British False Memory Society

NEWSLETTER

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Dear Reader,

In this issue we discuss the important topic of teenagers who are getting caught in an abuse trap. Their abuse comes not from being the victims of childhood sexual abuse, but from unsound theories and poor practice. The problem of teenagers (mostly girls) who make false allegations of sexual abuse after they have been admitted for psychiatric treatment is a new issue for this newsletter, rarely discussed in any print form. For the Society these cases could so easily fall into an abyss between the adult cases that we are used to handling and child cases which are referred elsewhere. Repeatedly we have been faced with the harrowing accounts of teenage girls who have been admitted to psychiatric units for diagnosis and treatment. The teenagers have serious problems and the parents fully support the attempts to get to the bottom of the cause of their illnesses. However, in the cases reported to the Society, the parents suddenly find that they are being excluded from the units on the pretext that their teenagers must deal, unhindered, with their problems. The next the parents know is that one, or both of them, is accused of sexually abusing their child who, of course, no longer "wants" (or is allowed?) to communicate with them. For a parent to loose contact with their child and thus any ability to protect them is a most frightening experience.

The forces in action are founded on much the same principles that enable an adult to build a new childhood history based on a false narrative. They are seeking answers, where none are clear, within a climate of strong belief that sexual abuse is the root cause of many teenage psychiatric problems such as depression, eating disorder or relationship difficulties. A father has courageously given an account, in this issue, of what happened to his family when his daughter went into a psychiatric unit specialising in teenage problems. His story began some years ago and the distressing fact today is that we are still hearing of similar cases. A mother, with determination to seek accountability for what has happened, describes how her family is currently caught up in this appalling situation.

Time and again, throughout the many professions allied to child protection work, we see examples of an unquestioning, almost automatic belief in an accusation of sexual abuse without recourse to the sound practice of reviewing the evidence before pronouncing guilt. We do not deny the severity of the crime of sexual abuse but we do seek a return to common sense in dealing with this issue. Many of the problems that arise are endemic to the child protection system. An opportunity to read a critique of the current system comes with the new book, *Has a Child Been Molested?* The book examines the US child protection system which influenced the British system and furnishes radical proposals for reform in the family and criminal courts. The review on page 21 highlights the importance of this topic for professionals and policy makers in the UK.

In the Spring I attended two conferences about "false memories", one organised by the New York Medical College and the other by the False

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Memory Syndrome Foundation. Comparing challenges and progress in a different culture was very interesting. Dr Paul McHugh, for example, felt confident that in America they had won the concept battles if not the clinical war. Undoubtedly in America successful lawsuits against offending therapists and the implementation of the *Daubert* ruling for expert evidence have provided powerful warnings to practitioners. So far, our own legal system does not lend itself readily to similar civil suits.

During the summer news arrived that Diana Russell, a leading feminist and researcher, had changed her mind about recovered memory. She says, "I now believe a high percentage of memories recovered in therapy and outside of it are false". She also maintains, "…many therapists in the recovery movement severely underestimate the prevalence of women and children who have had, and continue to have false memories of incestuous and ritual abuse…" Does this indicate a narrowing of the gap in the debate? Margaret Jervis puts this welcome turnaround under the microscope on page 12.

As we go to press the controversy around the "recovered/false memory" debate has been re-ignited in a criminal trial at Chester Crown Court, (see News Features). Attempts to box in or even refute "false memory" continue to haunt academic and clinical practice. We argue that the shoe is on the other foot; nobody has yet produced convincing evidence of "recovered memory" being genuine. Where it is first manifested is largely irrelevant but therapy or therapeutic concepts, remain the predominant midwife.

Clearly there needs to be a forum for a review of sound theory and practice across the board drawing together the many strands of this tangled web of systems failure.

Madeline Greenhalgh

Would you like a video or transcript of this year's AGM?

*** Videos are priced at £10 (inc. p&p)**
*** Transcripts of talks by the two invited speakers are priced at £5 (inc. p&p)**

STOP PRESS

Satanic report shelved

As we go to press, reports are reaching us that the Valerie Sinason satanic abuse adult survivor report has been shelved by the Department of Health and will not be published.
(see Ritual Abuse seminar shunned by professionals page 3)

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NEWS FEATURES

"False memory" titans clash in court

Claims that "false memory" accusations are solely a product of therapy were laid bare in Chester Crown court on October 18 when a jury acquitted a retired farmer accused by a woman having a history of anorexia and depression.

The court heard that the woman, a 30-year-old solicitor, had confronted family friend Edward Williams, now 72, in 1998 after undergoing counselling. But she claimed to have first realised she had been abused in 1988 when watching a programme about Childline but did not tell anybody until she entered counselling in 1996.

The jury took five minutes to acquit Mr Williams of eight counts of indecent assault held to have been committed 15 years ago.

The court heard that the woman had a long history of psychiatric problems and had received counselling from her doctor after developing anorexia at university but had not, at that time, mentioned the alleged abuse.

The defendant had denied all charges.

After the verdict, the presiding judge, Mr Justice Poole told Mr Williams, "The unfortunate complainant, who nobody criticises and who has a history of anorexia and depression, was truly suffering from false memory syndrome. That's to

say, genuinely believing in memories that were entirely false.

"You will leave this court without a stain on your character."

The trial marked the clash of two experts on a narrow divide of the false/recovered memory debate. Appearing for the prosecution, psychologist Professor John Morton disputed that a belief in abuse developed prior to therapy was unreliable. For the defence, psychiatrist Dr Janet Boakes told the court that a person could have a feeling or an apparent memory that is entirely false and then develop the narrative through "memory recovery" in therapy.

Professor Morton, who was the chair of the British Psychological Society working party on recovered memory in 1995, thought that the complainant fitted the profile of a likely candidate for "false memory syndrome" – she was thirty, well-educated and had undergone treatment for a psychological problem including an eating disorder – but that this was contra-indicated by the self-reported history of previous awareness triggered outside therapy.

Dr Boakes on the other hand, who sat on the Royal College of Psychiatrists recovered memory panel, saw the development of false belief and memory as being a process not limited to therapeutic influence.

The case highlighted the continued attempts by proponents of recovered memory to validate their cause and discredit false memory.

In March this year, psychologist Dr Bernice Andrews, who was also a member of the BPS working group, claimed to have discovered that most recovered memory was activated outside therapy. She went on to state that this cast doubt on interpreting recovered memory as false because, she claimed, this was only applicable to the use of recovered memory techniques *in* therapy.

Dr Andrews' findings, based on a sample of cases provided by clinical psychologists, was dismissed as bogus research by Professor Larry Weiskrantz, Emeritus Professor of Psychology at Oxford University. "One wishes in vain for a time when the BPS fostered genuine and responsible research in this area," he commented at the time. "There is genuine research to be carried out in this area. This is not it," he said

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"Ritual abuse" training shunned by professionals

Efforts to rehabilitate "satanic ritual abuse" suffered another set back when a professional training seminar set up the Association of Child Abuse Lawyers (ACAL) was cancelled for lack of support.

Originally entitled *Professional Perspectives on Ritual Abuse*, the conference scheduled for Friday October 13 was to feature a strong line up of speakers including three QCs. Also to speak were psychotherapist, Valerie Sinason and Metropolitan police officer, Clive Driscoll who have collaborated on research purporting to demonstrate the existence of satanic ritual abuse from adult histories.

The appearance of Sinason and Driscoll prompted speculation that the publication of the research, currently being peer-reviewed by the Department of Health was imminent. After a three-year delay, the report had been lodged with the Department earlier this year following a renewed bout of publicity attesting to the existence of ritual and satanic cult abuse.

It is understood that the conference, attracting six hours of Continuing Professional Development points for professionals, was renamed *Professional Perspectives on an Aspect of Abuse* after consultation with the co-sponsors and organisers, Butterworths Lexis Direct. The press were barred from attendance. In an introductory letter, chair of ACAL, Lee Moore, a former barrister and self-professed "recovered memory" satanic abuse survivor, stated "Victims of ritual abuse are frequently seen in the family courts, the criminal courts and more recently in the civil courts – as personal injury claims for compensation are presented. Such cases present distinct and severe difficulties for all professionals involved. As yet however, the powerful training need for professionals involved

in these cases has not been met."

The legal line-up included family law specialist Ernest Ryder, QC, a counsel to the North Wales Waterhouse Inquiry, prosecutor Nicholas Campbell QC and personal injuries lawyer Elizabeth Gumbel, QC.

Since the hey-day of belief in the late 80's and early 90's, professional interest in ritual abuse has largely subsided with claims being linked to the generation of stereotypical false narratives made by adults in therapy. Also indicated were the expectations of social workers dealing with disturbed young children after they had undergone training in recognising "symptoms" of the victimisation. Research by Professor Jean La Fontaine commissioned by the Secretary of State for Health examined the evidence for the claims made in cases involving children and adolescents. In common with other studies carried out by Scotland Yard in the UK and the FBI in the USA, she found no tangible evidence for the claims and provided an alternative explanation based on the unwitting transmission of fears and superstition which were projected onto children and disturbed adolescents.

Ms Sinason, formerly of the Tavistock Clinic in Hampstead but now working privately at the Clinic for Dissociative Disorders in Harley St, began her research in 1994 after the publication of her book, *Treating the Survivors of Satanist Abuse*.

See also www.offmsg.connectfree.co.uk

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Groups gather to fight injustice

The first national UK conference on false allegations of abuse will take place in London on Saturday, November 11. Entitled *Resisting the Inquisition - Rectifying an Injustice*, the conference is organised by the campaign group Action Against False Allegations of Abuse (AAFAA). It will discuss current failings in the investigation of sexual abuse and proposals for reform. Speakers will include criminologist and BFMS Advisory Board member Bill Thompson from Reading University, solicitor Chris Saltrese, who has represented many people falsely accused in retrospective children's home cases in the north-west, researcher Tania Hunter and BFMS legal affairs adviser and former journalist, Margaret Jervis. The keynote speech will be given by leading social commentator, broadcaster and writer, Frank Furedi from Kent University.

"There is a movement emerging to fight the injustices of false abuse allegations," says organiser George Williamson of AAFAA. "The conference is an opportunity to meet activists from like-minded kindred groups."

The last year has seen a number of campaign groups being set up to protest miscarriage of justice in abuse convictions. AAFAA has attracted a large number of prisoners with their supporters outside. It organised the first public demonstration outside a Childline conference attended by Cherie Blair and Hillary Clinton in May last year. Since then Falsely Accused Carers and Teachers (FACT) has emerged in the Northwest, centred on the mass retrospective allegations made in Operation Care. It is claimed that 90 former care workers and teachers have been falsely accused at one former approved school in Liverpool, with a number of men wrongly convicted and others facing trial.

Individual community support groups have also been formed. The earliest was the Bryn Estyn Staff Support Group, set up to counter the false allegations made against former staff in the media and in the Waterhouse Inquiry. The group has lodged an application to the European Court of Human Rights challenging the fairness of the three-year Tribunal. In South Wales, the convicted former head of the Welsh social services inspectorate is supported by Friends of Derek Brushett, while in North Wales, a similar group has been set up around a former care home head, Roger Owen Griffiths (FROG).

Prisoners have themselves set up protest groups such as the *UK2000* - the figure said to be an estimate of the number of people wrongly convicted for abuse allegations. The campaign was formed by prisoner Graham Walker, whose accuser made uncorroborated accusations 15 years after the alleged offences, claiming she had "blocked out" the memory until then. Despite the

lack of reliable evidence against him, Mr Walker has lost two appeals, including a referral by the Criminal Cases Review Commission.

This was the first case referred by the Commission not to be overturned by the Court of Appeal.

"When we first set up AAFAA we realised we had tapped into a huge vat of silent suffering," says Mr Williamson. " Many of the supporters of those affected cannot speak their names because of gagging orders and the taint attaching to sexual abuse allegations. If people are prepared to stand up and be counted within a movement, it will lend courage to others who will no longer be afraid to press for the restoration of justice."

The conference will be held at Friends House, 173 Euston Rd, (opposite Euston Station), London, WC1 from 10.30am – 4.30pm on Saturday 11, November, 2000.
Tickets, price £10, available by post or phone. Send cheques made payable to AAFAA at PO Box 84, Leeds, LS5 3XZ. Tel: 0113 2590812.

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FOCUS ON PRACTICE

Don't put your daughter in a unit, Mrs Worthington…

Entrusting an emotionally disturbed teenage daughter (or son) to psychiatric care is an upsetting experience, but one marked with relief and faith that the problems are being dealt with by expert and caring hands, outside the maelstrom of the family environment. Parents know, all too often, how difficult it is for teenagers to share their fears and insecurities with them in anything other than confrontational or withdrawn terms because of their need to strike out an adult identity in a confusing world. That is why they are so trusting in the professionals in the first place, as they have every right to be.

Because of the worrying precursors, the peculiar Kafkaesque nightmare that may then unfold may be, at first, passively accepted as a necessary stage in healing beyond the ken of lay mortals.

For after a honeymoon period of reassurance, there is a disturbing deterioration of the patient accompanied by increasing distance from the professionals and vagueness as to what is happening. Parents may hear of a "sexual trauma" - perhaps a stranger assault about which they knew nothing. This creates profound anxiety, rage and guilt, because they had no previous suspicion that such an awful event had taken place.

But rather than this horrific alleged event being clarified, so that appropriate action may be taken, the focus of accusation suddenly changes to the parents themselves. By this time contact between the family and the hospital is minimal, and may have been presaged by a complete information blackout. In fact the first time the parents know of the allegations may be when a police officer turns up at the door.

As the accompanying testimonies bear out, this pattern recurs in a disturbing number of cases that the BFMS hears about, but they are not the sole source of disquiet.

For there are other sorts of teenage cases, where no initial psychiatric treatment occurs but the allegations are made during a period of emotional disturbance or conflict – such as rows over boyfriends and staying out late. Or, having read of the brave plight of plucky abuse survivors, a teenager may make up a story to a friend for sympathy and the heroism of victimhood – not realising the conflagration that will begin when the friend tells a teacher or goes home and tells her mother.

In such situations, the protection that surrounds the false accuser becomes a straightjacket. If they retract, they are assumed to be in denial and pressure and rewards are touted for continuing to uphold the narrative that must be believed.

As the system takes over, whether it is psychiatric treatment, a criminal prosecution or both, the normal checks and balances of investigation are ignored. Alternative explanations – including environmental or personal suggestion, a motive to lie or a psychological imbalance creating a predisposition to sexual allegations or fantasies –

are not considered and the subsequent mental deterioration of the accuser is considered to be the predictable outcome of the abuse. This is assumed even though it is strongly correlated with the making of the allegations and not the pre-existence of abuse.

Only when she was withdrawn from the clutches of the unit did the immensity of the nightmare she had been induced to create sink in.

The reason why this happens is more than the natural tendency to want to side with a distressed youngster and nail her presumed assailant. Sudden allegations of abuse should always be treated considerately and with due seriousness. No child should be made to feel they will be automatically disbelieved or that a genuine perpetrator will be unpunished. But the reasons why the system places unwavering support in allegations, despite the antecedents and circumstantial reliability, lies in the flawed theoretical assumptions that have permeated our criminal justice and mental health systems over the past twenty years.

These assumptions are contained in the child sexual abuse accommodation syndrome (CSAAS) – a discredited contradictory Californian hypothesis redolent of the ducking-stool method of witch finding. The bare bones of it are that a child might not disclose sexual abuse but instead reveals it in anti-social behaviour or other kinds of physical or psychological symptoms. Alternatively s/he may "accommodate" it so successfully that there may be no symptoms at all. Many practitioners have assumed an inverse relationship between the degree of disturbance and the extent of the abuse, so that in the notorious ritual abuse nursery cases in the USA in the early 1980s such as McMartin, the fact that a child showed no symptoms meant that s/he may have been subject to the grossest possible abuse.

But the alleged syndrome is more than this. It is a pan-global ideological explanation for a vast array of societal problems – drugs, violence, crime and corruption - and because the abuse is presumed to be hidden, there is no way of disproving the thesis.

Imported into the forum of teenage problems, the CSAAS is potentially lethal. Not only may it be posited to explain current problems, real or imagined, but it will also justify the mental deterioration of the patient after the allegations are made. Thus the self-harm, overdosing and the dependency on psychiatric drugs in addition to recreational heavy drinking and drug use that all too often follows, will be blithely put down to the effects of the abuse, even though it was posited that the presenting problems were caused by the non-disclosure of presumed abuse that was "accommodated".

In one case we came across, an emotionally disturbed girl made allegations against 32 people both in the community and her own family under the tutelage of a psychiatric unit and social services. Only when she was withdrawn from the clutches of the unit did the immensity of the nightmare she had been induced to create sink in. She wrote letters apologising to those concerned, yet still the authorities refused to accept the retractions and so no lessons were learnt.

In similar cases, prosecutions have followed and innocent people have been convicted. This process is likely to have the additional effect of causing permanent damage to the accuser's mental and physical health since s/he has been pushed way beyond the possibility of reconciliation. In many cases, accusers are literally "scarred for life" through self-harm by the effects of the authorities encouraging or upholding false beliefs.

The CSAAS is the mechanism of an open scandal within our mental health and criminal justice systems. What is accommodated is not hidden abuse, but the damage caused by the application of the theory. Until there is a wholesale review of the circumstantial reliability of the knowledge base on sexual abuse as it has evolved over the last twenty-five years, the corruption of young lives will not just continue, but get worse.

Margaret Jervis

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Under a dark cloud

(names have been changed to protect identities)

My wife and I spent much of the 1990s under a dark cloud. Our daughter Ann became ill in early 1990 when she was preparing for her GCSEs. Her brother was eighteen, Ann was sixteen and her sisters were twelve, five and two. She was a bright girl, caring towards others and very good with her younger sisters. She was doing well at school and was very successful at sport.

Ann complained to people at school that she was unhappy about our impending move and she was probably also having difficulties about her identity. She started to become disturbed and stopped eating. Her self-starvation was so severe that she was hospitalised to a psychiatric unit, in May 1990. This specialised in treating eating disorders and adolescents. It was in pleasant surroundings and the psychiatrist, Dr C. (expert in treating eating disorders), and other staff appeared caring. My wife and I did not realise that we were exposing our daughter to many malevolent influences.

We visited Ann at the Unit most Saturdays and she started eating after a few weeks. We tried to understand what was wrong with her and attended sessions of family therapy. She soon made a "disclosure" and her therapist, Moira telephoned to say that something had happened to Ann, which was neither her fault nor ours, but Moira was uncertain whether Ann would ever tell us about it. Moira included relaxation, cognitive and psychodynamic therapy and aromatherapy in her eclectic repertoire. Ann also joined a therapy group, known as "the girls' group", which, as we learned later, was for abused girls. She entered this group around the middle of June 1990. Ann was not coerced into the group but must have been informed of its existence and purpose and I think likely that Dr C. or Moira diagnosed her as "abused" and suggested the group psychotherapy to her.

The group therapy was very disturbing. We were advised not to telephone on the day the group met because the girls were so disturbed. We got little information about this therapy but the psychologist in charge clearly believed that such intensity and disturbance was beneficial. Ann became more and more disturbed, took overdoses and absconded from the Unit as well as cutting herself and banging her head, often uncontrollably. This caused us much anxiety.

We attended family therapy and the Psychiatric Unit Case Conferences. At a family therapy session we were asked how we would feel if Ann had been raped. After we said that we would feel very sorry for her, Moira, not Ann, disclosed that Ann had been raped. Ann then ran out of the room and we were not allowed to see her again that day. We were very unhappy and puzzled about this. The Unit gave no details but the police contacted us later and explained what Ann said had happened.

Ann came home for a day in July to pack up her things and meet friends before we moved house. The Unit was worried that she would harm herself or abscond. However, she was only disturbed at the Unit although staff did not understand this. It was as though she had an identity for home and an identity for the Unit.

There were many disturbed girls at the Unit and we noticed that dislike of home was part of the group culture.

We were coming to terms with the rape by the next family therapy (27 July). This time Ann stayed in the observation room with the doctor and nurse who fed ideas to the therapist in the room with us. After the session Dr C. said that the family worked like a good team and he could not see why Ann did not want to stay with us. We didn't know about this. She was running away from the Unit, not home. There were many disturbed girls at the Unit and we noticed that dislike of home was part of the group culture.

Ann's disturbance grew and she would go into trance-like states of dissociation, i.e. what the ordinary person would call an hysterical fit. It is a state of altered consciousness like hypnosis and marked by high suggestibility. Her disturbed behaviour was regarded as consistent with a long history of severe abuse but we see it as part of the Unit culture with its peer group pressure in a

strange place where she, then very open to suggestion, was being traumatised by inappropriate therapy.

Near the end of July, and after about six weeks in the girls' group, a police sergeant and a WPC came to see her. They had told Ann that the rape story was falling down so suggested that she was covering up for someone in her close family. This suggestion upset Ann which, the sergeant claimed, proved that it was right. Soon after this, Ann began to make disclosures of incest to one of her therapists, Jo, a newly qualified nurse. Jo took a special interest in Ann, to the point of breaking professional boundaries by giving her presents and later on making Ann a bridesmaid at her wedding.

We heard about this "disclosure" on 13 September 1990, at a meeting at the Unit with the police, a social worker and a member of the Unit staff. This was another great shock on top of everything else. The dogmatic, prejudiced attitude of the police and others was particularly distasteful. When we got home my wife showed common sense by asking our middle child, Cathy, whether dad had tried to do anything wrong to her; Cathy was shocked at the very suggestion and this confirmed my wife's belief in my innocence.

My wife and I discussed the situation from every angle. At a Unit Case Conference the following week I denied the allegations and said that they only existed in Ann's head. We wanted to know what was the matter with Ann. Dr C. considered that she was not psychotic. He stated this later in a letter and said that, although Ann was often extremely emotionally disturbed, she must know whether what she said was true or not. His opinion was quite wrong because research into suggestibility, hypnotism, influence, guided imagery, cults etc clearly shows that mentally sound people can believe all sorts of incredible things under suitable conditions of influence, suggestion and suggestibility. His error had long term implications for Ann's treatment and the trauma being inflicted on the family.

Friends, new and old, helped us. Two people at the Unit offered support and we hoped they would see that the allegations were ridiculous. However, they seemed unconcerned about truth and we could not get through to the Unit that they were on the wrong track altogether. Moreover, the therapist, Moira, who was working with Ann insisted that it was her duty to believe her client. It meant that Ann got worse and her recovery was set back for several years. It also damaged my own mental health.

A social services case conference followed at which I explained that I thought the policeman's suggestion had triggered a fantasy in an imaginative and troubled person. It was felt that a proper statement would be needed but it was uncertain whether Ann would give one. However, she telephoned one evening and told both of us that she had imagined the whole story. We were relieved to hear this and hoped that things would improve. Ann also wanted to come home but my wife explained that this was difficult, not only because of the hurtful things she had said but also because of the attitude of the Unit. The Unit accepted that Ann was a voluntary patient and could leave at any time but if she attempted to leave they threatened to detain her under the Mental Health Act. She was their prisoner and they held her as a human shield so that it was impossible to challenge those most involved with Ann without affecting her.

Despite her retraction, a police statement was taken from Ann a day or two later, at the end of October 1990. I was arrested and questioned. The police were entirely biased. The senior detective told me that Ann, whom he had never met, was abused and I was the abuser. He said that he knew I was guilty and that he had never been mistaken. At this interrogation I learnt about the accusations which had previously been mentioned in general terms. I was accused of all sorts of sexual molestation, oral sex and full intercourse with Ann from the ages of 7 to 14, all of which I denied because I had never, ever, done or even thought of doing such things. At the same time a team from the police and social

> The police also said that my wife should tell Ann that she believed her even if she didn't.

services checked the rest of the family at home. I think they were surprised to find nothing to be concerned about. Strangely, they did not interview my wife. She queried this with the local social worker, Tom, and eventually two policewomen spoke to her. They showed her Ann's statement, thinking it would convince her but she was unconvinced and pointed out the flaws to the police. The police also said that my wife should tell Ann that she believed her even if she didn't. They re-interviewed Ann and, in early January 1991, we were informed that there would be no police proceedings and Ann could get no further with her story.

I was so upset and disturbed by what had happened that I lost about 20 pounds in weight over the three months September to November 1990. It was a terrible nightmare and seemed to get worse and worse. For example, we thought that the incest story would be discredited after the police dropped it. However, when my wife asked a keyworker at the Unit what was really wrong with Ann, she was told, "she has been sexually abused by her father". The Unit was deeply entrenched in a belief it had helped to create.

Social Services pursued the child protection issue. In November/December Tom, the social worker saw us, went to our former area, visited Ann's school and interviewed my former superior who wrote a paper about me, the family and why the accusations were out of character and context. We thought that this would show that the concerns were unfounded. It seems that some (possibly from the Unit) at the Case Conference in early January believed that there must be something wrong so we agreed to a further voluntary investigation by Tom. This took place during the spring of 1991 and continued to show that all was well at home. Nevertheless, at the next Social Services Case Conference, in mid-1991, the favourable report from Tom's many visits was not accepted as definitive. An external investigation was called for, presumably by those who believed that there must be serious risk to the children, i.e. staff at the Unit. They could not see that the problem was not to do with the family but with Ann and the Unit.

At the mid-1991 Case Conference the children were placed on the Child Protection Register, allegedly so the investigation could be carried out by an expert and financed by Social Services. Dr E., the expert, was approached, but did not make his investigation until Feb-April 1992. This delay and a further long delay waiting for his report to be sent were very stressful.

I did not think that anyone had deliberately done this but that given the way things were set up it was almost inevitable.

I had pointed out at Case Conferences and in discussion that the accusations of long term incest had no relation to Ann's life at home, that we had encouraged her to join social activities outside the home where she was free to talk with people. We, me especially, had encouraged her to go to the Unit. Ann's brother (two years older than her) also contradicted her statement and wrote a page on why he did not believe it. He emphasized the strong relationship between me and my wife.

Meanwhile Ann made progress and had setbacks. She continued to maintain the allegations and could not be dissuaded by us. If we tried to contradict her she remained adamant. Nevertheless, we met as often as we could.

I was greatly puzzled. Ann appeared to be telling the truth but I knew that she was not. As a result of my reading, especially R. Temple's book on hypnosis, *Open to Suggestion*, I found that a person can sincerely believe untrue things, especially under certain conditions. Ann's mental state and the conditions at the Unit made her more and more suggestible. There were suggestive influences - authority figures, peer pressures ... and the stressful group activities and the hysterical trances. I argued that Ann had been accidentally brainwashed. I did not think that anyone had deliberately done this but that given the way things were set up it was almost inevitable. I wrote this up as a paper and sent it to Dr C. All that I have read since confirms to me that the regime at the Unit in 1990 would provide a model for brainwashing. Dr C. and the unit dismissed my ideas. He said I was "playing games" and was offended that I questioned matters of diagnosis. I agreed to send a summary

of my ideas to Ann but the unit reneged on their agreement not to rubbish what I had written and explained it away as a form of denial. They seemed unaware of the subtle influence of worker expectations on susceptible patients.

I consulted Mr Temple who said that arguing with Ann would not help. We decided to develop our relationship with Ann without reference to the Unit. Mr Temple thought that there was no quick fix and we needed to think in terms of years, not weeks. That has proved to be wise and true.

In early 1992, my wife and I met three times with Dr E., the expert referred to by Social Services; at his office, at our home and with Ann at the hostel to which she had moved. He also met Ann on another occasion. In our third meeting with him, Dr E. suggested that we discuss Ann's statement and I saw it for the first time. He insisted that the group therapy at the Unit had taken place after the incest "disclosure" but, and Case Conference minutes confirm this, Ann had been in the girls' group for six weeks or more before the incest allegations. Although I corrected him, verbally and in writing, he refused to correct this misinformation.

We waited nearly six months for Dr E.'s report and then only had about a day to prepare for the Social Services Case Conference. Dr E. dismissed me and my ideas but considered that there was no point in the family being on the Child Protection Register. Although Ann was concerned for her sisters, Dr E. observed that they were fine, even after all the pressure we had been put through. He said that there was a special relationship between me and Ann and believed that I dominated my wife. He argued that I had more to gain from lying, therefore Ann was probably telling the truth. He did not investigate the psychiatric unit and simply said that I had fabricated my ideas about it. Thus the Unit was never investigated and its toxic therapy was ignored. In one place he described my wife as unable to test reality but had to contradict this because it was clear that she could. He said that my supporters, who spontaneously protested my innocence, could not see any other viewpoint. He did not test reality himself with regard to the Unit. However, where he did check reality, in meeting my wife and family at home, he found nothing untoward. He ignored the fact that Ann had not had a medical examination. I showed the report to my colleague and a visitor, a former educational psychologist, who was appalled by its loaded language, questionable opinions and unfounded statements. The report was a big disappointment to me and several years later my wife and I still consider it a disgrace. The deregistering of the children was accepted at the CP Case Conference in September 1992 where I again defended my position vigorously.

Meanwhile, Ann continued to be disturbed and only really settled down in mid-1992 after leaving the Unit. She settled in a hostel, then moved to a flat and we kept in touch with her. She was on good terms with us when we met her although we usually let her take the initiative in contacting us.

When the social services disengaged at the end of 1992 we thought we had finally succeeded. The Chair of the Case Conference, a very reasonable woman, hoped our daughter would get better. She noted the children were getting on well in spite of all the stress and that was a credit to us. Zoe, the social worker involved by that time, did not think my continual researching and concern revealed guilt, rather the opposite. We had convinced people in a situation in which one has to prove beyond all reasonable doubt that one is innocent. However, the awful truth began to register that Ann still believed these terrible things. In early 1993 I had a nervous breakdown, a reaction to all that had happened, and was off work for about 10 weeks. It was at least a year before I was able to function reasonably well and probably not until 1995 that I really recovered though I am still susceptible to anxiety attacks and agoraphobia. It is quite possible that the younger children were affected by the tremendous stress of those years. My wife was truly marvellous and showed powers of care and common sense that eluded many professional workers.

As a family we continued to contact Ann and the friend she lived with. They used to visit us and we saw them around Christmas 1997. Shortly after, we were visited by social workers. Ann was back in a psychiatric unit and her friend took the old accusations to the police who took no further action but passed the complaint to our

local social services. We discussed the matter with the social workers and allowed them to meet the youngest daughters who were still at home. A couple of weeks later we heard that they were going to take no action.

Some time later, Ann wrote to us, saying that she wanted no further contact with me and my wife. It was clear that she still believed the accusations. We replied as firmly as we could and assured her of our love and forgiveness. We didn't hear from her for several months although she contacted her sisters, especially on their birthdays. This was a great setback. However, the Royal College of Psychiatrists had just published a report on false memories which showed, among other things, that patients with these problems were likely to suffer relapses. We had always believed that that a treatment based on untruth could not succeed.

On Thursday 13 August 1998, I was washing the car when I was told Ann was at the door. She seemed bright and cheerful and responded positively when I shook her hand. I returned to washing the car and Ann appeared shortly afterwards with a mug of tea and said she had come for a purpose. She said that she was sorry for all the trouble she had caused. She had really believed those awful things but recently realised that they were not true. I put my arm around her and said that it had all been a terrible nightmare for us. I was tearful and she kept saying she was so sorry. I said that I had prayed every day that she would see the truth. It seemed that a psychotherapist had helped her to see things differently. One night she couldn't sleep and realised that her allegations had been wrong. Bravely, she decided to come in person. She thought that the Psychiatric Unit hadn't really been the best place and the staff were not well trained. I remarked that we had encouraged her to go there but she said that we were not to know what would happen. She thought that eight years had been wasted. Indeed, there has been much waste but I pointed out that we had helped some people with similar problems and told her that Mr Temple had said it would take years rather than months.

It was a very emotional day and I felt the pain draining out of me. I kept thinking about it for days. It had been a great delight to see Ann. However, my thoughts were not so positive towards those misguided folk who poisoned her mind through their lack of knowledge and skill. As for those who mentally and emotionally assaulted me, I hope and pray that the truth will dawn upon them.

by Barnabas, a falsely accused father

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Psychiatry failed my daughter

My daughter suffered from what her psychiatrist said was severe depression. At 18 she was admitted to the acute ward of the local hospital specializing in mental disorders. She stayed there for five months until her transfer to the Cassel Hospital in Richmond in November 1997. We tried to find out both from the Cassel staff and her psychiatrist what the Cassel's treatment programme consisted of, but with no result.

Eight months into her treatment, which included both individual and group psychotherapy we were called to the Cassel for a meeting where my husband was accused of sexually abusing my daughter.

Whilst at the Cassel my daughter's self-harm increased to such an extent that she now has horrific keloid scaring on both arms. At this point Social Services became involved and our daughter started to spend weekends away from the family home but she still visited on a regular basis.

She was discharged from the Cassel in December 1998 back to the care of her psychiatrist where she continued, following a suicide attempt in May 1999, to receive psychotherapy on a regular weekly basis.

Although not living at home she continued to have almost daily contact with my husband and myself. It came completely out of the blue when my husband was asked to go to the local police station where he was arrested and then bailed for rape and indecent assault. The charges laid by my daughter related from the ages of 4 until she went into hospital at 18. My daughter had been seeing the Child Protection Team and compiling a

detailed statement of abuse since March whilst still visiting the family home and spending time with my husband even knowing that I would not be there.

After the arrest and bail an horrific time followed. The local Social Services harassed and bullied my younger son and elder daughter about the grand-children. They had already obtained reports from our G.P. and the grandchildren's schools and were insistent that they interviewed the grand children alone. Each time my son demurred they increased the pressure saying that they would need to call a child protection conference and doubting their ability to keep the children safe. To prevent this my son and daughter-in-law agreed to let the social worker see the girls (aged 9 and 11) At the end of the interview, which revealed nothing, my son and his wife had to sign a document to say that although they knew my husband had done nothing wrong they would not allow the girls to see their grandfather alone until the matter was resolved .

My grandson, who is 16, refused to talk to the social worker and said he would continue to visit us and see his grandfather.

I first found out about the Cassel Hospital from their newsletter on the Internet and that the adolescent unit "specializes in the assessment and treatment of severely disturbed adolescents, many of whom have a long history of self-harming behaviour, suicidal attempts, sexual, physical and emotional abuse and depression." The same assumption applied to my daughter's individual psychotherapist. There was an expectation by the Cassel staff that abuse had taken place.

Since this we have learned from our elder daughter that my daughter's psychiatrist has told my younger daughter that she knew she had been sexually abused from the first time she saw her. All this without my daughter having said anything! So I now realize that all my daughter's psychiatric treatment has been based on the false premise that she had been sexually abused.

In fact my daughter has never been abused in any way. She has had a very normal childhood. She was intelligent, attended a good grammar school where she achieved nine GSCE's and three A levels. She plays the cello, was a keen sports player and had a place at Exeter University to read Sports Science. We have waited, with my husband on bail, for the last 14 weeks not knowing whether he would be charged. The Crown Prosecution Service has decided to take no further action so it appears to be over.

However I have a daughter whose present life is built upon false premises, who was sectioned for a time and returned to hospital and who is completely isolated from the family who have supported her. I have made a complaint against the Cassel Hospital and have reached the mediation stage. I do not intend to let the matter drop. I am also starting complaints procedures against her psychiatrist and Social Services.

The effect on the family has been devastating.

by Deidre, a mother of an accusing adolescent in psychiatric care

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FEATURE FORUM

Feminist researcher backs down on recovered memory

by Margaret Jervis

Not since Freud's repudiation of the seduction theory has there been such a spectacular climb down as feminist researcher Diana Russell's renunciation of recovered memory. In a new edition of her landmark 1986 book *The Secret Trauma*, she reviews the evidence for therapeutically excavated abuse histories.[1] They are, for the most part, fiction rather than fact, she concludes, with a composite profile in sharp variance to the case histories discovered through her own retrospective survey of incest, widely hailed as the definitive study of incest prevalence.

This turnaround is all the more remarkable for its graciousness. She documents the emergence of the "false memory" issue by and large without the customary gratuitous rancour of her peers in the survivor movement, reserving her vitriol for the therapy industry - particularly the multiple personality disorder trade and the "ritual abuse"

fiascos involving pre-school children in day-care.[2]

Russell's survey was conducted in 1978 in California. Its prevalence figures of 16 per cent of women sexually abused at least once before the age of 18 by a relative with 36 per cent of the sample reporting an incident of sexual abuse by any adult, fuelled the belief that chronic sexual abuse in the home was commonplace lending support to theories of repressed or hidden memories. But the comparison between her actual findings and the stereotypical "recovered memory" (RM) images of incestuous abuse reveals telling disparities. Usefully she charts the key differences relying, for her evidence, on documented retractor testimonies.[3] Whereas fathers were typically implicated in the RM scenarios, they accounted for only 4.5 per cent of her study. RM histories of incest typically involve a lengthy regime of serious penetrative abuse, often including bizarre and sometimes ritual behaviour, whereas her study indicated more mundane short-lived activity, often a single event. On this data alone, the stereotype of the "incestuous father" as the Jekyll and Hyde monster lurking behind Everyman suffers a mortal wound. While such abuse can occur, the perception of the probability of this happening without independent corroboration must be dramatically reduced.

Yet Russell's purpose is not to repudiate the incest survivor movement but to rekindle its flame by distancing it from the counterfeit incest recovery movement. In this she follows her peer, Louise Armstrong, whose attack on the recovery movement in her 1994 book, *Rocking the Cradle of Sexual Politics*, broke ranks with the fragile alliance of feminists and therapists.[4] Beneath the dazzle, this is the most interesting and problematic facet of Russell's enterprise. Unfortunately it begs more questions than it answers, reminding us that her underlying purpose remains, as with Armstrong, ideologically rather than scientifically driven.

Firstly, while Russell appears to have forsworn the Van-der-Kolk-ish journey to the centre of the amygdala in the quest for lost neurons of the trauma zone to support the flagging RM thesis, it remains unclear what her residual belief in recovered memory is. She postulates that her table of differences between the survey findings and retractor recovered memory histories might be a useful arbiter of truth, but, as she herself points out, it is possible that the publicised retractor histories are the most extreme leaving the truth value of more mundane recovered narratives in limbo. Furthermore her use of the terminology of memory recall is confusing and ill defined. Sceptics normally use the term "retrieve" to signify the ordinary authentic recall of a forgotten event, contrasting this with the bogus amalgam of experientially fresh delusional states which become seen as memory which is "recovered" only because it is termed "memory". Russell however uses the term "retrieved memory" to indicate the latter while ignoring the distinction between ordinary recall and visionary states. On the face of it therefore, sceptics would be prepared to accept certain memory events as authentic that Russell would discount, while doubting some that she would affirm because they did not satisfy her retractor criteria.

> The extent to which this process elicited imagined or embellished accounts cannot be established on the published data, but even if it had only a marginal effect, it could have resulted in significant distortion of recorded experience

Authentic retrieved memory would sit comfortably with the type of one-off events Russell's respondents for the most part remembered. Her definition of incest and its perpetrators was broad, so that a tipsy party kiss by a brother in law of a 17-year-old girl would qualify as incest. This fact should not be used to obscure the reality of closer relatives subjecting much younger children to more insidious abuse, but it provides a landscape within which we can regain a much-needed sense of perspective.

Even more problematic is the methodology of the 1978 survey itself. While fishing for repressed memories was not part of the brief, interviewers were trained to believe in their existence and

questions on sexual experience were graded in ways that "helped to tap women's memories of experiences, *some of them long repressed*" (italics added).[5] The extent to which this process elicited imagined or embellished accounts cannot be established on the published data, but even if it had only a marginal effect, it could have resulted in significant distortion of recorded experience.

Furthermore, although conducting quality control of the recording of the interviewers, the authenticity of the data itself was not verified. Russell assumed that all her respondents were telling the truth unless they were withholding experiences. Although it is likely that some women did not wish to reveal sexual incidents in their childhoods, and that these may well lie hidden among those who refused to take part, the failure to consider the possibility of fabrication is likely to have more far-reaching consequences for the interpretation of the data.

Assuming the majority of the experiences to be authentic, individual vignettes provide a valuable portrait of the types of abusive behaviour suffered and the effects, with Russell noting that where biological fathers were implicated even a minor transgression can be emotionally devastating. This in fact underlines the endurance of the incest taboo between parent and child indicating that for the most part the victims were well aware the behaviour was abnormal and wrong rather than their being readily brainwashed into believing that this was what "all fathers do" as the survivor movement would have it.[6]

However a number of the more serious detailed histories are disturbing because they do not, in totality, ring true. For instance childhood abuse for some women seems to have predisposed them to becoming violently serially raped by strangers in improbable ways. It is worth noting that when the study was undertaken stranger rape was a hot issue for feminists, only subsequently was it revealed that such incidents are comparatively rare. Therefore the possibility that a few respondents were, for whatever reason, cueing into expectations, cannot be ruled out. This indicates that even the small percentage of severely abused incest victims identified by Russell may be an unreliable guide to their actual prevalence.

But there is another reason for questioning the clarity of the divide between the incest survivor and recovery movements. For at the very moment when Russell was undertaking her research in 1978, the lore and language of recovered memory was already being peddled in popular prose by feminists themselves.

In the groundbreaking book *Kiss Daddy Goodnight*, fellow traveller, Louise Armstrong, presented autobiographical histories of incest including her own.[7] Yet subtly the reader is not merely being informed of the misfortunes of others, but being taught how to identify with and recognise oneself as an incest survivor, and thus join a putative political movement in the nascent gender wars. Again we might presume that some, if not the majority, of the histories are true. However, Armstrong herself, though initially presenting a complete narrative of flirtatious behaviour by her father leading to oral rape, reveals later on in the book that she had no actual memory of the latter event until many years later, when persistent anxiety in her adult life and throat gagging led her to a disjointed realisation through penning a night time free-associative narrative. Prior to this we learn the nature of the technique - sitting with her jotter holding imaginary conversations with her dead father. This technique, traditionally known as necromancy, is one of the most potent weapons in the recovered memory arsenal.

If this were not enough to convince the reader that personal survivorhood is only a memory blip away, Armstrong's central character in the anthology, Jenny, emanates a kind of aspirational incest survivor chic, courtesy of "recovered memory". In addition to suffering the pattern of paternal abuse now characterised by Russell as likely to be false memory, Jenny finds inspiration and a new fulfilment as a liberated lesbian feminist through her journey. She is American upper middle-class, college-educated and only discovered she was an incest victim when she visited a psychologist. Prior to this she had no awareness of anything untoward in her childhood. At the time of meeting Armstrong she has still not remembered the "grisly details" but is still "blocking most of it out". She had reached the stage of having "flashes" and dreamlike images - a fact put down to the abuse taking place mostly when she was asleep. "It was not part of my waking day at all," she explains helpfully. From

this point Armstrong develops the repressed memory motif. Jenny's progress is marked by her retailing the stages of narrative construction under Armstrong's tutelage, while other histories are presented as end products, some of the recovered ilk, others always remembered and one or two frankly improbable under any description.

So perfectly does "recovered-dream" survivor Jenny begin to fit Armstrong's political ideal of the incest survivor, and so close is the bond that develops between the two, that one begins to wonder whether she herself is anything more than a product of the author's imagination. As ever in this war of words, the pen is mightier than the sword.

The brutal truth is that the incest survivor movement could not and cannot survive as a political force without recovered memory. To pack a punch it had to be high on emotion and short on fact exuding a homogeneity that would unite women across class lines to resist the oppressor-perpetrator otherwise known as the patriarchal male, or Dad. Many people who have undergone such experiences quite rightly do not wish to have their lives blighted by a narrow, prurient, definition of self, while those that have not, but think they have, end up hurting only themselves, and the innocents who love them, in the name of gender solidarity. Meanwhile the dreamt-of mass movement ends up as a lynch mob against paedophiles on the other side of the track. Russell's study, for all its detail, fudges the issues where it counts and, crucially, lacks a sociological hinterland in case studies and analysis to render it any more than a stage on an ideological way.

Notes

1 (1999) Basic Books, New York.

2 There is however a garbled attack on leading memory psychologist Elizabeth Loftus, not primarily because she has testified against recovered memory proponents, but because she was a defence expert on a rape case at The Hague Bosnian War trials.

3 Introduction pp xxxiv-vi

4 Published by Addison-Wesley in the USA. UK edition published in 1996 by the Women's Press with a forward by Gerrilyn Smith.

5 p. 24

6 Russell herself points this out in her original text when she criticises the survivor movement presumption that it is not father-daughter incest that is taboo, but talking about it. She concludes that this is "misleading, if not seriously erroneous" (p261).

7 (1978) Pocket Books, New York

Déjà vu or the trauma of repressed repression

Psychiatrist Professor Bessel Van der Kolk's blind'em-with-science approach to recovered memory has long had aficionados swooning in the aisles - despite their not being able to tell a neurotransmitter from a jellied eel for the most part. Scorched by the evidence that the recovered memory hypothesis is simply hogwash "repressed memory" has now been relaunched in a new guise by the Professor as "traumatic memory". A recent flyer for a seminar explains:

> "These memories are different…..[R]ecent neuro-imaging studies have started to elucidate where in the brain these memories are stored and what the mechanisms might be of the recovery of traumatic memories."

Oh yes? Presumably the unpleasant experience of remembering really nasty events in the normal way is not a "traumatic memory" at all because these are available to conscious experience. So now we know: traumatic memory equals repressed memory equals recovered memory equals…….. false

Good Science and the Reform of the Mental Health System

by Tania Hunter

Dr Mark McFetridge, a Consultant Clinical Psychologist who heads the Psychological Trauma Services Unit at The Retreat in York, presented a paper on Eye Movement Desensitisation and Reprocessing therapy (EMDR) to this year's conference of the International Society for the Study of Dissociation (ISSD). McFetridge's study involved patients suffering from chronic post-traumatic stress disorder following road traffic accidents, and the purpose of the study was to

evaluate the effectiveness of EMDR in "reducing levels of dissociation" (which in lay terms presumably means getting back to normal). EMDR appears to involve a mix of fairly standard counselling techniques combined with a form of hypnosis.

Although McFetridge explained that he is not entirely clear how it works, he suggested that the physical interaction between eye movements and the brain may set off a triggering process which tap into fragmentary childhood memories. EMDR is receiving a great deal of attention within the therapeutic professions and is generating a fast-growing body of literature. Although it is claimed that it is a "neutral" or "harmless" technique for helping traumatised patients to recover from adverse experiences such as traffic accidents, the potential dangerousness of the process became apparent when McFetridge described how one of his patients had recovered a painful and apparently unrelated childhood memory. He suggested that EMDR could be used with dissociative identity disorder patients (formerly multiple personality disorder) and the Retreat's promotional leaflet supports this suggestion "Preliminary evidence that EMDR may be reassociating somatosensory fragments of traumatic experience, and integrating this with other life events. EMDR may be reaching parts …".

The expertise and opinion of a British medical expert does not have to conform to a universal standard of "good science"…..

By the time families contact the BFMS they will be all too aware of the extent to which the British health system allows therapists to offer treatments that are untested and unevaluated, even when that practice is conducted within a *bona fide* psychiatric institution. When my daughter was referred to a new psychiatrist in 1991, neither her GP nor her referring psychiatrist had any idea of the particular orientation of the unit to which they were referring her. As it transpired, this ignorance was shared by the Medical Director and the Chief Executive of the hospital trust, despite the fact that the psychiatrist in charge of the unit, far from working on his own, was responsible for a large staff. I would like to think that today things are different. But contact with parents, who are currently facing criminal prosecutions as a result of allegations of sexual abuse made after their teenage daughters' admission to psychiatric units, makes it all too apparent that nothing has changed. If anything, the heightened anxiety about child sex abuse (CSA) combined with the mental health profession's current obsession with trauma therapy has increased the likelihood of false accusations and damaging treatments.

Many practitioners believe that any problems which arise with therapies such as EMDR are not the fault of the techniques but are caused by inept practitioners. But a system that blames the individual doctor while ignoring the wider context in which he/she practices is flawed and offers no protection for patients. My family would have been protected from the damaging practices of a single psychiatrist if the hospital and the Department of Health had installed proper safeguards and systems of "quality control". Anyone who has had experience of child protection and health systems will be aware of the reluctance of hospital management, social services and other professionals to question a doctor's practice. But there is a difference between questioning expert medical knowledge and examining the way in which that knowledge has been arrived at and how it is put into practice. Realisation of the need for some form of control is slowly seeping into sections of medical practice in the wake of the inquiry into infant deaths in a Bristol heart unit. However, as yet there seems a reluctance to apply this approach to doctors of the mind, and even less inclination to examine the practices of doctors who specialise in child sexual abuse.

American lawyer, Chris Barden, who was a guest speaker at last year's BFMS annual conference, described the changes that have taken place in the American mental health system which had been "flying under the radar of the legal system for many, many years".

As a result of a ruling by the US Supreme Court in *Daubert v. Merrell Dow Pharmaceuticals, Inc*, since the early 1990s expert testimony has been

admissible in the courts only if it meets certain basic standards of scientific methodology. The criteria include:

- Has the theory been tested, published or subject to peer review?
- What is the known rate of error?
- Is the theory generally accepted?

The outcome in the United States is that experts who attest to theories such as massive repression, traumatic amnesia and multiple personality disorder are likely to be excluded from the courts.

The notion that a therapeutic treatment should have been tested by the standards of "good science" before being licensed for use on patients seems only common sense, but this is not the case within the British health and legal systems.

While the threat of litigation has meant that the American legal system has effectively regulated their mental health profession, in the British courts a judge does not have that same power. In Britain we retain a deferential respect for professional boundaries and the medical profession's long held right to self-regulation. Thus, while individual judges may ask psychiatrists to explain why the courts are still being presented with stark divergences of psychiatric practice and methodology in an age of advanced technology and scientific practice (Wall 1997), the courts cannot impose their own evidential standards on those of other disciplines. The expertise and opinion of a British medical expert does not have to conform to a universal standard of "good science", but depends on the somewhat *Alice in Wonderland* situation of "evidence deriving from the witness's expertise" (Wall 1997). Because of the lack of self-regulation and the disagreement amongst psychiatrists, expert witnesses of equal status can present diametrically opposed views both of which are considered sound because they are supported by a substantive body of opinion within their discipline. Legal reforms which encourage the sharing of one expert witness by both parties may seem to offer a solution to the problem of soaring costs caused by a proliferation of expert witnesses, but unless this move is accompanied by a requirement that expert testimony conforms to a criteria of "good science", the justice system will compound the risks of flawed legal decisions. The proposal to share an expert presumably rests on the assumption that a respected expert represents the consensual and current best knowledge of a particular discipline. However, if politicians and the judiciary apply themselves to the realities of psychiatric and psychological knowledge they will appreciate that there are considerable difficulties particularly in the context of sexual allegations. The divergences of practice and theory noted by Mr Justice Wall (Wall 1997) mean that in the absence of a universal standard of scientific practice at any one time, an expert witness may well be prejudiced against the circumstances of one or another client.

It is important to keep in mind, however, that therapists dealing with problems of the mind and behavioural disorders do not have the scientific knowledge or tools which are available to other branches of medicine. As yet we do not have a full understanding of how consciousness and the various mechanisms of the brain interact. Therapists are understandably concerned that the application of a "good science" test might exclude techniques which have a proven record as a beneficial medium, and ask why "neutral" or "harmless" treatments such as EMDR should be banned simply because they have the potential to be harmful in the wrong hands. But if a technique has the potential to be harmful, it cannot be considered to be "harmless" and thinking in these terms generates a dangerous climate of complacency. There is no reason, however, why treatments recognised as potentially harmful should be banned as long as there are strict controls and research into how they should be used. Electroconvulsive Therapy (ECT) is an example of a controversial treatment claimed to have a beneficial effect while known to be potentially very dangerous indeed. Although there is still no precise understanding of how it works, it has been retained as a resource for psychiatrists who may have no other treatment to offer their most severely disturbed patients. It is, however, monitored and cannot be administered without informed consent. While this does not eliminate all the concerns or the risks, it is arguably a reasonable compromise in the light of the realities of our present state of knowledge about psychological and psychiatric illnesses.

Patients who are treated with less obviously extreme procedures such as hypnosis and EMDR are not protected from the possible harmful outcomes, although it is clear that both techniques are potential vehicles for producing false allegations in the hands of therapists who believe that childhood trauma is the root cause of psychological disorders. For trust to exist between the public and the medical profession the necessary *quid pro quo* is that, in exchange for the freedom to experiment and use creative techniques in a difficult area of practice, therapists must be required to satisfy people who are not expert in their field that their work is sound. Until the government bites the bullet and imposes a proper regulatory system upon health services and social services to ensure that treatments and practices are subject to a universally agreed standard of "quality control", the acrimony and the waste of lives and resources will continue. Both NHS and private hospitals must be required to take responsibility for ensuring the safety and integrity of the treatments they supply, and private health insurance companies should demand and receive scientific evidence which independently evaluates outcome data before they agree to fund treatments.

When I look back I still find it quite incredible that it was possible for a psychiatrist to practice in such an extraordinary manner with impunity and to wreak such havoc on my family. I remain at a loss to understand how it is that a modern health system tolerates scientifically trained clinicians who offer diagnoses such as dissociative identity disorder, proclaim a belief in satanic conspiracies and interpret dreams as if they are meaningful. This is not an age of faith, and the days of unquestioning deference to doctors are past. In complex times both patients and doctors require the safeguard of open practices and the introduction of good science and good sense into the health service and child protection systems.

Notes

Barden, R. Christopher. 1999, *Law, Science and Mental Health: Protecting Liberty and Recovering the Mental Health System.* A summary of presentation to the BFMS on May 8.

Wall, Nicholas. 1997. *Rooted Sorrows*: *Psychoanalytic Perspectives on Child Protection, Assessment, Therapy and Treatment* Bristol, Family Law.

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Therapy in the eye of the beholder?

Extract from Life, Observer Magazine, 13th August 2000

Professor Peter Fonagy is one of the few therapists to have undertaken a serious far-reaching review of psychotherapy research. His book, *What Works for Whom?: A Critical Review of Psychotherapy Research* (£18.99, Guildford Press) co-written by Anthony Roth, reviews 50 years' worth of different kinds of studies and research, and is considered to be the definitive work of its kind. (It was published in 1996 and is currently being revised.) "There are many problems in researching psychotherapy," says Professor Fonagy. "I don't entirely accept the old, purist argument that it can't be studied empirically, but I do understand it. There is a large element of creativity in therapy. A dozen therapists may belong to the same school of thought, yet practise very differently. How do you quantify the elements of a human relationship? Many therapists see their work as part medicine, part art. They liken research to a reduction: how do you measure how funny a joke is? Or how beautiful a painting? But we cannot hide behind this argument. We can and should be measurable and accountable. It will probably take another 10 years, but we are finally moving to Evidence Based Medicine (EBM)."

MEMBERS FORUM

Prayer Group

Letter from Ian & Hazel Hutson

The Prayer Group started just before Christmas 1998 in response to our enquiry in the Newsletter asking if there were any people in the BFMS interested in forming a group who prayed

regularly for their members. We started a non-denominational Christian group of 11 families who pray regularly every Sunday using a number of prayers contributed by the Group. One of our members, a Minister, is prepared to counsel anyone who feels they need it. We keep a book of names and addresses of the families. Usually several families meet at the AGM and make friends. Otherwise surnames and addresses are not disclosed. Each family makes their own choice of members Christian names to be used in prayer.

We sent a letter out before the last AGM suggesting that we met after the main business. Five families turned up and two more phoned to say they could not make the meeting. All agreed that they found the Prayer Group supportive.

Madeline Greenhalgh, our Director, has told us that Tom & Joyce Rutherford, who incidentally many will remember when they came to address us some years ago, have informed her that there will be a "False Memory Syndrome" National Day of Prayer in the USA on November 1st 2000 and have invited us to participate with various suggestions about how to effect this. All our families have been informed. It is described as a special time to pray for our families and the families of others who have been damaged by a dangerous therapy.

If anyone would like to join the Prayer Group and take part with us in the National Day of Prayer please phone us, Ian & Hazel Hutson on 01935 813331.

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denial

The production of Arnold Wesker's play "denial" ran for a month during May and June at the Bristol Old Vic. The 90-minute play, brilliantly produced by Andy Hay, expertly portrayed the tragedy of parents who are victims of recovered memory allegations. In 21 scenes Wesker shows Jenny, whose marriage and career have collapsed, accusing her father of raping her as a child. Wesker highlights the point that wicked, proven child abuse should not deny the delights of physical contact in ordinary family life.

Although the play did not immediately move to London, Arnold Wesker said recently, "It's on its way into London…with strong interest in New York and Montreal, as well as Sweden, Germany, Greece, Italy and Japan".

denial

by Arnold Wesker

After a successful run at the Bristol Old Vic a video of this powerful play is now available from Heritage Theatre Videos.

See the leaflet enclosed with this newsletter for an order form or find them on-line at www.heritagetheatre.com.

NEWS FORUM

Psychotherapy complaints procedures under review

Holding professional psychotherapy bodies to account for the damage caused by the trust placed in false narratives and memory is fraught with problems - not least because of the difficulty in pursuing third party complaints. But in May 1999, a group calling itself *Justice in Psychotherapy* was formed to challenge this impasse.

"The questions raised for professional bodies by 'false memory' amount to one of the greatest mental health issues of our times," says John Banks, a founder member of JiP. John's name is a pseudonym. For like so many other people affected, he does not wish to reveal his true identity, because he fears that to do so would result in further distortion and unjust retribution as the deluded client will be told of the complaint while still under the thrall of the therapeutic *mésalliance*. This reservation cuts off his own, and many others', avenues of complaint.

"It is important to remember that although the professional organisations are determined to deny the extent of the damage false or distorted memories cause, they do not deny they occur,"

John stresses. "False or distorted memories have exposed the Achilles' heel of psychotherapy. And that is, that delusional ideas, often but not always connected with memory, and appearing to be absolutely true and real to the patient, can be discussed in the psychotherapeutic or counselling setting and the practitioner may not be in a position to tell whether these ideas have any basis in reality or not.

"JiP has brought to the forefront the central issue of the diagnosis or assessment of the patient and the real risk of a wrong diagnosis without any possibility of correction.

"At present a sound diagnosis or assessment of the patient's problems is usually dependent on the reasonable accuracy of the information provided by the patient, or the practitioner at least being in a position to know whether it is accurate or not.

"Yet the professional bodies have avoided discussion of this crucial matter. They have also avoided the issue that wrong diagnoses are a major cause of malpractice."

John points out that the 1998 book *Complaints and Grievances in Psychotherapy - a Handbook of Ethical Practice* by Fiona Palmer Barnes, chairperson of the United Kingdom Council for Psychotherapy ethics committee, fails to mention the issue of false diagnosis. "This is in spite of the fact that the British False Memory Society with a professional advisory board has been in existence since 1993", says John. "Added to that there have been successful actions brought by patients and third parties against therapists in the USA since 1996."

"JiP insists that when manifest and serious damage occurs, and is recognised by third parties, the psychotherapy organisations take action," says John. He points out that shortly after the prosecution of a number of complaints of individual cases by JiP, culminating in January this year, the UKCP launched an overhaul of its administrative structure and review of complaints procedures. "This may hold the key to the future of psychotherapy's credibility," says John.

Oliver Cyriax, a family law consultant who has prosecuted complaints on behalf of JiP explains: "As long as the complaints procedure exists primarily to exculpate the professionals concerned from blame, the profession denies itself the opportunity to distinguish between damaging and beneficial intervention in the lives of clients. It denies the profession the exact information needed for well-informed treatment.

"There is no proper monitoring of outcome, and complaints procedures were not viewed as an aspect as quality control. This in turn bears on professional training, accreditation and the ability of regulatory and umbrella organisations, such as UKCP, to vouch for the diverse groups comprising their membership."

Mr Cyriax predicts radical change. "Indications are that a wholesale review of internal procedures may now be underway within UKCP.

"In addition to administrative restructuring necessary to ensure its complaints procedure actually works, it is said there are two further moves in the pipeline. Firstly there may be the publication of a revised core syllabus incorporating a rational approach to traditional psychotherapeutic doctrine, and secondly the production of guidelines on the evidential basis not of 'false memory' in alleged sexual abuse, but of sexual abuse generally. If so, this is indeed encouraging."

Justice in Psychotherapy can be contacted at 4 Cardross St, London, W6 ODR.

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The never-ending story…

An inquiry into mass allegations of abuse at former residential reform school in Shelburne, Nova Scotia has concluded that the vast majority of allegations are bogus. (See *Newsletter, 2000 No 1, 1999, No 1*) The claims triggered an open-handed $39 million compensation fund without a single prosecution, with the destruction of the reputations of many former teachers and care-workers.

But rather than compensating the falsely accused, the Royal Canadian Mounted Police have redoubled their four year police trawl and have

drawn in child protection workers to stop some of the accused seeing their grandchildren on the basis of presumed risk, according to reporter Margaret Wente in Toronto's *Globe and Mail* October, 3 2000.

Conflict between the Nova Scotia's Justice Department, who conducted the inquiry, and the provincial government have meant that the report has not been made public, with the joint investigation signalling a "desperate attempt to uncover evidence – any evidence – of abuse."

Ms Wente comments: "It's been clear for quite a while now that the Mounties and the government are chasing the wrong men. Perhaps they ought to be chasing a few of the 1,237 men (many of whom are career criminals) who walked away with $39 million in settlement money without having to prove a thing. But that would reveal the embarrassing truth – which is that Shelburne was not a case of massive institutional child abuse, but a case of massive fraud engineered by credulous bureaucrats and opportunistic politicians."

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Wilkomirski award withdrawn

A non-fiction literary award to Binjamin Wilkomirski, the Swiss author who imagined he had been a Jewish child in a concentration camp, has been withdrawn. He had received the 1997 Jewish Quarterly, Wingate prize for his supposed memoir *Fragments*, written after re-inventing his childhood and undergoing therapy. The book, now known to be fiction, has been withdrawn from publication. (See *Newsletters No 1, 2000, No 1, 1999, No 2, 1998*)

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Memories of things past change with time

Adult experience and beliefs distort memories of childhood according to a study conducted by Dr Daniel Offer, psychiatry professor at Northwestern University Medical School in Chicago. A longitudinal study found that what 14-year-old teenagers said about their lives in 1962 had changed radically when interviewed again 34 years later. The findings are expected to have significant implications for doctors and therapists using self-reported patient histories as a basis for diagnosis and treatment.

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BOOKS AND REVIEWS

Review by Pamela Radcliffe and Andrew Gillis

Has a Child Been Molested? The Disturbing Facts About Current Methods of Investigating Child Sexual Abuse Accusations. By Lee Coleman, M.D. and Patrick Clancy, J.D., published by Berkeley Creek Productions, 1999

Has a Child Been Molested? should be compulsory reading for all those involved in proceedings relating to the investigation of child sexual abuse be they social worker, doctor, policeman, advocate or judge.

The authors, psychiatrist Lee Coleman M.D. and attorney Patrick Clancy, J.D. present a powerful critique of the prosecution machinery, by reference to respected academic research, documented cases and their own extensive experience. They argue that the current approach to the investigation of these cases is fundamentally flawed. The golden thread connecting each chapter is that the legal system is continuing to fail both the child accuser and the accused as a result of the methods it is employing. The authors explore the deficiencies and injustices arising from the use of certain interviewing techniques, various therapeutic intervention, pseudo-scientific practices and the medical examination of the child.

Whilst this book is written from an American perspective, the criticisms are equally applicable to the English Legal System. It is evident that notwithstanding the legal "shake up" which occurred in the Untied States and England following two particularly well publicised cases, namely the McMartin Preschool case in the States and Cleveland case in England, the time has come yet again to review how allegations of this kind should be investigated. I agree wholeheartedly

with Coleman and Clancy that we have not learnt from our past mistakes. The Memorandum of Good Practice provides guidelines on the video interviewing of child witnesses in England, but this does not go far enough. All too often the damage has been done to the Crown's case before it reaches the final police interview.

Coleman and Clancy's key exhortation is that the prosecution team should embark upon a quest for the truth and investigate from a platform of strict neutrality and objectivity, rather than presuming that the child is telling the truth and that the Defendant is guilty. There is no doubt from our experience, as is also demonstrated by Coleman and Clancy's research, that all too often, the accusation and evidence finally presented to the Defence and ultimately the court has been tainted, moulded and manipulated by over zealous interviewers, therapists and medical professionals intent upon revealing "the truth" of abuse which they perceive the child to have suffered. The prejudice which results to the accused from this approach is all too plain. If the Defendant is lucky, he will have an efficient and astute legal team who will investigate the manner and evolution of the allegation and seek appropriate disclosure, where it exists, of all investigative, therapeutic and medical records. However, even the best lawyers cannot ensure a not guilty verdict when a vulnerable child witness, whom, instinctively, a jury wish to believe, has come to mistakenly believe in his own "abuse" as a result of the flawed investigative procedures, and presents as a credible witness.

The object of this book is not a manual on "how to get the guilty off", but a mission to ensure that justice is seen to be done; to ensure that abusers of innocent children are rightly convicted and that innocent persons are not falsely accused. The suggested reforms by the authors may come too late in the day for some, but there is hope for the future.

Pamela Radcliffe is a Specialist Criminal/Family Barrister at Law and Andrew Gillis is a Special Criminal Caseworker at Messrs Bate Edmonds Snape Solicitors

Websites of Interest
www.offmsg.connectfree.co.uk
www.aafaa.org.uk

LEGAL FORUM

Will the Human Rights Act help the falsely accused?

The implementation of the Human Rights Act has prompted a welter of speculation and little hard fact as to how individual rights might be affected. For those falsely accused and convicted of abuse, hopes are high that injustice will be rectified through the advent of new perspectives in legal argument, while public bodies, such as social services, will be held to account for the decisions they make which are contrary to the European Convention of Human Rights.

However the Convention does not operate within a vacuum, and most of the rights embodied are subject to qualification. As a "living instrument" interpretation may be affected by the social conditions of time and place, which means individual rights could be narrowly interpreted in certain circumstances because of the existence or perception of evils affecting the rights of others. In the current climate of hysteria, misinformation and poor judgment surrounding issues of child sexual abuse, it cannot be assumed that courts will prefer, say, to endorse disclosure of psychiatric and social services records under Article 6 of the Convention (the right to a fair hearing) to the right to privacy of the complainant under Article 8 (the right to privacy). The forum is one of competing rights, and these will have to be fought for.

Nevertheless the change of focus will bring a breath of fresh air into the courts by allowing legal argument to be developed in less restricted ways. Furthermore, although primary legislation such as the disclosure rules in the Criminal Procedure and Investigations Act cannot be overturned by the courts if they conflict with protected rights (because this would contradict the principle of the sovereignty of Parliament) ministers will be under pressure to amend oppressive legislation through courtroom challenge and the issuing of judicial certificates of incompatibility.

One area of prime importance to the falsely accused will be Article 6 – the right to a fair hearing. The difficulty of defending accusations of uncorroborated offences committed, allegedly,

many years ago, is currently met by an abuse of process argument whereby the defendant has to prove on the balance of probabilities, that a fair trial is not possible. This position could be reversed, with the prosecution having to prove that a fair trial is possible raising issues such as sufficiency and testability of evidence. Arguably it could presage the introduction of a limitation period for the prosecution of certain crimes, in line with other European states (though this might be subject to "delayed discovery" rules as in the United States).

In the family courts, social services may be challenged under Article 8, the right to family life. European Court case law has interpreted this as more equal between parent and child than is currently the case under the Children Act 1989. The 1989 Act created the paramountcy principle of the welfare and needs of the child above that of parental rights. Some interpretations of this have led to arbitrary restrictions in public and private law, with the assessment of the child's welfare being entirely dependent on the opinions of officials. Parents who have restricted access to their children because of an unsubstantiated allegation should have a greater right of challenge.

Under Section 6 of the Act, all public authorities will be required to act compatibly with Convention rights. Thus the decisions of social workers and mental health professionals and anybody whose functions are of a public nature – such as the NSPCC - will be subject to much greater scrutiny and challenge provided the decisions are of a public nature.

For many observers, Section 8 of the Act is the most important breakthrough as it provides a right for individuals to recover damages for unlawful actions by a public body through private actions in law. It will no longer be necessary to demonstrate a duty of care, as in negligence, but the actions will have to be found to be unlawful, and there will be no duty to award adequate or even any damages.

Until case law develops through Court of Appeal hearings, the effect of the Human Rights Act will be uncertain. We will report on developments that might have effect for the falsely accused as and when they occur.

New measures for child witnesses

New measures for vulnerable witnesses in court will mean radical changes in the presentation of evidence in cases alleging child sexual abuse.

Under the Youth Justice and Criminal Evidence Act 1999, young children in sexual abuse cases will be cross-examined by counsel in chambers on video-tape prior to the hearing of the trial. Other measures will allow for the use of "intermediaries" to communicate with young children and people with learning difficulties.

Implementation of the Act, due to begin early next year, is expected to increase the number of prosecutions in child sexual abuse, particularly concerning young children under five and children and adults with learning difficulties. Some criminal law specialists have raised concerns that the provisions, many of which are complicated and experimental, will result in contaminated evidence and unfairness to defendants. All witnesses, bar the defendants, will be entitled to the protection of the measures if they satisfy the criteria and this will include defence witnesses.

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Call for N. East trawl inquiry

A campaign group against false allegations has called for a public inquiry into a multi-million pound police trawl in the North East. (*Darlington and Stockton Times*, October 14 2000)

Falsely Accused Carers and Teachers (FACT) say the Northumbria police investigation, code-named Operation Rose, has resulted in the ruination of lives of dozens of former care-workers while just three prosecutions out of 20, involving 30 care workers, have resulted in convictions.

The Home Office has refused to comment saying that it is an operational police matter. Northumbria police stated: "We have followed procedures laid down in child protection guidelines."

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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The Scientific and Professional Advisory Board provides the British False Memory Society 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 the Society 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, the Society may not always agree with the views expressed by members of the board.

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