The Newsletter of the British False Memory Society
Vol. 16, No. 1 – March 2008

Serving People and Professionals
in Contested Allegations of Abuse

Dear Reader

The year seems to have started off at a hectic pace. Leading up to Christmas we experienced a hopeful period with very few new cases, only to find that our optimism has been put on hold with a flurry of cases since the New Year.

One family faced a daunting trial as soon as the courts re-opened after the holiday period. This was their second experience of a criminal trial. The first trial resulted in a hung jury. This time around there was to be enormous relief when after three weeks in the courtroom the jury delivered their conclusion that the man was not guilty on all charges. The man's wife has written a moving account of their ordeal. See page 16. These 'ups and downs' as we call them are occurring around us all the time but there is never time to dwell nor to allow the grass to grow under our feet, after all, the most successful outcomes are achieved by hard work and the only way to deal with the challenges that keep confronting us is to respond with whatever we can. There is no doubt that the best chance of success for anyone facing a criminal trial is to devote themselves to preparing their case with whatever information they can muster. False memory type cases are still unusual to many solicitors and barristers and consequently the accused cannot simply retreat into his/her misery leaving the hard work to the legal team and expect to be reprieved.

On top of this disadvantage for anyone charged with offences likely to have arisen through false memory is the Government's recent pronouncement that it is determined to raise the conviction rate for the crime of rape. On the surface, a commendable aim unless, that is, you have been falsely accused. As part of that announcement came the plan to issue 'myth-busting' packs for juries although this has yet to be sanctioned as they could prove prejudicial to the trial. Will the myths surrounding 'repression for traumatic events' be included? What of the myth that the conviction rate for rape is horrifying low at 5.7 per cent when, in fact, that figure does not represent the figure for convictions at trial which is about 44 per cent, but is the rate for convictions secured out of the total number of allegations made. It is a sign of further injustice if an attempt to dispel myths about rape is fuelled by the propagation of yet more myths.

The news doesn't stop here. The recent ruling by the Law Lords in the case of convicted rapist Iorworth Hoare and Mrs A's pursuit of compensation for herself and others caught by the constraints of the Limitation Act, means that now it will be possible for an accuser to sue the accused for compensation even though their case would previously have been 'out of time'. It is important to understand this change in the law – see page 21 – for a clear and concise interpretation of what it will mean.

If this is the climate in which we live and work what can we do to help prevent further injustice to families? This is a plea for your continued help and support – the more hands

Table of Contents

Editorial 1
News 2
Articles 4
Members' Forum 16
Letters 18
Obituaries 19
Legal Forum 21

on deck, be it for letter writing, distributing information to policy makers, or being brave enough to speak out publicly, we can make an impact. One young woman is going to do just that when she exposes what she has seen within the adolescent mental health services that actively fosters an environment of self-harm and false allegations. Her first public speaking engagement will be at our AGM on 29th March (details page 23). Be sure not to miss it.

Madeline Greenhalgh

***

NEWS

Ten Thousand Therapists Needed

In October 2007 the Government made an historic decision to transform the lives of millions of people by making psychological therapy available to anyone suffering from depression or anxiety disorders. Previously this has not been possible due to a shortage of therapists. Statistics show that six million people suffer from diagnosable depression or crippling anxiety disorders. While 90 per cent of physical illnesses are treated only a quarter of people with depression get any treatment. People prefer therapy to drugs but there are not enough qualified therapists to help.

The National Institute for Clinical Excellent (NICE) guidelines recommend Cognitive Behavioural Therapy (CBT) which trains a person how to challenge negative thoughts and to develop positive thinking. Hundreds of trials show that after fewer than 16 sessions, more than half the people will have recovered. CBT is not the only therapy that works. NICE also recommends other therapies for particular problems and they will recommend more as the evidence accumulates.

The Government has been advised by Lord Layard's London School of Economics' Depression Report in which numerous references are made to the fact that therapy, if badly done, can do harm. There is mention of ensuring a high quality therapy service provided by properly qualified people. Certainly forward looking therapies are much safer than any that dwell on the past. The umbrella organisations for therapy, such as the United Kingdom Council for Psychotherapy and the British Association for Counselling and Psychotherapy, are fully aware of the dangers of using regression therapy which can lead to 'recovered memories'. We know that detail brought up during regression therapy will consist of a mixture of fact and fantasy, some memories will be true and some false.

Lord Layard estimates the financial cost to us all from loss of output due to depression and chronic anxiety at some £12 billion a year. Creating a service with 10,000 new therapists over the next seven years will deliver a service costing a mere £0.6 billion a year. The Government may have the mental health welfare of its public at heart but it is undoubtedly driven by the economics of the situation. It is vital that the Government honour their commitment to ensure a quality service. The cost otherwise, to damaged families caused by bad therapy is not measured in £billions because the quality of family life has been undervalued by successive governments but it is immeasurable. The public need to know that the future offers people who need it, a safe and tested therapy service that will not lead to more destruction of lives.

***

Justice for Katrina?

It was over ten years ago when Katrina Fairlie began her fight for justice after recovered memory therapy wreaked havoc in her life. In 1994, whilst undergoing the discredited psychiatric therapy at the Murray Royal Hospital, Katrina claimed she had been sexually abused by her father Jim Fairlie and 17 other men (including two MPs) in a brutal paedophile ring.

A subsequent investigation by Tayside Police proved her allegations completely unfounded

but Katrina and her family have had to live with the painful legacy.

In October 2007, just hours before her case, scheduled for a four week hearing, was due to start, Katrina, acting on legal advice, reluctantly accepted a £20,000 compensation pay-out from NHS Tayside. The payout came with no admission of liability and Tayside Health Board has maintained that the financial settlement was made "purely on economic grounds." Not surprisingly, Katrina is angry and frustrated at being denied her long-awaited day in court.

Katrina is now catching up on the life events she has missed.

A resolution of sorts, but justice?

***

Parental Alienation Syndrome

We are grateful to a contact in Spain for sending this cutting from the Costa del Sol News 21-28th February 2008. The judge appears to have taken a very much stronger view than happens in similar cases heard in the English courts where parental alienation syndrome is likely to be frowned upon.

A Torremolinos court has ordered a mother to hand custody of her 14 year old son to his father. The father claimed that the mother had turned the boy against him following their separation in 2003, when the boy was nine years old.

The judge found that the mother had essentially brainwashed her son into disliking and refusing to see his father, a phenomenon known as parental alienation syndrome (PAS) that arises primarily in custody disputes. PAS is understood to be the combination of such parental indoctrination and the child's own contributions to the vilification of the targeted parent, according to forensic psychiatrist, Dr Richard A. Gardner, who identified the syndrome in the 1980s.

According to the judge in the Torremolinos case, "experts agree that a court-ordered change of custody is the only solution for the syndrome." In his ruling, he urged the father to get the son psychiatric help, "even, if necessary, putting him in a treatment centre for a process similar to that used to deprogramme a member of a cult."

***

Conduct Committee Progress

The British Psychological Society's (BPS) disciplinary notice in the December 2007 edition of their journal, *The Psychologist*, raised our interest and approval.

After many unsuccessful attempts over the years by accused parents to gain recognition from the BPS of their complaints about the unsafe practice of a few psychologists, finally, in October 2007 one of the BPS's Graduate Members was disciplined for breaching the Society's Code of Conduct regarding the use of hypnosis. For failing to inform her client of the advantages and disadvantages of hypnosis, recommend alternative methods of therapy and advise her client that no technique can reliably recover memories, Mrs Janet Sinclair, was found in breach of Clauses 1 and 5.1 of the Code of Conduct. In addition, she was in breach of Sections 9 and 14 of the *Guidelines for Psychologists Working with Clients in Contexts in Which Issues Related to Recovered Memories May Arise* for failing to avoid being drawn into searching for memories of abuse and failing to avoid engaging in activities and techniques that are intended to reveal indications of past sexual abuse of which the client had no memory.

Mrs Sinclair was severely reprimanded with a condition on her membership that in any future consultations involving hypnosis with a client she must take full notes and present them to her supervisor whilst also presenting her signed supervision notes to the Society on a quarterly basis.

***

DSM: A DODGY DOSSIER?

by Maurice L. McCullough

The central assumption underlying recovered memory therapy is that long-lasting, reversible amnesia for trauma and/or trauma-related experiences is common. What is generally offered as the best evidence in support of this comes from research that has looked into the psychological consequences of (usually) sustained military action. The present article begins by examining a number of the most frequently cited studies. It finds them inadequate as demonstrations of reversible amnesia: Cases of 'failure to recall' seem better understood in terms of an original failure to encode than in terms of a failure to retrieve a previously encoded memory. The article then goes on to show how the 'reversible amnesia' assumption has found clear expression in successive editions of the Diagnostic and Statistical Manual of Mental Disorders [DSM] – primarily as a diagnostic symptom of Posttraumatic Stress Disorder [PTSD]. What is not to be found, however, is even an acknowledgement that a 'failure to recall' might often be due to inadequate encoding and would therefore be irreversible in such cases. It is suggested that this has been a serious oversight because readers will have inferred that reversible amnesia is a much commoner response to trauma than it is, and therapists will have been more willing than they should have been to undertake memory recovery work in the hope of identifying a history of trauma in clients who had no memory or knowledge of such a history.

Posttraumatic Stress Disorder [PTSD] as defined by successive editions of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* [DSM] and the theory underlying recovered memory therapy [RMT] appears to share a number of assumptions: 1) Trauma is a serious pathogen; 2) reversible amnesia for a trauma or significant aspects of it is not uncommon; 3) this 'reversible amnesia' assumption finds probably its strongest support in studies of traumatised military personnel.

Here is an example of assumption 3 in John Briere's influential book *Child Abuse Trauma: Theory and Treatment of the Lasting Effects*, published in 1992, a time when RMT appeared to many observers to be running out of control:

"Support for the relationship between nonsexual traumas and repression may be found in the dissociative defences of adult soldiers in wartime, who have been shown to experience a significant amount of combat –specific amnesia (Archibald & Tuddenham, 1965; Grinker & Spiegal, 1945; Kolb, 1984), often after especially stressful or violent events (Henderson & Moore, 1944; Sargant & Slater, 1941." [Briere, 1992, p. 40]

Briere's particular selection of 'war studies' is by no means peculiar to him, as the self-same studies have been pressed into service by many others in the same way and for the same purpose. (For more on this see McCullough, 1998, pp. 218-220, and McNally, 2003 pp. 215-219). In short he was expressing the received view. Nevertheless, it is hard to see how anyone who took the trouble to *read* the original accounts could share it. Indeed, two of the studies, far from reporting *anything* about failure to recall traumatic events, reported precisely the opposite: Archibald & Tuddenham (1965) opined that "while the man in the street, and some psychiatrists are inclined to urge such patients [chronically stressed by combat] to "forget it", these particular veterans cannot blot out their painful memories." (p. 480); Kolb (1984) noted that "To account for later symptoms…the assumption may be made that the sufferer is plagued night and day by arousal of memories, through persistence of his conditioned emotional response, which reinforce the memory traces of the combat experience" (p 241). While

soldiers plagued by traumatic memories could be described as having a memory problem, logic is turned on its head when they are recruited as evidence of amnesia for traumatic experiences.

Grinker & Spiegal's (1945) study essentially comprised a series of case studies with few clear instances of recovered memories and no instance of a corroborated one – their most striking case of amnesia [pps. 404 – 405] strikingly fits an 'incomplete encoding' hypothesis.

'Amnesia', receiving only three brief mentions, was far from Henderson & Moore's (1944) primary interest and it is hardly surprising that their report raises questions without providing answers. Seemingly, the type of experience that precipitated hospital admission in 85% of those who had seen combat was being "suddenly upset by exploding bombs or heavy shelling near them…" Of these, 50% had been rendered unconscious and 20% dazed. Many had amnesia after recovering consciousness. Without explanation, the separate non-overlapping category "amnesia for the event 5%" was included. Presumably these were patients thought not to have been concussed. For several reasons this cannot be taken as evidence of functional (reversible) amnesia, however. First, as Henderson and Moore conceded, "it was difficult to determine the reactions accurately [and, no doubt, the events that caused them] from the records available and from the patients' accounts", and it may be that some concussed patients persuaded the researchers that they had not been. Second, these 5% could have been amongst the large (but unspecified) number of patients whose amnesia did not persist beyond admission. Third, hypnosis featured in the treatment.

Sargant and Slater (1941), the last of the five studies cited by Briere, comes closest to a systematic investigation of recall failure following combat stress and of subsequent memory recovery. Indeed, it is almost certainly the 'war study' most frequently cited in support of the claim that severe stress can result in reversible memory loss; the authors of The British Psychological Society's Recovered Memories Report (1995) evidently regarded it as pre-eminent as it was the only one they referred to (p.13). (To be precise, the authors of the report used as their source a summary of the original study contained in Sargant's (1967) much later autobiography.) In fact, this study clearly exemplifies two serious questions that hang over this whole area of enquiry. One is whether instances of failure to recall (aspects of) traumatic experiences reflect problems with retrieving an existing memory rather than problems with encoding the memory in the first place. The other is the overlapping question of whether what is subsequently 'recalled' is a genuine memory rather than a false one.

> "Sargant and Slaters' study fails as evidence of reversible amnesia"

Sargant and Slater reported that memory loss - "states of fugue and [the more frequent, and the more relevant to the recovered memories issue] retrospective losses of memories of a functional type" - was present in 144 of the first 1000 military cases admitted to the Neurological Unit of Sutton Emergency Hospital. Amnesia was most conspicuous in their 'severe stress' group - present in 35% of the 251 cases. The report does not *specify* how many of the patients recovered memories but it nevertheless creates the impression that most, if not all, had.

Unfortunately, Sargant and Slaters' study fails as evidence of reversible amnesia because it falls far short of providing an affirmative answer to either the two questions outlined at the end of the last but one paragraph. Taking the first question first. This was how 'severe stress' was defined: ""Severe stress" means prolonged marching and fighting under heavy enemy action (e.g. in the evacuation from Dunkirk through which the great majority of these cases passed)" (p. 757). Even if the soldiers had been in good physical and psychological shape, it

seems unlikely that they all would have been encoding complete coherent narrative memories in such circumstances – circumstances where many of them may well have been devoting almost all their information processing resources over prolonged periods to dealing with the immediate threats to their life and limbs. But many of the soldiers were probably not in good shape. Certainly they were not when they were admitted to hospital. Here is a description of the presenting symptoms of a large subgroup of the severe stress group: "…very acute neurotic disturbance combined with a state of exhaustion resembling physical illness. This was particularly true of the earliest patients admitted after the Dunkirk evacuation. Many looked pale or drawn; others wore a blank or confused expression… Physical exhaustion, as shown by a weight far below normal for the individual in question, was often present." A description of the dreadful condition of a patient deemed to have retrospective amnesia can be found on p. 761. Also relevant here is that, despite an earlier assurance that cases "transient loss of consciousness after head injury are not included", Sargant and Slater reported that more than a quarter of the severe and moderate stress groups combined "…date[d] their amnesic disturbance from concussion or from being blown over and dazed by a bomb" (p. 758).

What about the related question of whether the 'memories' that emerged were genuine rather than fabricated? Referring to the severely stressed group Sargant and Slater wrote: "The history that the patient gave was often confused, hazy and full of amnesic gaps; on other occasions it was fairly coherent and the suppressions of memory were only found by investigations with hypnosis or barbiturate narcosis" (pp. 760-761). In a section on treatment they noted "…we have found …that the administration of an intravenous barbiturate is of particular value… Under the drug it is easier to establish a semi-hypnotic contact… The information gained will often be a mixture of truth and fantasy, and will have to be sifted." (p. 763). Presumably, all they did was filter out fantasies that sounded implausible. There is no longer much doubt that the procedures they used [hypnosis and barbiturate narcosis] are liable to elicit false memories (most of which are presumably likely to sound quite plausible).

On balance, then, incomplete encoding seems a likelier cause of the 'amnesic gaps' than some form of functional retrospective amnesia.

On balance, then, incomplete encoding seems a likelier cause of the 'amnesic gaps' than some form of functional retrospective amnesia[1]. The same could probably be said of many, if not all, 'war studies', and perhaps of studies of torture, also[2].

This general conclusion that many supposed instances of reversible amnesia for trauma-related experiences may be nothing of the kind but instead reflect an incomplete encoding or storage from which a complete genuine memory cannot be recovered is pivotal to the following consideration of the role that the Diagnostic & Statistical Manual of Mental Disorders may have played in the recovered memories controversy. If any readers are concerned that the evidence offered up to this point is too slight or selective, they might be reassured by consulting Chapter 7 of McNally's (2003) book where they will find an extensive review of the relevant literature and a similar conclusion drawn.

So how did the 1987 version of the Diagnostic and Statistical Manual of Mental Disorders [DSM-III-R] deal with amnesia in the context of posttraumatic stress disorder? A PTSD diagnosis required each of five criteria to be met. One was to do with the type of trauma that could be pathogenic. One was that the symptoms should last at least a month. The remaining three involved types of symptom. Their criterion C is the one relevant to current concerns. The following is an extract from the formal specification of the diagnostic criteria:

"C. Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following [seven]:

"…(3) inability to recall an important aspect of the trauma (psychogenic amnesia)..." [p. 250]

Something similar had been included in background text:

"In addition to the reexperiencing of the trauma, there is persistent avoidance of stimuli associated with it, or a numbing of general responsiveness that was not present before the trauma. The person commonly makes deliberate efforts to avoid thoughts or feelings about the traumatic event and about activities or situations that arouse recollections of it. The avoidance of reminders of the trauma may include psychogenic amnesia[3] for an important aspect of the traumatic event." [p. 248]

The context in which 'inability to recall' was introduced as a diagnostic criterion clearly implies that it was being construed as a reversible phenomenon. There was no acknowledgement anywhere of the possibility that, in some circumstances, it would be a consequence of inadequate encoding or storage and would, therefore, be irreversible. This may have been a serious oversight because recognising such a possibility would presumably have acted as a caution against what became, in the view of many, the over-enthusiastic use of recovered memory therapy. It is also worthy of note that DSM-III-R reports that psychogenic amnesia "…is rarely diagnosed under normal circumstances; it is more common in wartime and during natural disasters." and that "Military sources provide many clinical reports describing the disorder in young males during war. (p. 274). It would seem a reasonable presumption that the sources referred to – they were not referenced - were of the kind reviewed here earlier where the inability to remember often seemed more plausibly explained by mechanisms, principally, 'incomplete encoding', that were incompatible with the kind of reversible amnesia posited to underlie the phenomenon of recovered memories.

So, around, say 1992, what impact might DSM-III-R have had on therapists treating clients presenting with some of the following symptoms, all of which feature amongst the DSM-III-R PTSD diagnostic criteria (p. 250): Difficulty concentrating; difficulty falling or staying asleep; irritability; feeling of detachment or estrangement from others; restricted range of affect, e.g., unable to have loving feelings; diminished interest in significant activities; pessimism about long-term future? A therapist, after having established that there was nothing in the client's current life circumstances that might have accounted for the symptoms, would presumably have moved on to exploring the client's life history; particularly for female clients, this would have included their sexual history. If little or nothing emerged the therapist would have had either to abandon the trauma theory framework, or to proceed to memory recovery work on the assumption that there may have been forgotten trauma in the client's history. DSM-III-R provided a convenient justification for that assumption by indicating that "inability to recall an important aspect of the trauma" was a PTSD symptom. That it referred an important *aspect* of the trauma (rather than of the event itself) would not have been too troubling a qualification. A therapist at ease with 'dissociative' explanations could easily have surmised that the narrative and the emotional aspects of the memory had split one from the other and it was the former aspect that was beyond recall. A therapist at ease with Freudian notions would have had even less difficulty: The narrative aspects were trapped in the unconscious while at the same time the memory was expressing itself in the form of the troubling symptoms.

By the early 1990s there had been several other developments which had promoted the assumption that adults, especially women, presenting with symptoms consistent with child sexual abuse [CSA] victimisation very likely *had* been victims even if they had no memory of such victimisation. One was Masson's (1984) remarkably successful rehabilitation[4] of Freud's se-

duction theory that held that the only cause of hysteria – then [1896] a category that included a wide range of conditions – was unconscious memories of CSA in infancy. Another was the glut of survivor manuals (e.g., Bass & Davis, 1988; Blume, 1990) whose authors were promoting the idea that not only was CSA very common, and very commonly pathogenic, but so too was the failure to remember it.

Of course, when DSM-III-R (1987) was being prepared the recovered memory controversy was still in the making and its authors could not have anticipated how it might have promoted over-zealous recovered memory therapy. However, this was not the case for the 1994 revision (DSM-IV). So was that version more cautious in dealing with the nature of the 'inability to recall' symptom in PTSD? Probably not. A small cautionary paragraph about the danger of suggestion and the possibility of inaccurate recall *was* included. However, it was not in the PTSD section. It was the sixth of seven paragraphs in the sixth sub-section, headed 'Differential Diagnosis', of the Dissociative Amnesia section (p 480-1). Given the obscurity of the location, together with the absence of any mention of dissociative amnesia in the PTSD section, it is quite likely that the caution escaped the attention of a significant number of readers. On the other hand, there was one revision [an addition] in particular that very probably further encouraged therapists to trawl for memories of CSA.: In the course of describing the sorts of traumatic event that can lead to PTSD, it was noted that "For children, sexually traumatic events may include developmentally inappropriate sexual experiences without threatened or actual violence or injury." (p. 424). While there is little consensus about the extent to which CSA is pathogenic, this nevertheless appears somewhat alarmist, and invites the inference that there must be a very large number of adults, sexually abused as children, who are suffering reversible memory loss in relation to that abuse and who might profit from recovered memory therapy. Presumably, there were many therapists, especially amongst those already primed by their exposure to other influences such as the survivor manuals and Freud's rehabilitated 'seduction theory' mentioned above, who accepted the invitation and acted on it.

A small cautionary paragraph about the danger of suggestion and the possibility of inaccurate recall was included.

There were two other changes from DSM-III-R to DSM-IV that presumably would also have emboldened recovered memory therapists. These occurred in the Dissociative Amnesia section. The second sentence of the first sub-section [Diagnostic Features] began: "This disorder involves a *reversible* memory impairment…" [Italics added.] (p.478). What was new was making it explicit that the memory impairment is reversible[5]. In itself this may not have been particularly important because reversibility was clearly implied in the previous version. Nevertheless, it reflected a zeitgeist that was unreceptive to the idea that an inability to recall (aspects of) traumatic events might be irreversible. The other change was that for the first time it was stated that "In **Posttraumatic Stress Disorder**… there can be amnesia for the traumatic *event*." [Italics added] (p. 480; this was located two paragraphs before the cautionary paragraph about recovered memories). Now, seemingly, DSM had given the therapist permission to trawl for memories of trauma where there was no memory of any aspect of the trauma.
As regards its coverage of PTSD and Dissociative Amnesia, DSM-IV-TR (2000), the latest edition, has incorporated no significant changes.

To sum up and conclude: It has been argued that DSM has encouraged incautious approach recovered memory therapy by over-estimating the frequency with which traumatic experiences are associated with reversible amnesia. It has done this primarily by failing to acknowledge that an inability to recall trauma, or a significant aspect of it, can often be **ir**reversible for the simple reason that an adequate memory was not encoded in the first place. The next

edition of DSM should take pains to make good this oversight[6]. And, to underline the point, it might also add that 'dissociation', a phenomenon so readily enlisted in some quarters to try to explain how encoded memories can sometimes be very difficult to retrieve, offers a perfectly good explanation of why in many situations traumatic experiences may be encoded very poorly or not at all. In the meantime, there is no reason why DSM should not be entitled to claim a place alongside those dodgy dossiers, such as Bass & Davis's *Courage to Heal* and Masson's *Assault on Truth*, that have played a part in promoting insufficiently cautious recovered memory therapy.

Endnotes:

1 Even if some of the memories had been genuine, this could not be taken as evidence of an unconscious defence mechanism such as repression being overcome. It is likely that the mechanism would have been more straightforward - that on admission the soldiers were too exhausted or agitated to direct sufficient attention to the task of memory retrieval; when they were more rested and calm, retrieval became possible.

2 For example, Goldfeld et al's (1988) review of the literature has been cited (by van der Kolk & Fisler,1995, for example) in support of the 'reversible amnesia' thesis even though it offers little or nothing of the kind. Indeed the authors seemed to favour an account that would rule it out when, mindful of the high frequency of head injuries inflicted during torture, they opined: "Therefore, psychological symptoms displayed by survivors of torture may be secondary to nervous system dysfunction rather than to the psychological effects of the torture experience." (p. 2728)

3 In DSM-III-R 'psychogenic amnesia' was a discrete category with only one diagnostic symptom "…an episode of sudden inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness." (p. 275). In DSM-IV's PTSD section the references to "amnesia" were retained but the term "psychogenic" had been removed. It was not replaced by "dissociative", (even though the category 'psychologenic amnesia' had been renamed "dissociative amnesia")

4 Although the rehabilitation was successful insofar as a significant proportion of the academic and professional community enthusiastically embraced it, most of the evidence and argument on which it rested was spurious (see, for example, Esterson 1998; McCullough 2001).

5 There seems to be a widespread almost routine willingness to accept as reversible any amnesia for (aspects of) events that occurred during a period of what could be characterised as 'dissociation'. [For an example of this willingness, see the extract from Briere (1992) reproduced near the beginning of this article.] This is very puzzling because it is quite obvious why being in a dissociated state might often result in **ir**reversible amnesia. One reason is that there is an inability to devote sufficient information processing resources to the task of encoding a memory. Earlier it was argued that this lay behind the amnesia in traumatised soldiers reported by Sargant and Slater (1944). A different type of dissociation might occur in, say, torture victims who develops a strategy, perhaps through a kind of self-hypnosis, where they focus their attention on internally generated scenarios and exclude external reality as much as possible. If this strategy is successful, irreversible amnesia is an inevitable consequence.

6 In response to receiving a draft of a longer version of the current article, Richard McNally has drawn the author's attention to McNally (2004) where (p. 9) he suggested that the PTSD diagnostic symptom 'inability to recall' should be dropped in favour of the 'memory and concentration problems' symptom that had featured in DSM-III.

References

American Psychiatric Association (1987). Diagnostic and Statistical Manual of Mental Disorders (Third Edition - Revised) [DSM-III-R]. Washington DC: APA.

American Psychiatric Association (1994) Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition) [DSM-IV]. Washington DC: APA.

American Psychiatric Association (2000). Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition – Text Revision) [DSM-IV-TR]. Washington DC: APA.

Archibald, H.C. & Tuddenham R.D. (1965) Persistent stress reaction after combat: A 20-year follow-up. *Archives of General Psychiatry*, **12**, 274-481.

Bass, E. & Davis, L. (1988). *The Courage to Heal*, New York: Harper & Row.

Blume, E. C. (1990) *Secret Survivors: Uncovering Incest and Its Aftereffects in Women.* New York: Wiley.

Briere, J. (1992) *Child Abuse Trauma: Theory and Treatment of the Lasting Effects*. New York: Sage.

British Psychological Society (1995). *Report of the Working Party on recovered memories*. Leicester, UK: British Psychological Society

Esterson, A. (1998). Jeffrey Masson and Freud's seduction theory: A new fable based on old myths. *History of Human Sciences*, **11**, 1-21.

Goldfeld, A. E., Mollica, R.F., Pesavento, B. H. and Faraone, S. V. (1988). The physical and psychological sequelae of torture. Journal of the American Medical Association, 259 (18), 2725-2729.

Grinker, R. R. & Spiegel, J.P. (1945). *Men Under Stress*, Philadelphia: Blakiston.

Henderson, J. L. & Moore, M. (1944) The psychoneuroses of war. *New England Journal of Medicine*, **230** (10), 273-278.

Kolb, L. C. (1984). The post-traumatic stress disorders of combat: A subgroup with a conditioned emotional response. *Military Medicine*, **149** (3), 237-243.

Masson, J. M. (1984). [Revised (preface) edition, 1992] *The Assault on Truth: Freud and Child Sexual Abuse.* New York: Harper Collins.

McCullough, M. L. (1998). The recovered memories debate: How reliable is the scholarship? *Health Care Analysis*, **6**, 216-222.

McCullough, M. L. (2001). Freud's seduction theory and its rehabilitation: A saga of one mistake after the other. *Review of General Psychology*, **5** (1), 3-22.

McNally, R. J. (2003). *Remembering Trauma.* Cambridge, Massachusetts: Harvard University Press, and London.

McNally, R. J. (2004). Conceptual problems with the DSM-IV criteria for posttraumatic stress disorder. In G. M. Rosen (Ed.), *Posttraumatic stress disorder: Issues and controversies*, (pp. 1-14). Chichester, UK: Wiley

Sargant,W. (1967). *The Unquiet Mind*. London: Heinemann

Sargant, W. & Slater, E. (1941). Amnesic syndromes in war. *Proceedings of the Royal Society of Medicine*, **34**, 757-764.

van der Kolk, B. A. and Fisler, R. (1995). Dissociation and the fragmentary nature of traumatic memories. *Journal of Traumatic Stress*, **8**, (4), 505-525.

Prior to his retirement in 2005, Maurice McCullough was a Principal Lecturer in the Psychology Department at the University of Central Lancashire. Email: mlmccullough@uclan.ac.uk

Can you help?

Raising funds has never been an easy job for a 'controversial' charity such as the BFMS and sourcing potential new funders is an ongoing and challenging job. If any members know of, or have connections to grant giving trusts that may be interested in the work of the society, please could you let us know. Maybe you could invite a potential funder to an AGM, or pass on our information brochure? To quote those famous words "every little helps"!

Lady Jill Parker, our Chair, will be collating information so do please email her at ladyparker@bfms.org.uk. Alternatively call 01225 868682 if you have any questions and we will be happy to assist.

Misidentifying offenders: implications for false memory syndrome victims

by Robert Shaw

Editors note: Robert was falsely accused and after two attempts at appeal was finally acquitted of all charges in 2005. He uses the term 'false memory syndrome' in this article to ease description although the BFMS does not use it as it is not an officially recognised medical diagnosis and is all too readily dismissed as non-existent as a consequence.

The variety of victims

False memory syndrome creates several different victims:

- the victim of the 'recovered memories' technique (the victim-accuser)
- the victim of the false allegations (the victim-accused)
- the family of the accused, which may be the same as
- the family of the victim of the 'recovered memories' technique.

Historically, the British False Memory Society (BFMS) has supported the victim-accused and their families and, more recently, has become involved in supporting victim-accusers (and their families where the victim-accuser and the victim-accused come from different families). It has, as a matter of principle, declined to support those victim-accused who were known to be offenders.

However these victims of false memory syndrome share with innocent victims of false memory syndrome the misidentification of the offender; the offender in a false memory syndrome case is the person who inspires the false memories, for example, by using or encouraging the victim-accuser to use the 'recovered memories', or a related technique, not the victim-accused whether an offender in another situation or not. Offenders, in this context those who inspire false memories, often have a disturbed or a distorted view of reality which can make the treatment of their offending difficult. I shall not attempt to address this issue in this paper but rather some of the implications of trying to deal with the consequences of this misidentification. Among the difficulties faced by those caught up in false memory syndrome are:

- the victim-offender polarity,
- the denial of victim-hood and
- the responses of victims.

The victim-offender polarity

The victim-offender polarity normally affects all those involved; particularly in the early stages both victim-accuser and victim-accused can seek to get the other identified as the 'offender;' in effect, they have been caught up in the game 'Let's you and him fight' which the offender has set up (Berne, 1968) . To avoid playing the game, the victim-accused must avoid identifying the victim-accuser as the 'offender' and name the offender who inspired the false memories.

Unfortunately, like children in a playground, members of the victims' families can be drawn into 'Let's you and him fight', something which the offender may well encourage because that is part of their reward. If either party refuses to fight, the game is over and offender gets no reward. The offender is supported in their efforts both informally by the view that all 'victims' are good and all 'offenders', in this case the victim-accused, are bad and never the twain shall meet and by the formal separation of 'victims' and 'offenders' that characterises the English criminal justice system. Because it is an adversarial, rather than an investigative system, it can only operate if one party is designated as 'victim' and the other as 'offender'. It is ill-suited to dealing with false memory syndrome because there are three parties: the victim-accuser, the victim-accused and the offender, the last of whom will do everything they can to ensure that the victim-accused rather than themselves is

named as the 'offender'. Another consequence of victim-offender polarity is that a victim-accuser who retracts risks being characterised as an 'offender' for 'perverting the course of justice' on the grounds that, if the victim-accused is a 'victim', then the victim-accuser must be the 'offender'.

In most cases, therefore, the victim-offender polarity obscures the nature of the victim-hood of both the victim-accuser and the victim-accused.

Denial of victim-hood

Denial of victim-hood may affect both victim-accuser and victim-accused. There certainly have been a small number of cases where victims of genuine abuse have been disbelieved and have subsequently encountered a counsellor who has used the 'recovered memories' technique, turning them into victim-accusers as well. This double victim-hood can, of course, have even more damaging consequences than the original abuse for which they sought counselling.

But denial of victim-hood is most obviously likely to affect the victim-accused, whether or not they are subsequently convicted. Where allegations are made but no charges are laid, the victim-accused may have little to go on to understand the situation in which they find themselves or to refute any allegations which may hang over them for years. Where the victim-accused is convicted, denial of their victim-hood will be a routine part of their experience in prison, on licence after release and under supervision thereafter. Of course, that does not necessarily mean that everyone outside the family of the victim-accused believes that they are guilty. Sometimes those who make false allegations are rejected by their own communities and the victim-accused is supported by the community.

But each of these situations can make it more difficult to identify the offender. If someone has not been charged with an offence, they will find it difficult to prove the offender's responsibility for anything; once someone has been convicted, the barriers to clearing one's name are immense in England and Wales because it was one of the first appeal systems to be set up and the grounds on which someone can appeal are very narrow; without a successful appeal, there is little hope of naming the offender; if the community rejects a victim-accuser, the link to the offender may be broken making it more difficult to identify them.

To understand the various responses to both the victim-accuser and the victim-accused, we need to look at the normal processes affecting victims.

The responses of victims

It is becoming increasingly clear that victims vary considerably in the ways in which they respond to their experiences from forgetting (Loftus et al., 1994) through being 'seemingly untouched' to being 'forever scarred' (Dziech and Hawkins, 1998, pp. xvi--xvii) . Over thirty years ago Maas and Kuypers (1974) found that older people who had suffered some form of stress earlier in their lives were better able to deal with stress in old age than those who had not. We cannot therefore assume that the effects of the 'recovered memories' technique on the victim-accuser, of the false allegation on the victim-accused and of this situation on the victim-family will be the same in all cases or that their support needs will be the same.

Where a victim does not forget or is not able to rise above the abusive interaction so that, in a very short time, they are able to become a 'former victim', able to make relationships with others into which they have not been seduced or coerced by a potential offender, they need support to enable them to become 'former victims'.

That support has to meet seven needs (Marshall, 2005), for:

1. a safe space to speak of their experience
2. validation and vindication
3. answers to their questions
4. genuine truth-telling
5. empowerment
6. restitution or reparation and
7. hope of a better future.

A safe space to speak

Victims may be denied a safe space to speak for many reasons: speaking out may lead to loss of face or stigma; the offender may be more powerful, physically or socially, and may take revenge if they speak out; if they become witnesses, they will be restricted in terms of whom they can talk to and what they can say. They may also be disbelieved or blamed for their victim-hood because, if the hearer believed that they had been abused in the way they say they were, they would have to believe that they too were at the same risk of being abused; rather than do this, hearers often disbelieve the victim or blame them - it wouldn't have happened if they hadn't done such-and-such (Dziech and Hawkins, 1998). This can be compounded among women victims who have a greater tendency to blame themselves for anything that goes wrong in their lives.

As Loftus (1995) demonstrated, the 'recovered memories' technique involves denying the victim-accuser a safe space to speak; this is reinforced after the 'memories' have been 'recovered' in either or both of two ways

1. by creating the appearance of a safe space, in what is often styled a 'survivors group', where victims can share their 'recovered memories' and receive mutual reinforcement of those memories or
2. by becoming a witness, in the course of which discourse is restricted to that permitted in court where the pattern of cross-examination will also tend to reinforce the 'recovered memories'.

The victim-accused may also be denied a safe space to speak: the nature of the allegations or their relationship with the victim-accuser may be a matter of shame or stigma for them; if they hold certain posts or if the victim-accuser is in certain positions and they disclose the allegations, they may be vulnerable to suspension or dismissal or to those who want to take revenge on them for whatever reason. They may also find that people do not want to believe them because, to believe that someone could be the victim of random and totally unfounded allegations is frightening and people would prefer not to believe that or to blame the victim-accused for having brought the situation on themselves. Male victims are also more reluctant to acknowledge being victims (Owen, 1995).

For victim families, whether the families of the victim-accuser or the victim-accused or both, all the factors - shame or stigma, vulnerability to action being taken against members of the family, disbelief or blame - can combine with, in some cases, pressure from either side to become witnesses so that opportunities for them to have a safe space in which to speak are restricted.

In addition, it is in the interests of advocates of the 'recovered memories' technique and of those who want to use civil and criminal proceedings in these cases to ensure that no one is given a safe space within which to speak because that might result in the truth about false memory syndrome becoming apparent more quickly, both for the victims involved in such situations, and for the wider public.

Validation and vindication

The 'recovered memories' technique is intended to validate for the victim-accuser the reasons why they do not feel happy about themselves by externalising the causes in other people; as such it plays on the need all victims have, to have their experience validated. If the validation is vindicated by the conviction of the victim-accused, in theory the victim-accuser should be in a position to move on to the next stage. In practice, that does not happen because what has been 'validated' does not bear any relationship to what has happened.

Similarly the victim-accused needs validation that what has happened to them is false memory syndrome; in my own case, this arose as a result of a suggestion from my solicitor at the outset long before we had any idea that we were dealing with a case of false memories that I should compile a comprehensive account of everything that had happened over the years. A lot of the material that went into this compilation was not relevant to the situation but, as the case un-

folded, the fact that every piece of fresh evidence we have received has confirmed or filled in gaps in the story of how the false memories came about has served to validate my situation. But, though I have had my experience validated, I have not had it vindicated.

Less than half of those thought to be victim-accusers may validate for the victim-accused their victim-hood by returning; even fewer will validate it by retracting (McHugh et al., 2004). But this is not the whole story; victim-accusers also need to have their victim-hood validated and, given the unwillingness of most offenders in cases of false memory syndrome to acknowledge, let alone address, their offending behaviour, this can be very difficult. Without validation, it is difficult to obtain vindication, particularly as so many victim's stories are disbelieved anyway.

In a small number of cases victim-accusers may need to have two offences validated and vindicated:

- the offence(s) that induced them to seek counselling and
- the offence that took place during the counselling.

I am aware of one victim-accuser who had sought counselling for genuine abuse in the course of which false memories had been inspired; once these false memories had faded a witness to the original abuse was able to validate the abuse for which the victim-accuser had originally sought counselling and, in so doing, vindicate the victim-accuser's new found conviction that she had been tricked by the counsellor into manufacturing something which had not happened rather than dealing with something that had. But few victim-accusers will have access to that sort of validation or vindication as in most cases there will be no prior offence, just the offence of inspiring the false memories of which there is usually no witness.

Answers to questions and genuine truth telling

According to McHugh et al. (2004) very few victim-accusers become retractors, that is to say, engage in a process of talking about their experiences. There are a number of possible explanations for this:

1. the victim-accuser has never had a safe space to speak, particularly if they have been through a court process or been sucked into a 'survivors' group' intended to reinforce their false memories; it is worth noting that most retractors were returners in contact with the accused by avoiding a discourse on the subject for some time before they became retractors;
2. the victim-accuser has never had any validation or vindication of their experience, normally because most offenders do not acknowledge their offending behaviour, but also because, even where a retractor has had their story validated in outline, they may have difficulties in disentangling all their false memories from memories of genuine events;
3. the victim-accuser has never had any answers to questions or any truth telling from the offender;

The difficulty for the victim-accused is that it is all too easy to regard the victim-accuser as the 'offender' from whom to seek answers to questions and genuine truth-telling, as some respondents to McHugh et al. (2004) may have done, when in practice the offender is the person who inspired the false memories. If we see the victim-accuser and the victim-accused as both victims, it is quite wrong to expect the victim-accuser to explain anything to the victim-accused; it is the offender who needs to be explaining things to both victims.

In other words, the support the victim-accuser needs is to enable her/him to cope with the fact that the offender is not prepared to acknowledge their offending behaviour, to answer any questions or to tell the truth; the support the victim-accused needs is to understand that the victim-accuser has no obligation, legal or moral, to answer any questions the victim-accused or their family may have; the person from whom the victim-accused should be seeking answers and truth telling is the offender who inspired the false memories in the first place.

Of course, some victim-accusers may become retractors regardless of the actions of the

offender in the case; but that is a reflection of their way of dealing with their victim-hood and, since there are so many different ways in which victims deal with victim-hood, it is wrong for anyone to expect other victim-accusers to behave in the same way. Each victim needs the support to deal with the situation in the way that best suits them - not an easy task when there are so many victims in a single situation.

Supporting victims

With so many obstacles facing victim-accuser, victim-accused and their families, it is not surprising to find that empowerment, restitution or reparation and hope of a better future are unlikely to be available for the vast majority of victims of false memory syndrome in the near future.

For the time being, it is probably important for those who are supporting the victims of false memory syndrome to:

- distinguish, understand and treat both victim-accusers and victim-accused as victims
- identify if at all possible who is the offender
- seek to validate the experiences of the victim-accuser and victim-accused by collecting as much information as possible
- discourage victim-accusers, the victim-accused and their families from adopting the victim-offender polarity
- recognise the very different responses of different victims to similar events and try to provide support which is appropriate to those different responses.

References

Berne, E. (1968) *Games People Play: the psychology of human relations* Harmondsworth: Penguin

Dziech, B. W. and Hawkins, M. W. (1998) *Sexual harassment in higher education: reflections and new perspectives* London: Garland

Loftus, E. F. (1995) Remembering dangerously. *Skeptical Inquirer*, pp. 20-29 Reprinted in Baker Robert A (Ed.) (1998) *Child Sexual Abuse and False Memory Syndrome* Amherst NY: Prometheus

Loftus, E. F., Garry, M., and Feldman, J. (1994) Forgetting sexual trauma: what does it mean when 38% forget? *Journal of Consulting & Clinical Psychology*, **62**(6):1177-81. Reprinted in Baker Robert A (Ed.) (1998) *Child Sexual Abuse and False Memory Syndrome* Amherst NY: Prometheus

Maas, H. S. and Kuypers, J. A. (1974) *From Thirty to Seventy: a forty-year longitudinal study of adult life styles and personality* San Fransisco: Jossey Bass

Marshall, C. D. (2005) Satisfying justice - victims, justice and the grain of the universe. *Justice Reflections*, **10**(69):1-19. Reprinted from Australian Theological Review May 2005.

McHugh, P. R., Lief, H. I., Freyd, P. P., and Fetkewicz, J. M. (2004) From refusal to reconciliation: family relationships after an accusation based on recovered memories. *The Journal of Nervous and Mental Disease*, **192**(8):525-531. Abstract in The Newsletter of the British False Memory Society Volume **13**(1): 4-6 February 2005.

Owen, J. M. (1995) Women-talk and men-talk: defining and resisting victim status. In Dobash, R. E., Dobash, R. P., and Noaks, L. (Eds) *Gender and crime*, pp. 246-268. Cardiff: University of Wales Press

***

London meetings

A BFMS member has offered to host informal family meetings for members in the London area.

If you are interested please contact BFMS on 01225 868682 or email bfms@bfms.org.uk.

MEMBERS' FORUM

Never give up

I gave a talk at the 2006 AGM entitled 'Never Give up' where I described how hard we had worked and what we had achieved after our daughter accused my husband, our elder son and myself of sexually abusing her. How, as part of a process of trying to help her, we complained, successfully, to the Parliamentary and Health Service Ombudsman (formerly known as the Health Services Commissioner) and the General Medical Council. My talk ended with my describing how I had managed to befriend one of our daughter's neighbours and, as a result of this, I had spoken to our daughter on the 'phone. So, what did happen next?

Over a period of ten weeks in the summer of 2006 we were in contact with our daughter then, because we would not immediately buy her a house and agree to everything she demanded, she broke off contact again. We were very upset. I, in particular, was devastated as I felt that it was my fault as I had been the person most in contact with her. We also received a very aggressive letter from her solicitor which said that, if we tried to make contact with her in any way, we would be accused of harassment.

So, what did we do? Did we just give up? We left her alone for a year then thought we would try again. We suggested to her twin brother that he contact her on their birthday. Although he had not been accused, she had called the police out when he had tried to see her at her home and he was a bit apprehensive about contacting her but he agreed.

He wrote to her saying that he would call on her on their birthday and that, if she were out, he would just leave her birthday present on her doorstep. We were all totally amazed when he was invited in and even more amazed when she spoke to me the following day on the 'phone.

We have been in almost daily contact since then. We may be living in a fool's paradise but we feel that this contact is different. In 2006 she flatly refused to see her father. This time she seems to be very happy to see him. She expressed surprise when I said I still loved her saying, "Even when I have said dreadful things about you?". When her father said he had never stopped loving her she said that she could quite understand it if we no longer loved her. She has not asked for any money and actually apologised for her behaviour in 2006. She has given us the key to her house for us to check her post while she and her boyfriend are out of the country.

Whether this will lead to proper reconciliation or not we do not know. Only time will tell and we have no idea how to deal with her false allegations. For now, with her agreement, they have been consigned to a metaphorical 'box'. But, whatever, we are glad that we did not give up and had yet another try. Never Give Up!

Eileen, a hopeful mother

***

Enjoy the moment

I am writing this in the hope that all of you, who are going through the dreadful legal system of defending yourselves against horrendous false allegations, will get courage from our experience.

My husband Ted was arrested in August 2005 on suspicion of rape, two months later he was charged with eight counts of rape and seven counts of lesser sexual offences. My world fell apart; I was devastated, in total shock and felt like a steam train going aimlessly along a track. I wanted the court case to be heard tomorrow so that I could put things right. For that fleeting second I gave my daughters the benefit of the doubt but common sense prevailed.

I know every case is different, but with us, my two daughters had been abused by my previous husband when they were very young. They have been receiving counselling

on and off for over twenty years. But my biggest shock was my third daughter who, very much a mummy's girl, started counselling in 2004 for an eating disorder, and was now contributing to her sisters' allegations.

In the beginning, Ted told me that had I not stood by him, he would not have found the strength to fight believing that he had no chance of defending himself against something like this. We were very grateful that my son, in his mid twenties, stood by us.

I was not computer literate when all this started, and was writing every thing out in long hand, and presented our legal team with over a thousand pages of emotional diarrhoea, but much needed information. Then in January 2006, my son showed me how to use the internet. At first, I was typing in 'liars', 'untrue accusations', and then by chance, 'false memory', and behold, I came across the BFMS. I was in tears when I first rang Madeline, for suddenly here was a valid explanation for all the chaos that had been imposed upon us. In a way, it increased my anxiety as I was now questioning why the police and the Crown Prosecution Service had not explored this avenue before pressing charges. I now realise, that this is how the system works.

Ted's first trial was in February 2007. The very thought of what we were about to go through absolutely terrified us. It began to take its toll on our health. I left my hospital bed to give evidence, against the advice of the Doctors, and was not strong enough to deal with the prosecution's bombardment of questions. The whole trial was a complicated mess and it finished with a hung jury. I remember weeping when I heard the judge setting a new trial date and thinking I can't go through all this again. The new date was for September 2007. I spent most of the summer in and out of hospital, blighted with asthma which of course is brought on by stress; it was a vicious circle. Then on 2nd September, Ted suffered a transient ischaemic attack (a minor stroke which is a warning of a major one). I remember thinking how much more is "He" up there, going to throw at us.

Ted was in hospital for over two weeks and was deemed not fit for the trial and a new date was set for 3rd January 2008, our legal team at this point were convinced that Ted would be found guilty at the next trial; they almost gave up on us, and we were told that a new point of law meant the jury would not be told of the eleven other men that my daughters have accused of rape. Thankfully, Madeline emailed some very important facts for our team, who in turn, found a different way of presenting our case. I had also stumbled across a family video, filmed in 2003, showing my daughters behaving quite normally around Ted.

It was decided that I would not give evidence at this trial, as it became obvious that the prosecution were going to take pot shots at me, which in turn would confuse the jury. It was a good decision, we had some very convincing witnesses and Dr. Boakes was most compelling as our expert witness. The jury deliberated for three days. On Monday 28th January, as Ted left for Court, I was convinced he would not come home that night. His last words to me were "sell the house, get what you can for it, and make a new life for yourself". I was at rock bottom. I weighed six and a half stone and felt as if I were going to have a stroke. At 12.30pm, I received the first call from Ted, the jury were still deliberating, but had found him not guilty on all the rape charges. I almost collapsed, and rang Madeline in tears to let her know, and I remember her saying "enjoy the moment". At 4pm Ted called to say it was all over and he was on his way home. It was a very emotional evening.

I am writing this exactly one week later. Coping without all the stress is very strange. I am still doing battle in my dreams, but we now have the rest of our lives together. My anger is not with my daughters, but with the system, and the sadness that I have lost them and our six grand children. When I have recovered my strength, I intend to start fighting back at this hideous system and the witch hunt tactics of the police. They never came to me during their investigation. And, as for the detective constable involved in the case, I do hope that when he returns to his family at the end of his working day, he feels

very proud of his achievements. Yet another fractured family.

Thank goodness for Madeline and her team. Without their interest in our case, I think I might have lost the plot. I also want to say a very big thank you to Sheila who often phoned and emailed me and gave me the strength to keep going.

Jenny, a supportive wife

***

False memories: permanent and long-term consequences to health

by William Burgoyne

Much has been written about the damage caused to parents and other falsely accused third parties by recovered memory therapies but less is known about the permanent or long term consequences to the physical and mental health of those affected.

In the cases reported to the BFMS, some of which have been published in Newsletters and books such as *Fractured Families* and *Victims of Memory*, victims refer to having suffered breakdowns and depression. Relationships within family units are dramatically altered: the close relationships that normally exist between parents and children and between siblings are often destroyed. Grandparents may be denied access to their grandchildren. In a nutshell, the cohesive forces that hold extended families together may be irretrievably lost.

That much we know. But what of the ability of the human frame to repair these ravages? Is there long term or permanent, irreparable damage to mind and body? If so it is another dimension to the tragedy of false memories.

The BFMS would like to hear from members who believe that their long term or permanent physical and/or mental problems can reasonably be attributed to the stress of false allegations.

All information will be held in the strictest confidence and will be used to assess the size and nature of the problem before considering whether it might be the subject of a survey among members. Contributions can be sent by post or e-mail to the Director at bfms@bfms.org.uk.

William Burgoyne is the author of Counselling or Quackery?

***

LETTERS

from Dr Ray Aldridge-Morris

Politics and the reclassification of mental illness

The piece on Developmental Trauma Disorder (DTD) in the BFMS Newsletter, September 2007, Vol. 15, No. 2, misses the point. Logically, there is infinite scope for classifying "mental illness" but the exercise resembles counting angels on pinheads. Psychiatrists involved in this endeavour have come to resemble those Japanese soldiers who battled on, not knowing that WWII was over. Diagnostic labels in psychiatry are fragile human constructs with questionable validity. The fact that they may have defined their categories so tightly that they mostly agree on the labels they apply, means only that reliability has been enhanced (psychiatrists confuse validity with reliability). Essentially these categories appear in manuals like the Diagnostic and Statistical Manual of Mental Disorders (DSM) simply because irregular meetings of a powerful lobby have taken a vote. As my mentor, Hans Eysenck, observed 50 years ago, this is a curious example of the intrusion of the democratic process into the world of science.

Once new labels appear they are then reified and people queue up to join the categories and equally self-deceived psychopathologists start to freshen fading reputations with papers boasting how many of the new Xs they have discovered. Special training courses are mounted and those of us who mount scepti-

cal attacks on yet another psychiatric hoax are vilified.

Those of us who have been in court regularly witness defence and prosecution arguing over whether or not the complainant does or does not have, say, posttraumatic stress disorder (PTSD). Did he really feel his life was threatened at the time? Or was he just very scared? The diagnosis of PTSD hangs by this slender thread.

What is much more helpful is constructing formulations rather than playing 'doctor' and giving diagnoses. Formulations are carefully articulated descriptions of the patient's/ client's problem which include not only behavioural analyses (just what does the person do, just what do they find difficult) but also attempts to identify triggers and maintenance factors (what is happening on a particularly bad day, and what is happening on a good day) and, at all times, to try to present the problem through the eyes (the unique cognitions) of that person.

In this way we might provide a careful record of a person's sadness, its vicissitudes, the effects on behaviour and on family members, on that person's perception of themselves and their 'being-in-the-world'. Already we might be seeing how we can begin to help by working on the modification of both situational factors and negative thinking.

How much more useful this is than thumbing through DSM checklists and debating whether or not to label them as 'major depressive episodes' but hesitating because the symptoms have not lasted the required 'two weeks'.

It takes a degree of professional self-confidence to eschew the jargon and write in plain English but it tells you so much more about those you are trying to assist.

Dr Ray Aldridge-Morris is an Emeritus Consultant Clinical Psychologist.

***

OBITUARIES

George Davison - An Appreciation?

by Robert Shaw

George Davison (1940-2008), who died recently following an unsuccessful heart by-pass operation, was one of 17 children from a south London family who became a fighter throughout his life, not just for himself but for others. He left London to work for an engineering company and, as he gradually built up his understanding of engineering and people, he succeeded in setting up and running a successful engineering business where honesty and straight-talking got him a long way. He diversified into managing an old people's home before be decided to sell up and retire in his fifties.

Sadly his planned retirement was interrupted when he was a victim of false allegations from a patient receiving treatment at a psychiatric clinic. The situation escalated and, as this was in the early days of false memory syndrome, most people, including his barrister, did not believe him and he ended up with one of the longest sentences in a false memories case.

While in prison George's honesty and straight-talking gained him the respect of many prison officers and in at least two prisons he was given top jobs only open to the most trusted prisoners. His honesty and straight-talking didn't always endear him to all his fellow prisoners though many respected him for it and he was also able to offer a sympathetic ear which a number appreciated. He was not afraid to complain when he know things were wrong, as when he complained about a prison officer who was sexually molesting vulnerable prisoners, but this sometimes meant he ended up in the punishment block.

George kept himself physically fit in the gym and mentally fit behind his door where his cell was always neat and tidy, Radio 4 was

on and he would write a steam of letters, among them those to his beloved Maggie or to yet another solicitor in the hope of getting someone to take up his case.

Following his release he spent nine pointless months in a hostel before he was allowed to go home which, as he admitted, wasn't quite as he had expected. Maggie had had to do lots of things round the house that he used to do before he went to prison and he had to get used to the fact that she could and would continue to do some of these things.

He kept up his gym and was somewhat disappointed when the doctors said that he wouldn't be able to do press-ups for three months after his operation. Six of his friends from the gym acted as pall-bearers, carrying his coffin at his funeral.

The best news came at Easter 2007 when he heard that the Criminal Case Review Commission (CCRC) had agreed to review his case; unfortunately, he did not last long enough on earth to learn the result. Though George was not an adherent of a particular religion, he did believe in God and that he could pray to him and his funeral service recognised his faith in ways I think he would have appreciated.

Editors postscript: Maggie is relieved to have confirmation that the CCRC intends to continue the review of George's case posthumously.

***

George Williamson 1939-2007

George was a familiar name to many at the BFMS over the years. He showed particular concern for the plight of innocent people serving prison sentences and with our help set about researching this area and prison visiting before setting up his organisation AAFAA.

George Williamson was born in Hamilton near Glasgow shortly after the outbreak of World War II, the eldest son of a baker and a teacher. Like so many of his generation, the war had a big impact upon him; its futility and the sacrifice made by others in the name of Justice.

When he was eleven, his father died and his mother was forced to return to work. From an early age he learnt and experienced the value of 'pulling together', of caring for others, his younger brothers especially, and of shouldering responsibility. When he left school he became an apprentice architect and moved to London.

George was never afraid to confront difficult issues. He had his own personal reasons for aligning himself with the fight against false allegations of abuse. He was a founder member of AAFAA (Action Against False Allegations of Abuse), and organised its first Annual Conference in 2000 in London. AAFAA was an instant success. At its peak it was providing emotional support and practical help to several hundred people who sought its advice. Often George was the first person they turned to. He would support accused men through their trial, and later, when necessary, visit them in prison. He organised the first ever protest vigil on behalf of those falsely accused and wrongly convicted of abuse, when he marched with pride. Although at times his involvement nearly overwhelmed him, he remained committed to the cause right through to the end of his life.

George realised that the scourge of false allegations of abuse would not be lifted unless there was a united campaign, and a determined effort by all concerned, to counter the skewed politics of child protection and child abuse. AAFAA was instrumental in the forming of a united campaign (UCAFAA) which built up a very effective network involving like minded individuals and organisations, whose impact on the politics of abuse accusations has been very considerable.

In June 2004, when George considered he had taken AAFAA as far as it could go, he accepted the offer to become FACT's (Falsely Accused Carers and Teachers) campaign and lobbying coordinator.

George was a very caring and courageous man. He died from an inoperable brain tumour which was diagnosed in June 2007. He leaves a widow and two daughters from a previous marriage.

We are grateful to Michael Barnes of FACT for allowing us to print this shortened version of the Obituary which was first included in the December 2007 FACTION newsletter.

***

LEGAL

The subject of limitation periods was last discussed by Chris Yemm in the December 2001 newsletter (Vol 9, No.1). The Law Commission had just outlined a number of recommendations, many of which it appears will now be incorporated into changes to the Limitation Act 1980.

A v Hoare - Opening the flood gates?

by Chris Yemm

On 30th January 2008 the House of Lords delivered its long awaited decision in the case of the "Lottery Rapist". That case - one of six considered by the Court - concerned Mrs A who was subjected to a brutal sexual assault in 1988 by Mr Hoare. Following his conviction Mr Hoare served sixteen years of a life sentence. The claim arose because Mr Hoare won £7m on the National Lottery as a result of buying a winning ticket whilst on day release from prison in 2004. The Court had to consider Mrs A's right to commence proceedings against Mr Hoare long after the six year limitation period which applies to torts involving deliberate or intentional assaults had expired. A more deserving case could hardly be found.

The reason it was necessary for Mrs A to take her case all the way to the House of Lords was because they had in an earlier decision of Stubbings v Webb (1993 AC 498) drawn a distinction between intentional torts such as rape, indecent assault and trespass to the person and torts which were negligent or accidental for limitation purposes. The distinction was important.

Section 2 of the Limitation Act 1980 sets out the general rule that the period of limitation for an action in tort is six years from the date upon which the cause of action accrues. However, sections 11 - 14 of the Limitation Act contain ameliorating provisions which provide for a shorter limitation period of three years in cases of negligence, nuisance or breach of duty where the damages claimed are for personal injury. In such cases the three year period starts from either the date upon which the cause of action accrued or the "date of knowledge" of an actionable claim whichever is the later.

Crucially Section 33 of the Limitation Act gives the Court discretion to extend the three year period where it would be fair to do so. According to Stubbings v Webb deliberate assaults, for which read all cases of sexual abuse, do not come within the definition of negligence, nuisance or breach of duty as set out in Section 11. Therefore all claims for sexual abuse had to be issued within six years of the Claimant's 18th birthday (if a minor) or six years from the act complained of otherwise they would be statute barred. The only exceptions to this were cases where a disability, in particular a mental disorder, prevented time running from the victim's eighteenth birthday. This distinction came as a surprise to most legal practitioners. The law appeared to have been settled some years previously in Letang v Cooper (1965). Stubbings was appealed unsuccessfully to the European Court of Human Rights but has remained settled law for the past fifteen years. Accordingly the lower Courts of England and Wales have been bound to follow it although in Stingel v Clark (2006) the Australian High Court declined to do so. In recent years the decision has given rise to several anomalies. The first major opportunity for claimants to review Stubbings came in Lister v Hesley Hall Ltd (2002) 1 AC 215 where the House of Lords decided that a company which owned and operated a school boarding house could be liable in negligence for the sexual abuse of

its pupils by a man employed by them as a warden even though the claim against the warden himself (for assault) was statute barred. This decision led to a plethora of similar claims against schools and other institutions on the basis that if a school's management had been guilty of negligence in their employment of a member of staff the applicable limitation period was an extendable three years rather than the non-extendable six year period which applied to the perpetrator.

The most remarkable example of the anomalies thrown up by Stubbings had been the case of S v W (1995) 1FLR 862 in which the Claimant was permitted to sue her mother for sexual abuse perpetrated by her father. Proceedings were commenced nearly ten years after the last act of abuse complained of. The cause of action against the father for his intentional sexual assault was struck out as being more than 6 years old. However the cause of action against the mother for her negligent failure to protect the Claimant from her father was subject to

…Mrs A and two other Claimants have won the right to proceed with their claims but only to a limited extent.

a discretionary extension under Section 33 which was exercised in her favour and approved by the Court of Appeal. These illogical consequences of Stubbings were considered by the Law Commission in its review of the Law of Limitation in 2001 (Law Com No. 270). The report recommended a uniform regime for personal injury whether the claim was brought for negligence (non-deliberate) or for trespass to the person (deliberate). Although the Law Commission's recommendations have not yet been implemented by the Government, the House of Lords clearly had them very much in mind in their deliberations in Hoare and have taken the opportunity of remedying previous anomalies by - unusually - revisiting and rejecting their own earlier ruling in Stubbings.

So where does this change of direction leave prospective Claimants? In Hoare, Mrs A and two other Claimants have won the right to proceed with their claims but only to a limited extent. A further obstacle awaits in that Mrs A's case has been remitted back to a High Court Judge to decide whether the discretion in Section 33 should be exercised in her favour. Under this provision a Judge is expressly required to consider the reasons for the delay including, for example, whether the Claimant was for practical purposes disabled from commencing proceedings within the 3 year period by virtue of the psychological injuries she undoubtedly suffered. This may not be entirely straightforward. In Mrs A's case for example the identified perpetrator of the assault was for many years impecunious and in prison serving a life sentence. There would therefore have been no purpose in her commencing proceedings against him. It is only his subsequent winning of the lottery that has made such a course worth pursuing. It therefore remains to be seen whether however sympathetic one is to Mrs A's situation, a Judge, in exercising his judicial discretion to allow the claim to proceed so many years out of time regards this as sufficient on its own to relax the usual 3 year limitation which now applies.

In Stubbings, Lord Griffiths observed that he had "the greatest difficulty in accepting that a woman who knows that she has been raped does not know that she has suffered a significant injury". That view was approved by Lord Hoffmann in Hoare. Claimant's psychological state is only one of the matters to be taken into account by a Court exercising its discretion under Section 33 but it has been a controversial one. This is because of the overlap between those psychological sequelae and the wider issue of whether the Claimant has in fact been under a disability for such a long period of time In many "false memory" cases the Claimant is alleging that the impact of the assault on him or her was such so as to deprive them of

the knowledge of the injury being significant. The injury has been "blocked out" and only recently brought to the fore. The Law Commission's view was that in so far as dissociative amnesia was a "mental disability" it would indeed stop time running while the disability persisted. However, the psychological incapacity suffered by a victim of sexual abuse was too uncertain and indefinite a concept to be used to suspend the limitation period on the ground of incapacity.

In Hoare the House of Lords declined to treat victims of sexual assault as a separate category inhibiting victims' preparedness or ability to bring proceedings. In doing so they specifically approved the views of the Law Commission. Accordingly a victim who is not suffering from a recognised mental disability is likely to have immediate knowledge of the relevant facts so that in future the normal limitation period will expire three years after his or her 18th birthday (for a child) or three years from the date of the assault. As a result victims of sexual abuse will have to consider bringing claims against the perpetrators much sooner than has been the case to date. The House of Lords in Hoare recognised that their decision might well lead to a greater number of claims from victims seeking to disapply the three year limitation period. However, the inhibiting effect of sexual abuse upon a victim's preparedness to bring proceedings will not automatically lead to a Court exercising a Section 33 discretion in his or her favour. It will be just one of the factors to be considered by a judge when exercising discretion and in the absence of cogent evidence or of a complaint made and recorded at the time or of a conviction for the abuse complained of, many cases may well be unable to proceed out of time.

One interesting development to watch is in the judgment of Lord Brown of Eaton under Heywood where he postulates the possibility of all those who are victims of sexual abuse bringing immediate proceedings in order to obtain an interim judgment on liability only so as to be in a position to enforce that judgment at some later date if, as happened in Mrs A's case, the impecunious perpetrator comes into money. Not everyone however is going to be so lucky.

Chris Yemm is a partner in Fisher Jones Greenwood LLP of Colchester. He acted for the successful Defendants in Stubbings and has since represented a number of BFMS members.

***

Police face challenge

The police are finally to face a legal challenge over criminal records checks. Mr Pinnington was falsely accused of sexual abuse following the use of the controversial interview technique, facilitated communication, used with autistic adults and children. He was cleared by both the police and by his employer's own inquiry and yet more trouble was brewing.

Changes to his job made it necessary for him to obtain an enhanced Criminal Records Bureau (CRB) check which brought to light the allegations which, although dismissed by the police, were listed as additional information which legally could still be disclosed. The result was that Mr Pinnington lost his job.

In January he won the right to go to the High Court to challenge the right of the Chief Constable of Thames Valley Police to disclose the unfounded allegations.

It is not yet known when this case will be heard but we will report the outcome when it is available.

Diary Date

BFMS AGM
29th March 2008

Don't forget to book your tickets - call 01225 868682 for details.

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.

AUSTRALIA

AFMA Inc.
PO Box 694
Epping NSW 2121, Australia
Tel: 00 61 300 88 88 77
Email: false.memory@bigpond.com
www.afma.asn.au

CANADA

Paula – Tel: 00 1 705 534 0318
Email: pmt@csolve.net
Adriaan Mak – Tel: 00 1 519 471 6338
Email: adriaanjwmak@rogers.com

FRANCE

www.francefms.com

NETHERLANDS

Email: info@werkgroepwfh.nl
www.werkgroepwfh.nl

NEW ZEALAND

Donald W. Hudson
COSA New Zealand Inc
80 Avondale Road
Christchurch, New Zealand
Tel: 00 64 3 388 2173
Email: cosanz@clear.net.nz
www.geocities.com/newcosanz

NORDIC COUNTRIES

Åke Möller – Fax: 00 46 431 21096
Email: jim351d@tninet.se

USA

False Memory Syndrome Foundation
1955 Locust Street, Philadelphia
PA 19103-5766, USA
Tel: 00 1 215 940-1040
www.fmsfonline.org

The Scientific and Professional Advisory Board provides BFMS with guidance and advice concerning future scientific, legal and professional enquiry into all aspects of false accusations of abuse. Whilst the members of the board support the purposes of BFMS as set out in its brochure, the views expressed in this newsletter might not necessarily be held by some or all of the board members. Equally, BFMS may not always agree with the views expressed by members of the board.

ADVISORY BOARD: **Dr R. Aldridge-Morris**, Emeritus Consultant Clinical Psychologist. **Professor R.J. Audley**, Vice Provost, University College London. **Professor Sir P.P.G. Bateson**, Professor of Ethology, University of Cambridge. **Professor H.L. Freeman**, Honorary Visiting Fellow, Green College, University of Oxford. **Professor C.C. French**, Professor of Psychology, Goldsmiths College, University of London. **Professor R. Green**, Consultant Psychiatrist, Imperial College School of Medicine, Charing Cross Hospital, London. **Mrs Katharine Mair**, Consultant Forensic Psychologist (retired). **Mr D. Morgan**, Child, Educational and Forensic Psychologist, Psychologists at Law Group, London. **Dr P.L.N. Naish**, Principal Psychologist, Centre for Human Sciences, DRA Farnborough (Chairman of the Advisory Board). **Professor Elizabeth Newson** OBE, Emeritus Professor of Developmental Psychology, University of Nottingham. **Dr J. Ost**, Senior Lecturer in Psychology, International Centre for Research in Forensic Psychology, University of Portsmouth. **Mr. K. Sabbagh**, Writer and Managing Director, Skyscraper Productions. **Dr B. Tully**, Chartered Clinical & Forensic Psychologist, Psychology at Law Group, London. **Professor L. Weiskrantz**, F.R.S, Emeritus Professor of Psychology, University of Oxford. **Dr D.B. Wright**, Reader of Psychology, University of Sussex.

BFMS · Bradford on Avon · Wiltshire · BA15 1NF
Tel: 01225 868682 Fax: 01225 862251
Email: bfms@bfms.org.uk
Website: www.bfms.org.uk
Registered Charity Number: 1040683

Management and Administration
Madeline Greenhalgh, *Director*
Donna Kelly, *Administrator*
Roger Scotford, *Consultant*