



Dear Reader

One thing which I find hard to accept is to acknowledge the sometimes slow pace of progress. In an age of phenomenally high speeds of data transmission we have all become used to the expectation of instant results but in actual fact the reality is different.

It has taken the BFMS, with the help of its members, 14 years to write and publish its first book of powerful case histories which expose the horror of being caught up in the false memory saga. We report on the May book launch in the House of Lords. Sales are building steadily; copies are available from Amazon and all good bookstores. After early hiccups we are even assured that Waterstones bookshops can supply the book. We now need members within reach of a local branch to encourage them to stock it. We know that the book is reaching far off horizons as we have been supplying repeat orders to a bookseller in New Zealand.

During April we finally heard that there is a definitive outcome following the criticism of the General Medical Council's handling of the long running case against the paediatrician involved in the Shieldfield false accusations case. The two nursery nurses were acquitted of these charges in 1994 but it has taken 13 years to reach official closure of the case. For the outcome of the referral of the GMC's decision to the High Court by the Council for Healthcare Regulatory Excellence see page 2.

This autumn we expect to see the result of the only UK legal suit to be brought by a retractor against the health trust she holds responsible for her false memories. The case had been due in the Court of Session in Edinburgh in March 2006 but now it is scheduled to be heard this October. The retractor first made the allegations against her father and others to the police in 1995. It has taken a remarkable 12 years to reach this point.

The slow pace of progress is further exemplified by the Government's plans to see regulation of the talking therapies in place by 2008 which appear, not altogether surprisingly, to have been delayed. The Department of Health has indicated that regulation is unlikely to be introduced before 2009 and taking into account the dissent among the various interested parties, that forecast may prove to be an optimistic timescale, see the latest news of this on page 3.

We also report on the problems of overstating the conclusions of research in the field of memories for traumatic events with a critique of recent research and the press coverage that followed. The search for an evidence base for issues of memory continues year in and year out. We have been sent an interesting paper that discusses what is thought to be one of the earliest documented accounts of implanted trauma memory from over a century ago. It is a powerful piece of evidence to offer, together with examples of more recent research, to any clinician who continues to harbour reservations about the vulnerability of the mind.

New cases continue to arrive via the office helpline and in our attempt to understand why they are still happening I am reluctantly reminded that although there is progress, it is painfully slow. Perseverance is a trait that drives many of us forward and progress, however small and at whatever pace, is our reward.

Madeline Greenhalgh

Enemies of Reason

Professor Richard Dawkins when talking to *The Times* about his two-part television series entitled, *Enemies of Reason*, C4, said:

“There are two ways of looking at the world – through faith and superstition, or through the rigours of logic, observation and evidence, through reason. Yet today reason has a battle on its hands. Reason and a respect for evidence are the source of our progress, our safeguard against fundamentalists and those who profit from obscuring the truth. We live in dangerous times when superstition is gaining ground and rational science is under attack.”

NEWS FEATURES

The long and winding road....

It was over five years ago that the BFMS first reported on the proceedings against Dr Camille de San Lazaro, the consultant paediatrician and ‘expert witness’ at the centre of the Shieldfield allegations and subsequent libel trial.

In May 2005, the General Medical Council’s Fitness to Practise Panel concluded that Dr Lazaro’s conduct “fell short of that expected from a registered medical practitioner”, although they determined that she was *not guilty* of Serious Professional Misconduct.

Much criticism of the GMC's decision followed and the case was referred to the Council for Healthcare Regulatory Excellence who lodged an appeal the following month. Following **many** delays the appeal has been allowed, and on 25 April 2007 the High Court quashed the *not guilty* verdict.

The High Court ordered that "For an unlimited period of time Dr Lazaro must not in any proceedings legal or otherwise:

- a) act as an expert; and/or
- b) provide expert testimony

in relation to child sexual abuse."

However, the schedule follows on... "For the avoidance of doubt, this paragraph does not prevent Dr Lazaro from carrying out academic activities or teaching."

D i a r y D a t e

The Fourteenth BFMS AGM will be held on Saturday 29th March 2008 in London

Regulation of psychology, psychotherapy and counselling

A recent article in *The Times* referred to the Department of Health's statement that the law regulating all psychotherapists is unlikely to be introduced before 2009 because "time is needed to establish competencies and training".¹ The Government had previously stated their commitment to regulation by 2008. Further research reveals there is much dissent about the Government's proposed plans for the regulation of health professionals.

Although many of the psychology, psychotherapy and counselling organisations are concerned that regulation in some form is necessary for the protection of their professions and for the public, they appear not to be in favour of the generalised restrictions that would be enforced upon them by one regulatory body, the Health Professions Council (HPC).

A debate on the regulation in the House of Lords² during February this year heard Earl Howe explain the situation:

"If, as I fear, the Government are set on making the Health Professions Council responsible for regulating psychologists and psychotherapists, we are heading for real trouble. What unites those professions currently regulated by the HPC is

that, as a generality, they work within a context of delivering healthcare on behalf of employers whose function it is to do that. The focus of the HPC is on healthcare. As we have heard ...only a minority of psychologists work in a healthcare environment. Many work in industry and commerce.... To shoehorn psychologists, psychotherapists and counsellors, with all their very different modalities, into the HPC would be to blur the distinct and individual interests represented within those professions. That would not only do those professions an injustice; it would also be to the detriment of the clients whom they serve. It is very difficult to see how, under its present modus operandi, the HPC could accommodate and champion issues that may be very profession-specific...”

In the Government’s White Paper, *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*, published shortly after the debate in February 2007³, it is clear that there is no intention to establish any new statutory regulators. Nine professional bodies, including the *British Psychological Society*, the *United Kingdom Council for Psychotherapy* and the *British Association of Counselling and Psychotherapy*, all supported the alternative proposal that a Psychological Professions Council (PPC) be set up.

A detailed critique of the proposal for the PPC has been written by the Government clearly announcing that the proposal is unacceptable. The document states, “The Government notes that the bodies [the nine professional bodies] regard the latest attempt to regulate as failing because it attempted to fit a diverse field into a pre-existing template. The Government’s view however is that the template’s confines are restricted to those common elements of statutory regulation which apply to all regulated professions regardless of their conceptual model or scope of practice, and that the flexibility required by a diversity of professions is in fact provided for in the Government’s proposed route of regulation by HPC.

The UKCP announced its disappointment and the BPS says that the Society is still in discussion with the Department of Health about key principles in the proposed legislation and how these will be addressed practically but noted that they remain very concerned that the legislation should put in place clear guidance on how psychology might be regulated.

There appears to be some way to go.

1. Couple therapist who tells clients to strip uses loophole to cheat ban, *The Times*, August 6, 2007
2. Psychology, psychotherapy and counselling: regulation, debate House of Lords, February 5, 2007: 7.35 pm
3. Government’s White Paper, *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*, The Stationery Office, February 2007

RESEARCH

Memory ‘Myth’

The media have wrongly provided the ‘take-home’ message that people can block out memories of traumatic events, Dr James Ost argues here. In the process the distinction between *suppression* of memories *and repression*, has been lost. “...the two terms are not interchangeable.”

He is commenting on an article in *The Daily Telegraph* on 13 July 2007 by the newspaper’s Science Editor, Roger Highfield, under the headline “How to Forget Bad Memories.”

This reports research by Brendan Depue and others at the University of Colorado into the *suppression* of stressful memory. Of this study and an earlier one (Anderson and Green, 2001) Ost warns: “...the distinction between suppression and repression are of little interest to non-psychologists and headline writers.”

But years of psychological research have indicated that *repression* is a ‘clinical myth’.

Can we forget bad memories?

by Dr James Ost (University of Portsmouth) and Dr Kimberley Wade (University of Warwick)

On 13 July 2007, *The Daily Telegraph* ran a short piece by its Science Editor, Roger Highfield, entitled “How to forget bad memories”, reporting on recent research which claimed to show that, “with enough practice, disturbing and stressful memories can be ‘forgotten’”. The experiments, conducted by Depue and colleagues at the University of Colorado, indicated that certain parts of the brain became more active when participants tried to forget emotional material. This type of research is important. It could help inform current debates over the fate of traumatic memory – from individuals who claim to have repressed memories of abuse, to combat veterans with Post-traumatic Stress Disorder who try to distract themselves from remembering the trauma they have suffered. So does this research - as the newspaper headlines suggest - tell us how to forget bad memories? Well, as it turns out, the answer is not quite as sensational as the headline. The Depue *et al.* experiments are an extension of earlier work by Anderson and colleagues. Whilst Anderson *et al.*’s work has been expertly critiqued elsewhere (see Garry & Loftus, 2004; Hayne, Garry & Loftus, 2006; Wade, 2007) we need first to revisit their findings in order to place Depue *et al.*’s experiments in context.

In 2001, Anderson and Green published a paper in the leading journal *Nature* in which they claimed to have found a region of the brain responsible for suppressing unpleasant memories. In their study, participants were first asked to learn sets of word pairs (e.g. ordeal – roach), so that presenting the first cue word (e.g. ordeal) would lead participants to respond with the second, target, word (e.g. roach). Next, participants were presented with the first cue word of each pair (e.g. ordeal) followed by a cue either to ‘remember’, or ‘forget’ the target word (e.g. roach). This is referred to as the Think/No Think (T/NT) paradigm. In the final stage, participants were presented with all the cue words (e.g. ordeal) and asked to recall all the target words (e.g. roach). Anderson and Green (2001) found that participants recalled fewer of the target words that they had been instructed to forget than the target words that they had been instructed to remember. This, they argued, was evidence that people can learn to selectively ‘block out’ certain memories. In a follow up study, published in *Science* in 2004, Anderson *et al.* repeated the experiment. This time, however, whilst participants were attempting to ‘remember’ or ‘forget’ target words (e.g. roach) the experimenters used *fMRI* to measure participants’ blood flow to different parts of the brain. As a result of this new experiment, Anderson *et al.* claimed that they had discovered which areas of the brain were responsible for the suppression of unwanted material.

So had Anderson and colleagues finally found concrete evidence that the mind can block out horrific events? Whilst some journalists appeared convinced (one headline in the UK at the time read “Freud proved”), psychologists were more circumspect (Garry & Loftus, 2004; Hayne *et al.*, 2006; Wade, 2007). Garry and Loftus (2004), in an article in the *Skeptical Inquirer*, pointed to several limitations with the Anderson *et al.*, findings, a few of which are summarised here. Firstly, there are numerous theoretical and methodological problems with brain imaging techniques. For example, do increases in ‘metabolic’ activity (e.g. blood flow) to an area of the brain necessarily indicate an increase in ‘cognitive’ activity? At what point, statistically, do we conclude that one part of the brain has become ‘more’ or ‘less’ active? By creating an ‘average’ brain scan from the scans of different participants, are we running the risk of masking important individual differences in brain structure? Can we be sure that the brain areas identified are *facilitating* the processes under investigation (e.g. suppression), or could they be *inhibiting* another response instead? Brain imaging research is still in its infancy and many of these questions are a long way from being resolved. Thus any data need to be treated with caution. (The fact that psychologists appear to have been seduced by these technological advances led William Uttal to title his 2001 critique of neuropsychological techniques, *The New Phrenology*).

Secondly, the effects of the T/NT paradigm appears to be quite fragile. As Garry and Loftus (2004) noted, the degree of suppression in the Anderson *et al.* experiments was not particularly severe - instructing participants to ‘forget’ the target word (e.g. roach) led to a 10% reduction in recall. Even then, participants still recalled about 80% of the target words. Importantly, another group of Psychologists have failed to replicate these findings in three separate

experiments (Bulevich, Roediger, Balota & Butler, 2006; Wade, 2007). Such a fragile effect is not convincing evidence of a mechanism which would presumably be required to block entire traumatic, autobiographical episodes from consciousness.

Finally, the nature of the stimulus material used does not allow us to generalise to the kinds of traumas associated with repression or PTSD. Freudian repression allegedly results in the blocking from awareness of traumatic, threatening and emotional information. A diagnosis of PTSD requires exposure to a Category A traumatic stressor (such as witnessing someone being killed, McNally, 2003). As Garry and Loftus (2004) argued, word pairs (ordeal-roach) hardly mirror the impact of this kind of material. However, it is this last criticism that was recently addressed by Depue and colleagues in a replication and extension of the Anderson work (Depue, Banich & Curran, 2006).

Depue and colleagues (2006) wanted to find out whether the suppression effects found for word pairs would be replicated when more emotional material was used. Thus, rather than using words as both targets and cues, as Anderson and colleagues had done, they used faces as cues, and either emotionally neutral or negative words, or pictures, as targets. Participants first practised recalling 40 face-word, or face-picture, pairs until they could recall them with a high level of accuracy (97%). They then took part in an experimental phase where they were shown 32 of the face cues. Sixteen of these face cues were paired with an instruction to “think about” the associated word or picture targets, whilst the other 16 were paired with an instruction to “not think about” the associated word or picture targets. For half of the face cues, these “think” or “no think” instructions were repeated five times and for the other half they were repeated ten times.

Depue and colleagues found that participants who were instructed to “think” about the targets 10 times, recalled more of those targets in a final test than participants who were given the “no think” instructions (importantly, the “no think” instructions led participants to recall fewer word or picture targets compared to baseline word or picture targets for which they had been given no instructions). The emotional nature of the stimuli also seemed to magnify the effect. Participants recalled more of the emotional word or picture cues after ten “think” instructions, than they did of the neutral word or picture cues. Similarly, participants recalled fewer of the emotional, compared to neutral, word or picture cues after the “no think” instructions. Thus, according to Depue and colleagues, there is a “cognitive control” process in the brain which deals differently with emotional and non-emotional memories. When emotional material is repeatedly processed (or thought about) it becomes more accessible than neutral material, but when emotional material is repeatedly suppressed (not thought about) it becomes less accessible. In a follow-up fMRI study, the authors found evidence of two neural mechanisms which appear to be implicated in the suppression process (Depue, Curran & Banich, 2007).

So does this research tell us how to forget bad memories? The stark answer, despite newspaper claims to the contrary, is no. We've all had the experience of cringing, and trying to distract ourselves, when a memory for an embarrassing event suddenly comes to mind. Most of us try, often with limited degrees of success, not to think about events that upset us. This is called *suppression* – and Psychological research shows that we are not very good at it. This is mainly because the rule (“I must try not to think about X”) contains the thing one is trying to forget. Thus, most of us cannot help but picture a white bear, when explicitly instructed not to (Wegner, Schneider, Knutson & McMahon, 1991). Likewise, survivors of trauma generally find it difficult *not to think* about the events they have witnessed (McNally, 2006). Nothing in the Depue *et al.* experiments suggests that people can be trained to do this more effectively. If it *could* be shown that people could learn to effectively ‘suppress’ traumatic memories – would this offer hope for PTSD sufferers? Again – contrary to the newspaper article – the answer is no. Most treatments for PTSD do not involve helping survivors to ‘forget’ their experiences. Rather they aim to help sufferers change the way they react to, and cope with, their traumatic experiences (although PTSD itself is highly controversial; see Rosen, 2004, for excellent discussions).

More worrying, however, is the claim made in the opening lines of the article by Depue *et al.* (2007). They state that whilst there is evidence that people actively try to suppress memories, “others claim that memory repression or suppression is a clinical myth in search of scientific support” (p. 215). This sleight of hand, in which *suppression* and *repression* are conflated, is problematic – the two terms are not interchangeable. Suppression, as noted above, refers to cases where people actively try *not to think about* something, usually with very limited degrees of success (Anderson & Green, 2001; Depue *et al.*, 2007). Repression, on the other hand, is when an individual is allegedly *unable to remember* something because the mind has unconsciously blocked out any memory of the event. Years of psychological research have indicated that this is indeed a “clinical myth” (Hayne *et al.*, 2006; Kihlstrom, 2002)¹.

Yet the work of Anderson and colleagues, and Depue and colleagues, has somehow been seized on as providing evidence that it exists. This is probably because important qualifications – such as the distinction between suppression and repression – are of little interest to non-psychologists and headline writers. The accurate reporting of scientific findings is critical if we are to prevent further confusion in an area already plagued with misunderstanding and therapeutic folklore. Unfortunately, media reports of the Anderson and Depue work have provided the “take home” message that the latest advances in technology are showing that people can, consciously or unconsciously, block out memories of traumatic events. In fact, the evidence actually supports the opposite conclusion – survivors of trauma generally have difficulty forgetting the experiences they have been through (McNally, 2006).

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1. See Loftus and Guyer (2002a and 2002b) for discussion of the case of Jane Doe in which an allegedly 'repressed' memory was 'recovered' during a video-taped interview.

Politics and the reclassification of mental illness

A working group from the US National Child Traumatic Stress Network seeks to add 'Developmental Trauma Disorder' (DTD) to the dictionary of mental disorders published by the American Psychiatric Association (APA) and used around the world by psychiatrists and mental health professionals. This dictionary is called the 'Diagnostic and Statistical Manual of mental disorders'. The current edition is referred to as the DSM-IV

The APA has been organising a review of DSM-IV since 1999. DSM-V is scheduled to be completed in 2011.

The DSM manual is used in the USA and also other parts of the world, including the UK, to enable healthcare professionals to diagnose and then treat patients presenting with symptoms of mental or psychiatric disturbance. The manual is essentially a list of mental health categories.

There is also the ICD classification which stands for the International Classification of Diseases, 10th Revision known as ICD10. It is produced by the World Health Organisation and is the official classification for the rest of the world, including the UK National Health Service.

The key reason for the introduction of manuals was to achieve international agreement over diagnosis. Previously the same disorders were being given different diagnoses, which made any epidemiological studies difficult to interpret. One of the main features has been that the aetiology of a condition is not part of DSM, with the sole exception of Post Traumatic Stress Disorder (PTSD).

The insurance industry uses these manuals to base its response to health insurance claims. Classifying a new disorder can therefore have financial implications for business as well as implications for patients. American patients can't automatically get treatments paid for by their insurance schemes if they don't have a diagnosis.

The National Child Traumatic Stress Network is a government funded interest group in the USA. It is lobbying for the inclusion of a new category in the DSM-V called: 'Developmental Trauma Disorder'. This article looks into their reasons for recommending this new definition and raises questions about the possible impact on psychiatric and psychotherapeutic practices.

Why is the manual reviewed?

There are many reasons why the DSM is reviewed at regular intervals. Medical advances in disease understanding and new drug treatments mean that

practising doctors need up-to-date guidance on how to define and therefore manage new situations.

If you are aware of a defined disorder that describes a set of agreed characteristics, you then have a framework within which to make clinical decisions. If you have a framework you can communicate more effectively with colleagues. This should translate into benefits for patients.

Where does the pressure to make changes come from?

In our recent history, not just science but cultural politics and financial needs have played a part in the naming of medical disease and disorders.

In psychiatry there are many driving forces for change.

Accuracy - There is a continual need to review the description of mental disorders in the context of greater understanding of their causes, characteristics and treatment.

For example, until recently the term 'Manic Depression' was used to describe a condition where a person swings between two extreme moods from very high (manic) to very low (depressed). In the last ten years, this term has been replaced with 'Bi-polar Disorder'. This is because 'Bi-polar Disorder' more accurately, and literally, describes the two poles of emotion experienced by patients.

Social politics - Other more controversial driving forces for change include social politics. For example, until 1973, homosexuality was defined in the DSM as a mental disorder. This is a reminder that no matter how much we try to objectify medical treatment, it will also be a mirror for the social and political climate of its time. Another example is the dropping of the term 'Hysterical Neurosis', replaced in the 1980 edition of the DSM-III with 'Conversion Disorder'. Hysteria is a word that actually means womb and its use in medicine traces back many centuries to a belief that the movement of the womb and the emotional need in women for fertilisation produced a set of 'hysterical' symptoms. (However, it was removed, in part because of the intention to get rid of causal information and confine the manual to description alone).

New medical diagnoses and definitions can be driven by research - Research into new treatments can often be the driving force behind changes in the naming of diseases. Here is a fictitious example. Imagine that a drug company is doing some research to see if one of their drugs reduces symptoms of panic and agitation. Early research suggests that the drug only works in alcoholics who have just stopped drinking. So, the Drug Company and Alcoholics Anonymous join forces to persuade the medical community to agree the name of a new physical disorder. They call it: Cold Turkey Disorder. This makes it easier to lobby for funding treatment. You can't campaign for something that doesn't have a name.

Developmental Trauma Disorder (DTD) - classification or clarification?

On the American Psychiatric Association website the working group co-leader and psychiatrist Bessel van der Kolk is quoted by Tori DeAngelis as saying: “while post-traumatic stress disorder is a good definition for acute trauma in adults it doesn’t apply well to children, who are often traumatised in the context of relationships. Because children’s brains are still developing, trauma has a much more pervasive and long-range influence on their self-concept, on their sense of the world and on their ability to regulate themselves.”

In other words, van der Kolk’s observation is that trauma in children affects the development of their identity and personality. Trauma in adults is experienced by individuals who already have a sense of self. Of course, it is not possible to determine whether a particular trait in an adult’s personality has been caused by events in their childhood. No one can predict how they might have turned out anyway. DTD remains a hypothesis.

Van der Kolk claims that where there are agreed ways to define, diagnose and treat Post-traumatic Stress Disorder (PTSD) in adults following traumatic events in adult life, there are not agreed ways to define, diagnose and treat PTSD in children experiencing traumatic events.

He says that the majority of traumatized children do not meet diagnostic criteria for PTSD. If this is the case, then a possibility arises that children who need treatment cannot receive a diagnosis that is accepted by their insurance companies.

Van der Kolk states that a PTSD diagnosis does not capture the developmental impact of childhood trauma. Work developing DTD as a classification is focusing on issues of interpersonal trauma such as child sexual abuse.

How might agreeing a classification of DTD change healthcare practices?

The working group intends that by distinguishing DTD from Post-traumatic Stress Disorder, they will be able to treat children better. This is presumably because a new framework for responding to a defined set of symptoms will alert doctors to make a diagnosis and follow an agreed treatment protocol where before there was only a mini-adult version of PTSD therapy as an option.

Does anybody contest ‘Developmental Trauma Disorder?’

This is not the first time that Dr van der Kolk has lobbied for changes around the diagnosis of PTSD. In 2000 the DSM-IV committee reviewed the publication and discussed whether to include an associated feature of PTSD, called DESNOS. This stands for ‘disorders of extreme stress not otherwise specified’. The argument put forward by van der Kolk and others was that many individuals exposed to ongoing trauma beginning in childhood developed a

complex set of symptoms that did not fit the standard PTSD diagnosis. On review of their data, the committee voted against inclusion of DESNOS in DSM-IV on the grounds that there was no need for it. The committee's view was that those exposed to early chronic horrific trauma did meet PTSD and often also other disorders such as Borderline Personality Disorder (BPD).

The question arises therefore whether the initiative from the National Child Traumatic Stress Network to incorporate Development Trauma Disorder is further attempt to achieve DESNOS by another name.

Why is 'Developmental Trauma Disorder' of interest to the BFMS?

The group of psychiatrists and psychologists under the umbrella of the 'National Child Traumatic Stress Network' lobbying to classify this new diagnosis believes that trauma in childhood produces a different set of responses and consequences to those produced by trauma in adult life. They suggest that current classifications of PTSD fail to reflect the way childhood trauma presents.

It appears to fall into the same problems as PTSD. There is already a range of diagnoses that covers the behaviours: conduct disorder, late onset ADHD, anxiety disorders, depression, separation anxiety, grief, attachment disorder. It will also represent a second condition that is *defined* by its aetiology - i.e. you cannot make the diagnosis in the absence of knowledge and evidence of a trauma. Much adult PTSD was said to have its origins in childhood and to be the cause of BPD etc and was thrown out by the DSM-IV committee. This seems to be the same thing in a new guise.

If this hypothesis were supported by an evidence base, then one might ask why the BFMS would be concerned. But it is not evidence based. The studies in the paper are mainly surveys of adults, not prospective studies of children. It is a speculative hypothesis: to explain how something *might* occur (personality change) in the absence of evidence that it *does* occur and is enduring.

Our issue is with the way such a diagnosis would be sought, made and regulated. We are also concerned with the way the public might misinterpret this new disorder. If, for example, an adult person claimed to have DTD due to child sexual abuse, how would their claim be validated? Would juries find the use of terminology such as DTD lent credibility to the complainants' claims?

Indeed it is not clear how an adult *could* claim to have DTD when put forward as a category of childhood disorder. No one can say with any certainty how the adult personality would have turned out had the child not been exposed to a trauma. Most children are resilient and this proposal, like the previous one, also fails to take any account of the genetic contribution to adult disorder. This is the equivalent of ICD10's *enduring personality change following catastrophic trauma*, which some equate to the DSM category of DESNOS. This would not seem to be applicable to children and no studies have come to light that bear on

it, only van der Kolk's belief – a not implausible one - that a child's personality *could* be affected.

Potential for misuse if Development Trauma Disorder is included in the DSM–V edition

Alarm bells may therefore start ringing at the potential for misuse that a definition of DTD may bring. Karen Saywitz, chair of an APA interdivisional taskforce on child and adolescent mental health, notes that people vary dramatically in their resilience to adversity. Commenting about inclusion of DTD she is quoted in Tori de Angelis' APA report saying, both sensibly and practically:

“It is important the group is vigilant in its efforts to prevent misuse of a new diagnostic category and the untested treatments that may well arise.”

Those members of the BFMS whose families have been affected by *The Courage to Heal*-style pseudo-forensic historical trawling, may want to know exactly how such vigilance would be applied. Calling for vigilance per se is meaningless without reliable strategies for successful implementation.

The heart of the problem

Perhaps the worst-case scenario is not simply the inclusion of a new way to classify a specific set of traumatic childhood experiences. Even more damaging would be the faulty retrospective diagnosis of DTD and the prospect of adults being led to believe they must therefore have buried memories of child sex abuse in order to fit in with the emotional politics of a counsellor/therapist whose starting point is an assumption of abuse.

Yet again we may be facing the consequences of lawyers and other non-scientists believing they know and understand more of the science and research than they actually do. We must be aware that in the public mind, thanks to fiction and media frenzy, the idea that you can self-diagnose previously unknown abuse from your own biography has considerable currency.

If the proposed criteria and diagnostic tests for DTD are accepted by the American Psychiatric Association, some questions arise. Will this mean that therapists will be encouraged by particular groups to make retrospective diagnoses of DTD in adults and then go on the same old 'your life is the evidence' witch-hunt looking for answers? We would hope not. Practitioners are more aware than ever before of the dangers of retrospective diagnoses. There can be no justification for a return to the days when diagnosing a history of childhood sexual abuse, where none had been known before, did happen.

Expert witness

As any commissioning editor knows, a little learning is a very dangerous thing. You need to know who the experts are and seek their advice. In matters of the mind and memory, where such experts disagree hotly amongst themselves anyway, we must continue to lobby for the inclusion in a legal setting of expert witnesses in all matters of alleged recovered memory.

Alison Eden, Press Officer

van der Kolk, B.A. (2005). Developmental trauma disorder: towards a rational diagnosis for children with complex trauma histories. *Psychiatric Annals* pp 401-408.

A Valuable History Lesson

Critics of false memory phenomenon argue that research has failed to demonstrate that traumatic memories can be planted. Take for example the various pieces of research which have used word recollection testing e.g. Roediger (1995) and Anderson (2001). Researchers know that it is not easy to design research projects acceptable to ethics committees that come close to replicating the effects of trauma. However, more than a century ago, unhampered by strict current ethical standards of today, H. Bernheim wrote a series of articles reviewing theories and experimental findings on memory in 1889.

He implanted an horrific traumatic memory in Marie G. He suggested to her that she had seen, in detail, a vicious rape, telling her that this was not a dream but was “truth itself”. Three days later Bernheim asked a friend and distinguished lawyer to take on the role of a judge and question her. She related the facts as her evidence and although Bernheim attempted to persuade her to doubt herself, she maintained the truth of her testimony with immovable conviction.

This historical account of false traumatic memories has been written up by Gerald Rosen (who kindly sent it to the BFMS), Marc Sageman and Elizabeth Loftus in the *Journal of Psychology* Vol 60(1), 137-139 (2004). As the authors aptly point out: “if clinical psychologists keep this historical case in mind, alongside contemporary findings (McNally 2003), perhaps the construct of false traumatic memories will cause less dissension in today’s debates.”

Anderson, M.C., & Green, C. (2001). Suppressing unwanted memories by executive control. *Nature*, **410**, 366-369.

Roediger, H. L., & McDermott, K. B. (1995). Creating false memories: Remembering words not presented in lists. *Journal of Experimental Psychology*, **21**, 803-814

MEMBERS' FORUM

Research Summary

by Louise Turner

I would like to express my thanks to the 60 families who took part in a research study for me at the beginning of 2007. The results of this study have now been completed and a full copy is available from Louise Turner at studentlou@yahoo.co.uk.

The study looked at the support needs and theoretical viewpoints of those who have been affected by False Memory Syndrome (FMS). Through a self completion questionnaire, participants were asked to briefly outline their experience of FMS and discuss any ways in which it may have affected their lives. The study showed that despite high similarities in cases, such as children having received therapy, parents losing jobs and negative emotional impacts on the families, little has been provided in the way of suitable support for what can only be described as a syndrome with many victims.

The study was offered in electronic and paper formats and this enabled a wider geographical area to be studied. Participants came from mainly the UK and the USA with a small minority from China, Mexico and France.

There were significant amounts of participants who felt that their family relationships and self esteem had been negatively affected through their experiences of FMS. A large majority of participants of both accused and accusing identities stated that the most helpful support currently available is that which can be found in being heard and reading about others experiences.

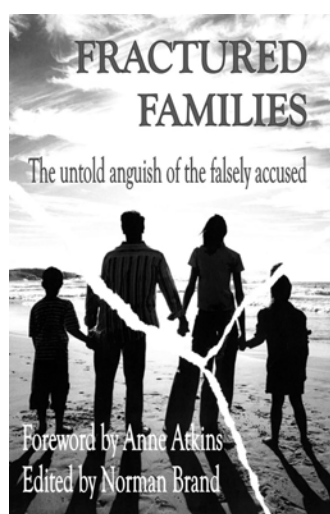
65% of participants felt that the current training of counsellors and psychotherapists in relation to the fallibility of memory is inadequate. Less than 10% of participants believed that support available to them was sufficient to meet their needs and others reported that different and easily accessible support needs to be offered. 60% thought that further research in the area of false memory should be conducted.

What has been shown throughout this study is the crucial need for those affected by FMS to have access to material written by others who have experienced the effects of FMS. Little difference has been shown between the self-reported life effects of retractors and those accused, suggesting that FMS can lead to a high level of distress for those who are falsely accused and those who have made false allegations which have been believed. For those affected by FMS the best support found to date is the sharing of experiences. The accused benefit from being heard and having their isolation, caused by being an alleged perpetrator of a crime, removed. Whilst those accusing benefit from being given the opportunity to talk

about the reasons behind their accusations and from being shown the understanding that what they have done might be awful but they are still loved and cared about by their families.

NEWS FORUM

Lords Launch for Fractured Families



May the 15th saw the launch of the BFMS book *Fractured Families* which contains accounts by parents of the devastation which the recovered memory cult has wrought in their lives.

Told first-hand these stories chart their adult children's estrangement from their families, through the influence of well-meaning but poorly trained counsellors and irresponsible self-help literature.

The launch of the book, which has a foreword by the journalist and broadcaster Anne Atkins, was held at the House of Lords and attended by trustees, officials and members of the academic board of the Society – and not

least by many of the families who had contributed to the book. Also, among its 18 contributors were, vitally, two women who had retracted their accusations.

Lord Howe, who sponsored the launch at the House of Lords, said during his speech that there were still some committed followers of the more extreme theories of memory repression who continued to practise and lecture.

There was a general lack of awareness about the whole problem. "Indeed many cases are still occurring that are characterised, I suppose, by an uncritical acceptance by the police and by social workers of claims about newly remembered abuse.

"And what tends to happen is that the system just closes up. The possibility of false memory is often ignored or overlooked. Indeed the lack of any objective evidence of abuse seems to be overridden by a need to protect the person who is perceived as being the victim.'

BFMS Director, Madeline Greenhalgh said the launch was happening at a time when the 'burden of proof' was being reversed. "The premise that a person is innocent until proven guilty appears no longer to be the case.

“Does this matter? In this room are accused magistrates who will say that it most certainly does, magistrates who have found in their own cases, that the presumption of innocence flies out of the window in matters of sex.

“If that were not scary enough, *Fractured Families* is published at a time when professional therapists and psychiatrists teach healthcare staff that you can derive a safe diagnosis of child sexual abuse from adult behaviour without any further evidence. This truly is trial by prejudice, trial by metaphor and conviction, often by dream. Correlation is not causation.

“Many people sexually abused in childhood may present a set of recognised behaviours but this does not mean that those behaviours are a safe diagnostic tool for recovered memory, exactly what certain self-help books and psychotherapists are teaching right now.

“At a time when there would almost seem to be a recovered memory movement with friends in very high places the BFMS exists to support members who contest allegations of child sexual abuse from adults who have recently recovered their memories.”

Mother tells of arrest

Earlier, an accused mother told of her experience of a dawn arrest, subsequent detention in a police cell and the eventual dropping of all proceedings. She said: “Nothing could have possibly prepared me for the shock of the police arriving at our doorstep one morning in January, a cold wet morning and myself being arrested for sexually abusing my daughter ... The treatment I received was designed to humiliate and intimidate me. I was locked up for 13 hours in jail until the police located and also questioned my elder son, whom my daughter had also accused.

“Our papers weren’t even passed to the Crown Prosecution Service, which just proves to me that the police knew that the allegations against us were not true.

“So you may think that’s the end of it but my husband and I travel regularly to the US. Because we’ve been arrested we have to travel on full visas. We’re often challenged as to why we travel on full visas and have been told that if we didn’t answer truthfully, telling the immigration officer we have been accused of sexually abusing our daughter, we would be hauled away for further questioning. So that is something we will live with for the rest of our lives.”

BFMS ‘grounded in science’

Dr Peter Naish, chairman of BFMS Scientific and Professional Advisory Board pointed out that the society’s choice of himself as the first specialist speaker at the launch underlined the stress that it put on science.

“They have chosen to put on first the chair of the Scientific Advisory Board and this I think grounds the whole thing in science. What we’re talking about isn’t some airy fairy idea that, well, people can excuse themselves of things by inventing this rather preposterous story that it is impossible to produce memories, which is what the world believes. And in fact the BFMS, right from its start, wanted to have an independent scientific board and I think that is greatly to their credit, so that they themselves didn’t start selecting people to go on it. They triggered the board and then it was self-selecting and completely independent.

“It could tread this very sad path, alongside the society but was independent from it, was not paid by it. There is no kind of lip service to it whatsoever. We are independent scientific thinkers who are honoured to be able to offer advice and ground these claims and explanations in good solid science so that no-one can dismiss it.

“And to give you a measure of the stature of the people who have been prepared to do this, my predecessor, the first chair of the board, was Professor Larry Weiskrantz who was the head of the Department of Experimental Psychology in the University of Oxford and a Fellow of the Royal Society and he attracted people of similar stature to join him and form his Board.”

Justice ‘may be in jeopardy’

Pamela Radcliffe, a barrister who in the last ten years has increasingly worked on cases involving historical sexual allegations, said that she believed that in cases of historical sexual abuse, the traditional court procedure tilted the trial process in favour of the Crown.

“I query whether ... we should be considering the introduction of a defence speech after the Crown’s commencement of trial which would fully and fairly set the scene for the evidence to be heard.”

She also said that where recovered memories had been generated by a therapy there should be a pre-trial, judicial determination on admissibility, following a valuation of reliability of memory evidence, that is, the memory used.

“It should be for the prosecution to prove this. In my opinion the current traditional approach whereby the defence reacts to evidence amounts effectively to a reversal of the burden of proof.”

Referring to what she called ‘the memory wars’ she said she feared the legal profession was unaware of the extent of concerned division within the mental health field about recovered memory. “I believe that justice may be being put in jeopardy by these kinds of allegations.”

A 'landmark event'

Fractured Families, is a book that brings into the open the stories of real families who have been brave enough to speak about their experiences and, indeed, accusers who have been brave enough to come forward and say that they are in a position to retract the awful things that they have said. Lord Howe said,

"I believe that the launch of this book is a landmark event."

Not what the Doctor Ordered ...

Sometimes the BFMS can push at a door and find it is open: not much maybe but not locked and barred. In brief we can report some *progress* in a campaign launched this time last year.

We reported in our September 2006 issue that Cornwall Library Service recommended *The Courage to Heal* as one of its 'Books on Prescription'. This self-help volume – sadly it will be new to some readers – urges people to work backwards from virtually any troublesome symptom to the point of identifying its 'cause' as forgotten memory of sexual abuse in childhood.

While the BFMS does not advocate censorship, controversy about the publication has raged and its value as a self-help book has been authoritatively challenged. As our article said here last year: "It should come with a warning that it may damage the health not only of the reader but also of his or her family or other innocents."

And as a result of a protest to Cornwall County Council which began with a BFMS member writing of his concerns, Madeline also wrote and the authority wrote to her on 28 March this year stating that it had decided to withdraw *The Courage to Heal* from its recommended texts.

Additionally it was removing the book *Breaking Free* from the list. This book, like *The Courage to Heal* has also led to parents being wrongly accused by their grown-up children of historical sexual abuse.

The letter from Cornwall County Council's Chief Executive, Communications and Libraries, said in part: "We appreciate that the issue of 'false memory' is contentious and we believe that under the circumstances our approach in withdrawing these two books would be prudent."

But that's not the end of the story. This has been a campaign and there is more encouraging news. Here is a comment from Cambridgeshire County Council (29 May 2007). Dr L. Brosan, from the Psychological Treatment Service at Addenbrooke's Hospital is quoted as saying of *The Courage to Heal*, "We do have

reservations about [it] and I don't think it should be on the list. The problem with it is that it over attributes symptoms to abuse, basically along the lines that if you have any psychiatric symptoms then you are likely to have been abused even if you can't remember, and is hugely worrying for people on that account."

As a result of this Cambridgeshire County Council withdrew the *Courage to Heal* from its Books on Prescription list, as it did *Breaking Free*, though Dr Brosan's reservations were less strong in the latter case.

In all the BFMS wrote to 28 local authorities and another 28 letters to Primary Care Trusts. The response almost universally has been friendly and open-minded, though in many cases non-committal, in the sense that they were going to look into our complaints. This is still going on.

Because we are still getting replies in it is difficult to make a final assessment. Here are a few of the results so far:

Durham County Council: Neither book on the prescription scheme.

Gloucestershire County Council: *The Courage to Heal* already rejected by the council's mental health partners. *Breaking Free* still on list.

Surrey County Council: Neither book on the scheme.

Suffolk Primary Care Trust: Will not include the books.

Options Service (East Sussex): *The Courage to Heal* not included. *Breaking Free* withdrawn as a result of our letter and their research.

Wiltshire County Council: Not on the list and won't be added.

The Courage to Heal, Bass, E.; Davis, L., Vermilion, London 1997 and other editions

Breaking Free: Help for Survivors of Child Sexual Abuse, Ainscough, C; Toon, K, Sheldon Press, 1996 and other editions.

LEGAL FORUM

The Court-Martial of Philip Coates - Lessons to be Learned

by William Burgoyne

(NOTE: All paragraph numbers refer to extracts from the transcription of the Court of Appeal's judgment, available on www.bailii.org. Certain quotes have been highlighted by the author).

The Court-Martial of Phillip Coates earlier this year and his successful appeal against conviction provide a sad commentary on the legal system's failure to learn from recent miscarriages of justice where evidence was based on memories alleged to have been recovered by a complainant in therapy.

The Court-Martial had to consider four statements made by the complainant. These statements were summarised in paragraph 27 of the Appeal Court's judgment, as follows: "The problem with these four statements does not require any substantial analysis. In the first statement made on the night in question, the essential allegation is that after kissing for a while the couple had intercourse on the sick bay bed because in the end she gave up trying to say 'no'. The second and third statements suggest the absence of any memory of the circumstances in which intercourse took place. The fourth statement conveys that intercourse took place notwithstanding the complainant's continuous struggling. Both the first and fourth statements involve allegations of rape, but there are significant differences in the circumstances in which it allegedly occurred."

It was only after seeing Dr McGowan, described as an "Accredited Consultant in Eye Movement Desensitisation and Reprocessing (EMDR)" that the complainant made the fourth statement in which she was then able to provide a more detailed description of the alleged incident (par 20).

The strange and disturbing feature of this case is that **"from the outset, the Crown's case was that the appellant should be convicted on the basis of the account given in the fourth statement. In fact the conviction was based on the first statement"** (par 28).

Prior to the Court-Martial, the Judge Advocate General had to consider whether the fourth statement following the complainant's visit to Dr McGowan should be excluded. He heard evidence from Dr McGowan and Dr Philip Dodgson, Consultant Clinical Psychologist, for the prosecution and from Dr Janet Boakes, Consultant Psychiatrist (retired), for the defence (later, after the Court-Martial commenced, Dr Mason, a Clinical Psychiatrist was called before the Board). The Judge Advocate General clearly had reservations about the fourth statement. But he was faced with the dilemma, following on from the prosecution's decision to base the case on the fourth statement, that if this was inadmissible **"then the whole evidence must go ... it all stays or it all goes."** (par 30)

The Judge Advocate General's response to the fourth statement should have been unequivocal. "Nevertheless he concluded that notwithstanding that the process undertaken by Dr McGowan had facilitated what was described as pre-memory recall in inappropriate circumstances, evidence based on the fourth statement should be admitted." (par 30)

Thus he felt able to allow the Court-Martial to go ahead.

In the event the defendant was convicted of rape and jailed for five years on the basis of an account in the first statement which was, in the words of the appeal judgment, “an account of the incident which the complainant herself disavowed in her evidence and which did not represent the Crown’s case against him. This is highly unusual” (par 38). Having allowed the fourth statement to be admitted, presumably so the case could proceed “on the basis of the account given in the fourth statement” (par 28), for the Crown then to proceed on the basis of the first statement (par 38) was not just “highly unusual”, to the lay observer it appears perverse.

Several comments made in the Appeal Court judgment provide an indication of the Judge Advocate General’s uncertainty when faced with evidence arising from therapy:

1) “In his ruling the Judge Advocate General concluded that it was agreed between the experts that the memories described in the fourth statement could be fact or fiction ...he was persuaded that the fourth statement was unreliable ...however he did not exclude it, nor indicate that he would direct the Board to ignore it” (par 34).

2) “He (the Judge Advocate General) said that the fairness of the trial could be guaranteed by very careful directions, with particular emphasis on difficulties arising from the involvement of Dr McGowan with the complainant.” (par 35) But see the Appeal Court’s comments in 5) below regarding the quality of these directions.

3) “The Judge Advocate General directed the Board to ‘exercise caution before they acted on the unsupported memories of the complainant after the therapeutic session with Dr McGowan’. **However he left open the possibility of a conviction for rape on that basis.** He summarised the evidence of the experts in detail. He did not comment on the reliability, or otherwise, of the fourth statement, or the evidence based on it, or the consequences of the complainant’s therapy with Dr McGowan.” (par 37)

4) “The Board had to consider whether to convict the appellant either on the basis of the complainant’s testimony or on the basis of the first statement. This required a careful analysis of the potential difficulties to the defence generated by what we shall describe as the McGowan process, and the deficiencies and unreliability of the evidence consequent upon it. We need not spend any time of this aspect of the case because, as we know, the Board rejected the post McGowan evidence. The Judge Advocate General, however, was also required to give extremely careful directions about the approach of the Board to the evidence, if they found, as they did, that the post McGowan evidence was unreliable.” (par 44)

5) “Without laying down any formalised straitjacket for the directions which the Board should have been given, the directions which were given were not as full

or complete as, in the very unusual circumstances of this case, they required to be.” (par 44)

6) “In our judgment, this conviction is unsafe, and must be quashed.” (par 45)

Author’s Comments

It is, perhaps, unfair to criticise the Judge Advocate General too harshly, for he was not the first, nor will he be the last, to find himself struggling to understand a mental process that has torn the world of psychiatry apart for decades, and one that is the biggest single issue dividing the profession - described by one of the world’s leading authorities on memory Professor Richard McNally as, “the most serious catastrophe to strike the mental health field since the lobotomy era” and “one of the most bitter controversies ever to afflict the fields of psychology and psychiatry.”¹

Memory differs from all other forms of evidence on which expert witnesses are asked to give their opinions. Evidence from other experts called upon to assist judges and juries in reaching a decision is founded to some degree on proven past events or research substantiated by peer group review. In the case of memory, there is no such firm basis for the opinions of experts. The most recent paper on the subject of recovered and false memories states, “what appears to be newly remembered (i.e. recovered memories) of past trauma are sometimes accurate, sometimes inaccurate and sometimes a mixture of accuracy and inaccuracy; that much of what is recalled cannot be confirmed or disconfirmed; and that, because of these two beliefs, reports of past trauma based on such recovered memories are not reliable enough to be the sole basis for legal decisions.”² Although the authors of this paper say that recovered memories of past trauma are “sometimes accurate”, none of the cases they included met their criteria of independent substantiation and peer group review. The McNally paper concludes by saying, “the evidence shows that traumatic events - those experienced as overwhelmingly terrifying at the time of their occurrence - are highly memorable and seldom, if ever, forgotten.”

There will always be a danger in allowing ‘recovered memories’ as evidence, no matter how heavily circumscribed they are by cautionary warnings. To all involved, it is a seductive proposition that a witness is able to recall events that bring to book someone who might otherwise succeed in escaping justice. It is doubly seductive because those who ‘remember’ do so in convincing detail and colour. The more bizarre the events recalled, the more likely are the judge and jury to believe “you couldn’t make it up”. It is not suggested that the Board consciously took this view (indeed, in par 44, the judgment states, “as we know, the Board rejected the post McGowan evidence”) but there must have been a risk that it may have had a marginal influence on the Judge Advocate General, who was under pressure that if he did not admit the fourth statement, the whole case would collapse.

There is one, very clear conclusion to be drawn from this and other cases: it is inevitable that as long as 'recovered memories' are allowed to be heard in court, miscarriages of justice will continue to occur. Until the psychiatric profession comes up with a resolution of its own problems with the concept of 'recovered memory', the questions that need to be asked are whether it has any place at all in the legal process and whether justice be better served if it was excluded.

Failing this, in order to avoid members of the judiciary being placed in the impossible position in which the Judge Advocate General found himself, the Department of Justice should issue clear guidance to judges on the doubtful provenance of any evidence arising from therapy.

1. McNally, R., "Debunking Myths about Trauma and Memory, *Canadian Journal of Psychiatry*, November 2005.
2. Wright, D.B., Ost, J. & French, C.C., Recovered and false memories, *The Psychologist*, Vol 19 No. 6, June 2006

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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