FMS Foundation Newsletter

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July 1, 1996

Dear Friends,

"Is there any progress being made back to sanity?" That is the question we are most frequently asked by families.

"What do you want? Why are you condemning all psychotherapy?" That is what some professionals ask us.

The answer to professionals is brief. We want their help in restoring our families. We want professionals to help us reach our children who have rewritten their histories. We want help with the reconciliation processes. We want assurance from professionals that this problem will not happen to others. We want professionals to join us in a search for a "litmus test" to help to distinguish those cases of true abuse from those of false memories.

We do not condemn all of psychotherapy. We consider psychotherapy to be a needed public service just as medical systems are. We expect those systems to be safe and effective. Certain types of memory recovery techniques are not safe, and we expect responsible professionals to ensure that unsafe practices are stopped.

The answer to families is "yes" profound changes are taking place, but we still have a long way to go. Children continue to return to families. We are now starting to hear regularly of returners who become retractors. It is not a fast process. This past month we heard from two families who had moving apologies and retractions from their children three years after they had resumed contact. Other families reported retractions after one and two years. Returning and retraction and reconciliation are processes that take work and time. Our children are worth the work and the wait.

A meeting on May 10, 1996 with representatives of the FMS Foundation, the American Psychiatric Association and the National Association of Social Workers in Washington, DC at the Psychiatric Association headquarters is a concrete example of the institutional changes that are starting. Dr. Paul Fink, a past president of the American Psychiatric Association, was instrumental in arranging this meeting. The purpose of the meeting was to have an open discussion of the problems that we all share and to look for solutions to them. The American Psychological Association is still considering its policy on attending future meetings at which FMSF representatives are present.

We left the meeting at the Psychiatric Association feeling that a positive and constructive start had been made that would lead to help for families and that would also advance clinical practice.

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July/August is a combined issue.

A continued flow of outstanding popular and scholarly books and articles about memory and related clinical practice is more good news. *Searching for Memory* by D. Schacter and *Memory: Remembering and Forgetting in Everyday Life* by B. Gordon are recent examples. New editions of *Making Monsters* by Ofshe and Watters and *Victims of Memory* by Pendergrast note the great changes in thinking that have taken place since their initial publication.

Not all is so positive. On April 27, 1996 a member received a mailing about the Masters and Johnson Sexual Trauma Programs at River Oaks Hospital in New Orleans and Two Rivers Hospital in Kansas City. Included in the text in the packet, "In order to open the doors to the actual memories and the child's experiences...Utilizing hypnotic techniques to abreact memories..." Surely it is misleading to imply that any professional or any hospital had some way to "open the doors to the actual memories." River Oaks Hospital was one of the places credited in the HBO video, "Search for Deadly Memories" in which viewers could see a physically restrained patient look for 'actual memories' of satanic ritual abuse during a sodium amytal interview.

Families must continue to challenge both misleading statements and individuals who mislead clients about their credentials. This is important since professional organizations and monitoring boards do not appear to exercise initiative but respond only to complaints. Good citizenship demands that families with evidence of wrong-doing report this to professional licensing boards. Although we know that these boards currently do not usually respond to complaints of third parties, this is the only way, other than through legal or legislative action, to alert these organizations to the scope of the FMS problem.

A recent talk with a psychoanalytically oriented psychologist and FMSF supporter gave us insight into the attitudes of some therapists. She noted that, "Most therapists still think that the FMSF is a place where perpetrators in denial can hide." We venture to guess that "most therapists" referred to have not actually met affected families. We reflect on the comment from the retracting therapist who wrote in "First do no harm" (*Skeptic*, Fall 1995) that when she practiced recovered memory therapy, she never thought about how the families of her clients might feel. Families must continue to make every effort to meet with professionals and professional organizations. It is easy to demonize someone you don't know. It is not so easy to demonize a real person who is telling a truthful story.

Pamela

CIRCLE MARCH 22 AND 23, 1997

Initial planning is underway for a national False Memory Syndrome Foundation conference on Saturday March 22 and Sunday, March 23, 1997. We have reserved space at the Renaissance Hotel (formerly Stouffer's, the site of the December 1994 conference) located at the harbor in Baltimore, MD. This third conference will be geared to discussions of the concerns of families and the Foundation in light of the changing scientific debate and rapidly changing legal and political climate. A continuing education program will be cosponsored with Johns Hopkins on March 20 and 21, the two days prior to the family conference. **Make your plans to join us in Baltimore next spring.**

Friends to Meet in Chicago on October 5

Plans are being finalized for a meeting of the *Friends* of the False Memory Syndrome Foundation in Chicago on the evening of October 5, 1996. These periodic get-togethers give members from across the country the opportunity to be briefed on the changing scientific, organizational and family developments. "Friends" are Foundation members who donate a minimum of $400.00 in addition to their dues. *Friends* will receive details in the mail.

The Illinois False Memory Syndrome Society has scheduled its annual meeting for that same day, so *Friends* who travel to Chicago can plan to partake in a full day of programs.

If you have questions about the meeting or would like to become a *Friend,* please contact Lee at 609-967-7812.

Continuing Education Program in Chicago on Oct. 4

"Clinical Issues in Dealing with False Memories: Prevention and Family Reconciliation," will be held in Chicago on Friday, October 4, 1996. Terence Campbell, Ph.D. and Carolyn Saari, Ph.D. from the FMSF Scientific and Professional Advisory Board will be joined by Jack Wald, DSW to discuss the research on memory, clinical preventative techniques and family issues and reconciliation. The program will include an interview with a retractor and a second interview with her family. Continuing education credits for psychologists and social workers have been confirmed. Medical continuing education credit for psychiatrists is being explored. A brochure will be available shortly and full details will be published in the September Newsletter.

Increasing Number of Groups Calling for Congressional Hearings

There is an increasing number of groups calling for Congressional Hearings to investigate the injustices which have arisen from false allegations of sexual misconduct. Letters are being sent to:

The Honorable Orin Hatch, R. Utah
Chairman, U.S. Senate Judiciary Committee
Rm #135 Russell Senate Office Building
Washington, DC 20510

Congressman Henry Hyde, Chair
House Committee on the Judiciary
2110 Rayburn House Office Building

SPECIAL THANKS

We extend a very special "Thank you" to all of the people who help prepare the FMSF Newsletter.

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Washington, DC 20515

FOCUS ON SCIENCE

From time to time, various scientific articles appear which discuss issues of childhood sexual abuse, memory, and responses to trauma. Since such studies are often widely cited in the scientific and popular press, it is critical to recognize their methodological limits. It is particularly important to understand what conclusions can and cannot legitimately be drawn from these studies on the basis of the data presented. As a result, we periodically present analyses of recent well-known studies, prepared with help from members of our Scientific Advisory Committee.

* * * *

Do Trauma Victims "Learn" to Dissociate?

Most of us who have experienced a serious traumatic event—a car accident, an assault, or a natural disaster—remember the experience in great detail. Indeed, people often report that they remember very little of what happened during the weeks or months just before and just after the trauma, but they remember the event itself vividly. Indeed, when viewed from an evolutionary perspective, it seems intuitively reasonable that the mind would work in this way. If one did not vividly remember being attacked by a lion, but instead "repressed" the memory of the trauma, or "dissociated" at the time of the attack, one would be liable to wander in front of other lions in the future - with inauspicious implications both for one's own survival and that of one's pedigree.

This reasoning, however, has not daunted theorists who argue that it is possible for the brain to develop psychogenic amnesia for a traumatic event. For example, one prominent theorist, Dr. Lenore Terr, has argued that individuals do not tend to forget single episodes of trauma (which she calls "type I" traumas), but that people can develop amnesia for repeated episodes of trauma (which she calls "type II" traumas).[1] There is a certain intuitive appeal to this theory. An individual subjected to a single unexpected trauma might possess no innate ability to banish the memory from consciousness, whereas someone experiencing the same trauma over and over again might gradually "learn" to dissociate at the time the trauma was happening, and thus become more skilled at developing amnesia for an intolerable experience. For example, a child subjected to repeated experiences of sexual trauma might gradually learn to dissociate each time that the perpetrator abused her, so that she imagined herself in a field of flowers, far away from her actual body, while the abuse was occurring. Thus she could display amnesia for the event even a short time after it occurred.

But does this idea stand up to scientific testing? Unfortunately, there appear to be no methodologically sound quantitative studies that have attempted to compare memory in victims of single vs. multiple traumas in a systematic way. There is one very interesting report, however, in which a group of experts on hypnosis located a group of victims with recurrent traumatic episodes of pain, and actually attempted to train them to dissociate! In this study, Dr. David Dinges and a large group of collaborators treated 78 patients, most of them boys and young adults, with sickle

1. Terr L.C.: Childhood traumas: an outline and overview. *Am J Psychiatry* 148: 10-20, 1991.

cell anemia.[2] Sickle cell anemia is the most common serious genetic disease afflicting African-Americans. It is characterized by periodic, unpredictable, painful "crises" which occur when blood vessels become occluded by clumps of abnormal sickle-shaped red blood corpuscles. Incapacitating crises can occur at any time - in the middle of a youngster's birthday party, while playing in the back yard, or while out on a date. Certainly, if one could learn to dissociate at the time of such a trauma, it would be a great advantage.

The patients were enrolled for up to one year. For five to seven months, they were administered weekly group training sessions to learn self-hypnosis, followed by biweekly sessions for another six months. In a preliminary analysis of the first 37 patients to complete the study, some promising results were observed: the number of days with pain was reduced by 8% and the number of days that subjects required pain medication was reduced by 6%. However, the crises experienced during the self-hypnosis treatment actually lasted longer, and were rated as more intense by the patients themselves. Overall, it appeared that self-hypnosis reduced the milder episodes of pain, but did not affect the more severe episodes. Certainly, there appeared to be no evidence that children could learn to forget the crises.

It might be argued that crises of physical pain differ from the trauma of repeated physical or sexual abuse. However, we cannot ignore the findings of the sickle-cell study: even with intensive training by experts, people can learn to "dissociate" only to a modest degree, and cannot obliterate major traumatic events from their memories. Thus, it would seem unlikely that a child, lacking any training in self-hypnosis at all, could become so adept at dissociating that she or he could completely expel an entire series of abuse experiences from consciousness. At the least, then, if one claims that individuals can develop amnesia for episodes of sexual abuse via "dissociation" or another such mechanism, one would be obliged to demonstrate how victims of sexual abuse have a unique ability to do this, when carefully trained victims of sickle cell anemia cannot.

> "We live in an age of evidence-based medicine, and we will increasingly be expected to justify the methods we use in psychiatry as in the rest of medicine. Can the proponents of recovered memory therapy give us any reasoned evidence that would convince a skeptical onlooker of the validity of either their theories or their practices? If so, they should produce it immediately, since there seems to be a growing groundswell of opinion against them."
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> Alistair Muro, MD, Editorial
> *Canadian Journal of Psychiatry* 41(4)
> May 1996 page 199

Some Suits against Humenansky Settled

The *Minneapolis Star-Tribune* (6/7/96) reported that Dr. Diane Humenansky's insurance company agreed to out-of-court settlements with four former patients who accused her of planting memories of abuse. Agreements had previously been reached with two other former patients of Humenansky, each receiving multi-million dollar awards. Four more lawsuits against the psychiatrist by former patients are pending.

2. Dinges, D.F., Orne, E.C., Bloom, P.B., et al. Medical self-hypnosis in the adjunctive management of organic pain: A prospective study of sickle cell pain. Presented at the NIH Workshop on Biobehavioral Pain Research, Rockville, MD, January 19, 1994.

Parents, Siblings Join Retractor in Lawsuit

The Springfield, MO *News-Leader*, June 23, 1996, described the case of Beth Rutherford, a young woman who accused her father, an Assemblies of God minister, and her mother of sexual abuse when she was a child. Ms Rutherford has since recanted her allegations and hired a lawyer to sue her unlicensed therapist. Her parents and two siblings will join in the court action.

Ms Rutherford's accusations included being impregnated twice by her father and being forced to perform crude coat-hanger abortions on herself. A gynecologist who examined her, however, reported she is a virgin. In addition, her father had a vasectomy when she was four years old. Rev. Rutherford was fired from his job after the allegations were made public and wound up working as a janitor. "The pain in our family can never be taken away," Mrs. Rutherford said.

Two New Books about Memory

SEARCHING FOR MEMORY: THE BRAIN, THE MIND, AND THE PAST
Daniel L. Schacter, Ph.D., Basic Books, 1996

The author of this scholarly book is a professor of psychology at Harvard who has spent much of his career studying and writing about amnesia. Readers of this newsletter will probably find Schacter's discussion of "dissociation" particularly helpful. One chapter is devoted entirely to the issue of recovered memories. We print just a few statements from the book to give an idea of both style and content.

Repression: "The strength of the scientific evidence for repression depends on exactly how the term is defined. When defined narrowly as intentional suppression of an experience, there is little reason to doubt that it exists. But when we talk about a repression mechanism that operates unconsciously and defensively to block out traumatic experiences, the picture becomes considerably murkier." page 255

Dissociation: "Dissociation, rather than repression, might be responsible for extensive amnesia in abuse survivors. Dissociation refers to a failure to integrate different aspects of an experience, with the result that it is difficult to explicitly remember the experience. ....Moreover, if people become skilled enough at dissociation to develop total amnesia for traumatic experiences, it would imply the existence of a dissociative disorder—a serious matter. If they have engaged in extensive dissociation, then patients who recover previously forgotten memories involving years of horrific abuse should also have a documented history of severe pathology that indicates a long-standing dissociative disorder." page 262

Accuracy: "The current state of scientific evidence concerning the accuracy of recovered memories of childhood sexual abuse can be summarized easily: there are a

few well-documented cases, but little scientifically credible information is available." page 267

MEMORY:
REMEMBERING AND
FORGETTING IN EVERYDAY LIFE
Barry Gordon, M.D., Ph.D., Mastermedia, 1996

This is a book written for a popular audience by a clinician/scholar who runs a memory lab at Johns Hopkins. The author begins by exposing some myths about memory. For example: Myth: "People tend to block out the memory of traumatic childhood events, such as sexual abuse." Debunked: "Publicly, controversy rages over whether emotional trauma makes you forget, or remember all too well. But scientifically, there is little disagreement. People, even children, are all too likely to remember a traumatic episode. These are *not* the kinds of memories you forget. A crisis or stressful situation triggers the 'fight or flight response,' and the release of hormones such as adrenaline. These hormones actually help *preserve* memories, not block them out.

Of special interest to our readers is chapter 35 in which the author directly addresses "repressed memories." He provides a very clear explanation of the problem of false positives within a medical framework on pages 264-266. Gordon uses an example of a medical test that has 95 percent accuracy in picking out a disease and only 5 percent in falsely reporting its presence. He asks how well would such a test do in a healthy population. To answer the question, he assumes a population of one million people and that one thousand in this population has the disease. The test will accurately pick up 95% of them (950 people). That is 95% accuracy. The test will also pick 1 out of 20 (5%) falsely. In a population of one million that will be almost 50,000 people falsely diagnoses. Even though this test is 95 percent accurate, it will falsely 'accuse' more than fifty times as many people of having the disease as it does identify those people who actually do have the disease.

This section concludes, "If we accept statistics which are only slightly more realistic, then 'recovered memories' become no better at 'identifying' a truly guilty person than the toss of a coin! And if we believe that 'repressed' memories are actually unusual - if they exist at all - and that a significant proportion of 'recovered memories' are false, then many more people are being falsely accused by 'recovered memories' than are being discovered through them."

A critical review of recovered memories in psychotherapy:
Joel Paris, MD
Canadian Journal of Psychiatry 41(4), May 1996

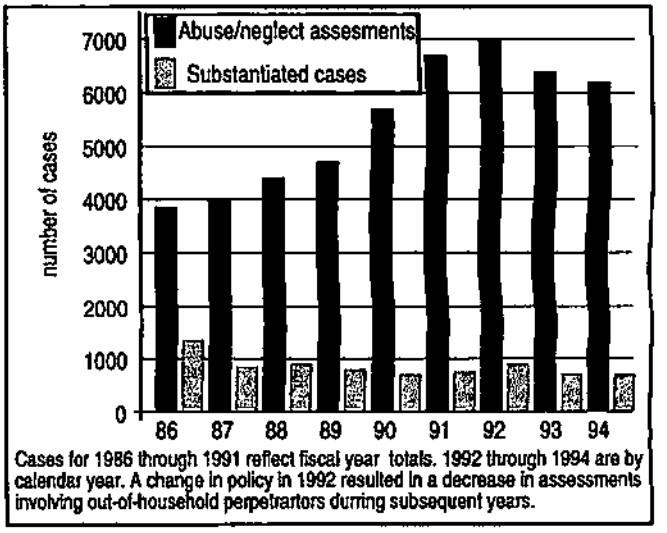
This article examines the implicit assumptions about trauma as it relates to memory and therapy. It concludes with recommendations for clinical practice. "1. Clinicians should continue to inquire about traumatic events in childhood... 2. The most reliable memories of trauma will have been present throughout the patient's life... 3. Childhood trauma exists in a larger psychological context... Where trauma is a factor in a mental disorder, it will be only one of many factors explaining the pathway to psychopathology."

A BIGGER NET

Research from Australia and Britain indicated that while expenditures for child abuse have increased greatly in the past decade, the number of substantiated cases has remained about the same (FMSF Newsletter, July/August, 1995, p.3). Data from two states, New Hampshire and South Dakota, appear to show a similar pattern.

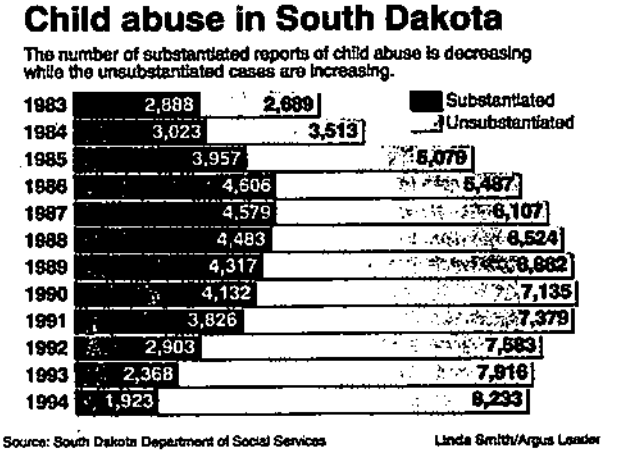
New Hampshire Sunday News, May 12, 1996
DCYF Critic Speaks Out by Nancy West

The Division for Children, Youth and Families in New Hampshire underwent phenomenal growth from 1985 to 1995. The total budget increased 865 percent. During that growth decade, the number of founded abuse and neglect cases declined from 1,338 in 1986 to 822 in 1994. "DCYF officials insist that doesn't mean that child abuse is going down."



Argus Leader, February 13, 1996
Bill aims to deter false abuse reports

Most of the 10,000 reports of child abuse each year in South Dakota are unsubstantiated. In 1983, one of every two investigations resulted in a finding of abuse or neglect. In 1994, less than one in five reported cases was substantiated. While the head of Child Protection Services says that the statistics indicate that they are doing a better job, falsely accused parents note how easy it is for a disgruntled neighbor or bitter ex-spouse to make an accusation.



***Important:** You are not eligible for coverage under our new professional liability program if one or more of the following apply to you:*

...You use hypnotherapy to assist clients in recovering failed or repressed memories of possible abuse;

1996 Professional Insurance Application

Clinical Cautions in the Use of Hypnosis with Repressed Memories

Anthony R. Quintiliani, Ph.D., NCAC II
President-Elect of the Vermont Psychological Assoc.

In a time of controversy about using hypnosis to uncover repressed memories of childhood sexual abuse, it is in the best interests of both the psychologist and the patient to follow very strict guidelines in all memory work related to the psychotherapy of trauma. The burden of proof for both memory repression and confirmation of reported new memories of childhood sexual abuse rests with practitioners and the courts. Although we are far from a final answer, the scientific evidence against hypnotically refreshed memory and the construct of repression may surprise you.

Some studies have demonstrated to a degree that the construct of repression may exist (Briere & Conte, 1993; Femina et al, 1991; Herman & Schatzow, 1987; Loftus et al, 1994; and, Williams, 1994). However, upon closer examination of the studies, either corroborating documentation that the trauma did occur or documentation of amnesia remains missing. Self-report, alone, cannot be used scientifically to document either past trauma or amnesia for it. Some research (Femina, 1991) even supports the fact that survivors of past sexual abuse may purposely withhold information about either abuse or the memory of it. In the research literature there appear to be no documented cases in which both confirmed trauma and long-term complete repression can be supported empirically. Van der Kolk, B.A., et al (1996) (Eds.) in Traumatic Stress, a more scientific presentation by some of the world's leading experts in the field, promises to summarize current research and knowledge related to biopsychosocial adaptations to traumatic stress. Of special interest is their review of memory and dissociation. Current brain research may present scientific support for the process of dissociation of traumatic experience.

If you are using hypnosis (or free association, relaxation training, visualizations, guided imagery, supportive probing, sculpting, projective drawing, meditation, dream therapy, primal scream therapy, family of origin psychodrama, past life regression therapy or other quasi-hypnotic techniques) to uncover repressed memories of childhood sexual or physical abuse, you MUST be aware of scientific implications and developing standards of care. The following information should stimulate extreme caution in the minds of responsible psychologists working with repressed memory, memory retrieval and hypnotically refreshed memory. At the same time, we MUST assist patients coming to us with such memories, and we MUST use the most effective psychotherapeutic techniques on their behalf. This dual requirement implies both an excellent working knowledge of the field of trauma treatment and use of safe, effective therapeutic techniques. In the following discussion the word patient is used in both clinical and legal (i.e., patient witness) conditions.

1. AMA Research Council Statement of April, 1985 Scientific status of refreshing recollection by the use of hypnosis. Journal of the American Medical Association, 253, (13). - The Council noted that memories obtained under hypnotic interventions contain confabulations, pseudomemories and inaccuracies. Self-report, alone, cannot be used to determine the reliability of true from false memories.

2. Kaplan & Sadock (1985)(Eds.). Comprehensive Textbook of Psychiatry, IV, Vol 2, 5th Ed., p. 1516. - Hypnosis not only fails to produce more accurate memories but also increases the patient's willingness to report unclear memories as facts. Confabulations, distortions, fantasies and cued responses all add to the potential unreliability of such memories.

3. Cogniscience Section, National Center for Scientific Research, Salpetriere Hospital, Paris, November, 1992. M. Orne and E. Orne presented information supporting the fact that hypnotic and many quasi-hypnotic techniques tend to make retrieved memories unreliable. The implication may be that hypnotic as well as non-hypnotic techniques may produce pseudomemories.

4. Coble, Y.D. (1994). American Medical Association Report of the Council on Scientific Affairs Re: Memories of Sexual Abuse. - In recovered memory work it is not yet known how to determine true from false memories. There is uncertain authenticity in such memories; therefore, external verification should be used.

5. American Psychological Association (August, 1995). Questions and Answers about Memories of Childhood Abuse. - This report confirms the fact that empirical research cannot yet support the existence of accurate recovered memories of past childhood abuse. The report also notes the high probability of added pseudoevents and distortions to recovered memories. Furthermore, the report cautions against making etiological interpretations of childhood sexual abuse based upon a single set of symptoms. Therapists who already hold absolute positions on etiology, repression and false memory syndrome MUST be more cautions than others who may be more balanced in their views. Lastly, the report notes that most victims of childhood sexual abuse tend to remember part or all of what happened to them.

6. Perry, C. et al (January, 1996). Rethinking per se exclusions of hypnotically elicited recall as legal testimony. The International Journal of Clinical and Experimental Hypnosis, XLIV, (1), 66-81. - The following list implies that hypnotically-induced memory is highly unreliable. The reasons are: a) Suggestibility increases; b) Confabulation increases; c) Confidence in the memory increases; d) Critical review of the memory decreases; e) Sources of the memory (and events) are confused; f) Reconstruction increases as a result of new in-puts; g) Free recall of events

may be corrupted; h) Fantasy development may increase; i) Practitioner's beliefs may influence the patient; and, j) It is unacceptable as testimony in most state courts.

7. Orne, M.T. (1979, 1985) Guidelines for the Forensic Use of Hypnosis. - These guidelines offer some safety in documenting that the hypnotic intervention did not alter the patient's memory. Some principles are: a) Videotaping the entire hypnotic process from first encounter through post-hypnotic contact; b) Documenting pre-hypnotic reports by initial free recall methods; c) Using independent documentation to support any changes in the pre-to-post hypnotic memories; and, d) Document (videotape) the patient's level of confidence in the memory prior to and after hypnosis.

8. FMS Foundation Newsletter, November/December, 1995. -The totality-of-circumstances-approach allows the courts to make case-specific decisions on admitting post-hypnotic testimony. Some criteria are: a) Could the hypnosis have pressured the patient to describe (or develop) a coherent story about the events in question? b) Could suggestions (about etiology of illness or memory) have influenced the patient's reported memories? c) Was a pre-hypnotic videotaped record made to show baseline memory? d) Was the hypnotist/hypnotherapist appropriately qualified? e) Was there independent corroborating evidence for events? f) What is the patient's level of hypnotizability and responsiveness to suggestions?

9. Schacter, D. (1996). Searching for Memory: the Brain, the Mind and the Past. New York: Basic Books. - In this scientific discussion of brain processes, mental mechanisms, memory and past life experience Schacter presents various lines of evidence in support of absolute caution regarding repressed memory. The interactions involving scientific brain-mind processes, personal memory and traumatic life experience do not, apparently, support clinical beliefs that repressed memories exist.

10. Pendergrast, M. (1996 Edn.). Victims of Memory: Sex Abuse Accusations and Shattered Lives. Hinesburg, Vermont: Upper Access. - This journalistic review presents a comprehensive critique of recovered memory therapy. A key conclusion is that incidents and details of sexual abuse can be forgotten and recalled later, but that "massive repression" (in which years of trauma are completely forgotten) probably does not exist.

11. Cohen, L. et al (1995) (Eds.). Dissociative Identity Disorder: Theoretical and Treatment Controversies. Northvale, NJ.: Jason Aronson. - This comprehensive text presents varied opinions in support of DID and repressed memory processes. However, it also presents some very strong critiques. The clash of ideas is very helpful.

12. Yapko, M.D. (1994). Suggestions of Abuse: True and False Memories of Childhood Sexual Trauma. New York: Simon and Schuster. - This book offers a good clinical review of the necessary cautions required in traumatic memory work. Of special value is the review's overall listing of how memory can be influenced, especially by hypnosis and other clinical interventions.

13. D. Corydon Hammond et al (1995). Clinical Hypnosis and Memory: Guidelines for Clinicians and for Forensic Hypnosis. - American Society of Clinical Hypnosis Press. This contribution offers practical recommendations to clinicians using hypnosis in repressed memory work. Noted recommendations to clinicians include:
a) clinical license and appropriate training required; b) no leading questions; c) documented informed consent (especially regarding imperfection of memory and legal limits on use of hypnotically recovered memory); d) mixed reliability of dissociation and prior suggestions with high hypnotizables; f) need for corroborating evidence; g) affect intensity does not imply truth in memories; h) hypnotic memory is not more accurate than conscious awareness; i) dissociative age regression may distort memory; j) balance support, empathy and scientific information in treatment of self-reported, repressed memory of trauma; and, k) litigation and confrontation against an alleged perpetrator should not be encouraged, especially if hypnosis was used without corroborating evidence of events.

I hope this review is helpful to you in your clinical work. Provide the most effective and safe services possible; however, it is your responsibility to be competent in this complex field.

Professionals Lack Consensus about the use of Hypnotic Techniques for Recovering Memories

The most reliable information currently available about professionals' beliefs and practices on the use of hypnosis and hypnotic techniques for recovering memories comes from a study by Poole, Lindsay, Memon, and Bull, *J of Counseling and Clinical Psychology*, 1995 Vol 63, No3. 426-437, "Psychotherapy and the Recovery of Memories of Childhood Sexual Abuse: U.S. and British Practitioners' Opinions, Practices, and Experiences."

"A survey regarding clients' memories of childhood sexual abuse was sent to licensed U.S. doctoral-level psychotherapists (Survey 1 & 2, n=145) and British psychologists (Survey 2, n=57). Respondents listed a wide variety of behavioral symptoms as potential indicators of CSA and 71% indicated that they had used various techniques (e.g. hypnosis, interpretation of dreams) to help clients recover suspected memories of CSA."

Technique	Using			Disapproving		
	US-1	US-2	GB	US-1	US-2	GB
Hypnosis	29	34	5	27	33	44
Age regression	19	17	7	35	33	46
Dream imagery	44	37	25	26	28	40
Guided imagery	26	32	14	34	31	31
Imagination	11	22	18	44	24	22
Family photos	47	32	29	13	13	13
Journaling	50	29	32	18	35	25
Physical symptoms	36	36	37	25	24	20

"Across samples, 25% of the respondents reported a constellation of beliefs and practices suggestive of a focus on memory recovery, and these psychologists reported relatively high rates of memory recovery in their clients."

BOOK REVIEW

Review of "Symposium on the 'False Memory' Controversy" *Psychoanalytic Dialogues* v.6 no.2 (1996): 151-294

Michael G. Kenny, D. Phil.

This 'Symposium on False Memory' takes the form of papers by two associate editors of *Psychoanalytic Dialogues* -- Drs. Adrienne Harris and Jody Messlet Davies -- with commentaries by C. Brooks Brenneis, an analyst with a skeptical view of recovered memory, Donnel B. Stern who takes a supportive position, and Frederick Crews, who questions psychoanalysis in all its forms and should be no stranger to the present readership.

The editor of *Dialogues*, Stephen A. Mitchell, sets the agenda in his Introduction, noting that the primary authors "attempt to address complex problems of epistemology, therapeutics, and clinical responsibility." They are grappling with the problem of memory, more specifically memories of sexual abuse, as encountered by analysts in their clinical practice. Behind the practice lie theoretical ambiguities about the relation between truth and fantasy that have been present since Freud's rejection of the seduction hypothesis.

The type of relational analytic therapy at issue here is intensive, long-term, and highly sensitive to problems stemming from transference and counter-transference: the reading of past patterns of interaction into the present therapeutic relationship. This intimate dialogue between clinician and patient is also the focus of outside suspicions about the genesis of confabulated memories. The contributions of Harris and Davies reflect the tension implicit in a changing practice that, instead of emphasizing an exact recovery of what really happened, now focuses on "the constructed nature of memory and a narrative view of the past." How is one to walk the line between constructivism, the real-world unhappiness of one's patients, and knowledge of the reality of sexual abuse? Dr. Davies asks herself: "how do we reconcile a belief in the primary pathogeneity of [abuse] with an equally strong belief in the essentially constructivist nature of the psychoanalytic process (p. 207)?" As the Symposium shows, it isn't easy.

Harris observes that "in this climate of highly politicized and polarized discussion of true versus false, remembered versus created and constructed, it is extremely hard to find a position morally, ethically and intellectually comfortable from which to do clinical work" (p. 160). All contributors agree that memory is not a clear-cut function, and that it is shaped by the circumstances in which the past is brought alive in the present. The psychoanalytic encounter is one of these, and our authors are well aware of it. They agree that the past is to some extent a social construct, but question whether therapists have the capacity to induce the fabrication of just any past. If not, what is the relation between past reality as it is presently construed, and what "what really happened" back then? Difficult issues to be sure.

These issues were brought into focus by what the authors characterize as the 'False Memory Syndrome Movement,' which they regard as having grossly caricatured the nature of analytic practice by emphasizing a "reductive and skewed picture" of the nature of repression and memory at the expense of a nuanced clinically-based account of the complex effects of abuse (p. 165). Nonetheless, the authors are attuned to some of the difficulties here: the influence of leading questions on children's testimony, the social dynamics of memory formation within families, the possibility of iatrogenic suggestion, the fact that "difficulties with suggestibility are particularly acute with people who have a history of abuse" (p. 180).

Harris's and Davies's solution to these problems takes two forms: (1) defusing the false memory critique by calling into question the relevance to clinical reality of the experimental work on memory done by cognitive psychologists like Elizabeth Loftus, and (2) emphasizing the known reality of abuse, recent research on Post-Traumatic Stress Disorder, and the capacity of analysis to uncover the dysfunctional relational patterns ultimately due to familial abuse. Dr. Harris takes on the first task, while Davies takes on the second.

Harris asks why research on eyewitness testimony has come to dominate the discourse of the critics: why positivist psychological experiments are taken to be an essential guide to a truth which in principle is complex, murky, and not easily mapped through oversimplified laboratory research. As an anthropologist attuned to work on complex phenomena in real-world settings, I have a certain sympathy for this point of view, but doubt that psychoanalysis -- though certainly complex -- is any better situated in this respect than cognitive psychology.

On the one hand Harris attacks the positivism of Loftus, while on the other Davis draws on Bessel van der Kolk's neuropsychology as a legitimizing strategy to affirm the reality of dissociated memory (and is called a "closet positivist" by Crews for doing so). She believes herself to be articulating psychoanalysis and current trauma research; what I think she has actually done is to accept *carte blanche* (as have many others) van der Kolk's "groundbreaking work on the neurophysiology of trauma" (p. 288) as a factual account of the nature of traumatic amnesia. In my view van der Kolk's so called groundbreaking work is a very shaky and metaphorical structure shot through with 'maybes, probablys, and coulds' presented in a haze of scientistic jargon. As far as I can tell, van der Kolk's therapeutic *practice* is no less psychoanalytic in its method than that of Harris and Davies, and therefore subject to the same caveats and doubts that our authors apply to their own work.

Be that as it may, Davies's essay exhibits a tension between positivistic neuroscience and psychoanalytic hermeneutics. There are in fact important issues here; Harris, more attuned than Davies to contemporary social theory and philosophy, is especially sensitive to this background influence. She observes that "positivism or some conviction that the analyst does have independent access to verification would be a relief" (p. 178); but it is a relief that Harris can't allow herself in the face of "the most terrible known in this debate; the importance of and epistemological shakiness of reality confirmation and validation" (p. 277). And yet she says that "psychoanalysis *is* about remembering" (272).

Harris and Davies *do not* think that their fundamental task is to recover specific memories, but rather to get inside the relational world of their clients on the assumption that past dysfunctional patterns affect present behavior in ways that are unknown to the patient, and in this sense unconscious. I do not find this controversial in itself. However, problems arise when one considers the methods used to access these patterns, as seen most particularly in Davies's assertion that they will, if all goes well, reveal themselves as *they really are* in the transference/counter-transference relationship. This is a big claim, one buttressed by reference to van der Kolk's assertion that traumatic memories may *still* be there as fresh as when first laid down — "state dependent memories of formative interactive representations" (p. 197).

There are other issues here that I cannot fully address in a review, but I will identify two that are worthy of further attention: (1) continued invocation of the slippery and trendy concept of 'dissociation' — an odd-job word that evades precise definition, and (2) the problems that Harris identifies concerning how memories are actually formed via communicative practices within families and elsewhere that "may leave the child utterly at sea as to what happened, why, and how to keep an orderly narrative of who did what to whom and why." The job of analysis is to help unscramble all that, to produce an orderly narrative, "an integration of thought and feeling" (p. 177). This is no easy task in the face of presumptive dissociative processes that decouple feelings, emotions, images, dreams, and thoughts to produce a life lived in poorly articulated fragments. The concept of 'dissociation' allows for an account of how and why such fragmentation has occurred, but as said it is a slippery notion. It can mean experience that was never verbalized at all (cf. Stern, p. 254), or experiences that are kept in separate compartments because they are cognitively incommensurable (this me loves father, that one hates him), or state-dependent memories that are neurochemically encoded in a different manner than normal memory. It's a muddle. However, I would point out that, if Freud taught us anything, it is that family life is a muddle as well — a melange of conflicting desires and contrasting perspectives. Our authors observe that their patients are often full of self-doubt about what *really* happened. As well they might be, especially when memories are vague or only recently surfacing, or with patients who conclude from the media that they *might* have been abused.

As for the commentators, Dr. Brenneis, drawing on his own clinical experience, examines the logic potentially leading to the invalid conclusion that because certain symptoms are manifest in the present then trauma can be assumed to have occurred in the past. He doubts that Harris and Davies have successfully dealt with the problem of tacit influence in psychoanalytic practice, stating that "we cannot, I think, escape the possibility that memory of early abuse may be created within the therapeutic dyad" (p. 227). Donnel Stern is much more sanguine than Harris about the capacity of a relationally-oriented psychoanalysis to arrive at something like truth. He does not think that constructivism implies relativism (263). Frederick Crews, on the other hand, finds nothing of value in any of this, and most in particularly Davies's claim to be able to access dissociated relational patterns through the transference/counter-transference process. In fine rhetorical fettle, he observes that "self-evidently, such a miasma cannot be expected to yield any nuggets of corroborated fact" (p. 244). Crews also targets what he calls "sexual politics," and regards the concept of 'dissociation' as an ideologically motivated dodge to get around the 'masculinist' implications of the Freudian notion of repression. His final advice is that psychoanalysts would be well advised to stay away from the recovered memory movement.

Our authors provide a measured response to the commentaries. Davies says that though relational psychoanalysis does not reveal 'the truth,' the truth can be approached "asymptotically." It can be identified when the patient improves as it is revealed. She finds that "it is hard to believe that simply cocreating an interesting and plausible narrative that had no relationship to an actual lived past" could bring about the changes for the better witnessed in analytic practice (p. 293). Harris regards Crews's juxtaposition of 'masculinist repression' and 'feminist dissociation' as simply 'goofy' (276), while accepting that a central problem in this entire debate is the "difficult problem of the subtle, apparently benign pulls for compliance and power of suggestion in even the most principled and reflective conduct of psychoanalytic and psychotherapeutic practice" (271).

All told an interesting and provocative exchange. Readers would be well advised to obtain it for themselves and think about it. Among other things it tells much about the current state of our intellectual culture, its doubts, anxieties, and epistemological uncertainties.

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LEGAL CORNER

FMSF Staff

Arizona Supreme Court Rules that PTSD is Insufficient to Extend the Statute of Limitations under the Disability Exception (Florez v. Gomez and Duncan v. Moonshadow (Consolidated) 1996 Ariz. LEXIS 59, decision 5/16/ 1996)

The Arizona Supreme Court held that two suits for sexual abuse brought by adults some two decades after the alleged events were barred by the statute of limitations. The court ruled that a diagnosis of post-traumatic stress disorder (PTSD) was insufficient to constitute insanity or "unsound mind" under Arizona Statute[1] and thereby extend the period within which the suit could be filed. The court further held

1. The purpose of so-called insanity or disability exceptions to the state statute of limitations is to provide extra time to a person who could not sue because they were mentally incompetent and/or unable to understand their legal rights. Arizona statute A.R.S.§A412-502(A) provides "if a person entitled to bring an action...is at the time the cause of action accrues...of unsound mind, the period of such disability shall not be deemed a portion of the period limited for commencement of the action."

that expert affidavits that offer conclusions without setting out "relevant foundation" do not support a legal finding of "unsound mind."

In one of the suits, Claimant Gomez alleged that a priest had molested him when he was about 12 years old, some 16 years earlier. Gomez argued that he had repressed the memories until 1990. He also stated that he "wasn't ready to come up and talk about it..." and that he had not made the connection between the alleged abuse and his psychological problems until recently. He also claimed he had been unable to file earlier because he was of "unsound mind," and offered support through an expert affidavit that he was of "unsound mind" because he had dropped out of high school, moved frequently, squandered his money, and suffered from depression and stress.

In the second suit considered by the court, claimant Moonshadow alleged sexual abuse of the most "perverse and criminal sort" by her father from age 6-17 over two decades prior to filing. She claimed that she was always aware of the abuse but had suffered from PTSD which had prevented her from bringing the suit in time.

Each of these suits would be dismissed as time barred unless the limitations period were extended under the Arizona disability statute. The court noted that while neither Gomez nor Moonshadow claim to be insane or incompetent, they argue that their PTSD is sufficient to extend the limitations period. Following a review of Arizona law, the court held that the focus of the unsound mind inquiry is on a plaintiff's ability to manage his or her ordinary daily affairs.[2] It does not depend on the plaintiff's ability to pursue the legal matter at issue.

The court ruled that while the expert affidavits presented by Gomez's and Moonshadow's treating psychologists set forth conclusions, they are insufficient to support a legal finding of "unsound mind." The court held that "simply attaching the PTSD label to a person's symptoms is insufficient to satisfy the...definition of unsound mind....An expert affidavit opposing a motion for summary judgment must set forth 'specific facts' to support an opinion...The affidavits here are not objectionable because they embrace an ultimate issue, but because they are without relevant foundation....The affidavits confuse the inability to bring an action with the inability to perform basic functions of human existence."[3]

Referring to a recent Michigan Supreme Court decision[4] the Arizona court stated that "hard evidence that a person is simply incapable of carrying on the day-to-day affairs of human existence...are empirical facts easily verifiable and more difficult to fabricate than a narrow claim of inability to bring the action." The problems with recovery of memories of childhood sexual abuse which the AMA[5] described as "of uncertain authenticity" were also noted by this court. The court reemphasized in its conclusion that "the legislature enacted statutes of limitations in order to protect against the nightmare of stale claims....It is not for us to enlarge the category of unsound mind through interstitial judicial lawmaking."

2. The Supreme Court concluded that the definition of unsound mind developed in the Arizona Court of Appeals is consistent with cases in other jurisdictions such that no state has found a diagnosis of PTSD alone sufficient to constitute unsound mind within the meaning of the relevant statute. In addition to the decisions cited by the Arizona Supreme Court, an FMSF Working Paper, Chapter VII.1 on the Disability Exception, also explores this question.
3. The court also noted that if the facts listed in the expert affidavit from Gomez' therapist (including moving frequently and squandering money) "were sufficient to support a legal finding of 'unsound mind,' then all those who have less than satisfactory lives would be of 'unsound mind.'"
4. Lemmerman v. Fealk, 449 Mich. 56, 534 N.W.2d 695 (Mich. 1995).

Patient-Therapist Privilege and Access to Clinical Records

The confidentiality, or privilege, granted to clients which restricts access to their therapy records originates both from state statutes and common law. While all states have passed statutes granting a certain degree of privilege in this area, most state and federal courts have, on a case-by-case basis, found it necessary to balance the need for confidentiality with Constitutional due process rights.[6] It appears that in many states, while privilege is recognized, it is not absolute and exceptions exist. Courts allowing exceptions to privilege have devised numerous safeguards to ensure the privacy of the individual where possible, while at the same time granting access to relevant records.

The issue in lawsuits based on claims of recovered repressed memories revolves around whether the allegations refer to actual events or are confabulation and the product of suggestion. As Elizabeth Loftus, et. al.,[7] point out, "To defend successfully against these allegations, one must have access to the clinical record to evaluate the extent to which the therapy process itself may have created a complex web of unsubstantiated or unverifiable memories and beliefs about prior life events."

Privilege in repressed memory claims may be overcome due to several characteristics of the claim. For example, a plaintiff alleging repression of childhood abuse necessarily has the burden of proving the elements of the claim. To sufficiently meet this burden, the plaintiff may need to produce documentation of the manner in which he or she came to discover the alleged abuse. Such evidence may include the therapist's notes and observations. Under these circumstances, where the plaintiff relies on the relevant documentation, the patient-client privilege may be waived.

In addition, the plaintiff in repressed memory cases typically claims psychological damages as a result of the alleged abuse. In many jurisdictions, there is an exception

5. Report of the Council on Scientific Affairs, American Medical Association, Memories of Childhood Abuse, CSA Report 5-A-94.
6. For a discussion of representative case law and the numerous legislative and judicial exceptions to patient-therapist privilege, see, e.g., Loftus, E.F., Paddock, J.R., Guernsey, T.F. (1996) "Patient-Psychotherapist privilege: Access to clinical records in the tangled web of repressed memory litigation," University of Richmond Law Review, 30:109-154. This article also discusses the privilege question in relation to third party suits. See also, FMSF Publication, Working Paper Chapter XI.
7. Loftus, E.F., et.al., (1996) Ibid., p. 111.

to the patient-therapist privilege where the psychological state of the plaintiff is put into issue.

Some jurisdictions have mandated that the court be informed where proffered testimony had been the subject of hypnosis. The use of therapeutic intervention involving hypnosis or hypnotic-like techniques may limit privilege in jurisdictions which employ a case-by-case evaluation of the impact of hypnosis on the reliability and, thus, the admissibility of the hypnotically enhanced memory.

A recent ruling in a repressed memory case illustrates the classic tension between the privacy rights of the individual and the defendant's due process rights. As the defense in Hungerford[8] pointed out in a motion for discovery of therapy records, "If this matter were ever to be before a trier of fact, not only must the defense argue that the incidents in the repressed memories did not occur, but the defendant must also be prepared to address the jury's question that if these memories are untrue, how did they occur?" The Hungerford court's ruling followed a pre-trial evidentiary hearing which considered the reliability of the theory of repression, and the process by which they had been "recovered." The court concluded that the techniques used were "highly suggestive" and "thoroughly and systematically violated the guidelines and standards of practice of psychotherapy."

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U.S. Supreme Court Upholds the Privilege of Psychotherapists to Refuse to Disclose Patient Communications in Federal Court Jaffee v. Redmond, et. al., 1996 U.S. LEXIS 3879, decision June 13, 1996.

On June 13, 1996, the U.S. Supreme Court ruled on whether federal courts should respect the confidentiality of mental health counseling records by giving psychologists, psychiatrists and social workers a specific privilege against having to disclose patient records in judicial proceedings.

In the case before the U.S. Supreme Court, Mary Lu Redmond, a Chicago policewoman was sued for wrongful death by the family of a suspect, Rickey Allen, whom she shot and killed as he was allegedly about to stab another man with a butcher knife. Since there was a factual disagreement as to when policewoman Redmond drew her gun and whether the man she shot was armed and threatening a third man, the family of Allen sought to compel a clinical social worker to reveal what officer Redmond had said in counseling sessions after the shooting. Officer Redmond had entered therapy to "work out the pain and anguish undoubtedly caused by Allen's death."

In 1993, a federal judge ruled the records of a social worker are not protected under federal privilege laws and that private discussions between Redmond and social worker Karen Beyer were to be disclosed. The 7th Circuit court ruled it was time to recognize a psychotherapist-patient privilege because "reason tells us that psychotherapists and patients share a unique relationship, in which the patient's ability to communicate freely without the fear of public disclosure is the key to successful treatment."

In their appeal to the U.S. Supreme Court, relatives of the dead man argued that the appeals court created such a broad privilege that their ability to prove their case at the new trial would be impeded.

The U.S. Supreme Court based its ruling on Federal Rule of Evidence 501 which authorizes the courts to define new privileges, and on Trammel v. United States 445 U.S. 40, 63 L.Ed.2d 186, which states that exception from the general rule disfavoring privilege is justified when the proposed privilege "promotes sufficiently important interests to outweigh the need for probative evidence." at 51

The majority opinion written by Justice Stevens held that psychotherapists' privilege serves private as well as public interests. "Effective psychotherapy depends upon an atmosphere of confidence and trust, and therefore the mere possibility of disclosure may impede development of the relationship necessary for successful treatment." (citing studies reviewed in briefs by the Am. Psychiatric Assn. and the Am. Psychological Assn.)[9] The court specifically extended privilege to social workers, stating that social workers now provide a significant amount of mental health treatment and their clients often include the poor and those of modest means.

The court bolstered its conclusion that a federal privilege was called for by citing the fact that all 50 states have codified some form of privilege for mental health workers in state statutes. However, the dissenting opinion by Justice Scalia not only argued against the logic of that reasoning, but pointed out that, "No state has adopted the privilege without restriction; the nature of the restrictions varies enormously from jurisdiction to jurisdiction; and 10 States, I reiterate, effectively reject the privilege [to social workers] entirely."

The majority opinion did not address the special circumstances which many state and federal courts had recognized might lead to exceptions to privilege. In reviewing the decision of the Court of Appeals in Jaffee, the majority specifically declared, "We part company with the Court of Appeals on a separate point. We reject the balancing component of the privilege implemented by that court and a small number of States. Making the promise of confidentiality contingent upon trial judge's later evaluation of the relative importance of the patient's interest in privacy and the evidentiary need for disclosure would eviscerate the effectiveness of the privilege....If the purpose of the privilege is to be served, the participants in the confidential conversation must be able to predict with some degree of certainty whether particular discussions will be protected. An uncertain privilege, or one which purports to be certain but results in widely varying applications by the courts, is little better than no privilege at all."

Following this statement the majority did, however, in a footnote allow that "there are situations in which the privilege must give way, for example, if a serious threat of harm to the patient or to others can be averted only by means of disclosure by the therapist."

8. State v. Hungerford, No. 94-5-45, 1995 WL 378571 (N.H. Sup. Ct., May 23, 1995), Memorandum of Law Supporting Defendant's Second Motion for Discovery and Motion for Depositions.

9. In fact 14 amicus briefs were filed which support the granting of privilege. They were submitted by organizations including the Am. Psychiatric Assn., the Am. Psychoanalytic Assn., the Am. Assn. of State Social Work Boards, the Am. Counseling Assn., the Natl Assn. of Social Workers.

Parallel to its reliance on FRE 501, the majority quoted from the Senate Report accompanying the 1975 adoption of the Rules of Evidence, which also recognized that Rule 501 "should be understood as reflecting the view that the recognition of a privilege based on a confidential relationship...should be determined on a case-by-case basis." It should be pointed out that following the majority statement rejecting "the balancing component of the privilege," Justice Stevens continued by saying, "A rule that authorizes the recognition of new privileges on a case-by-case basis makes it appropriate to define the details of new privileges in a like manner. Because this is the first case in which we have recognized a psychotherapist privilege, it is neither necessary nor feasible to delineate its full contours in a way that would govern all conceivable future questions in this area."

We will conclude with the remarks of Justice Scalia (dissenting opinion) who questioned whether the cost to truth and justice were truly justified in granting absolute privilege to psychotherapists: "The Court has discussed at some length the benefit that will be purchased by creation of the evidentiary privilege in this case: the encouragement of psychoanalytic counseling. It has not mentioned the purchase price: occasional injustice. That is the cost of every rule which excludes reliable and probative evidence—or at least every one categorical enough to achieve its announced policy objective. In the case of some of these rules, such as the one excluding confessions that have not been properly 'Mirandized'..., the victim of the injustice is always the impersonal State or the faceless 'public at large.' For the rule proposed here, the victim is more likely to be some individual who is prevented from proving a valid claim—or (worse still) prevented from establishing a valid defense. The latter is particularly unpalatable for those who love justice, because it causes the courts of law not merely to let stand a wrong, but to become themselves the instruments of wrong."

Admissibility of Expert Opinion Testimony

Editor's note: The admissibility of expert opinion testimony that certain psychological characteristics or behaviors are consistent with a history of past sexual abuse has been an issue in many child sexual abuse cases.[10] Most courts have not allowed testimony which offers the expert's conclusions on the question before the jury, i.e., whether the abuse, in fact, occurred. Some recent decisions, after finding that the basis of the expert testimony regarding so-called syndrome evidence is insufficiently reliable, have refused to admit the testimony for any purpose. Where admitted, the purpose of such testimony is generally limited to 1) providing the jury with information about characteristics of sexually abused individuals based on expertise the lay jury may not have; 2) bolstering the credibility of the complaining witness where the jury might otherwise negatively infer their testimony was impeached by certain psychological characteristics or behaviors. A recent Canadian decision contributes to sound judicial thought in this area.

Ontario Canada Court Finds Expert Testimony on Syndrome Evidence Inadmissible

Regina v. Wakabayashi, Ontario Court (General Division), No. CRIM (J) 4055/93, ruling May 1, 1996.
(Ruling available as FMSF Brief Bank #103.)

In a recent decision (5/1/96), Ontario Justice J. Langdon rejected many earlier formulations of the admissibility question as logically inconsistent and legally prejudicial. Justice Langdon states that while he had initially acceded to the admissibility of expert opinion that certain behaviors are consistent with a past history of sexual abuse, he consented to revisit the issue on motion by defense attorney Alan Gold of Toronto, Canada. The court considered the motion to limit the admissibility of expert opinion testimony in a criminal case in which defendant Wakabayashi was accused of sexual abuse of his 2 young stepchildren from 1971-1981.

The anticipated expert testimony would include statements about behaviors of the two complainants which included: "acting out, especially running away, conflict with parental authority, acts of self harm,...abuse of alcohol and drugs, promiscuous sexual behaviour, dissociative episodes, late disclosure of alleged sexual abuse..." Justice Langdon noted that such behaviors may lead a jury to reason that the complainants are troubled persons and that as a consequence their evidence ought to be treated with caution or perhaps rejected. The ruling made it clear that this credibility problem remains regardless of whether there is an "explanation" for it. In fact, Justice Langdon noted, "In order for the 'explanation' (that the behaviour(s) are consistent with a history of sexual abuse) to have any meaning and hence any impact on the jury's assessment of the complainant's credibility, the jury must find that the complainant was sexually abused....What could be more prejudicial than erroneously assuming the guilt of the accused?...It is illogical to reason that the past history of sexual abuse explains away the lack of credibility; it does not. Whatever the cause, the witness remains troubled and his or her credibility must be assessed accordingly." In addition, the court found that the admission of such testimony would be of "great prejudice in the sense that it would almost certainly be misused by the jury." (emphasis in original)

Justice Langdon also concluded that there were logical errors in the assertion that "particular behaviors [are] consistent with a history of past sexual abuse." The court noted that to be of assistance to the jury, one must also know what behaviors are consistent with not having been abused or with a person who was not sexually abused but who falsely claims he was. Otherwise the proffered testimony is "utterly without probative value." The court provided the example of expert testimony regarding CSAAS: "If the child delayed disclosure, that was consistent with the syndrome. If he or she did not, well that was not necessarily inconsistent with the syndrome. Similarly if the child recanted after disclosing; but if the child did not recant, it did not indicate that his or her claim was false. In

10. See, e.g., Askowitz, L.R. and Graham, M.H. (1994) "The reliability of expert psychological testimony in child sexual abuse prosecutions," 15 Cardozo L. Rev. 2027. See also, FMSF Publication #825 and Working Papers Chapter IV and Chapter XIX.

short, the syndrome was a crutch which handily supported any witness whose testimony betrayed obvious weaknesses but was incapable of discrediting a similar witness whose testimony did not. It had no other effect than to assist witnesses for the prosecution."

The court also noted that several of attorney Gold's arguments were persuasive: that the expert had relied on authorities which had not been subjected to peer review and were not in themselves reliable; that a number of learned articles argue that there are no behavioral identifiers of persons who have been sexually abused; and that there are no studies of behaviors which are "consistent with a history of not having been sexually abused but now falsely claiming to the contrary." Justice Langdon stated, however, that "without, myself, donning the mantle of an expert" he could not, at the time, decide that issue. By the reasoning given above, the court ruled the proffered expert opinion would not be admitted.

U.S. District Court, Pennsylvania Does Not Dismiss Third Party Suit; Settlement Negotiations Underway (Tuman v. Genesis Associates, et.al., 1996 U.S. Dist. LEXIS 5406 (Memorandum and Order, April 25, 1996)

The parents of Diane Tuman initiated this third-party suit in Sept. 1994, alleging that they had entered into a contract with their daughter's therapists to treat their daughter, then 20 years old, for bulimia and other emotional problems. Plaintiffs claim that during the time the defendants treated Diane from 1990 to 1992, they negligently implanted false memories in Diane that her parents had sexually assaulted her and routinely performed bizarre satanic rituals, including murdering children. Plaintiffs also claim that Diane's mental condition deteriorated significantly under treatment by the defendants, Genesis Associates and its principals, Patricia A. Neuhausel, a licensed social worker and certified addiction counselor and Patricia A. Mansmann, a licensed psychologist.

In July 1995, the judge in this case dismissed 2 of the Plaintiff's causes of action but allowed 6 others to remain against the 3 defendants for negligence, breach of contract, defamation, intentional infliction of emotional distress, misrepresentation, and punitive damages.[11] The judge ruled that a therapist may owe a duty of reasonable care to a patient's parents under certain circumstances.

On April 25, 1996, Judge John R. Padova revisited the issue on a more recent motion for summary judgment. The court did not dismiss the claims against Neuhausel and Genesis Associates for negligence, breach of contract, intentional misrepresentation and punitive damages, but did enter a summary judgment in their favor on the intentional infliction of emotional distress and defamation claims. The court also granted summary judgment in favor of defendant Mansmann on all causes of action, citing several reasons, including the fact that she never specifically treated Diane.

The court refused to dismiss the suit as time barred, holding that the date at which it was reasonable for the Plaintiffs to have first discovered that they had been injured by the Defendant's actions was not necessarily the date they first discovered the defendants' treatment was harmful to their daughter and that both dates were under dispute.

The court also rejected defendants' argument that plaintiffs' negligence claim must fail because Pennsylvania courts only recognize a cause of action for negligent infliction of emotional distress in so-called "bystander" cases (i.e., situations in which the plaintiff actually observes the defendant injure a close relative). Judge Padova noted that Pennsylvania also recognizes recovery in situations in which there is a contractual or fiduciary duty and, therefore, predicted that the Pennsylvania Supreme Court would allow plaintiffs who establish a reasonable duty of care to recover damages for emotional distress caused by the breach of that duty. However, Judge Padova, reiterating his July 1995 opinion, noted that plaintiffs would still be required to show that they were owed a duty by defendants which would be satisfied by showing: 1) the therapist specifically undertook to treat the child for the parents; 2) the parents relied upon the therapist; 3) the therapist was aware of the parents' reliance; 4) it was reasonably foreseeable that the parents would be harmed by the therapist's conduct. 894 F.Supp. at 188.

The court further held that because the record showed that a fact finder could reasonably conclude that plaintiffs had formed an oral contract with defendants, plaintiffs' claim of breach of contract could not be defeated on summary judgment motion.

It should be noted, especially in light of the recent U.S. Supreme Court ruling in Jaffee v. Redmond (reported elsewhere in this Newsletter), that, despite the fact that plaintiffs' expert did not have access to Diane's treatment records, plaintiffs were successful in defeating defendants' motion to exclude the opinion of plaintiffs' expert who was to testify that defendants' treatment deviated from the standard of care. After examining the record, the court held that plaintiffs' expert had sufficient alternative sources of information upon which the expert could have reasonably based his opinion and defendants may cross-examine the expert about the basis of his opinion at trial.

Settlement negotiations were entered into prior to trial which had been scheduled for May 20, 1996. However, as of the date of this writing, no formal settlement agreement has been reached.

Therapy Blamed in Delusions, Death; Woman Settles Suit, Says Grisly Memories Planted
Seattle Post-Intelligencer by Ellis E. Conklin 5/21/1996

A Washington State hypnotherapist will pay a $700,000 settlement to a former patient who caused a fatal car accident after becoming convinced that members of a satanic cult were pursuing her.

Patricia Rice, 51, went to hypnotherapist Gina Gamage in 1992, seeking help to lose weight and stop smoking. Instead, memories of sexual abuse by satanists were implanted through hypnosis, say her Seattle attorneys Rebecca Roe and Kristin Houser. Rice said she came to believe the cult was targeting her because she had "remembered" what it had done. In June 1992 she drove

11. See report in FMSF Newsletter, Sept. 1995.

around Oregon for two days believing that the cult members were closing in on her. She caused a head-on collision when she drove across the center line into oncoming traffic, all the while believing that a "good witch" was "telepathically directing her to safety." Rice was tried for first-degree manslaughter of the man who died in the accident and was found "guilty but insane." Although currently free and in therapy, Rice will be under the supervision and control of the court and the Oregon Psychiatric Security Review Board for 20 years.

The settlement with her former therapist was reached in a daylong mediation session about six weeks before Gamage was to have gone to trial to face Rice's allegations of negligent and harmful therapy. Under the terms of the settlement, Rice will receive from Gamage's insurance company $425,000, plus $1570 a month for the rest of her life. The name of Gamage's insurance carrier is being withheld from court records as one condition of the settlement.

Gamage continues to practice in Vancouver, Washington. Rice's attorneys note that there is no licensing process in Washington for hypnotherapists. They need only register with the state.

Editor's note: The FMSF Legal Task Force is tracking the progress of over 10 malpractice claims which are expected to settle by the end of July. Attorney Don Eisner, of Encino Calif. commented that from his experience, insurance companies are now more willing to settle malpractice suits by former patients alleging implantation of false memories. In the more than half dozen cases his firm is involved with, insurance companies appear to be defending mainly on technical or procedural grounds and are reluctant to defend on the merits of the case. Eisner notes that for defendant therapists, it is increasingly difficult to find an expert to testify that memory recovery therapy meets an established standard of care or that a belief in childhood ritual abuse experiences is justified.

Summary Judgment Granted Defendant in Malpractice Suit

In April, 1996 a summary judgment motion was granted in a case brought by Deborah David against numerous California mental health professionals.

David had originally entered therapy for depression after surgery. She was told by her therapist that she was suffering from repressed memories of having been sexually and ritually molested as a child and was subsequently referred to other therapists who specialized in such cases.

Two of the five defendants David originally sued for malpractice settled out of court within the past year. In the April 1996 ruling, the court held that David should have known of her injury on the date she left therapy in April 1992.[12] At the time she left therapy, David had no understanding that her memories were false. In fact, she was extremely upset with her therapist because he would not continue recovered memory therapy and made derogatory and negative statements about him to the effect that he had ruined her life. Over one year later, she came to realize that the memories of abuse had been implanted by the therapy process and were not valid. She then brought her suit. The theory of the defense on the summary judgment motion was that at the time that she was disgruntled with her primary therapist and left therapy, regardless of the reason, she was on notice that something was wrong and had a duty to contact experts to discover the extent of her cause of action.

David's attorney Patrick Clancy of Walnut Creek, Calif. states that this dismissal appears to be unique to the State of California and unique to the judge who ruled on the summary judgment motion.

12. The dismissal was based on California statute of limitations (Cal Civ Proc 340.5) which applies only to medical professionals. The statute of limitations states that a medical negligence lawsuit must be brought within three years of when the injury occurred and within one year of when the plaintiff knew or should have known that he/she was a victim of a medical malpractice.

Man Falsely Accused of Abuse by CPS Awarded $510,000

Seattle Times by Ronald K. Fitten June 8, 1996

A King County Superior Court jury awarded more than $500,000 to a man who said a state agency's negligent investigation of child sex-abuse allegations against him severed his relationship with his daughter and destroyed his relationship with his wife. He claimed that CPS caseworkers were biased in their investigation, that they never talked to him and that they made little effort to check into problems in the household of the woman who reported the allegations. As a result, his daughter was traumatized and would need ongoing therapy, he was falsely labeled a child molester, and had to spend thousands of dollars in legal fees trying to clear himself of the false allegations and reunite with his daughter.

The case began in 1992 when the mother of a 4-year-old friend of the defendant's daughter reported to CPS that both girls told her he had sexually abused them. Janet Keen, a social worker who did the sexual-abuse evaluation of the daughter, said she believed the allegations. However, her report has been severely criticized by experts on both sides of the case as substandard. Keen recently settled out of court for an estimated $90,000. Another evaluation was conducted by Roger Wolfe of Northwest Treatment Associates who concluded that there was no indication the defendant was a sexual abuser.

CPS referred the case to Seattle police for investigation and forwarded Keen's report but the police did not receive the report from Wolfe. Later in 1994 at the time of a custody battle, a court-appointed evaluator, concluded there was no indication that the father was a child sexual abuser. Defendant then regained full visitation rights and the police closed their case against him.

The actions of CPS and two caseworkers were found to be negligent. Several jurors suggested after the verdict that the overall impression they got from the evidence was that CPS had failed in almost every aspect of the investigation.

Assistant Attorney General Peter Berney said the state plans to appeal the ruling.

UPDATES:

State of California v. Franklin. In a brief hearing 5/31/96, San Mateo County Judge John Schwartz moved the re-trial date from Sept. 16 to Oct. 7 because of scheduling conflicts. The trial of George Franklin in the murder of a child 20 years earlier hinges on the testimony of his daughter, Eileen Franklin-Lipsker. Eileen claimed she had repressed the memory of the incident until she recalled it many years later.

Testimony at a second hearing, 6/14/96, may lead to the case being thrown out, according to Dennis Riordan, George Franklin's attorney. At that hearing, Janice Franklin, Eileen's sister, contradicted Eileen's claim that she had never been hypnotized. Janice Franklin said that she herself had been hypnotized by a therapist in 1989 and was later told by her sister and the therapist that Eileen had been hypnotized as well. Janice said that she had lied about this at the 1990 trial and originally refused to testify at the hearing last week. She took the stand only after she was granted immunity from prosecution in connection with possible perjury charges. California case law finds testimony by a previously hypnotized witness to be inadmissible, because hypnotically enhanced memories are unreliable and create a false sense of certainty that makes effective cross-examination of the witness impossible.

According to the *San Francisco Chronicle*, 6/18/96, San Mateo Deputy District Attorney Elaine Tipton refused to comment on how the testimony could affect the case. She said Janet and Eileen apparently had had a falling out, which could have led to the testimony.

Wenatchee situation: A 13 year-old girl, identified in court documents by her initials, M.E., recently stated that she lied about being sexually abused. She had testified in four sex abuse trials and her allegations of abuse were instrumental in an investigation of the so-called Wenatchee sex ring investigation which led to 14 guilty pleas and 5 convictions.

On June 6, she told the Associated Press she had never been molested. She said she lied initially because at least two CPS caseworkers and Wenatchee police Detective Bob Perez, the lead investigator who later became her foster father, pressured her to do so. The pressure to keep lying continued, she said, including sessions before she testified.

The girl's recanting of her earlier statements may open up possibilities of appeal for the people convicted in the trials where she testified. However, the burden will be on the defense to prove that the recantation is the truth, according to John Myers, a law professor in Sacramento, Calif, specializing in evidence issues in child abuse cases. "It's not easy to prove," Myers said. "Generally, courts tend to be very reluctant to set aside a verdict on the basis of recanted testimony."

According to *The Wenatchee World*, 6/5/96, M.E. was taken back into the custody of Children's Services within days after she recanted her earlier allegations. State officials said that they were acting in her best interests by removing her from her grandmother's care and placing her in a group home out of the area. A Douglas County sheriff's deputy refused to allow M.E.'s grandmother to accompany her.

A *Seattle Times* editorial, 6/12/96, reported that the citizens of Wenatchee may be forced to pay for the claims against the city and its agents due to the sex abuse investigations. Civil suits and other claims may reach over $90 million, a figure which is beyond the city's insurance capacity. Late in May 1996, the Wenatchee city commission decided that it may assess its property owners 75 cents per $1,000 of property valuation until any difference between what the city's insurance company will pay and the anticipated settlements and awards is made up.

Paul Ingram appeal: The Washington State pardons board which advises Governor Mike Lowry held a hearing on whether to grant Paul Ingram a pardon. Paul Ingram, a former Thurston County deputy sheriff, has served 8 of his 20-year sentence after he confessed to raping his daughters during nightmarish satanic rituals—crimes he now says never happened. Anita Peterson, chairwoman of the pardons board, said the panel will not decide until its next meeting on Sept. 6 whether to pardon the former deputy. Gov. Mike Lowry, the ultimate arbiter of Ingram's fate, won't make any determination until the board issues a final ruling.

Testifying at the hearing were Elizabeth Loftus, PhD, Richard Ofshe, PhD, and Lawrence Wright who had chronicled the Ingram case after conducting interviews of all parties. Thurston County Prosecutor Gary Tabor, Thurston County Sheriff Gary Edwards and Ingram's son, Chad Ingram also testified. Articles in the *Seattle Times*, 6/6/96, 6/8/96, summarize the testimony presented at the hearing.

Amirault appeal: The Massachusetts Supreme Judicial Court is scheduled to consider the appeal of Gerald Amirault's conviction early in the Fall of 1996. Amirault was sentenced in 1986 to 30-40 years for atrocious sex crimes allegedly committed in concert with his elderly mother and his sister against children in the family-run Fells Acres Day School. His now 72-year-old mother, Violet Amirault, and his sister Cheryl were released after eight years in prison when their conviction was overturned. The state is currently appealing the reversal of their conviction. A review of this case by Dorothy Rabinowitz was recently published in *The Wall Street Journal*, May 15, 1996.

California man freed after 10 years behind bars (*Santa Barbara Independent*, 4/29/96): Gary Wayne Mogensen was released from prison 3/19/96 after a dramatic hearing in Santa Maria Superior Court, due to newly discovered evidence supporting the defendant's assertions of innocence. Mogensen had served 10 years of a 24-year sentence for his 1985 conviction on charges that he sexually abused his then 9-year-old daughter. The girl, now 20, recanted her testimony and a continuous effort was made to free Mogensen.

An intensive investigation by the Sheriff's Department indicated that testimony by Dr. William Gordon, a child molestation expert and physician, was false and photographs supporting Mogensen's innocence were withheld by Gordon. As a result, more than 100 cases in which Dr. Gordon testified are being reviewed.

When bad men combine, the good must associate; else they will fall one by one, an unpitied sacrifice in a contemptible struggle. **Edmund Burke**

Thoughts on the Cause of the Present Discontent Vol. i. p. 526.

MAKE A DIFFERENCE

This is a column that will let you know what people are doing to counteract the harm done by FMS. Remember that five years ago, FMSF didn't exist. A group of 50 or so people found each other and today more than 17,000 have reported similar experiences. Together we have made a difference. How did this happen?

California: Families have renewed efforts to encourage book stores to carry books on FMS and related topics. First they contact the book store and ask for the manager's hours. When they arrive, they give the manager an FMS brochure, a Frequently Asked Questions brochure and an FMS bibliography. They point out the ever increasing number of books on FMS, the wide range of disciplines involved and suggest that the bookstore carry some.

So far they have been well received. Remember, they can also offer professionally done book displays from SIRS if the bookstore includes *Confabulations, True Stories of False Memories, Survivor Psychology* or *Victims of Memory.*

Missouri: A Wisconsin member reminds us that summertime brings school and family reunions. If you have the courage, take some FMSF brochures with you and when you tell your story to an old classmate or relative—give them some information. Who knows — they might just have been accused themselves.

New York: Families continue to monitor local medical centers and check to see if any topic pertaining to FMS is being presented. They attend and identify themselves if the occasion presents itself.

Oregon: Inspired by the Missouri report of a hypnotherapist who was arrested for letting clients believe that she was a psychologist, an Oregon member wrote to tell us that after checking the laws that govern professionals, he had called the attention of his state licensing board to individuals who appear to be misrepresenting their credentials in advertisements.

Send your ideas to Katie Spanuello c/o FMSF.

FREE LIBRARY DISPLAYS are now available through SIRS Publishers. Call 1-800-232-7477. This is an attractive and positive way to inform people about the many new books that are now available about false memories and the devastating effects this is having on families.

FROM OUR READERS

To the Board of Medical Examiners:

I am a parent falsely accused of inflicting sexual and satanic ritual abuse on my daughter who says that she repressed it for over 30 years. However, under the care of her therapist, she has been able to recall horrible memories of abuse and accuse her family of being responsible. Not understanding the accusations or knowing what to do, I have done nothing except to educate myself about repressed memory therapy and false memory syndrome these past six years. As the years have passed, the public, the American Medical Association, and the American Psychological Association have become aware of this inappropriate therapy within their ranks which destroys families and lives.

In addition to alerting you, I am also filing a complaint against one of your practicing psychiatrists... When my daughter first sought therapy, she was a very depressed young lady with marital problems. She was desperately looking for some help and some answers. Dr. "G" took her when she was her most vulnerable and brainwashed her into believing that she has multiple personality disorder (MPD) caused by childhood abuse, mainly satanic ritual abuse, inflicted by me and an intergenerational satanic cult. No one from Dr. G's office ever contacted me or any of my daughter's family to try to corroborate any of these "memories" or accusations.

While in Dr. G's care, my daughter has been unable to work, attempted to commit suicide, was admitted to the hospital numerous times, diagnosed with MPD, approved for government disability, and was advised to separate herself from her family. She has not spoken to her family in six years and, as far as I can ascertain, still believes that her family committed those heinous crimes of sexual and satanic abuse which are all untrue.

The theory of repressed memory of this type is unsupported by reliable scientific evidence. The use of this type of therapy by Dr. G is reckless and dangerous and has caused significant harm to my daughter and her family. Dr. G has failed to meet recognized medical standards and ethics. Her diagnosis, care, and treatment have been a direct cause of harm to her and her family.

Letter to My Sister

I feel I owe you an explanation of why I decided not to host a small family get-together in my home recently. During the Spring of 1992 I visited my lawyer on some business and he informed me that there were some horrible rumors going around town regarding my father and me being guilty of incest. He also informed me that the rumors were far reaching and would have a serious impact on my life. Being labeled with incest is a charge for which society condemns an individual upon accusation. This is a small community and I soon found myself being treated as a leper as old friends and acquaintances began avoiding me. It was these same rumors and the meanness of them that drove Mom and Dad out of town.

After some thought regarding a get-together with you, I became concerned that I was inviting trouble for myself and

the rest of the family. Based on what I have experienced, how can I be sure that you will not leave such a gathering only to level new accusations against us regarding your children? I could not have afforded to be left in the same room with your children nor even given them a hug.

My family has suffered many things in addition to the loss of my sisters. I can only hope that you never intended to cause the damage to us that you have. It is my understanding that our sister "E" has possibly retracted some of her accusations but I am uncertain where you stand. Even if you were to withdraw the charges of rape and incest that you recovered with the help of therapy, the permanent scar and damage to my reputation, to the character of my wife and to the innocence of my children shall remain.

It was you who built the wall separating our relationship. I can and have forgiven but now find myself unable to remove the barrier...that is something only you can do.

Your Brother

Retraction is a Pprocess

I caught part of a show about FMSF on television just at the point I realized that none of the "memories" in therapy were true. At the time, I was in shock and walking about saying to myself over and over again, "Oh my God, it didn't happen. What do I do now?" The program was a Godsend as I didn't know where to go or what to do and there it was right there on the TV -- Dr. Ofshe and some retractors. I called Dr. Ofshe and he gave me the number to the Foundation. I called them, scared, and very afraid as I'd heard the FMS people were perps and didn't know if I could trust them or not. I wasn't even sure of my name then because I had changed it so my parents couldn't find me. When a friendly voice answered, I spilled out what I thought had happened to me. They gave me support, love and they helped me out of the shock I was in so I could start to think for myself again. I was then able to realize even more what was reality and what had not been reality. I realized what the therapy had been like and I could find the answers for myself about what had happened to me and my family.

Debbie David

Letter to My Wife's Therapist

Justice was poorly served, but the trial and three years of bitter legal wrangling are over. There were no winners except the lawyers and the court officials who received gainful if not worthwhile employment in the process. My wife has primary custody of the children, at least until they are old enough that the court is required to hear their views and preferences...

I believe that my wife went to you in 1989 as a somewhat confused person who had trouble with close honest relationships, particularly focusing at that time on her relationship with her mother. As a result of your therapy, her problems were greatly exacerbated and she went from a person who had some difficulty with close long-term relationships to a person unable to maintain any such relationship. She deserved better. Her family deserved better. The children and I and my family deserved better.

You believed that her parents were abusive and her mother and brother were "in denial." You believed that her father sexually abused her even though she had no recollections of any such thing prior to counseling. You believed without any outside corroboration that all these things and more happened to her and were the cause of her problems. You said she showed great courage, "The Courage to Heal" in accepting that these things happened and that her problems resulted from the actions and influence of those around her. You told her that she needed to either sever or completely control her relations with people around her. She was unable to completely control her relations with any adult family members so all those relations were severed.

I stood by her through all this — until she left with the children and filed for divorce. I believe that your intentions were good but your judgment crumbled before your devout ignorance, arrogance and bias. I believe that my wife used you to validate her at the expense of all those around her. I believe you used her to make yourself feel good, wise, powerful and helpful. You have done a great disservice to the profession you tried to practice, to the person you tried to help, to the family around her and to the God who oversees us all. I forgive you for any wrongs done to me, but it is not mine to forgive you for the wrongs you have done to others.

Ex husband of your patient

Suprise Encounter

I unexpectedly encountered my "abused" *daughter in a* supermarket recently. After the initial surprise of meeting thusly, her countenance abruptly adjusted from composure to downcast. Such a familiar pose, as I now recall, from her earliest days when family associations or circumstances failed to please her... Though I felt certain she intended to stonily pass by me with just "Oh, hi," I nevertheless managed to greet her similarly and elicit a few comments from her about her teenage son's graduation, to which he's sent me an invitation. And then we parted. I wanted to touch her, hug her but... The phony barriers must remain intact for her; she cannot yet bear to be wrong about something so special that she's erected for herself—her chosen, unchanging role as victim.

So live alone, my daughter. Perhaps someday...

Why do we parents seem so "stuck" on the seeming necessity, the desirability even—of recovering lost equilibrium with estranged family members?

A Mom

Her Brother Can't Forgive

After 6 years, our daughter wants to be part of our family again. About 8 months ago, her favorite cousin came for a long visit with us. She called our daughter. Our daughter came to our house twice to visit. We took photos and videos. Periodic phone calls until last month. She let us know that she wanted to be part of our family again. Her brother (our son, who has believed and supported us for 6 years) asked her on the phone if she was recanting her stories. She told him NO, but she wanted to get on with her life and have a relationship with her family. He told her, that under

those circumstances, he wanted nothing to do with her. She then called us and told us she still believed her "memories." We told her that we still believed that she would recover her true childhood memories. We told her, we too, wanted her back in our family and that we forgave her for all the pain she had caused in the past 6 years. Her brother will not speak to her or come with us when we go out to eat.

A Texas Mom and Dad

How Do I Start?

Where do I start? How can I begin to convey to you my personal struggle that started in January of 1992 and continues today? The grief, the pain, the sorrow, the tormenting anguish, the emotional conflict is replayed every day of my life as it did in 1982 when my son David committed suicide. The only difference is that at age 38 my oldest son Michael had a complete mental breakdown and through his therapist's suggestions and her own interpretations of his feelings, she has convinced him that his father (deceased in 1985) and I sexually abused him.

I never knew how a lie would feed upon itself and take on a life of its own. My other two adult sons and adult daughter have suffered terribly. Our family has been torn apart. When my three other adult children said that they had never been abused, Michael cut them out of his life. Michael has had no support for his lie. I tried to meet with Mike and his therapist. I wanted to see him face to face but they refused to have any contact with me. I am left with the lie just hanging out there over me.

Michael tried to take his life in April of this year and he is still under her therapy. This therapist has taken a very vulnerable, emotionally ill man and twisted his thinking even more by feeding him terrible, vicious lies about his parents. She even convinced him that my parents molested me and that I am in denial!

We have been on a roller coaster both mentally and economically. My husband and I are both retired and lost our jobs after major surgery. We are forced to sell our home. This is only a small token but please keep sending the newsletter. I would be so lost without it. The newsletter has helped me stay sane. Knowing I am not alone out here means so much. Thank you. A Mom

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A Response to FMSF Program on Appropriate Standards of Care, Philadelphia 5/17/96

Some therapists are surely some part of the problem, but most of us are very interested in honest, nonjudgmental information and approaches to dealing with this problematic issue...[M]ost of us do build support structures for our clients. Most of us empower our clients. Most of us are very angry with therapists who over-influence, dominate, create falsehoods, and encourage clients to cut off from their families; these are bad actions by any school-of-therapy standards.

What I want from FMSF is a solid ground from which therapists can work on setting standards and directions for this problematic area, to look toward the future when these standards might become learning modules to educate therapists and graduate students. I also look to FMSF for leadership in healing the many wounded families, clients, and therapists who have been caught up in some psychological and sociological falsehoods. Our FMSF community should be vigilant against blame of the other. Positive change never comes from blame. Ellen Starr, ACSW, BCD
Licensed Social Worker

True Feelings

My accusing daughter came to share her joy of having a new grandson. My other daughter and I drove her around to see family members that she had not seen in four years -- since her accusation of August, 1992. I must say that I was nearly sick by the time they flew home. All of the family greeted her warmly and good conversations were had, and I would not have wanted it any other way; but as everyone played "Let's Pretend," I began to feel like the outsider, the one who was at fault in this ripping apart of my whole family. I'm sure no one thinks that, but it is how my feelings were in spite of my trying to show her that I still loved her.

A Mom

Rejoice with Us

Please rejoice with us! Our daughter has returned after a three and a half year separation. She recently moved with her husband out of state due to employment. She called before Mother's Day to say, 'I'm coming, mom, to help celebrate Mother's Day!' My heart leaped with joy, as did her dad's. We had a most beautiful celebration. How thankful we are. To those that are waiting still, we say "Don't give up hope." A Happy Mom and Dad

Before Therapy

4 April 1994
Dear Mom and Dad,

A mere thank you does not seem adequate for everything you have done for us. We are so excited about the baby furniture and are greatly appreciative to receive it. Your love and just being there has helped us through some scary times. Out little baby will soon be here and you know how impatient I am. You two need to be deciding what you want to be called. Thank you for everything.

Lots of love

After Therapy

Nov 6, 1994
Dear Mom and Dad,

This is extremely painful and difficult to express but it must be said. I am struggling with many different issues in my life and in order for me to work through these I will be unable to have any contact with my family. I realize that you may not understand but I can not share anything about these difficulties at this time. I have no idea how long I will need, but I will contact you when I am able to talk with you.

Your daughter

JULY/AUGUST 1996 FMSF MEETINGS

FAMILIES, RETRACTORS & PROFESSIONALS WORKING TOGETHER

key: (MO)=monthly; (bi-MO)=bi-monthly; (*)=see State Meetings list

CALL PERSONS LISTED FOR INFO & REGISTRATION

STATE MEETINGS

INDIANA
Sunday, July 28, @ 1pm
Nickie (317) 471-0922
fax (317) 334-9839
Pat (219) 482-2847

MINNESOTA
Saturday, August 3, @ 9am-220pm
Ft. Snelling Officers Club
St. Paul, MN
Dan or Joan (612) 631-2247

NEW MEXICO
Saturday, August 3, @ 1-4pm
Southwest Room, Presbyterian Hospital
Albuquerque, NM
Maggie (505) 662-7521 after 6pm

WEST VIRGINIA
Saturday, September 28, @ 10-3pm
Bonanza Steak House, Weston, WV
Speaker: Claudette Wassil-Grimm
author of Diagnosis for Disaster
Pat (304) 291-6448

UNITED STATES

ARIZONA - (bi-MO)
Barbara (602) 924-0975; 854-0404(fax)

ARKANSAS - LITTLE ROCK
Al & Lela (501) 363-4368

CALIFORNIA
NORTHERN CALIFORNIA
SACRAMENTO-(quarterly)
Joanne & Gerald (916) 933-3655
Rudy (916)443-4041
SAN FRANCISCO & NORTH BAY (bi-MO)
Gideon (415) 389-0254 or
Charles 984-6626(am);435-9618(pm)
EAST BAY AREA (bi-MO)
Judy (510) 254-2605
SOUTH BAY AREA Last Sat. (bi-MO)
Jack & Pat (408) 425-1430
CENTRAL COAST - Carole (805) 967-8058
SOUTHERN CALIFORNIA
CENT. ORANGE CNTY. 1st Fri. (MO) @ 7pm
Chris & Alan (714) 733-2925
ORANGE COUNTY -3rd Sun. (MO) @6pm
Jerry & Eileen (714) 494-9704
COVINA AREA -1st Mon. (MO) @7:30pm
Floyd & Libby (818) 330-2321
SOUTH BAY AREA -3rd Sat.. (bi-MO) @10am
Cecilia (310) 545-6064

COLORADO -DENVER-4th Sat. (MO)@1pm
Ruth (303) 757-3622
Art (303) 572-0407

CONNECTICUT - NEW S. ENGLAND
AREA CODE 203 (bi-MO)Sept-May
Earl 329-8365 or Paul 458-917

FLORIDA
DADE/BROWARD Madeline (305) 966-4FMS
BOCA/DELRAY 2nd&4th Thurs(MO) @1pm
Helen (407) 498-8684
TAMPA BAY AREA
Bob & Janet (813) 856-7091

ILLINOIS - 3nd Sun. (MO)
CHICAGO & SUBURBS
Eileen (847) 985-7693
JOLIET
Bill & Gayle (815) 467-6041
REST OF ILLINOIS
Bryant & Lynn (309) 674-2767

INDIANA -INDIANA FRIENDS OF FMS (*)
Nickie (317)471-0922(ph);334-9839(fax)
Pat (219) 482-2847

IOWA -DES MOINES
Betty & Gayle (515) 270-6976
2nd Sat. (MO) @11:30am Lunch

KANSAS -KANSAS CITY
Leslie (913) 235-0602 or Pat 738-4840
Jan (816) 931-1340

KENTUCKY
COVINGTON- Dixie (606) 356-9309
LOUISVILLE- Last Sun. (MO) @ 2pm
Bob (502) 957-2378

LOUISIANA- Francine (318) 457-2022

MAINE - AREA CODE 207
BANGOR -Irvine & Arlene 942-8473
FREEPORT -4th Sun. (MO) Carolyn 364-8891

MARYLAND -ELLICOT CITY AREA
Margie (410) 750-8694

MASSACHUSETTS/NEW ENGLAND
CHELMSFORD- Ron (508) 250-9756

MICHIGAN-GRAND RAPIDS AREA-JENISON -1st Mon. (MO)
Catherine (616) 363-1354
GREATER DETROIT AREA -3rd Sun. (MO)
Nancy (810) 642-8077

MINNESOTA (*)
Terry & Collette (507) 642-3630
Dan & Joan (612) 631-2247

MISSOURI
KANSAS CITY -2nd Sun. (MO)
Leslie (913) 235-0602 or Pat 738-4840
Jan (816) 931-1340
ST. LOUIS AREA)- AREA CODE 314
Karen 432-8789 or Mae 837-1976
SPRINGFIELD - 4th Sat. (MO) @12:30pm
Dorothy & Pete (417) 882-1821
Howard (417) 865-6097

NEW JERSEY (So.) SEE WAYNE, PA

NEW MEXICO- AREA CODE 505 (*)
Maggie 662-7521(after 6:30 pm) or
Martha 624-0225

NEW YORK
DOWNSTATE NY-WESTCHESTER, ROCKLAND, ETC.
Barbara (914) 761-3627 (bi-MO)
UPSTATE/ALBANY AREA (bi-MO)
Elaine (518) 399-5749
WESTERN/ROCHESTER AREA (bi-MO)
George & Eileen (716) 586-7942

OKLAHOMA -OKLAHOMA CITY
AREA CODE 405
Len 364-4063 Dee 942-0531
HJ 755-3816 Rosemary 439-2459

PENNSYLVANIA
HARRISBURG -Paul & Betty (717) 691-7660
PITTSBURGH -Rick & Renee (412) 563-5616
WAYNE (INCLUDES S. NJ)
Jim & Jo (610) 783-0396
July & Aug -no mtg

TENNESSEE - Wed. (MO) @1pm
Kate (615) 665-1160

TEXAS
CENTRAL TEXAS
Nancy & Jim (512) 478-8395
HOUSTON Jo or Beverly (713) 464-8970

UTAH -Keith (801) 467-0669

VERMONT (bi-MO)Judith (802) 229-5154

VIRGINIA Sue (703) 273-2343

WEST VIRGINIA (*)
Pat (304) 291-6448

WISCONSIN
Katie & Leo (414) 476-0285

INTERNATIONAL

BRITISH COLUMBIA, CANADA
VANCOUVER & MAINLAND
Ruth (604) 925-1539
Last Sat. (MO) @1-4pm
VICTORIA & VANCOUVER ISLAND
John (604) 721-3219
3rd Tues. (MO) @7:30pm

ONTARIO, CANADA
LONDON -2nd Sun (bi-MO)
Adrian (519) 471-6338
OTTAWA -Eileen (613) 836-3294
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