by its nature something that is rarely witnessed by third parties and, where the abuse is alleged to have taken place in the distant past - and there have been recent prosecutions of abuse said to have taken place in the 1960's - there will very often be no medical corroboration. In effect, the trial process will be reduced to the word of the complainant against that of the defendant. In these circumstances a thorough analysis of witness testimony is of paramount importance and *Analysing Witness Testimony*, inspired by earlier articles by the editors and lectures given at the series of annual seminars organised by the British Academy of Forensic Sciences (BAFS), appears to be a timely publication.

The importance of a detailed study of witness testimony is recognised by Eric Shepherd (co-author of the extremely instructive *Active Defence*, Law Society 1997) and Anna Mortimer in their chapter on "Identifying Anomaly in Evidential Text". Although this reviewer found their use of jargon irritating, their central point is one that is ignored at the peril of those wrongly accused; that only with a painstaking examination of exact detail can the defence lawyer hope to make any headway against uncorroborated allegations. The data-representation techniques described by Shepherd and Mortimer are especially useful to the lawyer whose client faces multiple allegations from several complainants. Less satisfactory is the same authors' earlier chapter on "The Frailty of Children's testimony" which is again riddled with jargon e.g. "Talking with another person requires the simultaneous engagement of several interconnecting systems - a transmission system, a tracking and guidance system, and what might be called a facilitation system.....". And the authors make no reference to the very pertinent judgement in the Shieldfield Nursery Case (1994) in which Mr Justice Holland ruled that the children alleging abuse at the hands of their nursery carers were not, because of their pre-school age and the delay in bringing the allegations, considered to be reliable witnesses. This most carefully considered judgement has, according to Newcastle solicitor Clare Routledge, "had a devastating effect on the willingness of the police and Crown Prosecution Service to prosecute those who are alleged to have committed sexual offences against pre-school age children." (*Law Society Gazette*, 21 April 1999).

At the BAFS seminar last December Dr Janet Boakes presented a paper on "False Complaints of Sexual Assault; Recovered Memories of Childhood Sexual Abuse" which was both powerful and stimulating (since published in *Medicine, Science and the Law*(1999) Vol. 39, No.2). It is therefore all the more disappointing to read Dr. Boakes' contribution to this work. Her chapter "Complaints of Sexual Misconduct" is a rather simplistic introduction to an extremely complex subject. It also has the feel of being written some time ago. It is generally unwise to put forward general propositions when discussing sexual abuse and Dr. Boakes' unsupported assertion that "most accounts by children of sexual abuse are truthful" is only partially redeemed by her later acknowledgement that "children may lie".

Moreover, whilst dealing perfunctorily with false allegations which are made by complainants undergoing therapy or suffering from mental disorders her observation that "unfounded and false allegations of sexual misconduct are *periodically* made"[italics

added] betrays an ignorance of the epidemic of false complaints of sexual abuse currently being made against careworkers and teachers throughout the country. Indeed such is the scale of these allegations that they threaten to dwarf those false complaints motivated by various forms of mental disorder. Any chapter purporting to deal with complaints of sexual abuse is certainly incomplete without reference to the torrent of retrospective allegations against residential workers which currently engage the majority of polices forces in the United Kingdom and which were the subject of the Waterhouse public inquiry in North Wales (for a most lucid exposition of this subject see Richard Webster's excellent *The Great Children's Home Panic*, The Orwell Press 1998).

The Police and Criminal Evidence Act 1984 introduced the tape recording of statements given to the police by suspects. However, there is no statutory provision that statements from other parties, whether complainants or witnesses, be similarly recorded. Thus the defence lawyer can never be confident that a written statement is an accurate representation of a witness's evidence. Indeed, the great majority of Criminal Justice Act statements are written by the police rather than the witness and are often shaped by leading and improper questions posed by the investigating officers. In such circumstances it would in fact be highly unusual if a CJA statement were an accurate reflection of the evidence of a witness. It is therefore not surprising that Messrs Heaton-Armstrong and Wolchover in their chapter "Recording Witness Statements" advocate the audio taping of interviews with "key witnesses", whilst Shepherd and Milne go a step further in arguing that all interviews in a criminal investigation should be tape recorded.

The tape recording of the evidence given by witnesses is an extremely sensible proposal and one which, to their great credit, has been implemented in part by Northumbria Police. However, it should be noted that even if witness interviews were to be tape recorded this would not prevent the police or other investigating body from "rehearsing" the witness before going on tape and those lawyers presently involved in defending clients caught up in large scale retrospective abuse enquiries may feel that every contact an investigating officer has with a witness should be tape recorded so as to ensure the independence of the witness's evidence.

We are told in the preface of this book that there has been "considerable resistance amongst lawyers to the acceptance of wisdom from scientists as to the mental processes". This is undoubtedly true. But lawyers have another problem with their colleagues in the sciences and it is this: for every expert who is prepared to argue the case for the defence there is another who will be only too keen to present an equally compelling case for the prosecution. It is this which often makes lawyers despair. Only when expert witnesses owe their allegiance to the truth rather than to their pet theories or paymasters are lawyers likely to grant them the deference being sought on their behalf by the editors of this work.

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Everything you wanted to know about recovered memory litigation…

Is there any time limit for prosecuting sexual abuse allegations?

Not in English law. In the United States there are usually criminal limitation laws restricting prosecutions of distant events apart from certain crimes such as homicide. 'Recovered memory' became a way of getting around criminal and civil limitation laws in the US (because the complainant did not previously remember the abuse) until evidence from recovered memories was largely ruled inadmissible.

……alleged uncorroborated abuse happening thirty years ago or longer may be reported for the first time now and a criminal prosecution may follow.

In the UK there is no need to claim recovered memory since alleged uncorroborated abuse happening thirty years ago or longer may be reported for the first time now and a criminal prosecution may follow. Civil limitation laws in the UK are absolute for assault - six years after the assaults or age of majority (i.e. 24). This covers the majority of retrospective abuse claims. However, there may be an exception where abuse is linked to negligence since there is a discretion for a judge to extend time periods beyond the usual limit of three years in these instances. The Law Commission has proposed changes to civil

limitation periods in line with the US and Canadian laws that allowed for 'recovered memory' claims. Under the proposals claims would be permitted based on retrospective discovery of either the alleged abuse or its psychological effects, even if there is no contemporaneous record of the abuse. The Commission's final proposals (likely to be subject to legislation) have not yet been published but the Commission has been briefed by the Society on the danger of relying on uncorroborated historical claims in the light of the Brandon report and experience in jurisdictions elsewhere.

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Can a wrongly accused person be psychologically assessed to clear his name?

Psychological profiling may be used to test a person's propensity to behave in particular ways. A report, however favourable, would be of very little use in a 'recovered memory' criminal case because the prosecution will state that the type of crimes alleged are committed in secret by people of otherwise impeccable reputations who are nevertheless masters of deception even though this cannot be detected in any other trait. Where psychological profiling may be useful is in risk assessment. Probation or social services might require this where allegations have been made, in connection with childcare. Assumptions and methods of profiling vary and if an assessment is requested, particularly in connection with family law proceedings, either the need for the assessment may be challenged or the theoretical assumptions and qualifications of the assessor may be inquired into, and, if inadequate, a profile by a reputable professional in this area might be obtained. Risk assessment is a rapidly expanding field because of the increase in convictions for sex offences and public anxiety surrounding dangerous paedophiles and child killers. Because innocent people are often assumed to be guilty people 'in denial', risk assessment knowledge bases may be flawed, underlining the need for careful choice of assessor.

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Can a person be convicted of serious sexual allegations without any medical evidence or other corroboration?

Yes. In line with witch trials under James I 'where evidence is hard to come by, an allegation alone will suffice for a conviction'. Medical evidence rarely proves or disproves allegations either because the offences were supposed to have happened a long time ago, or because some experts will claim that virtually any findings are 'consistent' with serious allegations. This may include rape where the child/complainant is found to be a virgin.

The legal position concerning corroboration is often misunderstood. It has never been the case that sexual allegations could only be proved if corroboration (independent evidence) was available. However, following rulings in the 19th century the practice grew up of giving warnings to juries that it was dangerous to convict on uncorroborated evidence but the jury could do so. By early this century the warning became mandatory and quite elaborate.

Juries at this time were generally deferential so if the judge warned them against convicting they would normally acquit. Consequently the number of prosecutions, and consequently prosecutions, dwindled.

In the 1970's the corroboration warning began to be criticised as cumbersome and overly rigid while the failure to issue a proper direction became a regular source of appeal. The warning was felt to be impeding the conviction of the guilty, while providing an escape hatch for the rightly as well as the wrongly convicted.

Research in the 1970's suggested that juries found the warning confusing and sometimes reacted paradoxically: they thought that if they could convict despite it being dangerous, the judge must be giving them a special message to convict. So either way the warning was felt to be superfluous and an impediment to justice.

This unease was underlined when public attention became focussed on sexual crimes in the 1980's and the treatment of women and children as victims became a priority. The so-called 'corroboration requirement' was cited by campaigners as a bar to prosecution for sex crimes. In fact this was not generally the case as it was only the warning and not corroboration itself that was obligatory.

The situation was different with regard to children giving evidence. Before 1988 this did have to be corroborated. When this restriction was lifted, there was no requirement for a warning to be substituted, so that it became theoretically easier to convict on children's evidence than that of adults.

Consequently pressure mounted for the warning to be abolished for adults in sexual cases and this was duly enacted in the Criminal Justice and Public Order Act 1994 under the direction of the then Home Secretary, Michael Howard who said it was 'demeaning' to victims (by which he meant complainants). There was not a murmur of protest from the then Labour

opposition (who in fact supported the amendment) and the civil liberties lobby who campaigned vigorously against other measures in the Act.

Before the mandatory warning was abolished, a new type of sexual offence trial began to be prosecuted. These were retrospective complaints of serious child sexual abuse made by adults, often daughters, and the first cases to go to trial appeared around the late 1980's. While many adult rape cases turned on consent, the issue in these retrospective trials was whether any sexual acts had occurred at all. A corroboration warning in these cases might have been seen as a necessary safeguard because the vagueness of the prosecution evidence, if not supported by independent evidence, would lay the grounds for miscarriage of justice. If ever it were dangerous to convict, it might be seen to be in these circumstances.

In fact the pendulum swung the other way. Once the mandatory corroboration warning was abolished there was an increase in these types of prosecutions based on progressively weaker evidence and more distant events. And although judges are allowed to give warnings on corroboration if they wish, there is no requirement to do so, and in practice, the force of the warning has withered away.

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Retractor's Legal Case Update

Dear Supporters,

It is difficult to summarise the events of the recent months in the legal action of L.C. Firstly, thank you to all those who donated money to this matter. Your generosity was much appreciated.

The psychiatrist concerned has made strenuous and, for the large part, successful efforts to avoid location. To be effective a writ has to be served personally; hence the problems that can be caused by disappearing at the opportune moment.

Where it is simply not possible to locate someone and service has to take place, it is possible to apply for an order that service be substituted i.e. an alternative body or person is served and this is then deemed to be effective. There is always a right however for the person or body who then is served to apply to have the order set aside or dismissed.
Since we had to serve the writ an application had to be made for substituting service at the address of one of his professional bodies. They were unhappy and applied to set aside the order. Had they been successful it would have meant legal action against the psychiatrist would have been impossible because we would have been beyond the time limits for legal action.

In fact the judge considered that service had been appropriate at the time but could see the problems of the professional body. He therefore allowed for extra time for service so that we could continue to act without being out of time and to substitute service on a firm of solicitors who may or may not have had some contact with the psychiatrist concerned. The firm of solicitors has been served.

These are relatively routine applications which form the start of many legal actions. They are often attempts to stop legal action at the beginning and therefore prevent costs being incurred. It is distressing for the client because these are issues which to a large extent are irrelevant to the major parts of their case, but have the potential to stop their action.

In April of this year the court system changed and new rules were introduced aimed at making legal action quicker, cheaper and more efficient. It remains to be seen whether they do so. One of the new rules is that at each hearing the costs can be evaluated. If you lose an interim hearing you may have to pay the costs of the other side within 14 days. Previously the costs were nominally allocated to one party or another and then calculated at the end of the matter. Each party now provides details of their costs shortly before the hearing.

The cost of an application will vary but approximately £2,000 would be a reasonable estimate for a High Court matter. The professional body provided a breakdown of their costs totalling £6,600. It could not have been anticipated and would not have been covered by the insurance. Whilst we were confident that we would not have costs awarded against us, we were obliged to inform the client of the possibility. We were correct in our belief and no costs order was made against us.

It is perhaps with this in mind and the pressure which has developed that Ms C has had to think very carefully about litigation. We still have one major hearing to go through, following which the insurance would then cover subsequent dealings effectively. The hearing on limitation (legal time limits) will be expensive and no insurer will cover this type of matter. Additional funds would certainly be needed for this and relatively quickly. These funds would cover the cost of the other side if we were

unsuccessful. We cannot proceed without these additional funds since we could not place our client in a position where she would be potentially liable for costs which she simply could not afford.

Legal action is expensive even when what is essentially being paid for is the cost of insurance, medical experts and the possibility of paying the other side's costs. This is particularly so when a "new" issue is being reviewed such as false memory syndrome. The problem is now that few people are eligible for legal aid and in any event, it is certainly likely in the future that the legal aid board will be unwilling to fund actions of this kind because of the costs and uncertainty of success. Private funding would cost £30-40,000 with the potential to double if the costs of the other side need to be paid. Even on a "no win no fee" basis costs can be excessive.

If there is to be a successful case and this issue is to come before the courts, considerable funds will need to be raised. The interim hearings are an unavoidable part of litigation but their potential to incur costs is significant. The need for funds, not only for this case but to put forward cases in the future, is an issue which does need to be addressed sooner rather than later. If we are to take the issue of false memory forward we are going to have to look not just at support and campaigning but at raising money to progress these issues through the courts.

In the meantime, however, we hope for more funds and thank you for all the support provided.

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Police investigations create 'false memory'

New research findings indicate that exploratory methods of police and psychotherapy interrogation may both be effective in creating 'false memory'.

The researchers from the University of Arizona found that in both situations people may respond to a particular unifying 'gist' which leads to distortion and fabrication. C E Brainerd, who conducted the research, explained the parallel distortion effect as follows: in therapy, sessions revolve around powerful uniting theses (e.g. emotional or physical trauma), with the events of the patients' lives being explored in relation to those themes. In witness interviews, questioning also revolves around powerful uniting themes (e.g. crimes that are under investigation) with witness' statements focusing on things that bear directly on those themes.

'Based upon our results,' says Brainerd, 'it no longer seems remarkable that false reports could be common to these situations with procedures that emphasise memory for substance. When strong gists are operative, things that were not experienced can seem more memorable than actual experience.'

He continued: 'Our findings help with two important problems in psychotherapy and police interrogation: diagnosis of memory and training of interviewers.'

Source: *Psychological Science* American Psychological Society, November 1998

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False root of Canadian inquisition

The astonishing growth of massive retrospective inquiries into serious sexual abuse in children's homes (see *Analysing Witness Statements* Book Review and *Terror in the Courtroom* News Forum in this issue) has parallels in Australia, Canada and Ireland.

In Canada, the case that set the ball rolling was the Mount Cashel orphanage in Newfoundland run by the Christian Brothers. The original complainant appeared on the Oprah Winfrey show making sensational and detailed claims of widespread serious physical and sexual abuse by the Brothers at the home.

Later however, many of the Mount Cashel instigator's claims were exposed as 'complete fabrications' and 'lies' and it is a little known fact that the Canadian Supreme Court overturned the conviction of sexual abuse against a former Brother, Joseph Burke. (*R v Burke* (1996) SCC). The Court further held that accounts of physical abuse were 'gross exaggerations' while maintaining the conviction of actual bodily harm based on excessive force in discipline.

Significantly the Court held that evidence of indirect collusion between the complainants creating a semblance of 'corroboration' rendered the sexual offence conviction unsafe and overruled the Newfoundland appellate court. The Supreme Court found that no reasonable jury could have convicted if properly directed. Although there has been extensive

media coverage in Canada for the Pandora's box of lurid claims which have exploded since Mount Cashel, this strong and unusual ruling based on a review of the evidence which indicated that the trigger case was a clear miscarriage of justice, has escaped scrutiny.

With the horse bolting before the Supreme Court could shut the stable door, Mt Cashel became mythologised through escalating claims and repetition. Credulous references in an Australian book, *Orphans of the Empire* by Alan Gill, stirred the pot of the claimsmakers in Australia. Both countries were influenced by the efforts of the Nottingham-based Child Migrant Trust in the late 80's which turned attempts to unite families separated by the policies of voluntary child care organisations into an investigation into alleged horrendous abuse by the Christian Brothers. These investigations spread over three continents.

The Christian Brothers, once a byword for firm discipline (including corporal punishment) allied with uncompromising intellectual integrity as educators, have since fallen into disarray and dissolution, with the Irish Christian Brothers going bankrupt.

Meanwhile the number of lawsuits filed against children's homes in Canada has reached 2000, with critics sensing a compensation gravy train inflated by false accusations.

Susan Martinuk, a Vancouver writer notes wryly:
"As one lawyer for the Mt Cashel victims stated: 'No amount of money will compensate these men for what has been done to them.' So why should the state and societal institutions go bankrupt in attempting to do so? Compensation is legitimate when abuse is legally proven, but is often paid before claims are subjected to the high standards of proof required by the courts.

"Many alleged victims of Canada's residential schools stated their cases before a royal commission. They were not cross-examined, there was no corroboration of testimony and no opportunity for churches or government to defend themselves. The most horrific accounts were exaggerated by the media. Yet, large amounts of money have exchanged hands based on this unchallenged testimony.

"…We have a moral obligation to right what is wrong, apologize when necessary, and pay compensation when appropriate. But large monetary payoffs have rendered sincere apologies and positive efforts worthless." (*National Post* 18/2/99)

[See also the *Australian False Memory Association Bulletin* Vol 6 Issue 2 July 1999 email: AFMA@bigpond.com.au]

Court of Appeal in the dark

Since the publication of the Brandon report, most clear cases of 'recovered memory' have been found to be inadmissible in English criminal courts on the submission of expert evidence. But doubts remain, and at least one recent Court of Appeal finding in a complex case (*R v M and others*, July 20 1999, unreported) appeared to sanction 'recovered memory' by default.

It is notable therefore that in an Australian State Supreme Court ruling, (*R v Eishauer* (1997) Supreme Court of New South Wales), it was held that where the alternative was between a 'true recovered memory and an honestly experienced, false memory', either might be true, but that such a situation entailed 'a reasonable doubt' and thus an unsafe conviction.

This finding echoes the *Hungerford* ruling on recovered memory expert evidence in the United States, where it was stated that divided professional opinion precluded reliance on recovered memory. Since both of these rulings, the weight of scientific evidence has swung in the direction of the unreliability of recovered memory, so it is disturbing to see the Court of Appeal in England and Wales still apparently in the dark.

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Belief, Myth and Folklore

Extract from *Medicine, Science and the Law* (1999) Vol. 39 No. 2, Dr Janet Boakes

The defining element in 'false memory syndrome', is a belief system.

First, is the belief that almost all sexual abuse has inevitable long-term psychological sequelae and that sexual abuse can reasonably be inferred from current symptoms, even when the patient has no recollection that abuse has taken place.

Second, is the belief that the mind can 'block out' repeated episodes of violent abuse (and the more severe or life threatening the event, the greater the likelihood it will be blocked out) and that these blocked memories can be recovered substantially accurately, often after the passage of decades.

Third, is the belief that the patient must recover full details of past abuse and 'work it through' in order to

integrate the past into present experience and so bring about closure. Only in this way can the patient be freed from the pathologising effects of the past, lose symptoms and move forward. In the service of such memory recovery some practitioners use a range of techniques, including hypnosis, age regression, dream analysis, guided imagery, various forms of creative writing, 'bodywork' (the interpretation of physical symptoms as memories) and drug-assisted abreaction.

These beliefs are widely accepted - indeed, one might almost say that 'everyone knows' them to be true. The cultural context thus serves as a reinforcer of belief, although the evidence in support is scanty at best. High profile sex cases, including the Clinton affair, recent enquiries into child abuse in care and evidence of international pornography, all heighten the contemporary sexualised atmosphere. In the recent past, allegations of multiple victim, multiple perpetrator rings, such as those at Cleveland and Rochdale, were portrayed in some quarters as a failure of the services to bring the guilty to justice. In our present cultural climate there are powerful social pressures that make it hard to take a measured view of events when faced with the possible sexual abuse of children, whether current or many years previously.

Dr Janet Boakes, St George's Hospital Medical School and Springfield Hospital

The Crop Circle Phenomenon

The parallel universes of 'recovered memory' and other forms of *fin de siècle* make believe are no more telling than in the supernatural beliefs attaching to crop circles – now demonstrably proven to be a hoax. On hearing that billionaire Laurance Rockefeller has donated an undisclosed sum of money – believed to be several thousand pounds – to UK crop circle researchers, artist and circle maker, Rod Dickenson, responded: "Along with the other participants of the crop circle phenomenon, Mr Rockefeller will find only what he expects to find. The phenomenon is regulated by the desire and belief of each individual recipient. This nebulous work of art continues to penetrate and extend its hold, like a form of mind virus that feeds on the visions, dreams and perceptions of others."

Source: *Fortean Times*, August 1999.

LETTERS

Letter from Professor John Morton OBE

Dear Editor

You state on p.2 of the BFMS Newsletter [Vol. Six No 1 December 1998] that a number of former members of the British Psychological Society Working Party on Recovered Memories can be associated with the claim that testimony based on recovered memories can be relied upon in court without "external objective corroboration". This is certainly not what we said in the report, is not what I believe, and it is not what any of the former members of the Working Party believe. In the same paragraph, there is also the implication that some of us have appeared as expert witness (*sic*) for the prosecution in "recovered memory" trials and have presented such claims to the court. My former colleagues and I wish it to be known that such is not the case and that you have been misled.

In the interests of ensuring that your members are properly informed, I would be grateful if you would publish this letter in the next newsletter. Misunderstandings of this kind do not help to promote a proper discussion.

John Morton

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Editor's reply,

We wish to thank Professor Morton for making this clear and we trust that, in order to prevent any misunderstanding in the legal context, he will include in his reports to the Courts a suitable statement to the effect that recovered memories cannot be relied upon without external objective corroboration.

We also understand from accused parents that he continues to quote researchers Lindsay & Read selectively by reporting to the Courts that they wrote,

> "There is little reason to fear that a few suggestive questions will lead psychotherapy clients to conjure up vivid and compelling illusory memories of childhood abuse".

Without quoting the authors' next sentence,

> "However, as described below, the techniques some authorities advocate for recovering repressed memories of childhood sexual abuse are vastly more powerful than the laboratory

procedures, and there is good reason to be concerned about the possibility that they sometimes lead to the creation of illusory memories". *Applied Cognitive Psychology* Vol. 8 No. 4 August 1994.

In the interests of justice, we hope he will include this vital sentence in future reports.

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Letter from Dr Jeremy Holmes
Chairman: Psychotherapy Executive
Royal College of Psychiatrists

Dear Editor

As Chair of the Psychotherapy Faculty of the Royal College of Psychiatrists, I am writing in response to the introduction to Volume Six No. 1 of your Newsletter, December 1998, which contained some serious inaccuracies.

You describe (a) the Royal College of Psychiatrists' Working Party on the subject of Recovered Memories, (b) the 'guidelines', which were published by the Royal College of Psychiatrists in October 1997, (c) the minority report prepared by Dr Whewell, and (d) the paper published in the British Journal of Psychiatry by other members of the Working Party in April 1998.

It is perhaps not surprising that, from the outside, the existence of these three documents – the report (unpublished), the minority report (also unpublished) and the guidelines might appear to reflect a 'split in the mental health profession'.

I think the first point to make is that Dr Whewell's minority report did not simply reflect a personal view, but was one that was strongly endorsed by the Psychotherapy Faculty Executive as a whole and its Chair at that time, Dr Sheilagh Davies. The published guidelines represented a consensus statement with a very practical bent, to which all parties within the College of Psychiatrists agreed. The published paper was a personal view of its authors and in no way represented official College policy.

The important point, however, is that what you call a 'split in the mental health profession' is not something to be deplored but reflects the established scientific facts: namely, that while false memories do undoubtedly occur, it is also the case that verified memories of real events can reach consciousness under a variety of circumstances, including stress, triggers reminiscent of the original trauma, and occasionally in the course of psychotherapy. The Psychotherapy Executive deplores vilification, attacks on individuals, and polarisation and stands for balanced, scientific approach to the whole question. I should add that there is no evidence that false memories have ever been implanted by therapists working in NHS Psychotherapy Units. It would be quite wrong to lump together a huge range of therapists and therapies which in fact differ enormously in orientation, experience, technique and modes of practice. Age regression and hypnosis, for example, play no part whatsoever in NHS psychotherapy.

As a specific instance of this blanket approach, you claim that Dr Whewell is a ' director of a unit which the BFMS knows actually still uses 'recovered memory therapy'. This is simply untrue. The Psychotherapy Unit is Newcastle is run along psychoanalytic psychotherapy lines and they do not use, nor ever have used, what are commonly described by false memory protagonists as recovered memory techniques – hypnosis, hypnotic age regression, drug abreaction, suggestion, etc. The position of all NHS Psychotherapy Units would be one of tolerance of uncertainty in which narratives of child sexual abuse are neither automatically believed nor disbelieved.

We welcome genuine open and scientific debate about this important issue. We deplore the pain which false accusations of abuse can cause to parents and families generally. At the same time we believe that it is vitally important that, where abuse has occurred, the sufferer should be heard, believed, and feel that those whose job it is to provide care for them, and society at large should take their injuries seriously. It is well known that clinical and sexual abuse are powerful predisposing factors to psychiatric illness. As psychiatrists with a brief both for treatment and prevention of mental illness, we, like yourselves, wish to keep this issue in the forefront of public debate. We must learn to listen to each other. My worry about your editorial was that it represented a kind of attack which leads to closure and hardening of positions rather than genuine dialogue.

Yours sincerely,

Dr Jeremy Holmes
Chairman: Psychotherapy Executive

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The previous editor replies,

Dear Dr Holmes,

Thank you for your letter outlining your concerns about our December 1998 newsletter. Although I am unclear to which "serious inaccuracies" you refer, I will try to deal with your points in turn.

Members of our Society are aware of the confusing conflicts within the Royal College of Psychiatrists concerning the publication of the "Brandon Report". These were reported in an earlier newsletter in December 1997 and I enclose a copy for your information. Although you say that the paper by Brandon et al. was a personal view, it was published in the College's academic journal after peer review. In contrast, Dr Whewell's minority report, as far as I am aware, has neither been subjected to peer review, nor has it been published. It is therefore alarming to learn that this minority report had such support within your Psychotherapy Faculty. For me, this demonstrates that 'the split in the mental health profession' is more profound than I had previously realised.

Even Dr Whewell's report characterises the controversy as "a battle between experts which has often seemed to devolve into argument between clinicians and experimental memory psychologists". Your letter indicates that it has devolved further into a battle between clinicians, so perhaps we ought to look at where the battle line has been drawn. But first we have to be quite clear what we are talking about.

Of course you are right that, as a result of certain triggers, verifiable memories of real events can be retrieved after decades of not remembering. We all do that, and when we do, we know that we have remembered before. We say, "I haven't thought of that for years". Or, "It needed that smell to remind me of my childhood". However, with 'recovered memories' it is not the same. They come as a complete surprise, a shock; more like a religious revelation. There is no feeling that they are old memories being re-remembered. In addition, from the wealth of our documented case histories, it is clear that these 'recovered' memories do not refer to minor incidents of abuse (no matter how distressing such incidents might be), they refer to a history of repeated episodes of the most severe sexual abuse perpetrated over a prolonged period.

The claims also contain the belief that the memories of this horrific abuse must have been subject to 'blocking out' or, as Judith Herman, an American psychiatrist, first called it, "massive repression". This in turn relies on the concept that the alleged victim's mind undertook a psychological process at the time to keep the memories of this prolonged abuse from awareness.

However, those who support this notion of the psychic deep-freeze have never explained whether each individual abusive act is repressed at the time it occurs or whether there is an awareness of the abuse between each episode until there is one massive repression at the end of it. Either scenario is difficult to envisage. The alternative explanation, 'dissociation', when used in the context of amnesia for the above, is equally flawed and subject to the same objections.

Surely, this is the divide. On one side are those clinicians who believe that it is possible to massively repress or dissociate memories of multiple childhood rapes and then recover them decades later. On the other side are those who do not believe in that notion and who can see no objective scientific support for it. At the BFMS we are criticised by clinicians, and others because we have brought this controversy to public notice. They accuse us of having polarised the debate: a criticism your letter seems to indicate that you share. Is it this divide to which they refer, and can there ever be any balance between the two? Either someone was abused in their childhood or they were not.

Without the input from false memory societies around the world, this mental health tragedy would still be in full flood. Don't shoot the messenger because you are afraid that, as Professor Fonagy and Mary Target say in their book, *Memories of Abuse,* "Just below the surface of the false memory debate, the profession of psychotherapy is fighting for its life".

We are not claiming that all therapists are planting false beliefs in their clients/patients, but your claim that no therapists working in NHS Psychotherapy Units would do such a thing is untenable. Whether it has been done unwittingly or not, we have compelling evidence that NHS psychiatrists have supported the notion of massive repression and are validating their patients' 'recovered memories' (as defined above). We would like you to talk to LH who was arrested, tried and acquitted after his daughter was given a drug

abreaction to enable her to recover the lost memories of abuse that her NHS psychiatrist thought she had been repressing. Or the NHS psychiatrist who knew his patient had been abused because she would not maintain eye contact with him. We can put you in touch with the family whose daughter saw an NHS consultant psychiatrist who believed that all eating disorders result from childhood sexual abuse. We can also introduce you to the consultant psychiatrist who, after attending a BFMS meeting, declared that all the parents present must be repressing the memory of their abusive acts, otherwise how else could they be suffering so much pain!

This is by no means a complete list of all the cases which bear witness to malpractice within the NHS.

Turning now to Dr Whewell's Psychotherapy Unit in Newcastle, we can arrange for you to interview LB, a mother who lost her career as a result of accusations of the most horrific abuse. Her daughter, who made the accusations, would also meet you and explain how her memories were 'recovered' in Dr Whewell's Unit where she was asked leading questions by the therapist and was only allowed to nod or shake her head in reply. You will be shocked when you realise what material surfaced during these 'guided interviews'. This 'therapy' was reinforced by placing the vulnerable young woman in a group of sexual abuse survivors for 'group therapy'. The Unit reported the accusations to Social Services and, although LB's daughter tried to withdraw them, she was not allowed to and subsequent disciplinary action caused her mother to lose her job. The seismic split within the family took five years to resolve.

Returning to your belief that certain fringe therapies "play no part whatsoever in NHS Psychotherapy", at a conference in Southampton in September 1998, Dr Whewell delivered a lecture on recovered memories in which he supported the use of techniques such as hypnosis, hypnotic age regression, truth drugs, journalling, guided imagery and guided meditation with the proviso that, "[T]he practitioner should be prepared to justify the use of the technique, obtain informed consent, and keep litigation-standard notes". Additionally, he recommended the book *The Courage To Heal* as "a useful compilation of self-help tips". In the opinion of our advisors, this is definitely not a suitable book for figures of authority to be giving to vulnerable young adults who have no memories of abuse. Dr Whewell is not alone because your own College's survey showed that one in 10 psychiatrists recommended the book to their patients. In the same survey one in five psychiatrists said they had attempted to recover memories of forgotten sexual abuse and one in six used checklists to 'diagnose' past sexual abuse. With facts like these, you must forgive us if a hint of alarm creeps into our argument.

In our last letter we invited you to come to our AGM. Unfortunately, by not coming you missed an opportunity to hear some excellent speakers from North America, and the chance to talk to families who claim they have been falsely accused of sexual abuse – where the vast majority of such accusations have arisen in the course of therapy.

Much as you "welcome genuine open and scientific debate", apart from the 'Brandon Report', of which you seem to disapprove, what other evidence is there of the College's willingness to address these issues? Dr Kendell, the then President of the Royal College of Psychiatrists, wrote in May 1999, "The issue of …. 'third party corroboration' of information revealed *or claims made in the course of psychotherapy is not currently an issue of concern to this College*" (my italics). Your letter however, does seem to concede that there is a problem. Do you agree that the College should show leadership in trying to address the issue?

As Chairman of the Psychotherapy Executive you are in the unique position of being able to research the current situation and report back to your colleagues on the Executive. To that end, may we invite you to visit our offices here so that we can show you the extent of the problem and make suggestions for future courses of action?

False accusations cause irreparable harm both to the accuser and to the falsely accused. There is no evidence that 'recovered memory' therapy is helpful as a diagnostic instrument or as a mode of treatment and, indeed, it may do a great deal of harm. The danger, endemic in the 'recovered memory' approach, is that by failing to distinguish true from false accounts of abuse, genuine victims will slip through the net.

We look forward to your reply.

Yours sincerely,

Roger Scotford
(Former Editor of the BFMS Newsletter)

Overseas False Memory Societies

Please feel free to write or phone if you have relatives in these countries who would like to receive local information. The American, Australian and New Zealand groups all produce newsletters.

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