FALSE MEMORY SYNDROME FOUNDATION NEWSLETTER

February 1997 Vol. 6 No.2

"The greatest crime of all in a civilized society is an unjust conviction." (1)
"It is better that ten guilty persons escape than one innocent suffer." (2)

Dear Friends,

Why do some people feel so passionately about the injustice of false accusations? Of course a false accusation or conviction is terrible for the wrongly accused, but the issue goes beyond individuals. Societies function because their members find ways to work together and willingly follow a multitude of conventions and rules. We stop at red lights, for example, and we expect that those who fail to stop at red lights will receive a ticket. It's easy to see how our traffic system would fall apart if no one stopped for red lights. But what would happen if lots of people who did stop for red lights were given tickets too? If people who follow the rules are punished, there is apt to be a loss of trust in the society that binds us. Social conventions fail when rules are not enforced, but they just as surely fail when rules are wrongly enforced. That point is frequently forgotten by those who see increased enforcement as the way to correct a wrong. Justice is a fine balance between the enforcement of rules and their fair application.

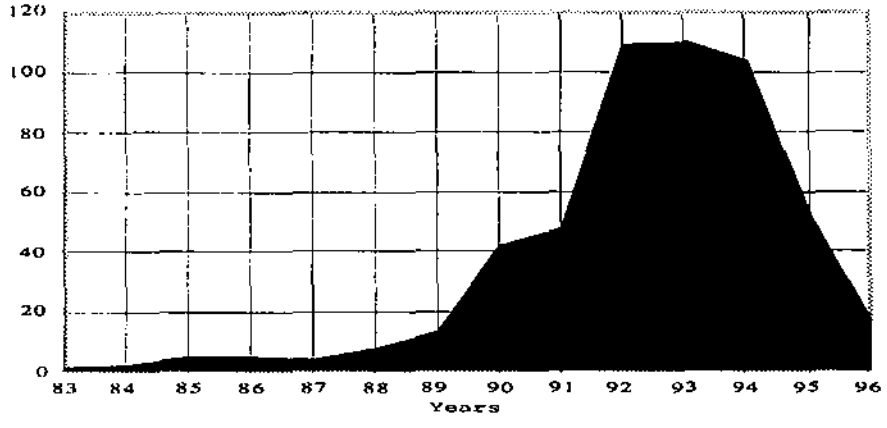
On January 14, 1997 approximately 200 people came together in Salem to mark the 300th Anniversary of the Day of Contrition. On that day in 1697, five years after the famous "witchcraft trials," the entire community for His Majesty's Province of the Massachusetts Bay, in obedience to a proclamation, took part in a day of fasting and remorse, an acknowledgment of the hysteria and judicial errors that led to 19 people being put to death. Sponsored by the San Diego-based Justice Committee, the 1997 event included video presentations by prize-winning authors Arthur Miller and William Styron.

Participants had the opportunity to apologize in person to wrongly imprisoned people such as Kelly Michaels, Bobby Fijnje, Brenda and Scott Kniffen, Jenny Wilcox, Rev. Nathaniel Grady, Cheryl and Violet Amirault, Peggy Ann and Ray Buckey, Pastor Roby and Connie Roberson and also to the children and wives and mothers and fathers whose loved ones are still in prison. For this writer, it was deeply moving to look into the eyes of these people, especially those who were themselves almost children when they were put in prison, and to realize what we have taken from them. Led by Carol Hopkins, the executive director of the Justice Committee, a group of participants made a visit to Ray and Shirley Souza who are still under house arrest – a token to those who may still be wrongly imprisoned.

Presentations covered a variety of topics: concern for the protection of children, historical analogies to Salem, examples of overzealous prosecution both for child abuse and for the mentally handicapped, an example of careful prosecution, the role of the media, and the search for ways to bring our system into better balance.

Sadly, a few chose to ignore the theme of the day: apology for injus-

When were repressed memory suits filed? n=517



In this issue...

tices. Instead, some members of the Psychology of Women internet group, for example, mounted an attack on the Day of Contrition urging people to send e-mail and faxes of protest. (The Day of Contrition must be bad, they reasoned, because there was an announcement of the conference on the FMS-News list.) The International Society for the Study of Dissociation prepared a document in which they really did write, "...this conference seems to focus on pursuing a political and legal agenda to silence all persons who recall abuse and those who treat them." To paraphrase a statement from the craze that led Arthur Miller to write *The Crucible*: "Have they no decency?"

While most of the media coverage of this event was positive, the *Boston Globe* reprinted one of the trite mantras of our critics, "Witches aren't real; child molesters are,"(1/15/97, McNamara). To see how silly this is, imagine it is 1953 when Arthur Miller's play *The Crucible* opened and try the following: "Witches aren't real; Communists are." Indeed, substitute any other group that has ever been the target of zealotry. That the Day of Contrition was memorialized shows that more people are unafraid of the worn-out attacks of overzealous critics. We are reminded of the final statement that appears on the screen in Miller's 1997 screenplay for *The Crucible*: "After nineteen executions the Salem witch-hunt was brought to an end, as more and more accused people refused to save themselves by giving false confession."

The fact that more people are now willing to identify themselves publicly as advocates both for children and for justice is reason for optimism. There is also reason for optimism that such an occasion could be held with the presence of so many people whose wrongful convictions had been overturned.

At the Salem meeting, the Massachusetts Civil Liberties Union announced that the national office of the ACLU is filing an amicus brief that supports the position that there is no scientific evidence for the theory of "repression" (for the New Hampshire v Hungerford appeal). This demonstrates the wide range of organizations that are concerned about appropriate justice in the courts. Justice is a balance between enforcement of rules and their fair application. The change in the legal situation represents a move toward better application of the rules in terms of standards of evidence. Standards of evidence should not be dropped just because a cause seems morally right or is a political "hot potato" as is the issue of "recovered repressed memories."

Data from the FMSF Legal Survey provide more reason for optimism. The graph on the front page shows the filing date of 517 lawsuits in the United States that were based on "repressed memory" evidence. It represents both criminal (15%) and civil (85%) cases. Note the great growth in 1992 and the sharp drop in filings since 1994.

At the Memory and Reality conference in March, we will present data that indicate many more repressed memory cases of which the Foundation is aware are being dismissed or dropped now than they were in 1992 when the Foundation was formed. We will also present data on cases from Canada; on cases like the Souza's in which a child claimed "recovered memories" but the lawsuit was filed on the accusation of a grandchild; on cases at the appeal level, and on the growing number of cases brought against mental health workers. The FMSF Legal Survey is a concrete barometer of the stages of the recovered memory phenomenon as it passes through our culture.

Another change is taking place. Enforcement of therapy standards as they relate to FMS is increasing. In this issue we describe not only the results of several more legal actions against therapists but also the circumstances in which three therapists have had their licenses taken from them. One of the major differences between the anti-Communist frenzy in the 1950s and this frenzy is that in the 1990s families expect to hold those who have done harm accountable for their actions.

Does all this mean that the work of the FMSF is finished? No. It means that we can now see the system moving into better balance, but the work of the Foundation will not be done until the problem of the alienated children and missing grandchildren is resolved. It will not be complete until the accusing adults enter into respectful dialogue with their parents whom they so cruelly accused. We expect the help of all FMSF families and of all mental health professionals in solving this last link in the tragic FMS phenomenon.

Pamela

(1) July 1992 ruling freeing Alberto Ramos. Quoted in LA Times, 1/5/97,"For Wrongly Accused Day-Care Workers, Freedom Is No Panacea"
(2) Blackstone, 1770.

special thanks

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

Editorial Support: Toby Feld, Allen Feld, Howard Fishman, Peter Freyd, Paula Tyroler. *Research:* Merci Federici, Michele Gregg, Anita Lipton. *Notices and Production:* Danielle Taylor. *Columnists:* Katie Spanuello and members of the FMSF Scientific Advisory Board. *Letters and information:* Our Readers.

Roundtables for Conference Taking Shape

Roundtables, a popular feature of the first two Memory and Reality conferences, are being planned for the FMSF family conference scheduled for March 22 and 23, 1997 in Baltimore. These semi-structured small groups give Foundation members the opportunity to discuss among themselves subjects that are of interest to them. Topics are recommended by members and are meant to reflect their interest. The opinions of the roundtable leaders or the participants do not necessarily represent Foundation policy. Roundtables will be led by both family members and professionals who have registered for the conference. The number of seats for each Roundtable is limited and allotted on a first-come first-served basis. Roundtable registration will take place on Friday from 7:30 - 9:00 PM and Saturday from 8:00-9:00 AM.

Some of the tentative topics include: *Family Mediation: What It Is, What It is Not and How to Use It; It Has Been a Long Time: Dare We Let Go?; Siblings Caught in the Middle; Meeting with your Child's Therapist; Reaching Churches about "Christian Therapy" and the Danger of FMS; A Returner in your Midst; Getting your Story out to the Media; Legal Remedies for Parents; Professionals Falsely Accused; Separating Good Science from Junk Science; What does the MPD/DID Diagnosis Really Mean?; Dealing with Licensing Boards; Coming out of the FMS Closet; Retractors Talking Together.*

Some of the Roundtable Leaders are Chris Barden, Ph.D., J.D., John and Nancy Bell, Merci Federici, Janet Fetkewicz, Eleanor Goldstein, John Hochman, M.D., Anita Lipton, M.A., Bob and Janet McKelvey, Mark Pendergrast, August Piper, M.D., Harrison Pope, M.D., Susan Robbins, Ph.D., Paul Simpson, Ed.D., Ellen Starer, M.S.W., and Holida Wakefield, M.A..

Calof Defense Fund and Chuck Noah

Both Chuck Noah and David Calof are licensed counselors in Seattle, Washington. Neither graduated from college. There the similarity ends. David Calof has had a clinical practice for many years. He has published a journal called *Treating Abuse Today*. He is a trauma therapist who has spoken of his belief in intergenerational satanic ritual abuse conspiracy.

Chuck Noah lost a child to FMS and is a retired construction worker who obtained a counselor license to point out how little such a license means in Washington. He decided that he would picket to try to free Paul Ingram. He went to Boston to picket for the Souzas. He also pickets therapists whom he believes contribute to the FMS problem.

Clash. Chuck Noah picketed a number of therapists briefly, but most of his efforts have been directed at David Calof, whom he believes published articles in his journal that were not truthful. Calof filed a lawsuit against Noah, who has insisted on his first-amendment right to picket. Calof has incorrectly implied that the FMS Foundation encouraged the picketing against him.

To date, Noah has been taken to court several times, has been subjected to restraining orders and is now represented by the Seattle branch of the ACLU. Noah neither solicits nor accepts contributions and represented himself in court for two years because he could not afford a lawyer. On the other hand a defense fund has been formed for David Calof who has been unable to publish his journal for a year. In a letter to friends, *The Courage to Heal* authors Ellen Bass and Laura Davis wrote, "We're truly facing a well-organized, well-funded group that's extremely accomplished at destruction," but they don't bother to substantiate the claim which we believe to be false.

Some of the other 14 supporters listed on an appeal letter for the defense fund are familiar names; Lloyd deMause, publisher of *The Journal of Psychohistory* that frequently publishes satanic conspiracy articles; Marjorie Orr, who uses astrology to diagnose abuse; and Gloria Steinem who was shown honoring Bennett Braun in the Frontline documentary *Search for Satan*.

The appeal closed as follows: "If you're part of an organization or group that publishes a newsletter, we would also be thankful if you would include a notice about the David Calof Legal Defense Fund in your next issue."

OK.

Two Upcoming Conferences

Continuing Education Program
WHAT'S NEW IN THE MEMORY WARS ?
Friday, March 21, 1997
For more information please call Johns Hopkins directly at
(410) 955-2959 or fax at (410) 955-0807

FMSF Family Conference
MEMORY AND REALITY: NEXT STEPS
Saturday & Sunday March 22 & 23, 1997
For more information please refer to the registration form on the outside cover of this newsletter.
Help us celebrate the Fifth Anniversary of FMSF.

INFORMED CONSENT:
AMERICAN PSYCHIATRIC ASSOCIATION

In June of 1996, the American Psychiatric Association released "Principles of Informed Consent in Psychiatry" prepared by the APA's Council on Psychiatry and Law and approved by the Board of Trustees in June of 1996 as a resource to the APA's District Branches. It does not represent APA policy.

We think that FMSF Newsletter readers will be well-satisfied with this document. Following is Section 7 (page 6):

"Psychotherapy: Informed consent developed in the context of invasive procedures and has since been extended to treatment with medication. There has always been uncertainty as to the extent to which the doctrine of informed consent is applicable to psychotherapy. Although discussions about treatment may fit poorly into some psychotherapeutic approaches, recent changes in practice that emphasize short-term, problem-focussed therapies are more accommodating (or even encouraging) of such interactions. Whether or not required by the law, it seems reasonable to encourage psychiatrists to discuss with their patients the nature of psychotherapy, likely benefits and risks (where applicable) and alternative approaches (both psychotherapeutic and non-psychotherapeutic) to their problems."

❑

FMS AND THE HEALTH OF ACCUSED PARENTS

Editor's note: FMS families live with the dual stress of losing a child and coping with false accusations. How is their health affected? Terry Collins, a member of the Vancouver Support Group, decided to do a survey to explore this. The results must be viewed with caution because the responses are subjective and because we do not have a comparison group. Perhaps Terry's results will encourage a more rigorous study. This is Terry's report:

A questionnaire was sent to the 63 families of the Vancouver Support Group. More than 50% of the families responded. With the help of a university professor, I developed a system that provided anonymity.

Question 1: Have you, or any members of your immediate family, been accused of incest, pedophilia and/or Satanic ritual abuse (including torture and murder)?

91% said yes.

Question 2: Has the accused person's physical health deteriorated since he/she was made aware of the false accusations?

68% reported that someone within their family showed signs of deterioration that varied from greater frequency of catching communicable diseases (such as colds or flu), through increases in attacks of arthritis and allergies, to repetitive cardiovascular heat attacks and cancer.

Question 3: Has the sense of emotional "well-being" of the accused deteriorated?

89% reported that someone within the family suffered from emotional health disability/disease/deterioration following the false accusation. There were a wide variety of effects centering around high levels of stress, fear, loss of self-confidence, anger, depression, withdrawal and thoughts of suicide.

Question 4: Has the accused or any member of the immediate family died?

14% of the sample reported deaths within the family following the false accusation, including one recanter who died before being fully reconciled.

What does this information tell us? For six years I have worked within the prison system in Canada and with sex offenders who have admitted to their wrongs. I have never seen the kind of physical deterioration in that group of people that I have seen take place among our families.

Martin Luther King on Forgiveness

"Forgiveness does not mean ignoring what has been done or putting a false label on an evil act. It means, rather, that the evil act no longer remains as a barrier to the relationship."

MAKE a DIFFERENCE

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

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

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 18,000 have reported similar experiences. Together we have made a difference. How did this happen?

California - A Mom wrote to tell me that she had called her local newspaper and interested a reporter in FMS by telling her story and tying it to the movie, "The Crucible." The movie is based on Arthur Miller's play of the same name about the Salem Witch Hunts. When Miller wrote the play it was especially relevant because of the infamous McCarthy Hearings. Forty years later it is especially pertinent because of FMS.

Illinois - At a Christmas party a falsely accused mother was talking to a young woman who was a freshman at DePaul, a large Catholic university in Chicago. The FMS mother inquired as to the student's major. The student told her that her major was German with a minor in journalism and she volunteered that her roommate was in Women's Studies. The FMS mother then confided that she had lost her daughter seven years earlier to FMS because of a women's studies program at the University of Wisconsin. The young woman was astounded! She related how she had witnessed her friend changing before her eyes. She had become rigid, narrow and self centered. She said that she and her roommate had started having arguments over women's issues. Her roommate would not tolerate any opinion that didn't agree with hers.

The mother has sent material on FMS and plans are in progress for an article in the student newspaper. A further effort is being made to involve the departments of psychology, women's studies and journalism in an educational presentation about FMS issues.

Send your ideas to Katie Spanuello c/o FMSF.

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 studies, with input from members of our Scientific Advisory Committee.

The Children of Wish-Ton-Wish

Harrison Pope, M.D.

To some people, it seems perfectly natural that memories can be "repressed." If one experiences a tragedy too terrible to contemplate, is it not only reasonable that the mind would try to expel the memory from consciousness?

Actually, from a Darwinian point of view, repression is anything but reasonable. If, for example, one did not vividly remember being attacked by a lion, but instead "repressed" the memory, then one would be liable to wander in front of other lions in the future – with inauspicious consequences both for one's own survival and one's chances of perpetuating the species. Surely it would seem more logical that Mother Nature would have designed us to remember traumatic events vividly, so that we could avoid a repetition of them in the future. And for most of us, this has been our personal experience: horrible things that have happened to us are still ingrained in our minds years after they occurred.

In a recent study, for example, members of our research group interviewed 53 victims of a freak tornado which struck the town of Great Barrington, Massachusetts, in the Spring of 1995. One woman was trapped in her car when the storm hit; a tree fell across the road immediately in front of her, and live power lines collapsed onto the pavement behind. The car shook; the walls of a neighboring garage blew away like playing cards. In the back seat, her children were screaming.

"Did you have any loss of memory for that experience?" we asked.

She looked at us in disbelief and said, "are you kidding?"

As this woman and many others can attest, terrifying experiences leave indelible memories. Therefore, where and when did the idea arise that the opposite could happen - that a traumatic memory could be completely banished from consciousness?

One way to examine this question is to look at world literature. As we look at stories, poems, and dramas written throughout the ages in different places and different cultures, where do we find characters who "repressed" and then perhaps later "recovered" memories of traumatic events?

We have put this question to a number of experts in literature. Such a survey, admittedly, is hardly a formal scientific study, but it is nevertheless revealing. Throughout most of history, it appears, no one in any story in the world's literature appears to have developed amnesia for a seemingly unforgettable traumatic event and later recovered the memory into consciousness. No one in the Bible, for example, seems to have repressed and then recovered a memory. Nor in Shakespeare— a veritable catalog of the possible permutations of the human psyche— do we find a clear instance of repression. No one has been able to show us a clear case of repression in classical Greek or Roman literature, in Islamic literature, or anywhere else in Western literature until well into the 19th century. Then, and only then, does repression begin to crop up (1).

As best as we can tell, one of the first cases of repression and recovery of memory appears in James Fenimore Cooper's 1829 novel, *The Wept of Wish-Ton-Wish* (2). In this tale, set in the mid-seventeenth century, Indians attack the little settlement of Wish-Ton-Wish in Connecticut and abduct two children. One is a teenager named Whittal Ring, and the other is a little girl named Ruth Heathcote. Years later, Rueben Ring comes upon his lost brother Whittal in the woods. Whittal is now dressed as an Indian; he is wearing war paint and calls himself Nipset. He has complete amnesia for his past as a White man. His sister, Faith, recognizes her brother, but is unable to persuade him of his former identity, even when he looks at his own white skin.

Later, Ruth is also found. She, too, has become an Indian and goes by the name of Narra-mattah. Her memories of childhood are also completely repressed, but she has recurring images of her mother in dreams:

"Narra-mattah has forgotten all ... But she sees one that the wives of the Narragansetts do not see. She sees a woman with white skin; her eyes look softly on her child ..."

Ruth's mother tries to help her child recover her lost memories, but in vain. Then, at the very end of the novel, the child falls ill and lies dying. And there, in the lush romantic prose of Cooper, we witness what just might be literature's first case of a repressed memory. The mother of the dying child speaks to her:

"Look on thy friends, long-mourned and much suffering daughter! 'Tis she who sorrowed over thy infant afflictions, who rejoiced in thy childish happiness, and who hath so bitterly wept thy loss, that craveth the boon. In this awful moment, recall the lessons of youth. Surely, surely, the God that bestowed thee in mercy, though he hath led thee on a wonderful and inscrutable path, will not desert thee at the end! Think of thy

early instruction, child of my love; feeble of spirit as thou art, the seed may yet quicken, though it hath been cast where the glory of the promise hath so long been hid."

"Mother!" said a low struggling voice in reply. The word reached every ear, and it caused a general and breathless attention. The sound was soft and low, perhaps infantile, but it was uttered without accent, and clearly.

"Mother - why are we in the forest?" continued the speaker. "Have any robbed us of our home, that we dwell beneath the trees?" Ruth raised a hand imploringly, for none to interrupt the illusion.

"Nature hath revived the recollections of her youth," she whispered. "Let the spirit depart, if such be his holy will, in the blessedness of infant innocence!"

Another possible case of repression arises in 1859, in Charles Dicken's novel, *Tale of Two Cities.* Dr. Manette, after 18-years imprisonment in the Bastille, has developed amnesia for long intervals of his past, including the period surrounding his release (3). He describes his amnesia in courtroom testimony:

"Has it been your misfortune to undergo a long imprisonment, without trial, or even accusation, in your native country, Doctor Manette?"

"He answered in a tone that went to every heart, "A long imprisonment."

"Were you newly released on the occasion in question?"

"They tell me so."

"Have you no remembrance of the occasion?"

"None. My mind is a blank, for some time—I cannot even say what time—when I employed myself, in my captivity, in making shoes, to the time when I found myself living in London with my dear daughter here. She had become familiar to me, when a gracious God restored my faculties; but, I am unable even to say how she had become familiar. I have no remembrance of the process."

And a few years later, in approximately 1862, Emily Dickinson in a poem implies more specifically that an event could breed amnesia simply because it is too traumatic to contemplate (4).

There is a pain - so utter
It swallows substance up
Then covers the Abyss with Trance
So Memory can step
Around - across - upon it
As one within a Swoon
Goes safely -where an open eye
Would drop Him - Bone by Bone.

By the end of the century, we find that "repression" and "recovery" of memory have entered romantic fiction in full-blown form. A typical case appears in the 1896 children's novel, *Captains Courageous*, by a Nobel prize winner, Rudyard Kipling (5). One of the characters in the novel is a former preacher, Penn, who had long ago lost his entire family before his eyes in a tragic flood. After the flood, Penn has completely repressed the memory of the entire trauma, and has even forgotten that he ever was a preacher or had a family. We find him instead working for Captain Disko as a fisherman on a Grand Banks schooner, oblivious to his past. One day, a passing ocean liner carves a neighboring fishing schooner in two, killing its hands, including the captain's son. The surviving captain is rescued by Disko's crew and brought aboard. At this moment, Penn abruptly undergoes a transformation. He suddenly recovers the memory of the loss of his own family, and his voice transforms from his usual "pitiful little titter" to the authoritative tones of a preacher. He consoles the grieving captain, prays for him, and shares with him the memory of the tragic loss of his own loved ones years ago. And then, within hours, Penn "re-represses" the memory. He again forgets his past, reverts to a simple fisherman, and asks for his customary game of checkers.

With the coming of modern times, repression has found a new and even more fertile soil in that uniquely 20th century art form, film. From the thrillers of Alfred Hitchcock to the childhood trauma of Batman, characters in the movies regularly experience amnesia for traumatic events, and then, at some dramatic moment, recover the memory. Indeed, repression is the perfect device for Hollywood. Many a celluloid hero is seen having a "flashback" - a fleeting, freeze-frame image, perhaps slightly out of focus - of a long-forgotten event. What is the dark secret from the past? Perhaps, if the hero could make sense of this recurring image, recover the repressed memory, all would be explained. By the end of the movie, this is usually just what has happened.

In short, for all of us who have grown up in the 20th century, repression seems like a natural phenomenon; we have read of it in novels and seen it in the movies all our lives. Perhaps this is why so many people accept the concept without bothering to question it. But we must stop to remember that repression actually appears to be a parochial notion, seemingly restricted only to recent times and only to Western European culture. And we must also remember that repression was not a scientific hypothesis first proposed by Sigmund Freud or Pierre Janet. Rather, it seems to have arisen as a romantic notion in the Victorian era, somewhere in the middle of the 19th century. It had entered poetry and prose well before Freud and Janet were even born. It has continued to flourish in literature and cinema throughout the 20th century. It is a powerful dramatic device that makes for good fiction.

But does it make for good science?

References.

1. The notion of repression also began to evolve in the writings of 19th century philosophers such as Schopenhauer and Nietzsche. For a detailed discussion of these beginnings, see Ellenberger, H. *The Discovery of the Unconscious.* New York: Basic Books, 1970.

2. Cooper JF. (1829) *The Wept of Wish-Ton-Wish..*

3. Dickens C. (1859) *A Tale of Two Cities.*

New York: Dodd, Mead & Co., 1942. See Book the Second, Chapter 3.
4. Johnson TH (ed.) *The Complete Poems of Emily Dickinson* . Boston: Little, Brown & Co., Boston, 1960, page 294, No. 599. I am indebted to Dr. Gail S. Goodman and her colleagues for having discovered this poem. See Goodman GS, Quas JA, Batterman Faunce JM, Riddlesberger MM, Kuhn J. Predictors of accurate and inaccurate memories of traumatic events experienced in childhood. *Consciousness and Cognition* 4:269-274, 1994.
5. Kipling R. (1896) *Captains Courageous: A Story of the Grand Banks.* New York: Doubleday, Page & Co., New York,. 1925, See chapters 3 and 7.

This column appears as a chapter in the forthcoming book, Junk Psychology: Fallacies in Studies of 'Repression' and Childhood Trauma, *by Harrison G. Pope, Jr. M.D., „ Social Issues Resources Series, 1996. Copies of this book will be available in March 1997 and may be obtained by writing to Social Issues Resources Series at 1100 Holland Drive, Boca Raton, Florida, 33427, or by calling 1-800-232-7477.*

WHAT ACCOUNTS FOR THE RESILIENCE OF SO MANY FAMILIES?

Some families cope by using humor. The following newsclipping was sent to us by A Dad: "...The main concerns that arise with aging parents are: (1.) Does the parent have the capacity to understand and appreciate the consequences of the situation? (2.) Is the parent being unduly influenced by another person?..."

from a Geriatric Psychiatrist
in letter to "Dear Abby"
Springfield, MO 12/6/96

This is the comment that the dad enclosed with the news clipping: "I enjoyed the Dear Abby column in today's paper. The writer's professional judgment of the main concerns in mental problems in the elderly makes me wonder if all of our accusing children are not preceding us into dementia. I guess he does not recognize undue influence as a problem if it originates in a psychiatrist. If you substituted the word 'child" where he uses "parent" it would apply directly to the problem of our accusing children.

BOOK REVIEW

The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder
Allan Young
(Princeton University Press, 327 pgs.,$35)
Reviewer: J. Alexander Bodkin, M.D.

Professor Allan Young's 1995 book, *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder*, is an impressive piece of scholarship in the history of medicine, a fascinating report of Dr. Young's extensive fieldwork in the anthropology of psychiatry, and the most penetrating critique yet published of Post-Traumatic Stress Disorder (PTSD).

For readers who are not familiar with PTSD, it is a psychiatric diagnosis that was introduced in 1980 to account for often late-developing psychiatric morbidity seen in some combat veterans, though more recently many practitioners have come to diagnose most of their patients with it. PTSD refers to psychological symptoms that are presumed to arise as a direct consequence of specific traumatic experiences which may have occurred years before the onset of illness.

Sometimes, no memory of the alleged trauma is available to the patient prior to psychotherapy. The patient is then said to have "repressed" or "dissociated" the traumatic memory. In other cases, patients do not initially attribute their psychiatric symptoms to a specific event because, prior to treatment, the traumatic nature of that event was not appreciated. Sometimes such a patient is said to have been "in denial." PTSD has come into increasingly common use by psychotherapists in recent years, as it seems to cry out for long-term exploratory psychotherapy instead of the medication and brief behaviorally-oriented treatment that other anxiety and depressive disorders increasingly receive.

Other than its purported traumatic basis, the symptomatology of PTSD is indistinguishable from that of a variety of long-established mood and anxiety disorders, with different terms used to describe the symptoms. Most of the time — if not all of the time — it is simply a matter of professional preference whether a given patient will be diagnosed with PTSD or, for example, major depression with panic attacks, or some related disorder. The practical difference is that, if one considers the condition to be an instance of PTSD, it is conceptualized as a natural reaction to an overwhelming trauma and receives exploratory psychotherapy to identify and delineate the trauma. The patient is then urged to "work through" the feelings associated with the trauma.

This process may take years before there is recovery — generally mirroring the natural time course of the untreated disorder. If such a condition is instead called, for instance, major depression with panic attacks, then the illness will be conceptualized as a neurobiological dysfunction and the primary treatment will be antidepressant medication. This regime usually brings about remission in a few months, often with the help of adjunctive psychotherapy focussed on functional adaptation.

Of importance to this readership, PTSD is the diagnosis usually given to women suffering from mood and anxiety symptoms when it is believed that the cause of their suffering is forgotten childhood sexual abuse. Occasionally the diagnosis will be Multiple Personality Disorder (MPD), but this is only in more severe cases where the alternative might be schizophrenia or borderline personality dis-

order. When the illness is milder, the usual diagnostic choice is PTSD.

In *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder*, Professor Young, an anthropologist who has been studying the disorder for many years, first provides the reader with a comprehensive review of the historical roots of the concept of traumatic memory, and the mental pathogen (toxic agent) supposed to underlie PTSD (and its various historical predecessors). The concept first emerged in the late 19th century, most prominently in the works of Charcot, Freud and Janet, only to drop into obscurity until World War I, when it reemerged in the work of the British military psychiatrist W.H.R. Rivers. Rivers is generally credited with shifting the understanding of war-related mental illness from a manifestation of brain injury to the consequence of traumatic memories. Later, just prior to America's entry into World War II, the American psychoanalyst Abram Kardiner wrote *The Traumatic Neuroses of War*. It provided the clinical descriptions and symptom lists that were imported many years later into the *DSM-III* diagnosis of PTSD. Underlying Kardiner's descriptions of disturbed soldiers and war veterans was an assumption that their problems were caused by specific traumatic memories of wartime experiences.

There follows an illuminating discussion of the origins of the *DSM-III*, psychiatry's first authoritative diagnostic manual, published in 1980. This manual marked the beginning of the modern attempt to place psychiatry on a scientific footing, making wide use of the methodological advances long standard in the rest of medicine. Unlike the earlier editions, *DSM-I* (1952) and *DSM-II* (1968), *DSM-III* rigorously excluded from psychiatric diagnosis the various competing theories of etiology (the medical term for the causative agent of an illness) that until then had confused discussion and impeded empirical research into psychiatric disorders. Now, for the first time, whether a given patient had a given disorder could be determined by whether a specified set of observable behaviors were present. Diagnosis was no longer a matter of endless controversy and interpretation; any adequately trained investigators or clinicians could now apply the standard criteria and agree.

Professor Young describes the events preceding the acceptance of PTSD into the new diagnostic manual. He notes that there was resistance by some scientifically-oriented psychiatrists about introducing a diagnosis that carried with it a ready-made theory of etiology. Unlike all the other major diagnoses in this manual, PTSD was conceived from the outset as having a predetermined etiology — a traumatic event — as the cause of the set of symptoms that were observed. Other disorders were only described in the *DSM-III*, and it was left to future scientific research to determine what their explanations might be. However, the authors of the *DSM-III* decided to make an exception in this single case, because of intense political pressure to provide a diagnosis for the many veterans of the war in Viet Nam who were winding up in VA hospitals with mental illnesses. Some clinicians, including those sitting on the relevant *DSM-III* committee, intuitively felt symptoms were due to the terrible experiences the veterans had encountered in the war. Thus PTSD was born, the lone survivor of an otherwise rigorous exclusion of unproven theories of etiology from descriptive diagnosis in psychiatry.

Professor Young then discusses some of the peculiar scientific problems that have dogged research into PTSD since its inception. One of the most striking problems has been that investigators cannot agree on how prevalent (or, widespread in the community) PTSD is, simply because they cannot agree in most cases whether or not it is present. This is because investigators differ in their determination of whether there has been a relevant traumatic event, this being an intrinsically murky question. Thus attempts to determine how common PTSD is both among war veterans and in the general population have all come to wildly different conclusions. This shows that researchers — let alone treating clinicians — cannot even tell when PTSD is present, let alone what causes or cures it.

Another telling finding of research into PTSD is that the severity of the identified trauma has not been shown to predict the occurrence or severity of subsequent illness. Rather it is the prior fragility of the victim of trauma that determines whether and to what degree illness results. These findings raise the question of whether the symptoms of PTSD are "due to" a specific trauma, or are only precipitated by it, just as a heart attack may be precipitated by nonspecific stressors such as an alarming piece of news or a vigorous walk after dinner.

The author moves next to a presentation of his medico-anthropological field work at The National Center for the Treatment of War Related PTSD. He presents vignettes of patients and treaters, and he describes the social processes both parties were engaged in. Indoctrination and coercion are described as central aspects of the experience at the Center, beginning with the medical director and filtering through the hierarchy of clinicians down to the patients. The similarity of this process to the spiritual indoctrination of members of a charismatic religious cult is striking to the reader, though the author does not state this explicitly.

Young spells out the powerful psychological benefits to all members of the Center's community resulting from this indoctrination. The clinician gains a compelling sense of what his or her professional task is, and learns to take credit for improvement in

those patients who do well and to accept the deterioration of other patients as a necessary part of the treatment process. The patient is taught to believe that "he is sick but not psychotic, that he has a reversible, psychogenic disorder and not a mental disease," and that he will be cured by the center's therapeutic techniques, which require disclosure of his trauma and acceptance of the theory that his psyche had been split by the trauma into an aggressive and a loving part. However, "this impression tends to fade over time, and many patients eventually conclude that the center does not possess an effective cure..." (p 212), because the patients did not generally recover as promised.

There was a powerful additional incentive for patients to accept and maintain the diagnosis of PTSD: it brought with it $12,600 per year in disability income from the VA in 1986 (it is substantially higher now). In addition there are often back payments of up to $60,000 to cover the years of disability before the diagnosis was made. As the reader can easily imagine, with such a practical impetus PTSD became a robustly self-perpetuating diagnosis.

In the next section, the author critically discusses some very inconclusive biological research into PTSD at considerable length. But he does not address one recent and highly publicized trend in PTSD research. These are the brain imaging studies which purport to show the specific physical brain changes that are caused by trauma in PTSD patients. This work often conveys the misleading impression that, because brain abnormalities are seen in association with PTSD symptoms, these abnormalities must be caused by trauma.

A critical reader will instantly see that it may just as easily be the case that these brain abnormalities are themselves the cause of the symptoms. These may be nothing more than the brain abnormalities of abnormally fragile people who do poorly when faced with stress, because of a tendency toward mood and anxiety disorders. It would be easy to resolve this question, but none of these researchers have tried to. Not <u>one</u> of these studies has compared the brain structure of PTSD patients to that of equally symptomatic anxious depressives who are not believed to have PTSD, or to family members of people with the diagnosis of PTSD, or to any other appropriate comparison group. Perhaps this oversight is a reflection of the fact that these researchers are in no hurry to weaken their case.

Finally, in his conclusion, Professor Young discusses the recent change the diagnosis of PTSD has undergone.When it was introduced in 1980, it required that a patient must (1) have undergone a traumatic experience outside of the range of normal human experience and that (2) would have been distressful to almost anyone who experienced it. However, clinical practice has consistently ignored those requirements over the intervening years, and the diagnosis has been made whenever it was perceived that something "bad" happened or *may have* happened.

Apparently in response to this (though without frankly acknowledging it), the authors of the latest edition (called *DSM-IV*) have revised the operational criteria of trauma to include virtually any experience that was severely frightening to the patient. Given the nature of life on earth, almost every human being will at some point have encountered such an experience. Since it is not required that the symptoms of PTSD follow closely upon the identified trauma in time, or even that the trauma can be <u>recalled</u>, it has become officially possible now to diagnose virtually anyone who suffers from a mood or anxiety disorder with PTSD if a clinician wishes to do so.

This has led to the development of a kind of parallel professional universe that employs unproven treatment methods and which features the speculative attribution of commonplace psychiatric symptoms to the memory of past trauma. These alleged pathogenic memories are often inaccessible to consciousness and often fatalistically odious in character; frequently a resented relative is cast as the villain. The seriousness of this problem should be immediately clear to readers of this newsletter.

In summary, I strongly urge serious readers with an interest in the false memory phenomenon to read this book. It is a genuine masterpiece. and it shines a scorching searchlight on the tenebrous diagnosis of PTSD. If it is widely read, it may open many eyes and begin to change current practices. If not, at least it expresses truths that up to now have been kept disgracefully hidden. The author's curious manner of not revealing his point of view may be a bit irritating to some readers, but at least you will feel that it is your own opinion you hold at the end of this book. And you will be far more knowledgeable about PTSD than all but a few of the legions of psychotherapists who diagnose and claim to treat it.

J. Alexander Bodkin, M.D. is a member of the Department of Psychiatry at the Harvard Medical School. He is a Staff Psychiatrist at McLean Hospital, Belmont, MA.

"Indigestible lumps"
Understanding traumatic memory

But yet again Marjorie Orr sounds a warning. "You can't take work done on people memorising shopping lists in labs and then apply it to people who have been persistently raped for nine years," she says. "Traumatic memory works very differently. It's stored in indigestible lumps encoded in a different way than ordinary memory. And it comes back in a different way, in bits and pieces, starting with a smell, a sound, a panic attack."

The Independent
November 16, 1996
by Vallely

LEGAL CORNER

Psychiatrist settles with former patient for $650,000, Tinker v. Tesson, in the Circuit Court of the 19th Judicial Circuit, in and for Martin County, Florida, Case No. 95-444-CA

In December, 1996, Sue Tinker agreed to a $650,000 settlement in a civil suit against psychiatrist Dr. Alan Tesson of Stuart, Florida. Tinker alleged that Tesson used hypnosis over a period of 2 1/2 years to retrieve "repressed memories" of satanic ritual abuse and had an affair with Tinker while treating her.

Among numerous allegations of negligence in the treatment of Ms. Tinker, the complaint included allegations that defendant failed to obtain informed consent of the risks of his chosen treatment techniques and misdiagnosed the plaintiff. According to plaintiff's attorney, Don Russo, Tesson diagnosed Ms. Tinker as suffering from Multiple Personality Disorder (over 200 personalities) as a result of Satanic Ritual Abuse (SRA). Dr. Tesson originally denied introducing the topic of SRA and SRA mind control, claiming these memories were brought up by Ms. Tinker herself in therapy. However, with the use of videotapes from therapy sessions during depositions, plaintiff's counsel was able to show that Dr. Tesson implanted false memories of SRA. Attorney Russo described Tesson as someone who was preoccupied with satanic ritual abuse.

Attorney Russo was also able to show that Dr. Tesson frequently consulted with self-proclaimed experts in satanic ritual abuse (Cory Hammond, Catherine Gould and Judianne Denson Gerber) on the subject of SRA mind control. For example, Catherine Gould testified that she consulted with Tesson on Tinker's case to teach Tesson how to detoxify the mind control in his patient for a fee of $5,000. And, court records show that Tesson attended a lecture for hypnotherapists, in which Hammond told the group a satanic cult had been introduced to the United States by Nazi scientists who devised a mind-control system to induce cult members to commit murder, ritual sacrifices and child pornography.

Attorney Russo commented that "as a trained medical negligence lawyer, I've never seen a case where the science got so far away from anything remotely connected to good medical sense and science. The same is true, in my personal view, of the experts that testified about repressed memory theory.... The deposition testimony of the defense experts show that there is no basis for saying repressed memory theory is in any way based on sound science."

Defendant's attorney said that Tesson was opposed to the settlement but that it was a compromise due to the concern that "perhaps a court ruling may have a serious impact on the physician."

❑

Malpractice Suit against California Therapist Settles Out of Court, January 1997

A malpractice suit originally filed in 1993 in Long Beach, California has been settled at long last. Melody Gavigan had sued her former therapists and a hospital for medical malpractice and negligence. Her complaint (1) states that she entered therapy for treatment of mild depression but that the defendants failed to ascertain the true cause of her condition. Instead, as a result of their misconduct and misdiagnosis and at their suggestion and encouragement, she falsely accused her father of child abuse.

The hospital settled out of court approximately a year ago. The treating therapist settled prior to trial rather than continuing with an appeal.

According to Melody's attorney, Donald A. Eisner, Ph.D., J.D., "One of the most disturbing aspects of the case was the intrusiveness into Melody's personal affairs, including who she associated with and wrote to. This case demonstrates that if you persevere, you will be victorious." Melody has been more public about her experience than are many other former patients in her position. She was the editor of her own publication, *The Retractor*, and has written a chapter on her life in a book entitled *True Stories of False Memories*. In court documents, Melody was made out to be a conspirator in collusion with the False Memory Syndrome Foundation seeking to bring meritless cases against psychotherapists. Eisner reports that E-mail, letters, articles, diaries and even phone company records were requested by the defense. Depositions were taken of persons who had even remote contact with Melody. Eisner notes that this defense tactic is unlikely to continue because of the expense involved and because it is becoming more apparent that it is below the standard of care for therapists to suggest that a patient can reliably retrieve a repressed memory–especially of Satanic ritual abuse. Melody currently lives in Nevada and plans to return to work in a few months.

(1) See FMSF Brief Bank #31

❑

A Second California Malpractice Case Settles Out of Court

On January 9, 1997, Lori Roberts settled out of court with the final defendant in a malpractice suit filed in 1994 in Long Beach, California. (2) She had previously settled with a treating psychotherapist and a hospital. (Interestingly, both Lori and Melody were treated at the same hospital, a hospital whose owners were later implicated in insurance fraud.)

Lori had suffered from an actual trauma several years before she was hospitalized for depression. According to Lori's attorney, Donald A. Eisner, Ph.D., J.D., it is doubtful that her depression was serious enough to warrant several months of inpatient treatment. During the initial phases of both outpatient and inpatient treatment it was suggested that perhaps the cause of her "depression" was due to some other trauma. The staff recommended sodium amytal to unlock her repressed memories. In December 1991, after Lori had written out some of her own questions, she was given sodium amytal intravenously. During the session, she "saw" her father molest her while she was wearing a blue nightgown. In fact, she never owned a blue nightgown. The staff had Lori meet and confront her parents with this new-found information. For the next year or so, she believed in the validity of the so-called retrieved memories.

Attorney Eisner states that the case was scheduled to go to binding arbitration. Dr. August Piper was chosen as expert and had been deposed and had prepared testimony. The day before the arbitration was scheduled, the insurance adjustor for the defendant called and offered to settle for a nominal amount without admitting liability. Eisner informed the adjustor that he would not settle for less than a certain amount and not to call back unless she could meet the demand. About two hours before the start of the arbitration, the adjustor acceded to the demand. Currently, Lori is attending Los Angeles Harbor College.

(2) See FMSF Brief Bank #22

❑

Minnesota Court of Appeals Rules Public Policy Precludes Discovery Rule Cheryl D. v. Estate of Robert D.B., Wisconsin Court of Appeals, District Two, December 18, 1996. Slip Copy. 1996 WL 725692.

Cheryl D., a 46-year-old woman, sued her father's estate for damages for an incident of incest alleged to have occurred between 1975 and 1976. The issue before the Court of Appeals was whether the discovery rule and public policy reasoning enunciated in Pritzlaff v. Archdiocese of Milwaukee, 194 Wis.2d 302, 533 N.W.2d 780 (1995), would apply to an adult incest case (3). The court concluded that Pritzlaff was applicable, holding that the statute of limitations was not tolled by the discovery rule. The court also ruled that public policy (against the interest of the public and in consideration of fairness), as outlined in Pritzlaff, further precluded the discovery rule from saving a claim under the facts of the case.

Cheryl D. maintained that the trauma of the alleged abuse prevented her from discovering the cause of her psychological injuries until she disclosed it to her therapist in 1993 (Judge P.J. Anderson notes in his decision that the allegations were not brought until after Cheryl learned that she was expressly disinherited from her father's estate). The Court of Appeals ruled that to apply the discovery rule would cause unfairness to the defendant's estate which would be forced to attempt to defend a suit for alleged emotional and psychological injuries where the alleged conduct took place twenty years ago, and where the defendant is deceased and unable to deny or verify the claim. Judge Anderson affirmed the trial court's ruling that to allow this action to go forward, "is clearly violative of public policy."

Judge Anderson further concluded that the threat of stale or fraudulent actions outweighs allowing claims of this nature, quoting Pritzlaff that "this court has frequently been dismayed by the examination of trial court records which showed a marked propensity of those who purport to have psychiatric expertise to tailor their testimony to the particular client whom they represent, fraud becomes a distinct possibility." Id. at 322-23, 533 N.W.2d 788.

(3) The court noted that this is the first application of Pritzlaff v. Archdiocese of Milwaukee, 194 Wis.2d 302, 533 N.W.2d 780 (1995), to an adult incest case.

❑

Eighth Circuit Court of Appeals Overturns Child Sexual Abuse Convictions of Four Native Americans

A panel of the 8th Circuit Court of Appeals in the U.S. v Rouse, 100 F.3d 560 (8th Cir. 1996), overturned the conviction of four Native American men who had been convicted and sentenced collectively to more than 120 years after a jury trial for aggravated sexual abuse of children under 12 years of age. Because the acts allegedly occurred at the family residences on a South Dakota Indian Reservation, the charges were brought in federal court.

The Sioux Tribe's Department of Social Services removed 13 children from their homes following allegations of child sexual abuse by a young Native American girl, R.R., following a single interview which was neither audio nor video taped. The court's opinion details how the children's accusations expanded "fantastically" while in custody of the Social Services Department as the untaped interviews with law enforcement and social workers continued.

Prior to trial, the district court denied independent medical and psychological examinations of the children. In addition, during trial, the defendants were denied the opportunity to present expert testimony that the investigation and interrogation of the children constituted a "practice of suggestibility." On appeal, these two issues served as the basis for the court's reversal of the defendants' convictions.

A reading of the decision reveals that the court was highly critical of the trial judge's handling of the case. In concluding that the expert testimony on suggestibility should have been admitted, the appellate court went into a well-reasoned Daubert analysis and quoted extensively from Stephen J. Ceci and Maggie Bruck's "Suggestibility of Child Witnesses: A Historical Review and Synthesis," 113

Psychological Bulletin 403-409 (1993). The court also wrote that in light of the manner in which the prosecution, state agencies and others have proceeded in the investigation, it was an abuse of the trial court's discretion not to have afforded a fair opportunity to determine by independent psychological examination whether the children had been improperly influenced. The result of the appellate decision was to remand the case for new trial.

Since the decision, the FMSF Legal Staff has contacted the attorneys who represented the defendants both at trial and throughout the appellate process. These attorneys were informed that the government has requested a reconsideration of the Court of Appeal's decision and made a suggestion that the matter be reconsidered, en banc, that is, by the entire court, not just the 3-judge panel which decided the case.

❑

Cleared of Child Abuse Five Times, Woman Sues Connecticut for Name of her Accuser

The New York Times, January 6, 1997
William Glaberson

In response to at least five anonymous calls, investigations by Connecticut Social Services over the past two years have yielded no evidence that Susan Leventhal of Berlin, Connecticut, was abusing her four children. Ms. Leventhal has filed suit against the Connecticut Department of Children and Families claiming a constitutional right to confront her accusers is as important as the state's interest in encouraging child abuse complaints. If she gets the names, Ms. Leventhal intends to sue for harassment.

Connecticut guarantees anonymity in order to encourage members of the public to make such reports. In recent years, legislatures across the country, including Connecticut, have made falsely reporting child abuse a crime. However, the law enacted in Connecticut on October 1, 1996, may not apply retroactively to Ms. Leventhal's complaints.

An editorial which appeared in *The New York Times* on January 10, 1997, calls for "crack down" on false and malicious reports, noting that while anonymous reporting is an important tool against child abuse and should be preserved, the system clearly needs "fine-tuning."

❑

Canada Lets Defendants Turn the Tables on their Prosecutors

Christian Science Monitor
by Mark Clayton and Brian Humphreys
November 8, 1996

During the past year, several Canadian Appeals courts have broadened the criteria for proof of misconduct by which prosecutors and police may be measured in cases alleging prosecution despite knowledge of a defendant's innocence (see, e.g., Milgaard v. Mackie, 118 D.L.R.4th 653 (1994); Milgaard v. Kujawa, 28 C.P.C.3d 137 (1994)).

Criminal law professor at Osgood Hall Law School at York University in Toronto, Alan Young, says the impact of these action is now rippling across Canada. "Every provincial attorney general's office is unhappy and very uncomfortable about the wider potential exposure to being sued," he said. "They felt they could live with the 'malicious' prosecution rule, knowing how difficult that is to prove in court. But 'negligent' prosecution is much easier to prove and will potentially expand their accountability."

Ethical Complaints

Loren Pankratz, Ph.D.

I recently discovered a letter that I wrote in 1976 to the Oregon Psychological Association Board when I was chair of the Ethics Committee. The letter said that no complaints were filed against psychologists that year. In 1988 I rejoined the Ethics Committee for a six-year stint. The second time around I discovered a different world.

In 1976 there were about 300 licensed psychologists in Oregon, and few were in private practice. There are now about 800 licensed psychologists in Oregon. About 400 psychiatrists are licensed, but there are about 1,200 Counselors and Marriage & Family Therapists and an additional 1,900 Clinical Social Workers. Consumers obviously have options in this state with a population somewhere over two million people.

Recently I gathered information about complaints from the Ethics Committee of the Oregon Psychological Association and the state licensing board for psychologists. I concluded that perhaps one complaint is registered for each 20 psychologists each year, although multiple complaints against some individuals may skew that figure. Information from the state of Washington suggested a comparable rate.

What accounts for this appalling figure? I don't know. But the variety of complaints that I saw during my tenure on the committee prompted me to write a brief article for our state newsletter about the vulnerabilities that therapists face over the stages of their professional career. I particularly stressed the need for a commitment to a scientific approach against the temptation of psychological fads.

In my opinion, the American Psychological Association Ethical Principles of Psychologists are more demanding than those of other professions. As readers know, the ethical standards prevent psychologists from discussing their clients without a specific release. This blocks third parties from making ethical complaints because therapists will not be able to discuss the case, even with an ethics committee. I recommended, therefore, that persons

concerned about the therapy of others provide them a copy of these standards with the section highlighted that says therapy should be terminated if the client is not benefiting or if service is harmful.

A complaint against a psychologist may be lodged by a consumer either through the ethics committee of the state association (if the person is a member) or through the state licensing board. It is possible to file a complaint with the American Psychological Association as well, but in our experience they want local organizations to resolve complaints. The local ethics committee can, in the worst case, recommend to its professional board that a psychologist be removed from membership. Therefore, our committee often suggested, and sometimes insisted, that complaints with the potential for serious consequences be presented directly to the state board. The board has the power to impose sanctions, including the removal of a license. We tried to educate those considering a complaint about their options.

Because the ethics committee has a limited oversight, we viewed our role as one of mediation and education, which I believe was appropriate. Most psychologists were completely cooperative with the committee. However, I suspect that some people who used our services were not very satisfied. The reason for the dissatisfaction probably resulted from being excluded from the process. There is little feedback about the work done behind the scenes, which might leave the impression that it is not being taken seriously. And the extended time it takes to resolve an issue might lead some to believe that nothing is being done about the complaint.

An ethics review is not a legal process. Thus, we refused to interact with any attorney who stepped into the process. In one case it was clear than an attorney was guiding a psychologist through our investigation process, which was certainly appropriate. However, that attorney eventually wrote us a letter with an innuendo of legal action against the committee. We were a volunteer group with doubts about our liability coverage in this situation. Therefore, we precipitously passed the complaint to our parent American Psychological Association.

The committee took each complaint seriously, sometimes throwing out parts of a complaint but sometimes adding issues that became apparent. Sometimes I was disappointed with individuals on the committee who would not let go of the mediation role. I never viewed this as an attempt to protect our profession, as an outsider might suspect. Rather, it was my opinion that some members could not give up their traditional role of talking out a solution when direct action was needed, especially with an uncooperative professional.

For example, in one case a psychologist violated some principles in a complex and unusual way. Our committee discussed this over several of our monthly meetings until we exceeded the time limits demanded by our Standard Operating Procedures. When we consulted our attorney, he thought that we had lost our standing in the case. Thus, we were forced to settle this case by default with a letter that could be ignored. The wisdom of a committee can become folly while working toward consensus.

To avoid ethical complaints with the committee, many psychologists give a copy of the ethical standards to their clients at the beginning of treatment. For both psychologist and client, it is best to resolve questions before they become conflicts.

Loren Pankratz, Ph.D. is a Consultation Psychologist and Clinical Professor, Oregon Health Sciences University in Portland, Oregon. He is a member of the FMSF Advisory Board.

❑

Colorado Board of Medical Examiners (Hearing Panel B) Revokes License to Practice Medicine for Spencer K. Anneberg (Case No. ME 96-08) Nov. 15, 1996

Until his license was suspended, Spencer K. Anneberg practiced as a psychiatrist in Greeley, Colorado. A third-party action was made possible by an unfortunate set of circumstances that provided the opportunity for a diagnosis of the patient by someone other than Dr. Anneberg. The Board of Examiners based their ruling on evidence presented in three complaints against Anneberg: Two by former patients and a third-party complaint filed by the parents of one of Anneberg's patients. In this summary, we focus only on the third-party complaint.

The third-party complaint was initiated by the parents of a young woman who went to Dr. Anneberg for help after a failed romance. The young woman's mental status deteriorated with extensive psychotherapy for her alleged repressed traumas of child abuse until she was hospitalized. She left the hospital against medical advice and was later found suffering from hypothermia. Hospitalized a second time, she again left against medical advice, stole a truck and attempted to hurt or kill herself. After a head injury was treated, she was transferred to another psychiatric facility where she was diagnosed and treated by Dr. Steven Dubovsky, Professor of Psychiatry and Vice Chairman of the Psychiatry Department of the University of Colorado Health Sciences Center. Dr. Dubovsky identified several major diagnostic possibilities.

The Medical Examiners made the following comments about Dr. Anneberg's treatment of this patient:

• Respondent failed to perform a careful psychiatric examination of patient. He did not obtain a detailed history or conduct a careful mental status examination.

(The patient history is often the single most important source of data available to a psychiatrist to assess the patient's current condition. A careful mental status exami-

nation assesses the patient's mood, the kind of thinking the patient is using, and issues of memory and attention. By failing to perform a careful psychiatric examination of the patient, Respondent failed to meet these generally accepted standards of practice.)

• Respondent ignored the patient's presenting symptoms which suggest she was suffering from depression and mourning in relation to the rupture of her significant romantic relationship.

(By failing to address the patient's serious mood disorder, Respondent failed to meet generally accepted standard of practice.)

• Respondent diagnosed the patient as suffering from repressed prior trauma...The basis for Respondent's diagnosis of repressed prior trauma was flimsy at best.

(Generally accepted standards of practice require that a psychiatrist have an adequate clinical basis for his diagnosis.)

• Based on his diagnosis, Respondent embarked on intense, insight-oriented treatment in which he assumed that the patient's problems arose from deeply rooted experiences in the past which needed to be dug out. The patient began a downhill course and was no longer able to function at her previous level. Respondent recognized the deterioration of the patient's mental health but did nothing to reevaluate or reorient his treatment plan.

(Generally accepted standards of practice require a psychiatrist to employ treatment calculated to address the patient's diagnosis and then evaluate the effect of the treatment in order to reassess the treatment plan. By choosing and continuing insight-oriented therapy, particularly in light of the deleterious effect it had on the patient, Respondent failed to meet these generally accepted standards of practice...Generally accepted standards of practice require a psychiatrist to consider the use of psychotropic drugs for a patient with a significant mood disorder.)

How were generally accepted standards of practice defined?

"A psychiatrist's compliance with 'generally accepted standards of practice' requires him to exercise the same degree of knowledge, skill, and care as exercised by other psychiatrists in the community during the time period in question. State Board of Medical Examiners v. McCroskey, 880 P.2d 1188, 1194(Colo. 1994); Kibler v. State, 719 P.2d 1198 (Colo. App. 1989); Melville v. Southward, 791 P .2d 383, 387 (Colo. 1990). The Board, through its expert witness, provided evidence of repeated violations by Respondent of generally accepted standards of practice. Based on this undisputed evidence, the judge found multiple violations of Section 12-36-117(1)(p)."

Editorial Comment: The issue of "generally accepted standards of practice" is one that has been of great interest to members of the FMS Foundation. Skip Simpson, a lawyer in Dallas, has used an analogy that may be helpful to our understanding: consider the situation in which the speed limit on a highway is 55 mph and a policeman stops a driver for doing 65. The driver may say that lots of other cars around him were also doing 65. The policeman, however, will be unimpressed and note that the speed limit is 55 mph. The driver will receive a ticket.

In a similar way, some recovered memory therapists appear to have cut themselves off from the mainstream thinking of the medical establishment. Like a driver who says that everyone else was speeding,some therapist seem to be in a closed sub-system. Within this system, a reason is found to discount any idea or anyone who presents alternative explanations. The danger for closed systems is that sooner or later they will collide with the mainstream.

❑

In the Matter of the Medical License of Diane B. Humenansky, M.D., Before the Minnesota Board of Medical Practice, OAH Docket No 12-0903-10686-2, Findings of Fact, Conclusions, and Final Order.

At a November 1, 1996 hearing before Administrative Law Judge Steve Mihalchick, psychiatrist Diane Humenansky entered a plea of no contest to the allegations against her. She does not admit to the allegations, but by virtue of her entry of a plea of no contest, they are deemed to be proven true. Since 1992, when the Board initiated its investigation, the Board received 20 complaints against Humenansky which allege multiple violations of the Medical Practice Act. (A discussion of the grounds for action by the Board of Medical Practice was included in the FMSF Newsletter, Nov./Dec. 1996, p. 6.)

The Board concluded that Humenansky's conduct would constitute engaging in medical practice which is professionally incompetent, engaging in unprofessional conduct and an inability to practice medicine with reasonable skill and safety to patients. In reaching this conclusion, the Board summarized the results of previous fact-finding hearings. It noted that numerous complaints had been filed, a Board-ordered mental evaluation had determined probable inability to practice medicine due to a mental condition, two juries had found Humenansky negligent in failing to meet the recognized medical standards in the diagnosis, care and treatment of patients, Humenansky's own insurance company had agreed to out of court settlements with four former patients who had accused her of planting false memories of abuse, and four more false memory lawsuits remain pending against her.

The Board ordered Humenansky's license be suspended for an indefinite period of time during which she may

not practice medicine in Minnesota. After three years she may petition for removal of the suspension, but only after submitting to a mental health evaluation, participating in individual psychotherapy, and reimbursing the Board for a portion of its costs incurred by the investigation and proceedings.

❑

State accuses therapist of abuse: License surrendered: Board says Portola Valley psychologist, who denies claims, dominated patients

San Jose Mercury News, California, December 24, 1996
by Daniel Vasquez

Douglas Detrick, a Portola Valley psychologist who specialized in treating patients for multiple personality disorder surrendered his license to the California Board of Psychology under threat that the license would be revoked. Following a nine month investigation, the California State Attorney General's Office filed a complaint against Detrick accusing him of 16 acts of gross negligence in the treatment of three women patients from 1987 to 1991.

The first woman, "K.W.", was treated for nearly three years for multiple personality disorder allegedly brought on by a history of satanic ritual abuse, sexual abuse and torture. A second woman, "L.B.", alleged Detrick's heavy use of "abreaction" or reliving of past abuses, left her in a deteriorated mental state culminating in a second suicide attempt. The third woman, "M.M.", had been treated up to two hours a day, five days a week, for nearly two years. Detrick had her relive satanic ritual abuse allegedly suffered as a child. "M.M." committed suicide in September 1991.

Detrick denied the allegations stating, "It's a case of false memory involving these patients, all of whom are very unstable people. ... These people cannot tell the difference between fantasy and reality, between the past and the present. This class of patients is very dangerous to treat because of (potential) accusations like these."

Detrick cannot be criminally prosecuted because the statute of limitations has expired.

Editor's note: *The San Jose Mercury News* article does not seem to question the SRA allegations, but is instead written from the perspective that the therapist mistreated the three women patients because of the methods used to dominate and control them. The author notes that the therapist did not provide therapeutic counseling after having them relive painful childhood memories, stating, "[T]he accusations against Detrick, who has been practicing psychotherapy for 19 years, reads like a patient's worst nightmare: Place one's trust in a therapist who is supposed to help process and heal the horrors of child abuse, only to be mistreated and denied proper psychological treatment."

FROM OUR READERS

Restoring a Family

I want to express appreciation to you, and to those families who have shared their personal experiences in the Newsletter. I truly believe that were it not for the guidance given by other parents, our family situation today would be different and far worse.

My daughter retracted. However, I am the only person she has told in the family. And, true to the input in the Newsletter, we don't talk about it. Her attitude initially, was that if we had problems with her false memory period, then that was "our" problem. So, none of us have discussed it with her. We did all go to her home for Thanksgiving, though none of us felt like it. She felt hurt that none of us had chosen her home for our holiday and didn't "get it" when I tentatively tried to point out "perhaps why." Slowly, everything is coming together again with the cooperation of all — and with nothing said. (Just as parents write in the newsletter.)

I would surely have given in to my anger — surely have distanced her — were it not for the advice in the newsletter. We might have held out and not gone to her home for Thanksgiving until she apologized. Instead, we are healing.

I want you to know how many people you have helped by forming the organization and bringing the issue public.

A Mom

❑

Restoring Relationships

There seems to be some disagreement among FMSF families as to how — or whether — to restore the family relationship and bring the errant daughter back into the fold. At one extreme, there are those who would welcome back the accusing child with absolutely no qualifications or conditions whatsoever. These people are willing to re-establish a relationship without ever mentioning or coming to terms with the false memory experience, as if to do so would jeopardize a possible reconciliation. Thus we hear stories of parents whose daughters begin visiting or telephoning on the condition that the accusations and the estrangement

Continued on page16

never be mentioned. These parents are so desperate to have a reunion with their lost child — and perhaps their grandchildren — that they are willing to accept almost any terms laid down for resumption of contact. Many will say that unconditional love is the key to regaining the lost relationship. I do not criticize these people in any way. Indeed, I sympathize with them and I respect their values. I can't even say that I disagree with their position, since I have seen this approach work in several cases where the family has once again come together as a close and strong unit.

At the other end of the spectrum are those who are so outraged and disgusted by the cruel and malicious treatment they have received from someone who owes them so much, that they find it impossible to forgive. It is tempting to say that these people are wrong-minded, but it's really impossible to make such judgments. As the old Indian adage would have it, you can't really understand a man until you've walked a mile in his moccasins.

The fact is that it's really impossible to come up with a solution to the family reconciliation problem which would work or apply in every situation, due to the wide disparity of experiences which vary from case to case. There is a big difference, for example, in a situation which simply involves an estrangement for a period of time, and one in which the accusing child has set out on a program of malicious persecution, resulting in public slander, loss of reputation, lawsuits, criminal prosecution, and the like. In the former situation, the parents feel profound loss, grief and worry for their sick child. In the latter, although one may experience the same anxieties, he sooner or later must bear down and concern himself with self-preservation. Often, as the accuser becomes increasingly narcissistic, strident and dominated by hatred and malice, it becomes more difficult for the beset parent to be "understanding" and full of tender concern for his obviously troubled child. It would be a naïve misassessment of human nature not to expect that some would succumb to bitterness, disillusionment and resentment as a result of such an ordeal.

My own case fits into the latter category, in that I was subjected to an extreme hate and persecution campaign which finally culminated in my winning a lawsuit in federal court brought in another state. Not only did I suffer many a sleepless night during this ordeal (without mentioning the expenses I incurred in defending myself against the false charges), but during the pendency of the suit it became apparent that it was motivated more by hatred and malice than by a desire for recompense for the imagined wrongs. My accusing daughter is still estranged, and I do not know whether she will ever return to sanity and reality, since she seems to take a perverse satisfaction in the sympathy and attention she has received in her new identity as a "survivor" of childhood sexual abuse. I have resolved, however, to be scrupulously fair with her should she ever decide to come to her senses and renounce this role. I am quite capable of forgiveness, but I don't suppose I can ever forget.

Forgiving and forgetting are two quite different things. One is a moral act which comes from the heart; the other is an intellectual function over which one has no real control (unless, of course, one is capable of "repressing" his memories). Restoration of trust, I recognize, also fits into the latter category. No matter how one might wish otherwise, trust has to be earned; it can't be forced or willed. Declarations of trust and confidence unwarranted by experience are mere exercises in self-delusion and playacting.

Consequently, one decision which I have made is to insist upon an acknowledgement of responsibility as a condition of any future reconciliation. By responsibility, I do not mean blame or fault. I am talking about a full, open and honest disclosure as to exactly what happened and why, together with a willingness to mitigate the damage done by setting things straight with everyone to whom the falsehoods were repeated. To demand less, in my opinion, would render the entire experience meaningless.

Recovered Memory Therapy is, after all, just scapegoating and responsibility avoidance pushed to their ultimate limits. One has problems, but instead of looking inward for a solution to them, one instead looks outward for someone else to blame them on. Failure to accept responsibility for the consequences of this behavior is almost certain to bring about a repetition or continuation of it in one form or another. One should always bear in mind the truism that if one fails to learn from history, he will be doomed to repeat it.

My entire point in all this is simply that there is no one, universal solution to the reconciliation problem. Every case has to stand upon its own facts. What works in one will not necessarily work in another. Again, what may be a very satisfactory resolution in one situation may be entirely inappropriate in another.

A Father

Our Cup Runneth Over

We are so happy to be sharing good news with you. Our daughter has returned!! Last year, she unexpectedly attended our family reunion which we have every Thanksgiving. It was the first time we had seen her in three years. Things went well then, and since that time, we have had lots of communication....

What seems strange and yet not strange — is the lack of tension between us. Our hearts have truly forgiven the hurts — and we are happy to pick up and go forward, so we have

not talked about the past — and I doubt that we even will. It has never been easy for our daughter to say she was sorry, but we know by her actions that she is — and that is sufficient. We truly believe that our family is whole again and we Thank God for that blessing.

We cannot express enough Thanks to you and the FMS Foundation and the Newsletter. Because of the work all of you have done and the information you have shared, we have made fewer mistakes than we might have otherwise, and because we felt the support of "kindred souls" and knew that we were not alone in this dilemma, it was easier to bear. You have done such a wonderful job of educating the public, that thinking people now know the truth about repressed memories and how evil this whole hoax has been. We will continue our financial support of FMSF so that others will have the same benefits that were available to us. Indeed, our cup runneth over!

A Happy Mom and Dad

❑

CORRECTION - We apologize for a misprint in a letter from a retractor in the January issue. We have reprinted the letter with the correct information in bold.

To the mother who responded to my letter,

I do understand your concern about my letter. It was not intended just to warm hearts; it was written to plead with families not to shut their doors eternally to their accusing children. Had that happened to me, I would never be where I am in recovery today.

I am sorry my letter was so useless to you. Hope has to come from within you. All I can do is tell you that time is a major factor in recovery from FMS. If it takes several years for your child to return, you may or may not be able to receive them. **Retraction is terribly painful, fearful, and draining; most of us cannot do it quickly**. But those of us who do eventually retract, need to find that crack in the door. How else can we all start the healing process?

There is no magic formula on how to break loose. We all do it in our own individual ways. My story is no model to apply to others. I wish I could tell you how I broke loose, but right now I can't. I'm not over the hump yet, but I am better every month. I pray that your child will walk the retractor's road and that you will be there to receive them home.

A Retractor

❑

She Believed

Michael Steinberg

She Believed
that one third or more of all the men
and boys she passed in the street
desired and practiced
penetrating incest
and the perpetual unending unendurable unspeakable sexual abuse
of their sisters
and their daughters
and their mothers
and their babies

She Believed
that her father
and her grandfather
and her great-grandfather
and her godfather
and her uncles
and her brothers
and her neighbors
and her pastor
and her professors
had raped
and beaten
and tortured
and murdered
and satanically ritually abused her
and dozens
of innocent women and children and babies
for decades,
wiping the memory clean,
freshly, every day
every month
every year
for decades,
from her consciousness

She Believed
the police
and the newspapers
and the media
and the FBI
and the government itself
were run
were influenced
were penetrated
by this all powerful
ancient
mind controlling
evil
obsessive
and abusive
inherently patriarchal
Devil worshipping cult,
which had existed for centuries
and had daily erased the memories
of thousands of helpless victims

She Believed this now
because her well respected therapist
and the founding feminist icon
role model to millions of young women
and all her new friends
and her
satanic ritual cult survivors extended family,
and all the books she was now allowed to read
and her almost daily therapy
of resurrecting and reliving
hypnotic and drug induced recovered memories"
of unspeakable horror,
and the ever growing number of multiple personalities
which she and her therapist believed
inhabited her body
told her so

Told her that finally
after a lifetime
of denial and abuse
and unspeakable horror
that now
she had recovered,
the Courage to Heal

F M S F

MEETINGS

KEY : (MO) - Monthly; (bi-MO) - bi-monthly
(*) - see the State Meetings List

UNITED STATES
ALASKA
Bob (907) 586-2469
ARIZONA
(bi-MO) Barbara (602) 924-0975; 854-0404(fax)
ARKANSAS
Little Rock
Al & Lela (501) 363-4368
CALIFORNIA
Sacramento - (quarterly)
Joanne & Gerald (916) 933-3655
Rudy (916)443-4041
San Fransico & 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
3rd Sat. (bi-MO) @10am
Cecilia(310) 545-6064
Central Coast
Carole (805) 967-8058
Central Orange County - 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
San Diego Area -
Flossie (619) 941-4816
COLORADO
Denver - 4th Sat. (MO) @1pm
Art (303) 572-0407
CONNECTICUT
S. New England - (bi-MO) Sept-May
Earl (203) 329-8365 or
Paul (203) 458-9173
FLORIDA
Dade/Broward
Madeline (305) 966-4FMS
Boca/Delray - 2nd & 4th Thurs (MO) @1pm
Helen (407) 498-8684
Central Florida - 4th Sun. (MO) @2:30 pm
John & Nancy (352) 750-5446
Tampa Bay Area
Bob & Janet (813) 856-7091
ILLINOIS
Chicago & Suburbs - 3rd Sun. (MO)
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; (317) 334-9839 (fax)
Pat (219) 482-2847
IOWA
Des Moines - 2nd Sat. (MO) @11:30 am Lunch
Betty & Gayle (515) 270-6976
KANSAS
Kansas City
Leslie (913) 235-0602 or
Pat (913) 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
Bangor
Irvine & Arlene (207) 942-8473
Freeport - 4th Sun. (MO)
Carolyn (207) 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)
Bill & Marge (616) 383-0382
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 - 3rd Sun. (MO)
Karen (314) 432-8789
Mae (314) 837-1976
Retractors group also forming
Springfield - 4th Sat. (MO) @12:30pm
Dorothy & Pete (417) 882-1821
Howard (417) 865-6097
John (352) 750-5446
MONTANA
Lee & Avone (406) 443-3189
NEW JERSEY (So.)
See Wayne, PA
NEW MEXICO
Albuquerque - 1st Sat. (MO) @1 pm
Southwest Room -Presbyterian Hospital
Maggie (505) 662-7521(after 6:30 pm)
or Martha 624-0225
NEW YORK
Westchester, Rockland, etc. - (bi-MO)
Barbara (914) 761-3627
Upstate/Albany Area - (bi-MO)
Elaine (518) 399-5749
Western/Rochester Area - (bi-MO)
George & Eileen (716) 586-7942
OKLAHOMA
Oklahoma City
Len (405) 364-4063
Dee (405) 942-0531
HJ (405) 755-3816
Rosemary (405) 439-2459
PENNSYLVANIA
Harrisburg
Paul & Betty (717) 691-7660
Pittsburgh
Rick & Renee (412) 563-5616
Montrose
John (717) 278-2040
Wayne (includes S. NJ) - 2nd Sat. @1pm
Jim & Jo (610) 783-0396
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
Susanne & John (608) 427-3686

INTERNATIONAL
BRITISH COLUMBIA, CANADA
Vancouver & Mainland - Last Sat. (MO) @ 1- 4pm
Ruth (604) 925-1539
Victoria & Vancouver Island - 3rd Tues. (MO) @7:30pm
John (604) 721-3219
MANITOBA, CANADA
Winnipeg
Joan (204) 284-0118
ONTARIO, CANADA (*)
London -2nd Sun (bi-MO)
Adriaan (519) 471-6338
Ottawa
Eileen (613) 836-3294
Toronto /N. York
Pat (416) 444-9078
Warkworth
Ethel (705) 924-2546
Burlington
Ken & Marina (905) 637-6030
Sudbury
Paula (705) 692-0600
QUEBEC, CANADA
Montreal
Alain (514) 335-0863
St. André Est.
Mavis (514) 537-8187
AUSTRALIA
Irene (03) 9740 6930
ISRAEL
FMS ASSOCIATION fax-(972) 2-259282 or
E-mail- fms@netvision.net.il
NETHERLANDS
Task Force FMS of Werkgroep Fictieve Herinneringen
Anna (31) 20-693-5692
NEW ZEALAND
Colleen (09) 416-7443
SWEDEN
Ake Moller FAX (48) 431-217-90
UNITED KINGDOM
The British False Memory Society
Roger Scotford (44) 1225 868-682

STATE MEETINGS
Call persons listed for info & registration
ONTARIO
Saturday, May 10, @ 1:30 pm
Speaker: Pamela Freyd, Ph.D.
Pat (416) 445-1995

Deadline for the March Newsletter is **Feb. 13**
Meeting notices **MUST** be in writing.

3401 Market Street, Suite 130
Philadelphia, PA 19104-3315
Phone 215-387-1865 or 800-568-8882
Fax 215-387-1917
ISSN # 1069-0484

Pamela Freyd, Ph.D., Executive Director

Do you have access to e-mail? Send a message to
pjf@cis.upenn.edu
if you wish to receive electronic versions of this newsletter and notices of radio and television broadcasts about FMS. All the message need say is "add to the FMS list". You'll also learn about joining the FMS-Research list: it distributes reseach materials such as news stories, court decisions and research articles. It would be useful, but not necessary, if you add your full name: all addresses and names will remain strictly confidential.

The False Memory Syndrome Foundation is a qualified 501(c)3 corporation with its principal offices in Philadelphia and governed by its Board of Directors. While it encourages participation by its members in its activities, it must be understood that the Foundation has no affiliates and that no other organization or person is authorized to speak for the Foundation without the prior written approval of the Executive Director. All membership dues and contributions to the Foundation must be forwarded to the Foundation for its disposition.

The FMSF Newsletter is published *10 times* a year by the False Memory Syndrome Foundation. A subscription is included in membership fees. Others may subscribe by sending a check or money order, payable to FMS Foundation, to the address below. 1997 subscription rates: USA:1year $30, Student $15; Canada: 1 year $35 (in U.S. dollars); Foreign: 1year $40. (Single issue price: $3 plus postage.)

Yearly FMSF Membership Information

Professional - Includes Newsletter $125_____
Family - Includes Newsletter $100_____
Additional Contribution: $_____
please fill out all information
__Visa: Card # & exp. date:_____
__Mastercard: # & exp. date:_____

__Check or Money Order: **Payable to FMS Foundation in U.S. dollars**

Signature: _____

Name: _____
PLEASE PRINT

Address: _____

State, ZIP (+4) _____

Country: _____

Phone: (_____)_____

Fax: (_____)_____

Memory and Reality: Next Steps – Registration Form

PLEASE COMPLETE AND MAIL TO: False Memory Syndrome Foundation, 3401 Market Street, Ste. 130, Philadelphia, PA 19104-3315. Include a check payable to False Memory Syndrome Foundation. FAX: (215) 387-1917 (for credit card registrations only) ***Please print or type.***

last name/degree first name middle initial

last name first name *(for additional attendees - family registrations only)*

mailing address

city state zip+4 code

Registration fees:	Before 3/1/97	After 3/1/97
FMSF Member	100.00	125.00
Add'l family member	50.00	60.00
Non-member	175.00	200.00
Student* or add'l family member	50.00	60.00

(*Attach photocopy of student ID)

____Yes! I want to take advantage of the membership registration fees. Enclosed is an additional sum of: *(please circle one)*

$100 – family membership. $125 – professional membership.

Total Amount _____

For credit card registrations: ___Visa ___MasterCard

Card # _ _ _ _ - _ _ _ _ - _ _ _ _ - _ _ _ _

Exp. Date_ _/_ _

Name as it appears on card
(please print clearly)

Signature Date

Let us know if you have any special needs.

NON-PROFIT ORG.
U.S. POSTAGE
PAID
PHILADELPHIA, PA
PERMIT NO. 1408

FMSF FOUNDATION
FALSE MEMORY SYNDROME
3401 Market Street, Suite 130
Philadelphia, Pennsylvania 19104 - 3315

POSTMASTER : Address correction requested.
Please hold if temporarily away. Paid subscription.

SAVE THE DATES

MARCH 21, 1997

What's New in the "Memory Wars": Implications for Clinical Practice

MARCH 22-23, 1997

Memory and Reality: Next Steps