FALSE MEMORY SYNDROME FOUNDATION NEWSLETTER

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Dear Friends,

Do "hit and run" accusations, "isolation" and "cutting-off" from family and friends constitute legitimate psychological treatments? That is the question that many families have asked the Foundation, but it is more appropriate to ask that question of professionals and professional organizations.

"Isolation" is old stuff in psychiatry. In *A History of Psychiatry*, Shorter reminds us that in 1817, Esquirol recommended that "removal from family and friends would contribute greatly to diverting the patient from the previously unhealthy passions that had ruled his or her life." (p. 13) Shorter writes that "The notion of isolating asylum patients from friends and family was also very familiar. Historically, these are techniques that each generation of psychiatrists invents for itself."(p. 131)

"Hit and run" accusations, "isolation" and "cutting-off" seem to have become therapy practices accepted by too many clinicians in the 1990s. They were suggested by Bass and Davis in the book most widely recommended by therapists, *The Courage to Heal* (1988), a book endorsed by Judith Herman, M.D. (*Guide to Self-Help Books*, 1993).

> "The initial confrontation is not the time to discuss the issues, to listen to your abuser's side of the story, or to wait around to deal with everyone's reactions. Go in, say what you need to say, and get out. Make it quick. If you want a dialogue, do it another time." (p. 139)

John Briere, Ph.D. (*Therapy for Adults Molested as Children*, 1989) noted that psychological surgery or a "parentectomy" may be warranted when the "nonoffending" parent directly or consciously defends the molester and negates the survivor.

Renee Fredrickson in *Repressed Memories: A journey to recovery from sexual abuse*, (1992) recommends:

> "Avoid being tentative about your repressed memories. Do not just tell them; express them as truth. If months or years down the road, you find you are mistaken about details, you can always apologize and set the record straight. You cannot wait until you are doubt-free to disclose to your family. This may never happen." (p. 203)

The Canadian Psychiatric Association has put itself on record as to the dangers of the kinds of confrontations that have been a component of recovered memory therapy, but no professional organization has yet addressed the practice of cutting-off and isolation. The concern of families is that cutting off and isolation are the very same practices used by cults to control information and to prevent exposure to alternative ideas.

The current acceptance of "cutting-off" appears to be a carry-over from the 1940s when mothers were thought to be the cause of schizophrenia, autism and homosexuality. The term *Schizophreno-genic mother* was coined in 1948, the heyday of explanations favoring child-rearing attitudes as the central cause of schizophrenia. Because the mother was considered to have caused the problem, therapists who held this view removed the patient from the family, and to undo the damage, the therapist would reparent the patient. This belief kept a strong hold on a segment of the psychiatric community through the 50s and 60s until the genetic bases of psychiatric disorders began to be understood. It still continues in some therapy groups.

Untold thousands of mothers suffered needlessly because of the misguided idea of *schizophreno-genic mother*, just as untold thousands of mothers and fathers are suffering needlessly now because of this recycled belief.

Families should ask the professional organizations to address this question: *Do "hit and run" accusations, "cutting-off" and "isolation" from family and friends constitute legitimate psychological treatment?* What does the evidence show? We suggest you ask;

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Pamela

In this issue...

F M S
N E W S

Correction

In the April newsletter on page 2 under "Our Critics" the reference to the preface of an e-mail solicitation of protest letters was ambiguous. The author of the preface was "martin" and the subject reference was "Urgent Action Call re: Abusers Lobby." The sender was crossposted on the ACAADC@aol.com mailing list. Ms. Sherry Quirk, the president and legal counsel for ACAA, was not the author of the preface and we apologize for any confusion.

Lawsuit Filed against Renee Fredrickson, Ph.D.

On April 4, 1997, a lawsuit was filed against Renee Fredrickson, a St. Paul psychologist who became a best selling author and nationally known speaker by claiming expertise in "repressed memories" of sexual abuse and "recovered memory therapy." In the lawsuit, Renee Fredrickson, Ph.D. was accused by a former client of using hypnosis, misinformation and suggestion to implant horrifying false memories of "ritual cult abuse." Through her books, audiotapes and seminars, Fredrickson trained hundreds of other therapists in the controversial methods of "memory recovery." Fredrickson was a founder of one of the organizations that merged to become the American Coalition of Abuse Awareness (ACAA). The plaintiff's lawyer is R. Christopher Barden, Ph.D., J.D. See "Legal Corner" of this issue for more details.

First Amendment/Blacklist Project

On March 12, 1997, there was a press conference at the Motion Picture Academy in Los Angeles to launch a project to commemorate the victims of McCarthyism and the blacklist. In addition to some of the famous blacklisted writers, Carol Tavris was asked to speak. Among her words:

> "The second lesson is that the blacklist wasn't unique at all. It has recurred throughout our history—never in the same form, but always part of the same impulse. McCarthyism was what sociologists call a moral panic—a contagion that allows people to displace their fears and anxieties onto the social devils of the moment. In various times our devils have been witches, Communists, foreigners, pedophiles, homosexuals, prostitutes, and of course rock and roll musicians. At this very moment, thousands of parents have had their lives ruined, and nearly a hundred daycare workers are in jail, because of preposterous and wholly unconfirmed charges of sex crimes against children, such as satanic ritual abuse. During McCarthyism, teachers feared for their jobs if they belonged to a left-wing group. Today teachers fear for their jobs if they hug a crying child. As in all moral panics, an accusation is enough to destroy a person's life. Hysteria trumps evidence."

For more information about the First Amendment/Blacklist Project, write to 9538 Brighton Way, Suite 332, Beverly Hills, CA 90210.

Memory Systems and the Psychoanalytic Retrieval of Memories of Trauma

C. Brooks Brenneis, *JAPA* 44/4

This article about flaws in the concept of traumatic memory notes that the concept of a special traumatic memory includes the notion that an overwhelming psychic experience generates a defensively altered state of consciousness (specifically dissociation), "which encodes memory in unassimilated visual, somatic, and behavioral, rather than linguistic modes. Analytic reevocation and interpretation of the original altered states of consciousness then permits the transformation of 'early' traumatic memory into 'later' explicit memory." He believes that the flaws in this theory when extended to patients without explicit memory of trauma are: "first, dissociation is a chameleonlike process, perhaps as closely associated with suggestibility as with trauma; second, state-dependent learning does not adequately account for the absence of explicit memory and third, implicit memory does not map onto explicit memory in any direct or simple fashion." He notes that the "clinical application of current propositions about traumatic memory to patients without explicit memory of trauma may warrant considerable caution."

Sybil-The Making of a Disease: An Interview with Dr. Herbert Spiegel

New York Review of Books, April 24, 1997
Mikkel Borch-Jacobsen

The diagnosis of Multiple Personality Disorder (MPD) was born with the publication of *Sybil* in 1973. Although there were earlier books, such as *The Three Faces of Eve*, it was *Sybil* that tied MPD to child abuse, a notion that has become an essential feature of present-day MPD. MPD was included in the *DSM-III* in 1980 due to the efforts of Putnam, Braun, and Kluft.

Dr. Herbert Spiegel said that he did not believe Sybil suffered from MPD. He also said:

> "The therapists, with some exceptions, have become unconscious con artists. They are taking highly malleable, suggestible persons and molding them into acting out a thesis..."

> "I think in this respect that the MPD phenomenon of Sybil is an artifact that was created by Connie Wilbur..."

> "But I understand that the insurance companies are wising up and are cutting down on this. This may well be the end of the whole epidemic..."

When asked why he had not spoken out about this before now, Dr. Spiegel replied, "Because I was never asked as you are now asking me."

Returner and Retractor Research

FMSF Staff

In the April newsletter, we presented data from the Family Survey Update. We noted that 7% of the adult children of the families who returned the survey had retracted and about 25% had "returned." ("Returners" is the term that we use to refer to children who have returned to the family in some ways after a period of alienation and accusations but who do not talk about what happened.) What do we know about returners and retractors? How do families cope with the changed situations? This month we include (1) the results of interviews with nine families after their child had returned, (2) a summary of the retractor research and (3) an article by Joseph deRivera, Ph.D. that reports on some retractor research and its implications for returners.

Prior to the Family Survey Update, we conducted a series of three structured telephone interviews each with nine families over a time span ranging from eight to fifteen months, starting when they first notified us that their child seemed to be a returner. We hoped we might gain some insights into the family dynamics that lead from returning to retractions. The ages of the parents ranged from 56 to 84 and the accusers age ranged from 28 to 48 years old. One therapist sent a letter to the parents explaining how she reached her diagnosis of sexual abuse by using scores on Blume's "Incest Survivors After Effects Checklist," Fredrickson's "Symptom Checklist for Repressed Memories," and Whitfield's "Core Issues of a Person Raised in a Dysfunctional Family." They seemed typical of FMS accusations and families.

Most of these parents did not really know what brought about the reconnection to family. One mentioned it happened when the accuser had a baby. Another mentioned that her child returned on Mother's Day. Another said that illness in the family accounted for the return to the family. One person thought that her daughter returned because she had changed therapists while another believed that her intervention on behalf of the grandchildren was the reason.

In each of three interviews parents were asked about the amount of contact and the type of contact, and how that developed with time. In three cases the reconnection was with just the mother. Contact involved letters, phone calls and face-to-face meetings at family gatherings.Topics for discussion included such things as grandkids, daily life and baseball. The majority of parents indicated caution, but they also seemed upbeat ("it gets better," "felt good," "distance is closing"). In a few cases more negative statements were detected ("tired of the game," "felt the coolness," "feels superficial"). One family did not want to have a third interview. Their daughter had retracted and apologized and they just "wanted to put this behind them." In the nine families involved in the course of the year one family reported a retraction, two families indicated that communication did not continue, and the rest of the families reported that relationships seemed to be improving. None of the nine families was seeing a professional for help with reconciliation.

Although these data provide no clear guidelines for the hundreds of families who are now struggling with the problem of how best to handle family reconciliation, they indicate what occurred in a small sampling of families with returners.

Retractor Survey:

Harold Lief, M.D. (FMSF Advisory Board Member) and Janet Fetkewicz (FMSF staff) studied retractors to see if they could gain insights into the processes that take place. The FMS Foundation has helped a number of researchers make contact with retractors and a number of studies are emerging that are listed in the references.

Lief and Fetkewicz's first work involved obtaining basic profiles of retractors that included demographics, therapy history and family contexts. Their ground-breaking analyses of the comments of 40 retractors have informed everyone working in this new area. Lief and Fetkewicz identified specific themes that seemed to be involved with acquiring and later leaving false beliefs. Some of their findings have appeared in the Journal of Psychiatry and Law in 1995 and others are currently in review.

Janet Fetkewicz and Toby Feld are currently expanding on this work. Structured interviews with a much larger population are in progress. Not only do they hope to gain greater depth and detail, they want to identify specific groups for further research. For example, the March FMSF Newsletter contained a short notice of work about suicides and the MPD diagnosis. We will continue to work with other researchers and publish information in as timely a fashion as is possible.

Current Retractor Research

deRivera, J (in press). The construction of false memory syndrome: The experience of retractors. *Psychological Inquiry.*

Lief, H.I and Fetkewicz, J.M. (1995). Retractors of false memories: the evolution of pseudomemories. *Journal of Psychiatry and Law*, 23, 411-435.

McElroy, S.L. and Keck, P.E., Jr. (1995). The formation of false memories. *Psychiatric Annals*, 25, 720-725.

Nelson, E.L. and Simpson, P. (1994). First glimpse: an initial examination of subjects who have rejected their visualizations as false memories. *Issues in Child Abuse Accusations*, 6, 123-133.

First-Person Accounts by Retractors in Journals

Gavigan, M. (1992). False memories of childhood sexual abuse: a personal account. *Issues in Child Abuse Accusations*, 4(4), 246-247.

Hines, S.H. (in press). A retrospective tale of psychotherapy: An incest dream. *Psychotherapy Bulletin.*

Pasley, L. (1994). Misplaced trust: a first-person account of how my therapist created false memories. *Skeptic*, 2(3), 62-67.

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.** ***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.**

UNDERSTANDING FMS

Joseph deRivera, Clark University

We know from the reports of retractors that many people have developed false memory syndrome (FMS). Still, it is difficult for most of us to understand how this might have happened. In this article we describe three different ideas or models that may help explain how FMS could happen: mind-control, self-narrative, and role-enactment. We then describe a study in which we asked retractors if they felt that these models described their own experiences. Following is an abbreviated description of the three models:

Mind-control

The essential feature of mind-control is that a person's confidence is undermined. Lacking confidence, a person then allows someone else, an authority, to provide a story that accounts for the person's behavior. Because the authority figure usually controls information, behavior, thoughts and emotions, the patient's confidence is undermined. Information control is achieved by actively discouraging contact with people who think differently and by systematically distorting any disconfirming evidence. Behavior control is achieved by telling the person what to do and by requiring that the patient get approval for personal decisions. Thought control is achieved by a particular use of language. On the one hand, the language that is used overly simplifies issues and makes the person feel special and part of a group that is "good." On the other hand, the authority uses language that confuses the person's sense of guilt and responsibility. The language promotes a fear of what will happen if the patient leaves the authority figure. Although a person may feel ashamed or guilty because of making a false accusation, it is important for others to realize that in some sense she or he was not really responsible for the accusations the authority figure had the person make. (For further information see Steven Hassan, *Combating Cult Mind Control*).

Self-narrative

All people try to make sense of their lives by creating a story to explain why they behave the way they do. When people are unhappy, they may search for explanations from childhood in an effort to find an acceptable story. Because there are many books and people that talk about repressed memories, people may use their own imagination to create a story about how they were abused based on some isolated images and feelings. Gradually a person starts to make sense of problems by assuming that a horrible trauma must have occurred. A therapist may believe a patient's abuse story and help her to develop it. A therapist may assume the patient repressed a memory and may even become a coauthor of the story. In contrast with a mind-control model, however, the patient retains control and acknowledges that she or he was the author of the story. In this model, a therapist or well-meaning others can lead a person to give credibility to his or her own imagining. (See Ted Sarbin, A narrative approach to 'repressed memories' in the *Journal of Narrative and Personal History*, 1994).

Role-enactment

We all enact roles such as fathers or mothers, or teachers or students, prisoners or guards, etc. Recently, our society has created a new role, that of the "survivor" of abuse. Regardless of whether a person chooses that role or is cast in it, his or her behavior fits the expectancies of others. Survivors are expected to search for traumatic memories and discover horrible things that happened. They are rewarded when they play the role correctly and may be validated by others. This role, like any other role, has certain advantages and disadvantages. One of the advantages is that survivors of sexual abuse are not expected to be perfect husbands, wives, or parents. They are, however, expected to be justifiably afraid of, and angry at, those who "abused" them. A person may be somewhat aware that she or he is enacting a role or, like a good method actor, persons may almost completely forget that they have been cast into a role. In this model, a patient is not so much an author of a story (as in the narrative model) or the subject of a therapist's story (as in mind-control model), as they were actors in a drama that is being played out in our society. (See, for example, The account of role enactment in a simulated prison by Haney, C., Banks, C., & Zimbardo, P. in the *International Journal of Criminology and Penology*, 1971).

Do any of these ideas really apply to the development of FMS? We asked people who had actually experienced FMS if they feel that any or all of the ideas apply to their own experience?

A 14-page questionnaire was mailed to 159 retractors asking people to rate each idea (on a seven-point scale) as to the extent it was not at all (1) or completely (7) applicable to their experience[1]. 56 (35%) returned completed questionnaires.

The table below shows the number of people who reported that an idea fit their experience, as indicated by a rating of at least 5 ("captures a lot of my experience").

Number of Persons Endorsing Each Idea	
Idea 1 Mind-control	23
Idea 2 Self-narrative	10
Idea 3 Role-enactment	2
Idea 1 and idea 2	1
Idea 1 and idea 3	7
Idea 2 and Idea 3	3
All these Ideas	4
None of the Ideas	6

A majority of retractors endorsed the idea of mind-control and a therapist's "undue influence" is a factor in at least 63% of the sample. However, it is clear that mind-control is not the only factor involved in these cases, and 15 cases are better explained by the ideas

of self-narrative or role-enactment[2]. Since no one theory can account for all FMS cases, it is important for us to realize that there are different ways FMS can develop, and different factors that may be important in each individual case.

It may be easier for families to cope with FMS cases that involve mind-control or role-enactment. While there is little that can be done until circumstances lead to a cessation of therapy, once the undue influence is removed communication may sometimes be reestablished if the family understands how the person was trapped in an impossible situation.

To the extent that a person's own imagination is involved in a self-narrative, a family faces a difficult task because the accuser is immersed in a narrative that may function to explain problematic behavior, troublesome feelings, provide relief from self-blame, or provide sympathy. Whether or not such a self-narrative will change may depend a great deal on forces in the patient's situation that led her to therapy in the first place. If the person is no longer immersed in a group that encourages her to be a survivor, if the stresses that led the person to therapy are reduced, and if the person becomes more focused on current functioning rather than memories, she may be more open to alternative explanations. Because information from their families is so suspect by the accusers, it will likely be other persons, articles, TV shows, etc. that will suggest the possibility that at least some elements in the self-narrative may be incorrect. Families are important to most people. To the extent there are emotional bonds with family members it is likely that the accuser will want to have a coherent narrative that she can share with them.

Unless deliberate deceit is involved, it seems unwise for family members to insist that a returner make an acknowledgement of error. They may, however, begin to suggest alternative narratives that can explain problematic behavior. Disagreements can simply be acknowledged and communication can be reestablished. Until a person is able to create a different narrative to explain her problems, it will be difficult for her to fully relinquish the old narrative. A returner probably needs time and space to acknowledge the harm that has occurred. Sometimes within the context of the false narrative, a first step is for the accuser to state that she or he has "forgiven" the supposed perpetrator. To the falsely accused, it may seem ridiculous to be "forgiven" for something that was not done. At the same time, we have all made some mistakes and we probably all need some forgiveness. The emotional connection afforded by the forgiveness may pave the way for trust to be reestablished. It can be confusing and frightening to one's identity to recreate a self-narrative. Gentle patience, time, communication with other family members, or work with a good therapist may help the person to get on with life, explore issues of trust and, ultimately, create a more authentic self-narrative and even deeper relationships with family members.

References

(1) The first part consisted of 51 questions that asked about the process of therapy and how false memories developed, and the third part asked for background information and how the false memories were relinquished. (These results will be presented in a separate paper.)

(2) In fact, persons who experienced straight-forward mind-control may find it easier to retract once circumstances have led them to separate from their therapists. If so, our sample is skewed and there may be a much greater percentage of FMS cases to whom the second (or third) ideas apply.

"She has very self-destructive symptoms, but these began only after she started therapy."
A Sister

FOCUS on SCIENCE

This is the third in a 4-part series examining the question of whether childhood sexual abuse causes psychiatric disorders in adulthood. The series is not intended to "forgive" or exonerate the morally repugnant phenomenon of child sexual abuse in any way but simply to examine the methodology of scientific studies claiming that child sexual abuse causes adult psychiatric disorders. The remaining column in the series will appear in the next issue of the newsletter.

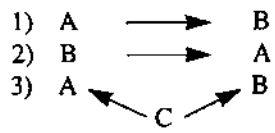
Don't Buy that Lawrence Welk Recording! The Problem of Confounding

Harrison Pope, M.D.

In the previous two columns, we have shown how selection bias and information bias seriously compromise virtually all retrospective studies. But let us suppose that our intrepid investigators of our previous two columns, Drs. Harrison and James, have now received an even larger research grant to do an even more refined study. They obtain a huge community sample, and select individuals with eating disorders and matched control subjects with careful attention to minimize selection bias. Then they interview subjects in both groups under blinded conditions to avoid any information bias introduced by the investigator. Instances of sexual abuse in both the eating disordered and control group are scored only if they are unequivocal and meet rigorous diagnostic criteria of demonstrated reliability. Further, let us suppose that the investigators are able to obtain confirmatory evidence in some manner to show that the sexual abuse actually did occur in the cases in which it is reported (this last item is probably a somewhat unrealistic expectation, but let us grant it for the purposes of argument). Let us suppose that, even with all of these rigorous methods to control for bias, Drs. Harrison and James still are able to show a statistically significant difference when they compare the prevalence of sexual abuse in the subjects with eating disorders and the control subjects. Can they now, at last, conclude that

childhood sexual abuse contributes to the etiology of eating disorders?

Unfortunately, they still cannot. We will now grant that they have shown as association between childhood sexual abuse and eating disorders. However, as we have stated earlier, the fact that there is an association between A and B does not necessarily mean that A caused B. In fact, logically, there are three alternative explanations for the association as shown in the following figure:



In examining this figure, let us assume that childhood sexual abuse is "A" and adult psychiatric disorder is "B." The first possibility, as the figure shows, is that A causes B. In this case, that would be the possibility that childhood sexual abuse causes adult psychiatric disorders. This of course in the hypothesis that we wish to test. But to *establish this possibility*, we must first rule out two other possibilities. First, we must consider the possibility that B causes A (i.e., that psychiatric disorder somehow predisposes to sexual abuse), and second, we must allow for the possibility that B and A do not cause one another, but both are caused by a third factor, C (which is often called a "confounding variable").

Let us look at these alternative possibilities. First, consider the possibility that B causes A. There are many examples of this type of association in ordinary life and in clinical medicine. Suppose, for example, that we interview 100 overweight subjects and ask them if they have a history of having used artificial sweeteners in their coffee at some time in the last year. We then pose the same question to 100 thin subjects. We find a highly significant difference showing a clear association between use of artificial sweeteners and being overweight. Do we conclude, therefore, that artificial sweeteners cause obesity? Clearly not. The true direction of causality is that B causes A, namely that being overweight leads individuals to use artificial sweeteners more frequently.

More difficult and less trivial examples come from clinical medicine. Thirty years ago, for example, a study found that agricultural workers who were more physically active were less likely to develop heart disease than sedentary agricultural workers[1]. Would it be correct to conclude, therefore, that being sedentary contributes to the evolution of heart disease? No. We must allow for the alternative possibility that workers who already had early symptoms of incipient heart disease (e.g. chest pain on exertion) would be more likely to choose sedentary agricultural jobs than their counterparts who had no symptoms of evolving cardiac disease. In other words, B may have led to A, rather than A to B.

Another obvious example exists in the area of sexual abuse: individuals with mental retardation are more likely to have experiences sexual abuse than individuals of normal intelligence[2]. But clearly it would be illogical to conclude that childhood sexual abuse causes mental retardation. Rather, mentally retarded individuals are more at risk for victimization because they are less able to defend themselves against abuse.

But do these arguments extend to adult psychiatric disorders? Is it reasonable to argue that bulimia nervosa or depressive illness, or anxiety disorders, appearing in an individual at the age of 20, could possibly have predisposed him or her to have been sexually abused at the age of eight? This possibility is not as far fetched as it might seem. Specifically, studies have shown that individuals with adult psychiatric disorders have often experienced prodromal symptoms (in other words, premonitory symptoms) of their disorders extending far back into childhood. For example, adults who display panic disorder or bulimia nervosa are more likely to have experienced fear of going to school ("school phobia"), fear of being separated from their mothers ("separation anxiety") or bedwetting ("primary enuresis") in childhood[3]. Similarly, individuals with eating disorders as adults often have histories of depressive or anxiety disorders long prior to the onset of the eating disorder[4]. Therefore, it is possible that some individuals with eating disorders in Harrison and James' study may have displayed a degree of depression or other psychological distress, even years ago in childhood, that rendered them more vulnerable to being preyed upon by potential abusers.

Admittedly, this particular direction of causality might account for only a small portion of the possible association between childhood sexual abuse and adult psychiatric disorders. However, we still have to rule out the last of the possibilities shown in the figure above, namely that A and B are both caused by a confounding variable, C. The issue of confounding is again a constant problem, both in ordinary life and in clinical medicine. To begin with a simple example, suppose that we were to study 100 residents of a nursing home and ask them if they had ever purchased a Lawrence Welk recording. Lawrence Welk was a famous performer many years ago, and his recording were very popular in the 1930's and 40's. Therefore, we would likely find that a high percentage of the nursing home residents reported that they had bought at least one such a recording at some time. If we then obtained a comparison group from the community at large, we would undoubtedly find that a far smaller percentage of our comparison subjects had made such a purchase. In fact, some of them would probably report that they had not even have heard of Lawrence Welk. Does it follow from our findings that buying a Lawrence Welk recording will cause

you to end up in a nursing home? Should we put warning stickers on all Lawrence Welk recordings in record stores, alerting potential purchasers of the risk? Clearly not. In fact, the association between ownership of Lawrence Welk recordings and nursing home residents is simply attributable to the confounding variable of advanced age. In other words, age is the "C" in the figure above.

Turning to medicine, the literature is filled with the corpses of theories that failed to take into account the possibility of confounding variables. Even elegant and expensive studies, involving big teams of investigators and hundreds of thousands of dollars in costs, have sometimes proved dead wrong when it was later discovered that a confounding variable had created a mere illusion of causality. Of many examples that could be cited, one was the finding of an association between the use of inhaled nitrites (so-called "poppers") and the development of AIDS[5]. In the early 1980's before the human immunodeficiency virus (HIV) had been isolated, various epidemiologic studies were conducted to assess what factors might cause people to develop AIDS. It was found that homosexual men who used "poppers" to get a "rush" during sexual activity were markedly more likely to develop AIDS than homosexual men who had not used these drugs. Some studies even conducted elaborate statistical tests, called regression analysis (to be discussed in more detail next month), in an attempt to rule out possible confounding variables. Nevertheless, inhaled nitrites still emerged as a statistically significant factor, and it was concluded that they might cause, or at least contribute to, the development of AIDS.

Now, of course, we know that nitrites do not cause AIDS, and that the disease is instead caused simply by infection with a specific virus, HIV. It turns out, in retrospect, that certain sexual practices that predispose to HIV transmission (especially receptive anal intercourse) are closely associated with use of "poppers." In other words, the association between nitrite use and AIDS was a real one, but it was not a causal association at all. Instead, the association was caused by the presence of a confounding variable, namely specific sexual practices.

Returning, then, to the new hypothetical study by Drs. Harrison and James, we see that an association between childhood sexual abuse and adult psychiatric disorder, however rigorously proved, might not be a causal association at all. it might simply be due to any of a number of confounding variables. Individuals who have been sexually abused in childhood are also likely to have been physically abused, neglected, or subjected to all manner of other difficulties while growing up. Even more importantly, there may have been a genetic loading in their families for disorders such as alcohol dependence or manic-depressive illness[6]. Relatives with alcoholism or manic episodes (the "high" periods of manic-depressive illness), in turn, may be more likely to abuse a child in the family. But that abuse victim already carries the genetic predisposition to develop psychopathlogy, even if she were not sexually abused. In other words, childhood sexual abuse and psychopathology would be expected to "travel together" down the family tree as a result of the confounding variable of genetics alone, even if the sexual abuse did not itself cause psychiatric disorders.

Data that support this speculation come from one recent study that described 12 sexually abused women with bulimia nervosa[7]. This study was one of the few in which the psychiatric diagnosis of the perpetrator, as well as that of the victim, was assessed. Of the eight women in this study found to have been abused by a biological relative, six (75%) were abused by a family member diagnosed with alcohol dependence, a major mood disorder (such as manic-depressive illness), or both. Now, there is substantial evidence that alcoholism and major mood disorders are more prevalent in the family trees of individuals with bulimia nervosa than in the population at large, raising the possibility that there is a genetic link among these various disorders[8]. It is possible, therefore, that genetic factors alone might account for the association of sexual abuse and bulimia nervosa observed in this investigation, and that sexual abuse itself had no role in causing the adult eating disorder at all.

In summary, association does not prove causality. This is not a difficult concept. It represents one of the most basic teachings of "Psychology 101." And it is easy to illustrate, as shown by our examples of the association between use of artificial sweeteners and obesity, or purchase of a Lawrence Welk recording and nursing home residence. Yet this elementary principle is ignored, or only barely acknowledged, in many scientific studies of childhood sexual abuse. It is even more rarely noted in popular reports of these studies in the media. The lay reader, hearing the latest media report of a new "major study" like that of Drs. Harrison and James, must be wary. A history of childhood sexual abuse may well be associated with some adult psychiatric disorders, but it is premature to jump from this finding to an assumption of causality.

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This column appears as a chapter in the book, Psychology Astray: Fallacies in Studies of "Repressed Memory" and Childhood Trauma, by Harrison G. Pope, Jr. M.D., Social Issues Resources Series, 1996. Copies of this book are now available 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.

In the 12 months ending last June (1996), 182 adults, nearly all of them women, called or visited Nebraska sexual assault centers about childhood sexual abuse. That's more than the number of children treated for sexual assault at the same centers and nearly as many as those seeking help after being assaulted as adults.

Omaha World-Herald,
March 2, 1997 "Repressed Memories Illustrate Horror of Sex Abuse"

The first annual meeting of the National Feminist Alliance of CSICOP (Committee for the Scientific Investigation of Claims of the Paranormal) will be held on June 6 and 7 in Boulder, CO. One focus of the conference is the impact of gender politics and feminist rhetoric on the field of psychology. Speakers include Elizabeth Loftus and Debra Nathan. The keynote address by Carol Tavris is entitled "Back to Rationality."

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LEGAL CORNER

Illinois Appellate Court Holds that Therapist Owes a Duty to Third Party

Doe v. McKay, Illinois Appellate Court, 2nd District,
No. 2-96-0532, March 17, 1997[1]

An Appellate Court in Illinois found that a therapist's duty to the patient to use reasonable care in the treatment process is extended to the parent. The case involved allegedly repressed memories of sexual abuse where the parent was brought into the treatment process by the defendant psychologist.

From 1990 through October 1995, Jane Doe, the plaintiff's daughter, underwent psychological treatment under the care of the defendants. During the course of that treatment, she says she discovered repressed memories of alleged sexual abuse by plaintiff. Plaintiff denied that he ever abused his daughter. During three joint sessions that included the plaintiff, Jane Doe, at the direction of McKay, accused her father of sexual abuse. McKay allegedly repeatedly suggested that plaintiff might further harm the daughter. McKay also advised plaintiff that he had repressed memories of his abusive conduct and that he should begin psychological treatment. Plaintiff paid defendants over $3,000 for services rendered to his daughter during 1992.

In 1994, the father sued McKay and her professional association.The first amended complaint lists 17 counts, but only causes of action concerning two issues were considered on appeal: the negligent treatment of Jane Doe which deprived plaintiff of the loss of his daughter's society and companionship, and intentional interference with the parent-child relationship. The trial court had dismissed these claims, holding that they were not recognized by Illinois law. The other claims remain pending at the trial court.

The appeals court noted that a third party generally cannot maintain a malpractice action in the absence of a direct physician-patient relationship between the doctor and the patient. The court reversed dismissal of the claims, holding that a special relationship existed between the patient and the third party under the doctrine of transferred negligence.

The appeals court cited Renslow v. Mennonite Hospital, 67 Ill.2d 348 (1977), in support of its decision. In Renslow, the Illinois Supreme Court held that logic and sound policy required the creation of a legal duty on the part of a hospital to a child born of a mother treated in the hospital. That court noted that derivative actions, such as those of a husband or parent for the loss of the wife's or child's society, demonstrate that the law has long recognized that a wrong done to one person may invade the protected rights of one who is intimately related to the first and therefore recognizes a "limited area of transferred negligence."

The appeals court said that transferred negligence was applicable to the "unique circumstances" in this case. "In determining whether a duty exists, the court must weight the foreseeability of the injury, the likelihood of the injury, the magnitude of the burden of guarding against it, and the consequences of placing that burden on the defendant," citing Gouge v. Central Illinois Public Service Co., 144 Ill.2d 535, 542 (1991).

"Key to this finding are the special relationship plaintiff shares with his daughter and the therapist's action to bring plaintiff into the treatment process," the court said. "Once plaintiff was immersed in his daughter's treatment process, as a quasi-patient himself, it was not only reasonably foreseeable, but a virtual

certainty, that McKay's conduct would harm plaintiff's relationship with his daughter." Therefore, the court said, the defendants' duty to use reasonable care in the treatment of their patient extended to the father, referring to Tuman v. Genesis Associates, 894 F.Supp. 183, 187 (E.D. Pa. 1995).

The court said that "[t]he risk and magnitude of harm to our society, namely, tearing a family apart without regard to the manner in which false accusations of sexual abuse are made, is so significant that it requires the protection of our law. A therapist's allegedly erroneous conclusion that a patient has been sexually abused by a parent endangers the parent-child relationship, and that where the therapist draws the accused parent into the patient-child's treatment, accusations of sexual abuse are undeniably devastating and may not be made with impunity and disregard of the therapist's obligation of reasonable care."

The court continued, "The therapist is in the best position to avoid such harm and is solely responsible for handling the treatment procedure. Defendants could have warned plaintiff and his daughter of the controversial nature of repressed memory therapy in separate sessions. We therefore hold that in a case such as this involving repressed memories of sexual abuse, where the parent is brought into the treatment process by the therapist, the therapist's duty to the patient to use reasonable care in the treatment process is extended to the parent."

Attorney for plaintiff John Doe is Zachary M. Bravos of Wheaton, Illinois.

(1) See FMSF Brief Bank #46.

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Minnesota Court of Appeals in Unpublished Opinion Declines to Recognize Duty to Third Party

Strom v. C.C., 1997 Minn. App. LEXIS 327
March 18, 1997

In March 1997, a Minnesota Court of Appeals declined to extend the law to recognize a duty to third-party non-patients when there is no contractual relationship, duty to warn, or duty to control, citing McElwain v. Van Beek, 447 N.W.2d 442, 445-46 (Minn. App. 1989), review denied (Minn. Dec. 20, 1989). It affirmed summary judgment dismissing defamation claims against two nephews who had alleged that Everald Strom had sexually abused them as children. It also affirmed dismissal of defamation and negligence claims against the nephews' therapists.

In its unpublished opinion, the court stated that not recognizing a duty to third-party non-patients is consistent with established public policy because imposing a duty on therapists to protect the interests of falsely accused individuals would adversely affect the interests of sexual abuse survivors in effective and uninterrupted therapy.[2]

The court noted that with a charge of negligence, the inquiry is not whether there is probable cause to believe that Strom actually sexually abused his nephews. The issue is whether the nephews or the therapists had a sufficient basis for believing that his own statements regarding Strom's conduct were true. The court wrote it could not conclude the nephews did not have a valid reason for believing they were speaking the truth because some of the memories allegedly developed prior to therapy. The court also concluded that the therapists had reasonable and probable cause for the statements they made. On the other hand, the court recognized that one nephew's memories "may not provide an accurate source of information as to Strom's past conduct" and he would "not be allowed to testify as to memories that came about as the result of therapeutic hypnotic recall, robust memory recall, or recalled memory from traumatic amnesia."

(2) The court cited Bowman and Mertz (1996), "A dangerous direction: Legal intervention in sexual abuse survivor therapy, 109 Harv. L. Rev. 549, 586-90.

❑

Question of Duty to Third Party by Therapist May Be Considered by Federal Appeals Court

On March 22, a U.S. District Court certified an interlocutory appeal in a third-party suit, Lindgren v. Moore, 1996 U.S. Dist. LEXIS 3450. The order refers to an earlier Memorandum Opinion, Lindgren v. Moore, 907 F.Supp. 1183 (U.S. Dist., Sept. 29, 1995) which had let stand two counts against a therapist and her supervisor for IIED and loss of society. Defendants wish to appeal the denial of their motion to dismiss those claims with a decision on whether Illinois law recognizes a third party cause of action and whether defendant therapists owed a duty to any plaintiff which was breached here. In certifying the appeal to a Federal Appeals Court, it was noted that because any later trial decision could require reversal if decided incorrectly, it is prudent to decide the question of duty now.

❑

Jury Finds for Doctor in Repressed Memory Trial

Sullivan v. Cheshier, U.S. District Court, verdict
April 2, 1997

On April 2, 1997, a U.S. District Court jury found in favor of unlicensed clinical counselor Dr. William Cheshier. The suit against Dr. Cheshier had been filed early in 1993 by the parents of one of his patients. The parents alleged that the doctor, using hypnosis, had implanted false memories of sexual molestation in their daughter.

In 1994, U.S. District Judge James B. Zagel[3] had allowed the parents to proceed to trial on three counts: malpractice, loss of companionship and society, and public nuisance (persons injured by one who practices clinical psychology without a license have a right of action under the Illinois Clinical Psychologist Licensing Act). However, on the day of trial, U.S. District Judge Elaine E. Bucklo limited jury consideration to only one count: loss of society and

companionship. In addition, Judge Bucklo ruled that the plaintiffs must prove the injury to their family relationship was inflicted by defendant's reckless or intentional acts which were directed toward them.

At trial, the plaintiffs' daughter, Kathleen, age 30, admitted that she had not thought about being the victim of childhood abuse until she was treated by Cheshier and that after only a few sessions, Cheshier suggested to her that hypnosis might offer some insight into her troubles. She agreed to undergo hypnosis and after several sessions she claimed she gradually realized she had been physically tormented and molested by an older brother. Kathleen denied, however, that her therapist's actions injured her family relations.

In reviewing this verdict, it may be useful to recall the summary of issues as given by Judge Zagel in March 1994, "Dr. Cheshire told [the Sullivans] he had hypnotized Kathleen Sullivan and while under hypnosis she stated that she was abused by an older sibling...The Sullivans conducted an investigation of the truth of the statements and found no evidence to corroborate the statements and have a witness who denies the truth of the statements. Prior to Dr. Cheshier's hypnosis, Kathleen Sullivan never made similar statements. Finally, there is the statement by Kathleen Sullivan while being treated by Dr. Cheshier, arguably admissible under F.R.E. 803(2) or 803(3), that she would decline all family contacts unless family members admitted the statements were true...There is no question that after the statements were made by Kathleen Sullivan her relations with her parents and siblings changed for the worse. It would be hard to doubt that the family relationship would be seriously and negatively affected in this situation. A trier of fact could reasonably lay it at Dr. Cheshier's door."

Thomas P. Ward, attorney for the Sullivans, said that a motion for new trial has been filed in District Court.

(3) Sullivan v. Cheshier, 846 F.Supp. 654 (N.D. Ill., Mar. 2, 1994).

❑

Minnesota Psychologist Accused of Planting False Memories in Patient

Doe v. Fredrickson, District Ct., Second Judicial Dist., Ramsey Co., Minnesota, Case No. C6-97-3540[4]

In a Complaint filed April 4, 1997, Dr. Renee Fredrickson, a St. Paul psychologist and author of a book on repressed memory therapy was accused by a former client of implanting horrifying false memories. The woman, identified as Jane Doe in the lawsuit, alleges that Fredrickson negligently used hypnosis, guided imagery, dream interpretation, automatic writing, "body memories" and other "memory recovery" methods to implant terrifying false memories of "ritual cult abuse," torture, and murder. Doe alleges that Fredrickson failed to obtain informed consent or to inform her that the techniques used are known to produce vivid, convincing, but false "memories." As a result of Fredrickson's "treatment," Doe became suicidally depressed for the first time in her life and made false accusations to her immediate and extended family. Her family relationships were shattered by these accusations.

Doe's husband attended some of his wife's therapy sessions and under the "advice" of Fredrickson came to believe his wife's emerging "memories" were true. He witnessed his wife's deterioration while under Fredrickson's "treatment" and was told that such deterioration, including suicidal depression, was a sign that the "repressed memories" were surfacing and that the "cults" had "programmed his wife to kill herself if she ever remembered or told others about the cult."

Jane Doe and her husband have also filed complaints to the Minnesota Board of Psychology seeking the revocation of Fredrickson's license to practice psychotherapy.

Jane Doe is represented by William Mavity of Minneapolis and R. Christopher Barden of Plymouth, Minn.

(4) See, FMSF Brief Bank #138.

(5) Fredrickson, R. (1992), *Repressed Memories: A Journey to Recovery from Sexual Abuse*, New York: Simon and Schuster.

❑

Editor's note: *In March 1997, U.S. District Court Judge John R. Padova revisited two of the many lawsuits which involve a Philadelphia mental health clinic called Genesis Associates, psychologist Patricia Mansmann and social worker Patricia Neuhausel.[6] As described below, both of these suits are spin-offs from a third party suit filed in 1994 against Mansmann, Neuheusel and Genesis Associates by the parents of a former patient.[7]*

Pennsylvania Court Considers Whether Patient Could Have Understood That Therapy Caused Injury While She Was In Therapy

Lujan v. Mansmann, Neuheusel, Genesis Associates, 1997 U.S. Dist. LEXIS 2960 March 14, 1997

In this case, brought by former patient, Brooke Lujan against Genesis Associates, U.S. District Court Judge John R. Padova rejected defendants' motions to dismiss all but one of the charges against them. Defendants had argued that Lujan's claims were barred by the statute of limitations. Lujan had entered treatment with them in 1990 but did not file her initial complaint until July of 1996.

Judge Padova left standing claims of negligence, breach of contract, willful, reckless and wanton misconduct, intentional (IIED) and negligent infliction of emotional distress, and breach of confidentiality. In doing so, the court applied the objective standard used in Pennsylvania to determine whether a reasonable person in plaintiff's position would have been unaware of the salient facts. The court quoted extensively from Plaintiff's Amended Complaint and decided that it could not, at this stage of the proceedings, conclude that the time it took Lujan to discover any injury, or

the cause of that injury, was unreasonable as a matter of law.

Significantly, the court continued, "the dynamics of the psychiatrist-patient relationship contribute to this finding. Patients do not immediately assume their treating psychiatrists are perpetrating tortious acts through harmful and psychologically damaging treatment. Instead, patients are reluctant to either impute ulterior motives to the advice of their psychiatrist or automatically question the propriety of the psychiatrist's treatment. Lujan may have had no idea, as a lay-person, what 'proper' and 'improper' treatment was. Lujan, quite typically, may have assumed her psychiatrist was providing proper treatment and may not have become suspicious until December, 1995."

Lujan's Complaint states that it was not until December 1995 when she received information about her parents' lawsuit[7] against her therapist, that she "began to question the veracity of her memories and the appropriateness of the treatment she received from defendants." She further states that defendants failed to meet a standard of care by encouraging her "to believe in certain memories, including memories of satanic abuse, satanic murders and deviant sexual assaults;" convincing her that "she was being stalked by a cult and that her life was in danger;" and inducing her to undergo plastic surgery "to alter her features so that the 'cult' would have a more difficult time finding her."

The Complaint also alleges that defendants encouraged her to detach herself from her parents and cut all communication with them except for financial matters; prevented her from completing her college studies; and did not request needed medical treatment in a timely way following "rage therapy."

❑

Pennsylvania Psychologist Sues Parents of Former Patient for Defamation

Mansmann v. Tuman, et al., 1997 U.S. Dist. LEXIS 3291
March 13, 1997

In 1996, after psychologist Patricia Mansmann was granted summary judgment from a third party malpractice suit,[7] she sued the parents and the parents' attorney who had filed the earlier action against her. She alleged that the Tumans and their attorneys had acted "with actual malice" and "merely for purposes of harassment or to maliciously injure" her. U.S. District Judge John R. Padova dismissed all counts against the defendants except the defamation charge against the Tumans and the charge of interference with business relations against the Tumans and one of their attorneys. Judge Padova noted that Mansmann's Amended Complaint "is long on Defendants' intentions and short on their implementation of the intentions."

Judge Padova dismissed the charges that the Tumans and their attorneys had made wrongful use of civil proceedings by filing the suit against her without fully investigating the allegations. Judge Padova notes that although Mansmann alleges they had no probable cause to continue the lawsuit, based on evidence adduced during discovery, she gives no clue as to what that evidence might have been nor does she support her claim of improper motive.

Charges of defamation, interference with business relations and intentional infliction of emotional distress stemmed from allegations that the Tumans (and their attorneys) made statements that Mansmann had committed professional malpractice and misconduct, had given their daughter treatment she did not need for monetary gain, and had forced the daughter to distance herself from her parents and to detach entirely from them. Mansmann alleged that such statements were made "regularly and with malice" in documents to the Court, various police and other investigative agencies, orally at deposition, to psychological professional organizations, at public meetings, and to the media. Mansmann also claimed that the defendants attended numerous meetings in an attempt to put her out of business and see her stripped of her license to practice.

The court held that judicial privilege would apply to statements the Tumans and their attorneys made in the context of their suit, but not to statements made in other contexts. Judge Padova concluded that, accepting all the facts alleged in the Amended Complaint as true and liberally construing it in the light most favorable to Plaintiff, the defamation and interference claims survives the Tumans' motion to dismiss. The interference claim also survives against one attorney who attended meetings. However, Judge Padova dismissed all claims of intentional infliction of emotional distress, finding that the conduct alleged was not sufficiently extreme or outrageous as to sustain that cause of action.

(6) Several other lawsuits are currently pending. See *FMSF Newsletter*, Oct. 1996.

(7) The first lawsuit against Genesis Associates was filed in 1994, see, Tuman v. Genesis, 894 F.Supp. 183 (U.S. Dist., July 20, 1995); Tuman v. Genesis, 1996 U.S. Dist. LEXIS 5406 (April 25, 1996). In that case, parents of a Genesis patient alleged that through the psychological counseling provided to their daughter, false memories of satanic rituals were implanted in her mind. The parents alleged that defendants had encouraged their daughter to move to another state and cut off communication with them. In 1996 charges against psychologist Mansmann were dismissed by Judge Padova who agreed that there was no evidence that Mansmann had treated the daughter. In June 1996, the remaining defendants settled out of court.

See also, FMSF Brief Bank #60 and PBS Frontline Film "Divided Memories" April 11, 1995.

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Father Wins Million Dollar Jury Award Against Minirth Meier Clinic

WORLD Magazine, April 5, 1997, Bob Jones

Early in April 1997, an Atlanta jury awarded a father $1 million in compensatory damages after he was falsely accused of abusing his minor children. The father and his wife had sued a Minirth Meier New Life Clinic after the clinic reported suspected abuse of his minor children to DDS simply because he had told them he himself had been

physically abused. The father phoned the clinic after hearing a radio broadcast saying that those who were abused as children are likely to grow up to be abusers themselves.

After the jury verdict in his favor, Mr. Rogers said that more important than the money was the return of his good name.

❑

Two Panels of Michigan Court of Appeals Reach Different Conclusions in Repressed Memory Cases

Two recent Michigan Appeals Court decisions have drawn different conclusions about the intent of the Michigan Supreme Court decision, Lemmerman v. Fealk, 534 N.W.2d 695 (Mich., 1995),[8] in decade-delayed cases where there is some admission by the defendant. In both cases, the defendants admitted there had been some contact years earlier but denied any sexual abuse.

One court[9] noted that the Lemmerman opinion specifically stated that under current Michigan statutes, even upon presentation of "objective and verifiable evidence" of plaintiff's claim, neither the discovery rule nor the insanity exception extend the limitations period for tort actions allegedly delayed because of memory repression. That court concluded that footnote 15 to the decision does not carve out exception to the general holding in Lemmerman but merely deals with the retroactive effect of the decision. If the Lemmerman court had intended to create an exception to the statute of limitation, "it would have done so in the test opinion, rather than in the footnote."

Four days prior to the Guerra ruling, another panel of the Michigan Court of Appeals,[10] in an unpublished ruling, allowed a repressed memory claim after concluding that Lemmerman did "not address cases in which the defendant admitted sexual contact...Express and unequivocal admissions remove those cases from the area of stale, unverifiable claims such as the two repressed memory cases in Lemmerman."

(8) See, *FMSF Newsletter*, July/August 1995 and FMSF Publication #837.
(9) Guerra v. Garratt, 1997 Mich. App. LEXIS 92 March 14, 1997.
(10) Demeyer v. Archdiocese of Detroit, et al., *Lawyers Weekly*, No. 28395 (4 pages), March 1997, unpublished per curiam.

❑

Nebraska Supreme Court Affirms Dismissal of Repressed Memory Suit

Teater v. State of Nebraska, 252 Neb. 20, Neb., March 14, 1997

The Nebraska Supreme Court affirmed dismissal of a repressed memory claim, finding it barred by the statute of limitations. The court upheld the trial court's finding that plaintiff, Teresa, age 36, had failed to meet the burden of proof that she suffered from a mental disorder which would prevent her from understanding her right to maintain a legal action. Although Teater alleged in her petition that she was unaware of any sexual abuse by her foster father, the court found that Teater was aware of the alleged abuse when she reported it to school officials at the age of 14. The court found that Teater's denial of knowledge of the abuse thereafter was inconsistent with her own actions.

Teater sued the State for negligence in its failure to supervise and monitor her placement with the foster family. She states that it was not until 1992, when she learned she was a ward of the state during the period of the alleged abuse, that she was able to discover her cause of action against the state. The court held that because Teater had not sufficiently pled that the state wrongfully concealed the fact that her status was still as a foster child, that the theory of fraudulent concealment could not be invoked.

Therefore, the court held that the cause of action as pled was barred by the statute of limitations.

❑

Canadian Repressed Memory Case Ends in Acquittal

Regina v. Ross, Supreme Court, Northwest Territories, Canada, No. 02958 March 11, 1997[11]

After hearing the evidence in a Canadian criminal case based on repressed memories, Justice V. A. Schuler found that a young woman's claims of sexual abuse, including intercourse with a neighbor over 10 years earlier, included many inconsistencies that in combination caused "a great deal of concern about the reliability of the complainant's evidence." Justice Schuler concluded that the Crown had not met its burden of proof beyond a reasonable doubt. Therefore, the defendant was found not guilty.

Justice Schuler specifically noted the contradictory testimony from the complainant and the complainant's therapist as to how the "memories" developed. The complainant stated she blocked the memory until her therapist asked her repeatedly whether the defendant had abused her and told her to think "really hard" about it. The therapist was adamant that she had not told the complainant to think really hard about whether the accused had abused her and denied being the first to bring up the question of abuse.

Justice Schuler's discussion of these discrepancies is quite interesting, "I have to ask myself, Did these further memories flow from, were they suggested by, the idea that the complainants' problems might be explained by the sexual abuse? ...If I reject the complainant's evidence about how the disclosure came about and accept the [therapist's] evidence that she had not been the first one to bring up the question of abuse, then I am still left with the question about the further memories after the counseling session, and I am left with a question about the reliability of the complainant's memories generally."

(11) Transcript of Reasons for Judgment delivered by Justice V.A. Schuler on March 11, 1997 available as FMSF Brief Bank #139.

Eighth Circuit Court of Appeals Revisits Child Sexual Abuse Case

United States v. Rouse, 1997 U.S. App. LEXIS 6659
April 11, 1997

A three-member panel of the 8th Circuit Court of Appeals reconsidered the convictions of four Native American men for sexual abuse of several young children. In November 1996, the divided panel had reversed and remanded the cases for new trial on the grounds that the district court erred in excluding certain expert opinion testimony regarding the effect of repeated questioning on the young children and in denying defendants' motion for independent pretrial psychological examinations of the abused children.[12]

On reconsideration of the parties' contentions, the panel, again divided, now affirmed the convictions. The opinion concluded that the defense had not established sufficient cause to conduct additional medical or psychological examinations of the children and therefore the district court did not abuse its discretion in declining to order DSS to subject the children to further medical or psychological examinations.

The new majority of the 1997 Circuit Court panel now concluded that exclusion of a portion of the defense expert testimony that opined on the impact of questioning by specific individuals was harmless error—a conclusion with which the dissent strongly disagreed. The dissent stated that the jury needed the excluded expert testimony to render a truly informed judgment about whether the children's testimony resulted from implanted memory.

(12) A summary of the panel's ruling in November 1996 can be found in *FMSF Newsletter*, Feb. 1997, pp 11-12. U.S. v. Rouse, 100 F.3d 560 (8th Cir., 1996).

❑

Legal "Briefs"

The unpublished decision from a Washington State Appellate Court in the case, Jamerson v. Vandiver, reported in last month's *FMSF Newsletter* has been published in part as Jamerson v. Vandiver, 1997 Wash. App. LEXIS 492 (filed April 7, 1997).

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On April 15th, the FMS Foundation submitted an *amicus curiae* brief to the Tennessee Supreme Court on behalf of the Defendant/Appellee in the case, Hunter v. Brown, No. 03S01-9607-CV-00070. The brief considered issues raised by "repressed memory" claims under the reasonable person standard for application of the discovery rule. It also reviews factors leading to the development of false memories, the repressed memory debate, current scientific findings, and relevant case law in other jurisdictions. The brief is available as FMSF Publication #812.

BOOK REVIEW

SECOND THOUGHTS: Understanding the False Memory Crisis and how it could affect you.

Dr. Paul Simpson
Thomas Nelson Publishers
246 pages, paperback $12.99
Reviewer: Robert McKelvey

"A local chapter of the FMS Foundation had just been formed in the Phoenix area...I decided to attend their next meeting, convinced that I would encounter a room full of pedophiles and satanists. I couldn't have been more wrong. Here were families that represented the very heart of the American family. They had lived productive lives, raised their children, worked in their professions. Their grown children had gone into therapy, and from there, with little warning, the nightmare had begun..."

The speaker is Dr. Paul Simpson, describing how he began his tortuous climb from the dark pit of repressed-memory belief back into the light of reality.

In the wacky world of regressionist therapy, psychologist Simpson is a rare figure—rare because he is both a dedicated scientist AND a devoted Christian. He also is a onetime regressionist-therapist who embraced repressed memory therapy (RMT), infected clients with the plague of false memories, then saw the light, retracted, and tried to salvage the lives of those he had harmed. Today Dr. Simpson wields his speaking, writing, and teaching skills in a crusade to stamp out the RMT doctrine he views as monstrous.

"...I write to you out of moral imperative," Simpson proclaims. "What is happening in the False Memory Crisis is wrong, horrifically wrong..."

"*Second Thoughts*" is Simpson's way of presenting the case against RMT in a readable fashion. The author deliberately avoids what he calls a "textbookish" writing style in favor of one more familiar to general readers. In doing this, however, he avoids any temptation to "write down" to his audience.

The book devotes considerable attention to what science knows about memory—how it works and how it doesn't work. Simpson also devotes a chapter to his argument that Christian counselors who practice regressionist therapy are flouting church principles, such as "Honor they father and thy mother..." His conclusion: "regressionism is not a doctrine taught anywhere in the Bible." "The reality is that the Christian regressionist and client are not engaging in an act of faith," writes Simpson. "What they're doing is classic hypnotic trance."

Although Dr. Simpson's book should become a powerful weapon in the inter-church struggle over THE repressed-memory issue, I found it equally valuable for providing

insights into some of the mysteries of the false memory crisis.

One mystery is this: Why is the false memory crisis no longer exploding? Speakers at the recent Baltimore FMSF conference acknowledged that the foundation is receiving fewer contacts; lawsuits have radically fallen off; the press publishes more and more positive stories debunking recovered memories; retractors and their families are winning million-dollar judgments against therapists; insurance companies are refusing to insure RMT therapists.

Despite all these signs, there is no indication that psychotherapists have revised their belief in regression therapy. As "*Second Thoughts*" points out, one study showed that 71 percent of doctoral level psychologists have made use of regression techniques in an effort to recover repressed memories in clients. Another study finds "a stunning 83 percent of therapists believe that hypnosis counteracts the defense mechanism of repression."

Most observers have seen little change in the views of regressionist practitioners. Simpson himself concedes he had little success in efforts to change the minds of zealous Christian regressionists.

So, once more, why is the memory crisis no longer exploding? Perhaps we've been looking in the wrong place for the answer. Most observers focus on the therapist as the main partner in the RMT *folie a deux*, while minimizing the role of the client. Simpson offers another possibility.

In the chapter "Monsters From Within," Simpson points to research that shows a small but significant percentage of the population (4 - 10 percent) is highly susceptible to hypnotic suggestion. These people are described as "fantasy prone" and "Grade Five Personalities." Whatever the label, they are so easily hypnotized that they are able to put themselves in a trance without the aid of a hypnotist. (An example would be Paul Ingram, the imprisoned Washington state father who could implant false memories in himself.)

We frequently hear this argument about the false-memory phenomenon: "It could happen to anyone." But could it?

Using Dr. Simpson's data, we might raise this question: Is being a "Grade Five" a necessary prerequisite for becoming an RMT dupe? And is it possible that the supply of these candidates is quite small, not enough to sustain the RMT craze at a fever pitch indefinitely? To find out, we need to look at women who entered regression therapy, but never abandoned reality in favor of false memories.

While readers should find "*Second Thoughts*" a persuasive argument against RMT's True Believers, some may find a few regrettable omissions in the book. One is the lack of an index. Another is the shortage of details when Dr. Simpson talks about his own experience as a regressionist therapist. He is silent about the number of clients treated; how many of them were saved; how many continue to revel in their repressed memories. Most importantly, he fails to tell how many, if any, of his clients never bought into the theory at all.

Regardless of these minor quibbles, readers all can agree with Dr. Simpson's conclusion about RMT believers and victims: "The funny thing is, truth never asks our permission, it just is. And those who fail to conform their lives to truth are ultimately doomed to be crushed by it."

Robert McKelvey retired after 20 years as a reporter for the Cleveland Plain Dealer. He is currently working to educate church leaders about the harm that can come to families because of false memories.

"Our daughter is wallowing in a sea of polluted memories."

A Dad

Review of The Counseling Psychologist: Delayed Memory Debate, 23 (April 1995)

Robyn M. Dawes
Carnegie Mellon University

This issue of *The Counseling Psychologist* has been widely advertised as one devoted entirely to the "delayed memory debate." Most of it is, but rather than consisting of a number of articles of roughly equal length and importance, it contains a major paper by Caroline Zerbe Enns, Cheryl L. McNeilly, Julie Madison Corkery, and Mary S. Gilbert (University of Iowa)—followed by a number of comments of people who can be roughly categorized as "pro" or "anti" the attempt in therapy to recover repressed memory of sexual abuse, particularly in satanic cult rituals.

The major contention of the Enns et al article is that the debate over the validity of delayed memories must be understood "within the historical context." That begins as a reasonable hypothesis, because there are many phenomenon that are best understood with context. What is much more questionable is the claim that a phenomenon that is very difficult to understand (the nature of the recovered memories) can be understood only by first assessing something that is even more difficult to understand (a broad historical context involving a "male dominated" culture).

Moreover, this broader context is not understood on the basis of what could be called "science," but rather on the basis of ideology. Thus, the core of the argument is that since the study of recovered memory might be best understood by investigating it within the context in which it occurs (a possibly true argument), ideological assertions about this context imply factual knowledge about delayed memory (an unjustifiable leap from the premise). Many of these understandings, moreover, are just assertions. For example, some authors are quoted approvingly

as stating: "We *believe* that the greater the degree of male supremacy in any culture, the greater the likelihood of father-daughter incest" (pg. 193, italics added). Enns et al. themselves move from belief to appearance when they write: "However, the outcry about false memory *seems* to *reflect* in part the type of reaction that often occurs when women and victims appear likely to gain real power in a tangible recourse for gaining justice"(pg. 197, italics added). But what it is that is apparently reflected, and other appearances, do not constitute justification. The authors realize that gap when they write: "until further research is conducted, it is impossible to draw any firm conclusions about the accuracy of these memories"(pg. 207). In the meantime, unfortunately, they move from belief and appearance to made-up statistics. (No one could possibly estimate the percentage of reports that are accurate versus inaccurate on the basis of what is currently known.)

It is possible to reach a valid con*clusion* from a dubious premise (as a form of "material implication"), and Enns et al. occasionally offer pretty good advice—mainly about being cautious. In the meantime, however, the authors accept many assertions as factual for which there's very little evidence at all. For example, they believe that abreaction, or at least "working through" previous negative experiences (especially childhood ones), is an important part of therapy. That is their prerogative as therapists. As commentators, however, they should not refer to such phenomenon as if they were established facts, which they are not. The "Dodo bird" finding—that aside from specific cognitive and behavioral "protocol" therapies for well-defined problems (e.g. phobias, unipolar depression) all those based on the "therapeutic alliance relationship" do about equally well—contradicts the idea that there are certain critical characteristics of good therapy.

Finally, I question the statements that transformation from visual to verbal form are necessary in order to understand anything, because many of us progress in the opposite exact direction; that is, we believe we do not understand anything until we have transformed the mere words describing it into some sort of visual coherence, even "vague visual forms." There is a certain imperiousness in arguing that "if the client's memory consists primarily of imagistic or motor impressions rather than verbal, lexical memory, it may be possible for clients to arrive at 'gut feelings' about the past without achieving *full verbal recall*" (pg. 240, italics added)—without suggesting that this "full verbal recall" may in fact be a source of distortion not only of historical reality but of internal feelings and attitudes as well. Those of us who change in the opposite direction do not insist that everyone who things verbally has not "achieved understanding" until they "progress" in *our* preferred direction.

Nevertheless, I want to emphasize in finishing my discussion of the Enns et al. article that they do often urge people to be cautious about interpreting what a recovered memory means—in particular assuming it is (is not for that matter) historically accurate. The fact that they do not urge similar caution along the way about such things as using a Gestalt-chair experience is secondary. Even the vague and platitudinous nature of their final comments about training and social change issues can be forgiven, because that quality is not unique to them, but shared with many people who propose "standards" based on training and "consideration" as opposed to what practitioners actually do. (The platitudinous nature of these recommendations can be understood by inserting the word "not" in them. For example, we should not encourage faculty and students to pursue research on child sexual abuse in order to understand it better.)

The commentators contributions can be pretty well predicted from their reputations. Beth Loftus emphasizes "*primum non nocere*" and discusses burden of proof. She also writes (pg. 302): "Although many of the women claimed they had corroboration for their abuse, Herman and Schatzow never independently checked the corroboration, not did they show that any of the women with the 'severe memory deficits' had any independent corroboration whatsoever." Yes. Stephen Lindsay generally agrees with Loftus when he discusses problems of iatrogenic illusory memory.

Unsurprisingly, I am more critical of the comments by John Briere and Christine Courtois than of the comments by Lindsay and by Loftus. One statement I found particularly puzzling in Briere's comments is the following: "As psychologists know, science (by definition) cannot rule out the null hypothesis—in this case, that memory 'repression' or dissociation never happens. At most, one might establish that some cases of so-called repressed memories are actually confabulated. Even were this to be shown to be a reliable phenomenon, the issue would remain whether the presence of false reports rules out the reality of the true reports,"(pg. 291). First, often all we do is to rule out null hypotheses (by finding results that are extremely improbable if these hypotheses are true). Generally, our ruling these out involves a bit of convoluted reasoning that usually takes the form: if nothing is there, I found an unusual value of it; therefore, I reject the null hypothesis that nothing is there. We can however rule out with certainty the null hypothesis that repression and dissociation never occur by finding a single case in which they do. Moreover, no one ever claimed to my knowledge that the presence of a false positive can rule out the possibility of a true positive. The statement is just baffling.

The comments of Christine Courtois are, however, a bit more than baffling. After discussing scientific standards and a need for collaboration (not corroboration) she writes: "Unfortunately, a number of memory researchers are erring in the same way that they allege therapists to be erring: They are practicing outside of their areas of competence and/or applying findings from memory analogues without regard to their ecological validity and making misrepresentations, overgeneralizations, and unsubstantiated claims regarding therapeutic practice" (pg. 297).

That statement can be derived from the—in this reviewer's view very unfortunate—equation of training with competence, which is made throughout the American Psychological Association's Ethics Code. Thus, people who do not have training in recovering repressed memories really shouldn't comment on the process, while people who do have training in doing so are by definition competent to do so. The point is that the critics are coming from a basis of what is known about memory *in general*. There may be something different about memory of trauma, but if so, it is up to the person claiming this difference to specify what it is, and provide evidence for its existence. Instead, what we have is a hypothesized difference, and equating the *hypothesized* difference with a true one (without stating exactly what it is), Courtois concludes that generalizing without recognizing this difference is invalid.

Finally, Laura S. Brown also accepts the idea that it is easier to understand broad political matters than to understand memory—so that "political understanding" provides specific understanding. She also has some very unusual comments, for example that believing that childhood experiences have little impact implies that "people simply cannot change" (pg. 313). She also relates the answers to the questions of "Why this issue?" and "Why now?" to the 1994 election results and to the horrible (in this writer's view) practice of treating children charged with certain crimes as adults and filling our prisons with people failing "three strikes" laws. The problem with these connections is that an equally good case could be made that it is the authoritarian belief in experts in the absence of corroboration that is related to reactionary political stands (in fact, a return to practices prior to the *Magna Carta*, which spelled out the need for corroboration in Chapter XXVIII). At least those of us who abhor courts' acceptance "expert opinion" as a modern type of corroboration that can send people to jail (or deny children of a parent) might "find it plausible" that a reactionary and vindictive "political context" is positively related to belief in recovered memory, rather than negatively related. Not having done a survey of even an informal nature about the relationship between conservative versus liberal political ideology and position about recovered memory, I cannot state what the relationship is. But Laura Brown's assertions inadvertently illustrate how the belief about the relationship is a matter of ideology, not of evidence. Given that it is possible to make a plausible ("seems to reflect" — to use the terminology of Enns et al) argument for a relationship in the exact opposite direction of that postulated by Brown, her assertions illustrate quite neatly the flaw in attempting to assess the "political context" first in order to understand the actual evidence later, if at all.

Robyn Dawes, Ph.D. is a University Professor of Psychology in the department of Social and Decision Sciences at Carnegie Mellon University. He is the author of House of Cards and Rational Choice in an Uncertain World, and is a member of the FMSF Scientific Advisory Board.

Memory and Reality: Next Steps (video description)
March 22 & 23 1997

TAPE 222 160 minutes (approx.)
- Welcome and Introductions
  - Lee Arning
  - Charles Curry
- Making A Difference
  - Pamela P. Freyd, Ph.D. *Introduced by André Brewster, Esq.*
- What We Still Need to Know
  - Elizabeth Loftus, Ph.D. *Introduced by Paula Tyroler, Ph.D.*

TAPE 223 160 Minutes (approx.)

Part 1 Legal Task Force, *André Brewster, Esq.* Moderator
- The Foundation as Friend of the Court
  - Thomas Pavlinic, Esq.
- Families and the Courts: Report on the Legal Survey
  - Anita Lipton and Merci Federici

Part 2 Panel, *Ralph Slovenko, J.D., Ph.D.* Moderator
- Family and Retractor Panel: Dealing with the Legal System
  - Nadean Cool, Charles Congdon, Beth Rutherford, Tom Rutherford

TAPE 224 120 minutes (approx.)
- Helping Families is to Help Everyone
  - Paul R. McHugh, M. D. *Introduced by Eleanor Goldstein*
- Family Panel: The Wisdom of Families and Retractors *Allen Feld, LCSW* Moderator
  - Donna Anderson, Frank Baxpehler, Shara Rutherford, Bernice Schaffner. *Introduced by Charles Caviness*

TAPE 225 100 minutes (approx.)
- Reforming the Mental Health System: Education, Regulation, Litigation and Legislation
  - Christopher Barden, J.D., Ph.D. *Introduced by Robert Koscielny*
- Closing Remarks
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FROM OUR READERS

Therapy Threats

While I know you are familiar with all the methods that therapists use to create and maintain false memories, I want you to know that my therapist took this much further. As therapy progressed, whenever I disagreed with his insistence that I attend group sessions, he threatened to involve my husband and hospitalize me or go to my employer. If I tried to visit my parents without his permission, he said he would get a mental health warrant and detain me. While he talked about protecting my confidentiality, he reiterated his obligation to prevent me from harming myself. He repeatedly spoke with my daughter's therapist, always with the concept of "working together" but I later saw this as a way to reinforce all the falsehoods. He told me that if I didn't "work through the memories," my daughter could not be helped and any harm she caused to herself or others would be my responsibility. These threats kept me in a constant state of overt cooperation with my therapist as I tried to sort out all my conflicting ideas internally. I didn't feel free to terminate therapy with him.

A Retractor

❑

BEFORE AND AFTER

BEFORE
1988

My hero is not a famous man in the eyes of the world, but he is the most important kind of man in this world. On the mature side of fifty, he has lived beyond three wars, a major economic depression, several social revolutions and countless personal problems...

The day-in, day-out process of going about our lives is not glamourous. It typically does not bring with it fame and fortune. No covers on Newsweek, nor millions in the bank has he. My hero has also been a man of leadership. Yet he has learned, too, when it is best to follow instead of lead. An army officer for twenty years, he was drafted during the Korean conflict and then served twice in VietNam. However it is the years between and since these two wars that I find heroic. War is not a time for heroics, it is a time for survival. The heroism comes in working to keep us out of war.

Most of all, though, I admire my hero for his attitude toward life. He has never lost his optimism nor his integrity. To be a moral man in an immoral time takes a courage above all other bravery. There is a simple beauty in a person who will stand up for what he believes in. I do happen to love my father very much, and I think he is a truly great man.

AFTER
To: Mr. "T Father"

You have some nerve calling this house on Father's Day of all days. When were you ever a father to me? ... I will no long permit you to hurt me in any way. Therefore I will be setting the following limits on your outrageous behavior until you are ready to admit your guilt and apologize. I will not allow you to communicate with anyone in this household. Any letters you send will be thrown away unopened. If you call, we will hang up immediately...

1990
Dear Mom,

Not only have I lost a father, he is trying to make sure I lose the support of my entire extended family. He molested me for at least 13 years. My memories start when he left for Viet-Nam. Whether he started earlier, I simply don't know...He abused me in every imaginable way and some ways you would never imagine...He got me pregnant and secretly took me to the doctor...

❑

Nothing has Changed

Nothing has changed with our daughter who has accused us, but we hear she is doing very well with her career - family - husband, etc. We are fortunate that the other three children are wonderful to us - which we appreciate. We are especially thankful about the youngest one as she did not want to have much to do with us for the first two or three years after this happened. Now and for the last two years she has been like her old self, just like the daughter she always was. So we feel very grateful - even though we still miss our accusing daughter. We feel that people do get used to things in time no matter how terrible it was for so long. I would never want to go through that again!

I sometimes wonder if maybe our accusing daughter now wonders if she made a mistake but since things are going well for her now that she doesn't want to take a chance of upsetting anything. I wonder if any other parents feel this could be a factor. I still send birthday and Christmas gifts to her and our grandchildren and I write notes once in a while but I don't get anything back.

A Mom

STATE MEETINGS
Call persons listed for info & registration

MINNESOTA
Saturday, May 3, @ 9:00 am
Fort Snelling Officers Club, St. Paul
Dan & Joan (612) 631-2247

MONTANA
Saturday, May 3, @ 10:00 am
Colonial Park Hotel, Helena
Lee & Avone (406) 443-3189

ONTARIO
Saturday, May 10, @ 1:30 pm
Speaker: Pamela Freyd, Ph.D.
Pat (416) 445-1995

ISRAEL
June 16 & 17, 1997
Speaker: Elizabeth Loftus
Bar Ilan University, Ramat Gan
Prof. Israel Nachshon (972) 3-635-0995

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Pamela Freyd, Ph.D., Executive Director

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