

FMS Foundation Newsletter

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February 8, 1994

Dear Friends,

Science or belief systems? That is the fundamental issue underlying the problems of FMS. What are those statements about the recovery of repressed memories of abuse that come from scientific thought and what come from belief systems?

Professionals and professional organizations have begun to make statements that relate to the difference between belief systems and science. On December 12, 1993, the American Psychiatric Association issued a *Statement on Memories of Sexual Abuse*. Some people have written to tell us that "The statement doesn't say anything," while others have said, "You have no idea how far this conservative organization has come." The APA statement appears in this newsletter so readers can form their own opinions.

The statement does make clear one very important facet of the FMS issue: the role of the therapist. "Psychiatrists should maintain an empathic, non-judgmental, neutral stance towards reported memories of sexual abuse. As in the treatment of all patients, care must be taken to avoid prejudging the cause of the patient's difficulties, or the veracity of the patient's reports." A basis for this recommendation is scientific research evidence that shows that "While aspects of the alleged abuse situation, as well as the context in which the memories emerge, can contribute to the assessment, there is no completely accurate way of determining the validity of reports in the absence of corroborating information."

The APA statement of neutrality is in direct contrast to recovered memory therapists who see their role as validators of memories of abuse, i.e., "If you think you were abused and your life shows the symptoms, then you were," (Bass and Davis p 22) or "The existence of profound disbelief is an indication that memories are real." (Fredrickson, p 167). The role of therapist as validator arises from a "belief system" rather than from a scientific base.

The APA statement includes the advice that "Psychiatrists should refrain from making public statements about the veracity or other features of individual reports of sexual abuse." We are pleased to see this statement. We hope that this means that there will be no more TV documentaries featuring doctors with patients with multiple personalities which we are told arose because the patients had been abused, especially when the alleged abusers are not given an opportunity to respond. We hope that this means that hospitals such as the Institute for Pennsylvania Hospital will cease making statements in their advertising brochures validating the claims of abuse of movie stars. We hope that this means that psychiatrists such as Dr. Judith Herman will cease making judgments about the percentage of true or false reports received by the False Memory Syndrome Foundation—at least until they either read the reports or interview the families.

The APA statement is a first step in calming the hysterical climate and bringing reason into this vitally important area, but far more is needed. "The American Psychiatric Association has been concerned that the passionate debates about these issues have obscured the recognition of a body of scientific evidence that underlies widespread agreement among psychiatrists regarding psychiatric treatment in this area."

We have written to thank the APA for this statement and also to request further information. Specifically, we have requested the body of scientific evidence that supports the evidence for and the treatment for repressed memories. We have requested the specific evidence that "Many individuals who recover memories of abuse have been able to find corroborating information about their memories." What is "many" and who has independently checked the evidence? We have requested the scientific outcome studies that determine whether clients are better served by searching for memories of trauma or by dealing with the here, the now and the future.

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Survivor check lists: On January 27, Dorothy Cantor, a Board Member of the American Psychological Association, appeared on the ABC program, "Good Morning America." She commented about "sets of symptoms" of abuse noting that "There are many,

many symptoms that can be caused by a variety of different reasons and one must wait and see how the material emerges." We desperately need to have statements from professional organizations addressing "survivor check lists" because they influence so many people. The incest survivor literature is filled with check lists that supposedly indicate if a person has been abused. Thousands of parents have reported to us that their children told them they had "all the signs of being abused." What is the basis for these check lists? Are they based in science or in belief systems? Following is an example that took place when a caller phoned the television program *A.M. Philadelphia* on December 9:

Host: Caller on line five, you say that in the last year you've discovered through suppressed memory coming forward that you were sexually abused. Why do you believe it? Why, why do you believe that our guests, in essence, this morning are wrong.

Caller: One of the reasons is that at an education seminar I attended, a check list was passed out. Because of the type of work that I do, I am in contact with people who may have a catharsis type of situation. I'm a massage therapist and we're taught how to deal with it because it can be very emotionally cathartic when you have body work done. And on this check list which was maybe fifty different red flags that we should look for when we're working on people, I had about seventy-five percent of them myself. And I actually became physically ill at the seminar which was a pretty good indication.

We include a checklist from one of the best known incest survivor books in the box on page 2.

On the other hand, seeing that traumatic memories might be absent in other cases of neurosis (which would then have to be explained and treated in a different way), great care must be taken to avoid discovering traumatic memories when they do not really exist.

Pierre Janet

Psychological Healing, 1925

SYMPTOM CHECKLIST from

Repressed Memories: A Journey to Recovery from Sexual Abuse
 Renee Fredrickson, Ph.D., Simon and Schuster, 1992, p 47-51

"Check each item that applies to you, even if in a different way than the question indicates... People who have not been sexually abused have nightmares, overeat, and sometimes hate their bodies, but if you check several times in each category, or nearly all the items in a single category, you will want to consider the possibility that you have repressed memories.

Sexuality 1.I began masturbating at a very early age. 2.As a child, I used to insert objects into my bottom, and I do not know where I learned to do this. 3.I seem to know some things about sex even before they were explained to me. 4.I showed no interest in sex until I was in my twenties. 5.I can't stand to be touched in certain sexual ways or on areas of my body. 6.My experiences with sex are degrading or short-lived. 7.I freeze up or can't say no when someone wants to be sexual with me. 8.I have a sexual dysfunction, such as premature ejaculation, inability to have an orgasm, or pain during intercourse. 9.I am preoccupied with thoughts about sex. 10.I feel as if there is something wrong or bad about me sexually. 11.There is only one way I can have an orgasm or one position that turns me on. 12.I have fantasies of sexual abuse during sex. 13.I have had a period of sexual promiscuity in my life

Sleep: 1.I often have nightmares. 2.I have difficulty falling or staying asleep. 3.I sometimes wake up feeling as if I am choking, gagging, or being suffocated. 4.Sometimes I fear or sense that someone is in my bedroom. 5.I had or have recurring dreams. 6.I remember vividly one or more nightmares from my childhood. 7.I have awakened from sleep trying to attack my partner. 8.I often wake up frightened at the same time every night.

Fears and Attractions 1.I am frightened of one or more common household objects. 2.I would never go into a closet or any dark, confined space. 3.Basements terrify me. 4.There are certain things I seem to have a strange affection or attraction for. 5.I am scared to be alone or to leave my house. 6.I hate going to the dentist more than most people. 7.My mouth seems repulsive to me. 9. I hate to have someone touch my hair. 10.I am always alert to the possibility of sexual assault. 11.I have often taken foolish risks with my safety.

Eating Disturbances 1.I have had periods in my life when I couldn't eat, or I had to force myself to eat. 2.Sometimes I binge on huge amounts of food. 3.Certain foods or tastes frighten me or nauseate me. 4.I am seriously underweight or overweight. 5.I gag or choke easily. 6.I make myself throw up, take laxatives, or exercise exhaustively to control my weight.

Body Problems 1.I do not take good care of my body. 2.I hate my body. 3. I have odd sensations in my genitals or rectum. 4. I avoid going to a gynecologist, or I dread it terribly. 5.Whenever I think of a certain person from my childhood, I get a sensation in my genitals.

Compulsive Behaviors 1.I sometimes hurt myself in a way that marks or scars my body. 2.I have an addiction to drugs or alcohol. 3.My drug or alcohol use started before I was thirteen. 4.I do some things to excess and I just don't know when to quit. 5.I pick at my body too much. 6.I can't seem to control myself when it comes to spending money or gambling.

Emotional Signals 1.There have been times when I was very suicidal. 2.I feel a sense of doom, as though my life will end in tragedy or disaster. 3.I have unexplained bouts of depression. 4.I have a strong sense that something terrible has happened to me. 5.I identify with abuse victims in the media, and often stores of abuse make me want to cry. 6.The pain in my life seems to be big compared to what I know has happened to me. 7.Nothing seems very real sometimes. 8.I am not in touch with my feeling: I am usually numb. 9.Sometimes really violent or strange pictures flash through my mind. 10.I startle easily. 11.I can't remember much of my childhood. 12.Other people seem to have childhood memories at an earlier age than I do. 13.There is a blank period in my childhood when I can remember nothing. 14.I space out or daydream.

Media Circus: Dr. Cantor said that she believed that the problems of repressed memories of abuse should not be played out in public but rather in "professional and academic circles." We wrote to Dr. Cantor to say that more than 10,000 families agreed with her. We noted that if professional organizations and monitoring boards would consider complaints by people accused of criminal behavior that arise in the course of therapy, this might be a start. If professional organizations would establish guidelines for therapists when such memories arise, this might be helpful. If professional organizations such as the Michigan Psychological Association would stop inviting the press when they sponsor personal vilification talks, it might be a start.

Therapy guidelines: The January issue of National Association of Social Workers News included an article that featured therapy guidelines for readers' information, "Walking the Fine Line of Abuse Recall." The guidelines are not formally issued by NASW. One of these guidelines by Peter T. Dimock, Minneapolis therapist seems to us to be exceptionally important: "Consider a variety of possible explanations for the symptoms a client exhibits." Were we naive in assuming this was an essential feature of a good diagnosis? According to the article, "NASW's Council on the Practice of Clinical Social Work began preparing a statement last fall" on issues of repressed memory of abuse.

Syndrome. For a while our critics attacked the word "foundation" in our name. That attack didn't work and now they've moved on to the word "syndrome." Their favorite claim is that the false memory syndrome isn't "a scientific syndrome." We are encouraged that they might begin to believe that science is relevant when the subject is memory and we hesitate to discourage that belief. But we must point out that the process that ends with a general acceptance of a syndrome is rightly a slow one. It's one thing to say that FMS isn't yet listed in the DSM (*Diagnostic and Statistical Manual* of the American Psychiatric Association) and quite another thing to say that it doesn't exist. Just as we were preparing this newsletter we were reminded of how long it can take for a syndrome to reach the DSM by a letter that appeared on February 5 in the *New York Times* from Robert Kress, Professor of Psychiatry, University of British Columbia. Dr Kress reviewed the history of Post-Traumatic Stress Disorder. It first appeared under the name "survivor syndrome" in 1952. The term was used to describe people who had been imprisoned in German concentration camps. "These previously normal people were so affected by beatings and famine that they suffered symptoms like difficulty in concentration, irritability, emotional instability, impaired memory and sleep disturbances, including nightmares of captivity... This has been called concentration camp syndrome, survivor syndrome and, in the 1980 DSM, post-traumatic stress disorder (chronic)."

British False Memory Society: The BFMS has held its first Advisory Board Meeting and set out some directions for research. The Advisory Board members are: Dr. R. Aldridge-Morris, Principal Psychology Lecturer, University of Middlesex; Professor R. J. Audley, Vice Provost, University College, University of London; Professor A. D. Baddeley, F.R.S., Professor of Cognitive Psychology, University of Cambridge; Professor P.P.G. Bateson, F.R.S.,

Provost, King's College, University of Cambridge; Dr. T.H. Bewley, C.B.E., Past President, Royal College of Psychiatrists; Professor P.Fonagy, Freud Professor of Psychoanalysis, University College, University of London; Dr. G. Gudjonsson, Reader in Forensic Psychology, University of London; Dr. J.A.C. MacKeith, Consultant Forensic Psychiatrist, The Maudsley Hospital; Professor Elizabeth Newson, Professor of Developmental Psychology, University of Nottingham; Professor J. Sandler, Past President, International Psychoanalytical Association; Dr. W. Thompson, Lecturer in Forensic Psychology, University of Reading; Dr. B. Tully, Chartered Clinical & Forensic Psychologist; Dr. Elizabeth Tylden, Honorary Consultant Psychiatrist, UCH & Middlesex Hospital Medical School; Professor L. Weiskrantz, F.R.S., Professor of Psychology, University of Oxford.

Retractors: We have received several letters in the past few weeks from retractors and from families describing retractions. Some of these have happened in difficult circumstances. Imagine waking up one morning to find your yard filled with digging equipment and the police informing you that you are being investigated for sexual torture and murder reported by your daughter who had recovered memories. Imagine the legal fees. Imagine the situation when friends of the family have their yards dug up too. Imagine these accusations dragging on for years in spite of the fact that there was no evidence. With the support of a therapist who understands the FMS problem, the daughter in a family to whom this happened has retracted, and the family has welcomed her back.

Families that thought they could never get back together are discovering that when their child begins to act like the "before memories" person they knew, they respond to that person. We know that not all families will be able to reunite but we are learning that even after lawsuits and police investigations, it is possible to pick up the pieces help others through this tragedy.

Thanks: The FMS Foundation has now been in existence for almost two years. We've weathered the growing pains, and begun to establish a more stable organization. Next year the position of Executive Director will become salaried, for example. Thank you.

How long will the FMS Foundation exist? How long will it take the mental health community to solve the problem? There are now over 10,000 families who have complained that someone they love has received radical therapy for a condition that did not exist. If any other medical product or procedure had so many complaints, it would be taken off the market and examined. No one seems to know how to do that when the product is therapy. No professional organization, no monitoring organization, no government organization is in charge.

Child abuse is a tragedy, an unconscionable crime. Destroying families and lives is also a tragedy and a crime. Until people learn to listen respectfully to each other, neither problem will be solved. We need to place the research evidence in the public forum and examine what is offered. What is science and what is a belief system? Both have places in society, but they should not be confused.

Pamela

COMMENTS ON L. MEYER WILLIAMS RESEARCH ABOUT MEMORIES OF CHILDHOOD TRAUMA

Although the work of Linda Meyer Williams is still in press, it has been cited frequently on the radio and on television by people arguing for the validity of repressed memories. (e.g., Kathy Pezdek, Ph.D., Dec. 6, 1993; Connie Kristiansen, Ph.D. SWAP, 20(2))

ERRATUM

To FMSF Newsletter Editor:

When I sent you the original draft of my letter commenting on the Linda Meyer Williams study, I did indeed state: "I consider the study to be an excellent one and I consider the results to be valid." After I sent you the letter, and thought more about the article, I realized that there was a major flaw in it that I did not originally appreciate. Because this flaw was beyond the purposes of my letter, I called your office and asked you to delete the second half of this sentence regarding my considering the results to be valid and to publish only: "I consider the study to be an excellent one." Unfortunately, this was not done, and the original sentence appeared in print. I would appreciate your bringing this error to the attention of your readers. Thank you.

Richard A. Gardner, M.D.

Our sincere apologies. The correction had indeed been made but somehow in the process of a final proofreading was reinserted

Response to Williams Study Terence W. Campbell, Ph.D.

For some period of time, mental health professionals identifying themselves as specialists in "repressed memories" have enthusiastically cited the study of Williams regarding the alleged incidence of repression related to childhood experiences of sexual abuse. This study, which has yet to appear in a peer-reviewed scientific journal, identified a sample of 129 women who had been sexually abused as children. Specifically, the sexual abuse of these women which occurred between April 1, 1973 and June 30, 1975 was documented by hospital records. In 1990 and 1991, Williams interviewed these women and reported that 38% did not remember their documented history of sexual abuse. Unlike other studies, none of these women had ever been in therapy; and as a result, their recall—or apparent inability to recall—could not have been influenced by a therapist. More recently, a paper corresponding to Williams' presentation of this study at the Annual Meeting of the American Society of Criminology in October 1993 has been available for review. A careful examination of this paper reveals glaring errors in her methodology necessitating a wholesale reinterpretation of her findings.

Williams reported that, "The interviewers were not blind to the purpose of this study, but they were unaware of any of the circumstances of the child sexual abuse reported in the 1970's." This statement raises the question of exactly what did the interviewers know about this study if they were "not blind" to its purpose. Depending upon what the interviewers knew about the purpose of this study, the likelihood of experimenter bias effects increases enormously.

For example, related research has demonstrated that

when interviewers are asked to determine whether interviewees are extroverts, they tend to ask leading and suggestive questions allowing them to conclude that the interviewees were extroverted. Conversely, when other interviewers were asked to determine whether the same interviewees were introverted, they slanted their questions accordingly and concluded that the interviewees were introverted. In other words, the archives of behavioral research are littered with examples of interviewers finding what they expect to find. Therefore, Williams is obligated to clarify exactly what her interviewers knew about the purpose of this study.

Williams also explained, "Because many of the women reported different or multiple incidents of child sexual abuse, two raters later assessed whether the women had or had not recalled the 'index event.'" By 'index event,' Williams is referring to whether or not any particular subject in the study recalled the specific episode of sexual abuse documented by hospital records. Williams reports that 38% of the women in the study (49 in number) could not recall the 'index event.' Nevertheless, of the 49 women who did not recall the index event, 33 of these women reported experiencing one or more other incidents of sexual abuse as children.

In interpreting her data, Williams neglected to consider the effects of what is known as proactive and retroactive inhibition. Proactive inhibition refers to circumstances where events occurring at an earlier point in time interfere with memory for a similar event occurring at a later point in time. Applied to Williams' study, considerations of proactive inhibition account for why a subject may have reported an incident of sexual abuse after the index event, and not have recalled the index itself that occurred at an earlier point in time. In other words, the later abuse can also interfere with recall of earlier abuse. Rather than acknowledge that the well-established effects of proactive and retroactive inhibition account for the apparent memory deficits of her subjects, Williams tacitly encourages those who are so inclined to leap to unwarranted conclusions regarding repression as they interpret her data.

A closer examination of Williams' data reveals that while 49 of her subjects apparently did not recall the "index event," 33 of those subjects did report a history of childhood sexual abuse other than the index event. Only 12% of the total sample (16 in number) reported no memory for any episode of sexual abuse occurring in their childhoods. In other words, the widely publicized 38% figure related to this study—supposedly indicating a substantial number of women who have no memory for their documented sexual abuse as children—just became 12%—not 38%.

In summary, then, careful evaluation of Williams' methodology clearly indicated that this study cannot support the conclusions about repression that too many ill-informed mental health professionals want to draw from it. More than anything else, this study merely demonstrates

that Williams forgot to consider the documented effects of proactive and retroactive inhibition on her data.

The Cost of Violence?

In February 1992, we reported the findings of the cost of repressed memories to the Victims Compensation Fund in the state of Washington. (*Repressed memory claims are costing more than other types of claims allowed (non-family sexual assault: \$1,552; family sexual assault: \$1,997; repressed memory: \$9,127; all other types: \$1,794)*). In following months we reported that new policies in the state had drastically reduced the payments for repressed memories.

In the Palm Beach Post on January 9, 1994, another set of statistics caught our attention. An article by Andrew Mollison suggests that the cost of violent crimes is one of the reasons why "Americans spend more on health care than virtually any other country in the world." Results of a new study were cited.

The Cost of Violence, 1991-92

Medical Care for Violence \$14 Billion

- Drunken driving: \$6.9 billion
- Murder, rape, robbery, assault, arson: \$3.6 billion
- Suicides and hospitalized suicide attempts: \$3 billion
- Non-hospitalized suicide attempts, other: \$0.5 billion

Mental Health Care for Violence: \$13 Billion

- Caused by recent violent crimes: \$3.5 billion
- Adults physically or sexually abused as children: \$4 billion
- Unmet mental health care needs related to violence: \$5.5 billion

The authors of the study are Ted Miller, National Public Services Research Institute, Landover, MD and Mark Cohen of Vanderbilt University. Funding for the study came from the National Institute of Justice in a grant to determine the cost of crimes to victims. The results were presented in testimony before the Senate Finance Committee in October 1993. The data for the cost of medical care are from a variety of published sources. The data for the cost of mental health care were collected through an exploratory telephone survey of mental health care professionals (random sample of psychiatrists, psychologists, social workers, counselors, pastoral counselors, etc. There were 10 to 30 people in each group. N = 168) The questions that they were asked were, "How many of your clients were served in 1991 primarily because of the aftereffects of: recent child sexual abuse, recent child physical abuse - not sexual; child sexual abuse years earlier; child physical abuse - not sexual - years earlier; other attempted or completed rape, etc." This study has nothing to say about repressed memories or the truth or falsity of any accusations.

"What is extraordinary is that the professions do so little by self-regulation to protect their reputations. The result is rot by litigation. Professionals are unable to admit fault. Negligence insurance invites huge suits, and huge fees. The trust that used to underpin dealings between professional and client, including the acknowledgement of error, is destroyed.

"I suppose what has really gone, and I doubt if this is recoverable, is the idea that life can be cruel without there being anybody to blame."

Simon Jenkins, December 15, 1993
Opinion Page, *The Australian*

"My therapy cost over one-million dollars," a retractor told us. "When my daughter is hospitalized for MPD, it costs more than \$40,000 a month," said a father. "My daughter is in her 30's and had a good job, but now she is living on social security disability," said a mother. "She got social security because of post traumatic stress. She said she had recovered memories of being sexually abused by me, but no one checked. Her therapy is paid for by the government. The lawsuit she brought against us was dismissed with prejudice. She is still on disability."

Psychiatry's Time Bomb was the headline of an "Opinion" column by Adam Blatner, M.D. in *The Psychiatric Times* way back in November 1987. It arrived in our mail on the same day that we received the statistics about the cost of violence. Blatner made some startlingly accurate predictions.

"In the early 1970s, concern about the influence of excessive numbers of unused beds in hospitals on health care costs led to regulatory programs. 'Certificates of Need' were required before more hospitals (or units) could be constructed. However, in the deregulating atmosphere of the Reagan Administration, these programs have been allowed to lapse. It served as an invitation for the health care industry to vigorously compete, and as a result, corporations have exerted vigorous construction and marketing efforts. Hundreds of hospitals and thousands of beds have been and continue to be opened...

"The problem of having all these psychiatric inpatient units opening up is that it's unclear where the patients will come from. Over the previous 15 years, patients who have needed inpatient care have not been deprived of such services because the beds were unavailable. Few existing hospitals were running at full census...

"We are in the midst of a self-destructive trend. Our failure to recognize and police our own tendencies to over-utilization of expensive resources will lead to not only an economic backlash, but also a besmirchment of our professional integrity...

"More dangerous than the economic sanctions that will be forthcoming is the threat to the intellectual and moral integrity of the psychiatric profession. This is not simply a matter of public relations, but rather an issue of whether we in the profession are willing to recognize and criticize our own failings and those of our colleagues."

As we read "Psychiatry's Time Bomb," we thought about the ongoing federal investigations into private mental hospitals and about the high costs of medical care that have finally pushed the current restructuring of health care delivery. We also thought about the fortuitousness that the epidemic of MPD (which requires extensive hospitalization) came just at the time that hospitals were adding beds and dissociative units.

STATEMENT ON MEMORIES OF SEXUAL ABUSE

This statement was approved by the Board of Trustees of the American Psychiatric Association on December 12, 1993.

This Statement is in response to the growing concern regarding memories of sexual abuse. The rise in reports of documented cases of child sexual abuse has been accompanied by a rise in reports of sexual abuse that cannot be documented. Members of the public, as well as members of mental health and other professions, have debated the validity of some memories of sexual abuse, as well as some of the therapeutic techniques which have been used. The American Psychiatric Association has been concerned that the passionate debates about these issues have obscured the recognition of a body of scientific evidence that underlies widespread agreement among psychiatrists regarding psychiatric treatment in this area. We are especially concerned that the public confusion and dismay over this issue and the

possibility of false accusations not discredit the reports of patients who have indeed been traumatized by actual previous abuse. While much more needs to be known, this Statement summarizes information about this topic that is important for psychiatrists in their work with patients for whom sexual abuse is an issue.

Sexual abuse of children and adolescents leads to severe negative consequences. Child sexual abuse is a risk factor for many classes of psychiatric disorders, including anxiety disorders, affective disorders, dissociative disorders and personality disorders.

Children and adolescents may be abused by family members, including parents and siblings, and by individuals outside of their families, including adults in trusted positions (e.g., teachers, clergy, camp counselors). Abusers come from all walks of life. There is no uniform "profile" or other method to accurately distinguish those who have sexually abused children from those who have not,

Children and adolescents who have been abused cope with the trauma by using a variety of psychological mechanisms. In some instances, these coping mechanisms result in a lack of conscious awareness of the abuse for varying periods of time. Conscious thoughts and feelings stemming from the abuse may emerge at a later date.

It is not known how to distinguish, with complete accuracy, memories based on true events from those derived from other sources. The following observations have been made:

- Human memory is a complex process about which there is a substantial base of scientific knowledge. Memory can be divided into four stages: input (encoding), storage, retrieval, and recounting. All of these processes can be influenced by a variety of factors, including developmental stage, expectations and knowledge base prior to an event; stress and bodily sensations experienced during an event;

"It is not difficult to understand why the judge and many of the attorneys would prefer to keep the arguments and deliberations secret; they say it is to protect the confidentiality of the children, but the real protection is being offered to the various legal and governmental parties who appear to have made such grievous errors in looking out for the children's welfare."

Bob Greene, January 9, 1994
Parkersburg News, "Illinois Governor Wants Answers About Children"

post-event questioning; and the experience and context of the recounting of the event. In addition, the retrieval and recounting of a memory can modify the form of the memory, which may influence the content and the conviction about the veracity of the memory in the future. Scientific knowledge is not yet precise enough to predict how a certain experience or factor will influence a memory in a given person.

- Implicit and explicit memory are two different forms of memory that have been identified. Explicit memory (also termed declarative memory) refers to the ability to consciously recall facts or events. Implicit memory (also termed procedural memory) refers to behavioral knowledge of an experience without conscious recall. A child who demonstrates knowledge of a skill (e.g., bicycle riding without recalling how he/she learned it, or an adult who has an affective reaction to an event without understanding the basis for that reaction (e.g., a combat veteran who panics when he hears the sound of a helicopter, but cannot remember that he was in a helicopter crash which killed his best friend) are demonstrating implicit memories in the absence of explicit recall. This distinction between explicit and implicit memory is fundamental because they have been shown to be supported by different brain systems, and because their differentiation and identification may have important clinical implications.

- Some individuals who have experienced documented traumatic events may nevertheless include some false or inconsistent elements in their reports. In addition, hesitancy in making a report, and recanting following the report can occur in victims of documented abuse. Therefore, these seemingly contradictory findings do not exclude the possibility that the report is based on a true event.

- Memories can be significantly influenced by questioning, especially in young children. Memories also can be significantly influenced by a trusted person (e.g., therapist, parent involved in a custody dispute) who suggests abuse as an explanation for symptoms/problems, despite initial lack of memory of such abuse. It has also been shown that repeated questioning may lead individuals to report "memories" of events that never occurred.

It is not known what proportion of adults who report memories of sexual abuse were actually abused. Many individuals who recover memories of abuse have been able to find corroborating information about their memories. However, no such information can be found, or is possible to obtain, in some situations. While aspects of the alleged abuse situation, as well as the context in which the memories emerge, can contribute to the assessment, there is no completely accurate way of determining the validity of reports in the absence of corroborating information.

Psychiatrists are often consulted in situations in which memories of sexual abuse are critical issues. Psychiatrists may be involved in a variety of capacities, including as the treating clinician for the alleged victim, for the alleged abuser, or for other family member(s) as a school consultant; or in a forensic capacity.

Basic clinical and ethical principles should guide the psychiatrist's work in this difficult area. These include the need for role clarity. It is essential that the psychiatrist and

the other involved parties understand and agree on the psychiatrist's role.

Psychiatrists should maintain an empathic, non-judgmental, neutral stance towards reported memories of sexual abuse. As in the treatment of all patients, care must be taken to avoid prejudging the cause of the patient's difficulties, or the veracity of the patient's reports. A strong prior belief by the psychiatrist that sexual abuse, or other factors, are or are not the cause of the patient's problems is likely to interfere with appropriate assessment and treatment. Many individuals who have experienced sexual abuse have a history of not being believed by their parents, or others in whom they have put their trust. Expression of disbelief is likely to cause the patient further pain and decrease his/her willingness to seek needed psychiatric treatment. Similarly, clinicians should not exert pressure on patients to believe in events that may not have occurred, or to prematurely disrupt important relationships or make other important decisions based on these speculations. Clinicians who have not had the training necessary to evaluate and treat patients with a broad range of psychiatric disorders are at risk of causing harm by providing inadequate care for the patient's psychiatric problems and by increasing the patient's resistance to obtaining and responding to appropriate treatment in the future. In addition, special knowledge and experience are necessary to properly evaluate and/or treat patients who report the emergence of memories during the use of specialized interview techniques (e.g., the use of hypnosis or amytal), or during the course of litigation.

The treatment plan should be based on a complete psychiatric assessment, and should address the full range of the patient's clinical needs. In addition to specific treatments for any primary psychiatric condition, the patient may need help recognizing and integrating data that informs and defines the issues related to the memories of abuse. As in the treatment of patients with any psychiatric disorder, it may be important to caution the patient against making major life decisions during the acute phase of treatment. During the acute and later phases of treatment, the issues of breaking off relationships with important attachment figures, of pursuing legal actions, and of making public disclosures may need to be addressed. The psychiatrist should help the patient assess the likely impact (including emotional) of such decisions, given the patient's overall clinical and social situation. Some patients will be left with unclear memories of abuse and no corroborating information. Psychiatric treatment may help these patients adapt to the uncertainty regarding such emotionally important issues.

The intensity of public interest and debate about these topics should not influence psychiatrists to abandon their commitment to basic principles of ethical practice, delineated in *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*.

The following concerns are of particular relevance:

- Psychiatrists should refrain from making public statements about the veracity or other features of individual reports of sexual abuse.

- Psychiatrists should vigilantly assess the impact of their conduct on the boundaries of the doctor/patient relationship. This is especially critical when treating patients, who are

seeking care for conditions that are associated with boundary violations in their past.

The APA will continue to monitor developments in this area in an effort to help psychiatrists provide the best possible care for their patients.

To obtain the full News Release of the APA statement, contact Greg Phillips, 202-682-6142.

If you have comments about the statement:

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Washington, DC 20005

VAGARIES OF MEMORY

In past newsletters we have mentioned the need to create a climate in which people can change their theories and change their minds. As people gain new information, they should be encouraged to revise their opinions. Unfortunately, sometimes when people change their minds, they completely forget what they thought or said at an earlier time. This month we had an example that points to how unreliable memory can be.

The example was provided by a woman named Vanessa. On the Jane Whitney program in December, 1993, Vanessa said that "I went into therapy because I had those [memories] spontaneously. I wasn't in therapy when I had them. I've never been led by a therapist. I've never been hypnotized or taken through visualizations ever." She also stated that, "No, I never claimed to have satanic ritual abuse memories."

Another participant on the program, Laura, asked Vanessa about statements she had made in other television programs that did not seem to agree with this statement that she had never had hypnosis. This led us to review what Vanessa had said and done on *Prime Time Live* in January 1993.

Vanessa: It was premeditated, systematic, methodical, fragmenting of our personalities and then using other children and sacrifices to terrorize us.

Narrator: Children were murdered?

V: um-hm.

N: What happened?

V: One time there was a baby there and they stabbed the baby and killed it and we all had to drink blood.

Vanessa claimed in December 1993 that her comments in January 1993 had been taken out of context. We asked a group of people to view the *Prime Time* (January 93) segment. No one questioned that Vanessa was clearly under hypnosis and being encouraged by her doctor to name the thirteenth person in the satanic cult.

People misremember all the time. It is the norm. Even people who are certain they have been abused can misremember. Some people can even forget that they had hypnosis or that they ever thought they had memories of murdering babies or drinking blood

MEMORY AND EMOTION

What do we know about the relation between emotion and memory? Daniel Reisberg, Ph.D., Associate Professor of Psychology at Reed College, wrote a short article on the topic for the *Reed Alumni* magazine in June 1993.

People have a common-sense notion that memories that are highly emotional are more likely to be remembered. Reisberg notes that, "there is an element of truth in the 'more emotion — more memory' claim. Emotion does promote the recording of events into memory, allowing fuller and more accurate recollection later on. In fact, the mechanisms for this are relatively well understood: emotion is typically accompanied by a pattern of physiological arousal, which includes (among other things) an increase in epinephrine levels in the bloodstream. This in turn leads to increases in blood glucose levels, and this seems quite directly to promote the process of 'memory consolidation.'

"But we need to say considerably more to capture the complex interaction between emotion and memory. For example, emotion also influences how we pay attention to an event or scene. In essence, emotion 'narrows' our attention, so that we end up focusing on a few central aspects of the scene, to the exclusion of all else. Thus, as emotion increases, we focus our attention more sharply, taking in less and less of an event, but, thanks to the consolidation mechanisms just discussed, we are then more likely to remember what we have attended.

"In addition, in our culture we regularly converse about the emotional events in our lives: you tell me your story, and I tell you mine. In this exchange of memories, we regularly 'edit' out recollection—often without realizing we are doing so—to create a better tale, to allow a better conversation. Similarly, we may unconsciously fill gaps in our recollection with plausible inferences to make sure our story is a coherent one. Much evidence indicates that we are then likely to lose track of which elements in our remembered-tale were supplied by memory, and which were created in the retelling, so that the retelling literally changes how the event is remembered. This can easily lead to memory errors—remembering things that did not occur, remembering distorted versions of actual events. Evidence indicates that these memory errors are then largely undetectable: 'false memories' are recalled with just as much confidence and just as much detail, as are *bona fide* memories."

There is a solid body of scientific research on the relationship between memory and emotion. The claim has been made over and over in the survivor literature that for children who experience sexual abuse another process operates. Is this scientific or is this a belief system? This question has captured the interest of the professions and the media.

Further reading: Gold, P (1993). *Modulation of emotional and non-emotional memories. Same pharmacological systems, different neuroanatomical systems.* In J. L. McGaugh (Ed.), *The Neurobiology of Learning and Memory—Proceedings of the Fifth Annual UCI Conference.* New York: Oxford University Press.

**Who is doing therapy in America?
Social workers are now the largest group of mental
health providers.**

A recent article, "The Changing Face of Social Work," by Beth Baker, *Common Boundary*, Jan/Feb, 1994, documents the changes that have taken place over the past two decades to explain how social workers now outnumber psychologists and psychiatrists as mental-health providers. The following data are provided:

Profession	#Practicing	#Graduates	#Programs	Fee
Psychiatrists	40,000*	1,300	199*	\$ 101
Ph.D. Psychologists	45,000	1,300*	174	90
Social Workers	80,000	11,500	106	75
Marriage & Family	40,000	N/A	73	80
Prof Counselors	42,000	9,400	230	75
Psychiatric Nurses	10,500	643	96	N/A
Pastoral Counselors	2,100	N/A	104	N/A

Mental health is by far the most popular speciality of social workers, "according to a recent study 'Who We Are,' published by the 146,000 member NASW." 32.7 percent of NASW members list it as their primary practice area and 27.7 percent place it second.

Social workers "say their approach is non-authoritarian and non-threatening. And while they cannot prescribe medication as psychiatrists do or perform psychological tests as psychologists do, their training in psychotherapy is on a par with that of other professions. Before a social worker may be licensed at a clinical level, he or she must complete a two-year master's program that included 900 hours of field instruction. In addition, two years of supervised clinical social-work experience are required. Like other psychotherapists, the social worker also takes part in a wide variety of workshops and other training."

In the January newsletter, we reported the results of a survey of social work schools in which Allen Feld documented the minuscule amount of course work in memory and repression currently required in schools of social work. If it is indeed the case that the training of social workers "in psychotherapy is on a par with that of other professions," an examination of all professional training programs whose graduates are allowed to do psychotherapy is immediately called for. Lack of training about scientific information on memory by professional schools could explain why Michael Yapko found a significant percentage of therapists to hold misconceptions about memory and hypnosis. Yapko's data is reported in the January 1994 issue of *American Journal of Clinical Hypnosis*.

In 1890, in Philadelphia, Sir William Osler referred to the education of physicians as an example of "criminal laxity" in education. It seems that a "criminal laxity" now confronts us in the education of psychotherapists. Osler was instrumental in upgrading the miserable status of education of medical practitioners at that time. It is time that all professional organizations look at his focus on education and apply it to psychotherapy.

Questions and Answers

With the February 1994 issue, we introduce a new column. August Piper, Jr., M.D. looks forward to receiving your questions.

**FALSE MEMORIES AND MULTIPLEPERSONALITY
DISORDER: WHERE WILL IT ALL END?**

The pleasant voice coming from the telephone receiver belonged to Pamela Freyd, who was requesting a column on multiple personality disorder for the False Memory Syndrome Foundation newsletter.

I told Dr. Freyd that for her even to consider asking me to write such an article was a real honor. However, I had some questions for her. Should the FMS Foundation become involved in the multiple personality disorder controversy? Would members of the Foundation be at all interested in the topic?

"The Foundation is already involved, because the controversy has come to our doorstep," she said, "and yes, I do think out readers would like to know more about MPD.

What did she think should be in the column?

"Why not discuss the relationship between false memories and MPD? And maybe talk about the history of MPD." She added.

And so this column was born.

* * *

A thimbleful of history to start. Before 1970, MPD was extremely rare—so rare, in fact, that psychiatric journals almost never printed papers on the subject; less than one article each year appeared in the literature. In 1980, the entire world literature contained only about two hundred cases, with only eight having been reported between 1960 and 1970.

However, between 1980 and 1990, the number of professional papers on MPD increased sixty times. The number of reported cases also skyrocketed, so that by now, the MPD phenomenon has become an epidemic. Over 6,000 cases are supposed to have been diagnosed in North America by 1986; that year, one of the experts in the MPD field commented that more cases of the condition had been reported within the previous five years than in the preceding two centuries. One advocate of this condition predicts that ten percent of all adults in North America may have disorders similar to MPD; he believes that more than one hundred million people worldwide may have one of these disorders. Soon, the proponents say, any clinician who has not recently seen a patient with MPD may expect to be questioned about his or her diagnostic ability or lack of familiarity with recent literature.

Not only have the number of cases increased dramatically, but the usual number of personalities per case has also soared. In the last century, reported cases usually had two personalities, but now, cases average between six and sixteen personalities; in one recent series almost half the patients had more than ten alters. There have been reports of three hundred, four hundred, and one thousand alter personalities.

What is going on here? Those who champion the cause of MPD offer several explanations for this unprecedented proliferation. None of them, however, makes as much sense as the obvious: some clinicians are simply grossly overdiagnosing the disorder.

Where will it all end?

False memories and MPD affect each other in two ways. First, because a major criterion for the diagnosis of MPD is a history of sexual abuse, a therapist obtaining such a history may be influenced to diagnose MPD. Some of these reports are false; an erroneous history of childhood victimization may well lead to a misdiagnosis of MPD, based partly on that inaccurate report.

The second aspect of this relationship is somewhat more subtle, but ultimately may be more damaging to the patient. Imagine: a therapist has diagnosed a patient, Ms. S, as having MPD. She has no memory of being physically or sexually abused as a child. The therapist, however, reasons as follows: "The MPD experts say that over ninety-five percent of people who have MPD have been abused as children. Since Ms. S has MPD, she almost certainly was abused. The fact that she doesn't recall the abuse simply means she is repressing the memory of it. In order for her to recover from her MPD, she must deal with her abuse history. Therefore, my task as her therapist is clear -- I have to break through the repression barrier and unearth these hidden, repressed memories." In other words, the patient must be convinced of the correctness of the therapist's view.

The patient in these situations not infrequently makes an effort to be a "good patient," searching hard for the material the therapist says must be there. The current professional literature contains several reports of patients going so far as to make up stories to please their therapists. On the other hand, members of the Foundation know that some patients are now beginning to appreciate and become outraged at the damage done to their lives, and to the lives of those around them, by what another FMSF Board member calls this "cookie-cutter therapy."

MPD proponents will sometimes go to extremes to discredit beliefs, memories, and experiences that are that are incompatible with the diagnosis, and replace them with those that are. Does the patient deny having been abused as a child? The proponent can say that MPD patients often attempt to hide their abuse histories. Does the patient fail to show evidence of other personalities? The proponent can say that a patient has "secret MPD," in which the other personalities do not emerge unless the host is alone. Does the patient deny having MPD? No problem—people can have MPD and not even be aware of it themselves. Does the patient fail to show any sign whatsoever of MPD? Not a problem either, because the essential core of the disorder is the presence of a mental structure—an "entity"—which, curiously, remains obstinately invisible to all but those therapists who have the special ability to discern it.

Sometimes this discrediting involves an attack on the memories of the patient him- or herself, or on those of the family. A hospital once asked me to review the case of a

Ms. B. This was a schoolteacher who had been reasonably functional before her admission; she had gone to work every day, for example. She was thought by the admitting psychiatrist to have been satanically abused as a child by her parents; he also thought she now had MPD. Ms. B stayed in the hospital for 72 days—about six times longer than the institution's average at that time.

During the hospitalization, the psychiatrist endlessly explored the sexual abuse and the satanic rituals to which Ms. B had allegedly been subjected. She progressively deteriorated, so that she had to be committed to a state hospital at the end of the 72 days. It is noteworthy that the patient initially disputed both the diagnosis as well as the doctor's belief that she had been ritualistically abused. However, by the time she left the hospital, the chart notes no longer mentioned any disagreement. The family always disputed the history—but the physician did not interview them.

In the words of another Board member: "The value and good sense of psychiatry become suspect as wonders multiply."

Where, indeed, will it all end?

Dr. Piper will answer questions from families on a regular basis. Please send your questions to Dr. Piper, c/o FMSF Newsletter.

LEGAL ACTIONS AGAINST PARENTS

The update of the ongoing FMSF legal survey is nearing completion. In November, 1993, 800 questionnaires were mailed to families that had indicated they were involved in legal actions based on repressed memories. As of January 31, 200 questionnaires had been returned. Consistent with the data reported in April, 1993 the following is the case: One out of seven families that contact the Foundation report that they believe they have been threatened with legal action, while one of sixteen families actually reports that legal action has been brought against them. Three quarters of the legal actions are civil

suits and one quarter are criminal. Of the civil actions, we have learned that 50% are dismissed with prejudice meaning that no further action can be taken on those specific charges. We are currently making a summary of the reasons cited for the dismissals and will report on these soon.

Lawsuits are considered part of the healing process. A number of Florida professionals sent us copies of an identical letter that they had received. The letter from a member of a Tallahassee, Florida law firm informed them that the Florida Statute of Limitations had recently changed to allow suits by "survivors of physical, sexual, or mental abuse occurring in childhood, elder abuse, and incest" against perpetrators. The letter noted that "victims of post traumatic stress syndrome from this type of victimization often do not discover their injury and its causal connection until their adult years." The lawyers noted that "As a pro-

Unfortunately, anybody can say anything about anyone, and the accused is then in the position of defending himself. All too often, if the maligned individual is a high-profile personality, the feeding frenzy begins, the headlines are a foot high and the TV coverage is relentless. By the time the facts are made public, the victim is thoroughly discredited and his reputation in shreds.

Too often the culprits are the therapists who "help" their patients recall incidents they are led to believe have been repressed for dozens of years. Add to that mix, lawyers who see an opportunity to make a killing by nailing a well-known (or well-heeled) person.

Ann Landers, December 12, 1993
The Philadelphia Inquirer

professionals who may come into contact with persons recovering from various forms of childhood abuse, elder abuse and incest, you are in a position to raise the legal awareness of those survivors whose rights might potentially be affected." The writer of the letter states that, "for those for whom confrontation and restitution would provide empowerment and closure, it could be an important final step in the healing process. If someone you know, currently treat or have treated in the past is an abuse or incest survivor, please make them aware of Chapter 92-102."

FROM OUR READERS

"Our daughter confronted her father in November 1991, the day after Thanksgiving. I think it literally broke his heart. He was diagnosed with liver cancer in early December, 1992 and died less than a year later. Just one week before he died, she wrote to him saying that her stories may be metaphors for her anger and that she loved him. She is a part of the family circle again, but has never really recanted. It remains a deep sorrow for me to know of the suffering that she and her therapist brought to our family."

A Mom

"Let us never forget our human, parental imperfections are unrelated to the incubation and cultivation of the hate disease spread by toxic therapists and now ravaging and laying waste to the love that once bound our families."

A Mom

"Of course, the foundation is not going to remodel the whole psychological community but we have opened the door to its abuses. We are credible and we've got an army behind us of people who will never let us down once they know they can trust us. We have gained great power in a very short time."

A Mom

"We've regained our self respect and started to live again. We won't give up hope that our daughter will return one day because we gave the same amount of love to her as we gave to the boys and they are returning it already."

Parents from Germany.

This notice is to inform the parents, retractors and professionals involved in the False Memory Syndrome Foundation that my daughter, Jennifer, and I have successfully settled a lawsuit against two therapists, in part, for creating false memories. The suit was filed on December 19, 1991 (before the FMSF was founded) and was settled July 29, 1993.

In conjunction with the terms of the settlement, I will not name the defendants, the location of my "treatment," or the amount of settlement.

I am writing this due to many people having not received the information and to help reaffirm the fact that this problem must be stopped. For me, the lawsuit was successful and enabled me and my daughter to be compensated, somewhat for damages, but more importantly gain my mind and power back from those who took it from me. I can never get the years my daughter and I lost and for this I grieve. There is no way to put a price tag on the loss of

years out of a relationship. However, I can have a fresh start and work towards emotional health from this moment on.

Laura Pasley

I attended four Incest and Rape Support Group meetings in my state. I wanted to obtain first-hand information about what goes on at these meetings. Attending the meetings were a hypnotherapist, a retired psychologist, two women who said they were sexual abuse victims and myself. I also said I was a victim of childhood sexual abuse.

The hypnotherapist said that she programs and reprograms the subconscious so that the conscious can deal with the problem and completely heal. She offered to give me a hypnosis treatment free, in order to search my subconscious to see if I had any inner feelings about a need for healing. (I had previously told her that I didn't feel that I needed healing.)

The psychologist walked into my first session and placed the book *Courage to Heal* on the table and said that this is a book written by women for women. He recommended that they should read it.

At one session, the hypnotherapist introduced a Reiki master teacher who relieves stress and tension through deep relaxation. She then showed us a video tape on reincarnation.

At the next session, after being asked how I enjoyed the last session, I replied that I was very uncomfortable and disturbed by all those people believing in reincarnation. The hypnotherapist admitted that she too had problems with reincarnation in the beginning.

At the fourth and my last session, I was told that there are never any records kept at therapy sessions in the event of a lawsuit. Barnum and Bailey were sure right: "There's a sucker born every minute."

A Father (72 years old)

The past two years, although agonizing and devastating, have enabled me to learn a great deal about what happened to my daughter. She has been telling stories now for more than four years in which she portrays herself as a victim. This has enabled her to get support and attention from a variety of individuals and groups.

This started when she was a minor. From the beginning the Department of Social Services supported her delusion even though they had no concrete evidence. But now that she has retracted the problem is not over.

The Department of Social Services refuses to change their records. The records currently say "unsubstantiated" and they refuse to change them to "ruled out." They say they don't care whether or not abuse occurred. They will not admit they have made a mistake.

To this day, the social workers who support my daughter will not talk to us. My daughter says she wants to reunite, but I feel she is still defaming us. She identifies herself as a 'victim.' A retraction does not mean that the problems of FMS are over.

Please help us update our records.

We have included an "information update" on the last page. Please take the time to fill it in and return it.

My Mother Abused Me, Didn't She?

by Elizabeth Godley

Reprinted with permission

Modern Woman January 1994

I was 38 and living alone, picking up the pieces after a failed relationship. Even though I had friends and a good job, my life felt empty. I felt guilty, unlovable and alone in the world. It was my second visit to a new therapist when, in the middle of a conversation about my troubles, she shattered my composure with an unexpected question. "Elizabeth, do you think you might have been sexually abused by your mother?" My reaction was immediate and devastating. I was flooded with nausea. I felt lightheaded and breathless. Was this the reason I'd been in and out of therapists' offices for the past 20 years, seeking comfort for the debilitating depressions that plagued me?

My new therapist, a former nurse with a Ph.D. in psychology, was beginning to forge a reputation for treating incest survivors, an emerging issue at the time. She was struck by the way I responded to her question about my mother. Convinced we were on to something, she urged me to remember as much as I could of this traumatic event. In my apartment that evening, I dutifully began to "remember": I was four years old...my mother and I were in the woods near our house, where we often walked, picking huckleberries (my mom taught me the names of all the trees and plants in the lush coastal forest)...we sat down under a tree and my mother forced me to do certain things...

I reported this scene to my therapist. Then, I acted on her suggestion that I write letters to both my parents to vent the rage and pain I felt about my discovery, and to say I didn't want to see either of them in the foreseeable future -- perhaps ever.

My mother's response was unwise, but understandable. She was shocked and frightened by my accusations. She sent me a brief, angry note, letting me know that I should not blame my problems on her. My therapist interpreted her defensiveness as further proof that my mother had abused me.

For the next four years, I had no contact with my mother, and almost none with my father. I believed that my parents were toxic, and my memories of sexual abuse gave me good reason to cut them out of my life. After three years of weekly and twice-weekly therapy sessions, I was beginning to think there was no cure for my depressions. I felt I was wasting time there, and wanted to get on with my life.

The truth dawned slowly, gradually, in a process that intensified after I stopped seeing the therapist. My sense that I had made up my memories of abuse became stronger. I had recently married, but within six months my husband and I began having difficulties. We consulted a counselor, who was concerned about my estrangement from my parents, and who told me I could not resolve problems in my marriage until I came to terms with my family. That made a deep impression on me, and I became more and more certain that my mother had never abused me. But why had I accepted the therapist's theory so easily?

Certainly, I was desperate for answers--a drowning woman grasping at anything to keep afloat. On the surface,

I appeared to have everything -- a promising career, intelligence, attractive looks -- but I was miserable. My temper was explosive, my relationships with men stormy; I was extremely vulnerable to criticism; my self-esteem was non-existent. At work, I couldn't get along with my supervisors or my colleagues. So when I was offered an explanation for my depression and problems, I lunged at it. It was easier to blame my mother than to accept responsibility for my unhappiness. Guided by my therapist -- and I believe she meant well -- I began to enjoy my status as a victim; she rewarded me with outpourings of sympathy and commiserations, as well as an entree into a select group of her patients, all incest survivors. I now had an answer to all my questions about myself. I no longer had to think or struggle. Problems at work? With friends? With men? Well, what could I expect? I had been sexually abused. It was almost like joining a cult, with my therapist as guru and me a faithful disciple, the pitiful casualty of a horrendous crime.

The role of victim can be very appealing, as psychologist Carol Tavris points out in *The Mismeasure of Women* (Simon & Schuster, 1992). Tavris stresses she is not speaking of real incest survivors, and acknowledges as I do) the many thousands of women who have suffered real abuse as children and adults. But she believes sexual abuse "crystallizes many of society's anxieties, in these insecure times, about the vulnerability of children, the changing roles of women, and the norms of sexuality." Those who feel vulnerable and victimized, and who wish to share in society's sympathy, are drawn to identify with incest survivors, Tavris suggests. "For some women, the sexual-victim identity is...a lightning rod for the feelings of victimization they have as a result of their status in society at large." When incest was first in the news a decade or so ago, "public horror and outrage focused on the perpetrator" -- usually a man, Tavris writes. Today, though, much of the fury is directed at mothers, who are blamed for failing to protect their daughters, for "enabling" the abuser.

I can relate. By falsely accusing my mother of sexual abuse, I tapped into a dark pit of rage against her; rage that had been repressed for more than 30 years. An only child, I grew up under the thumb of authoritarian parents who pushed me to be the perfect daughter. Negative emotions were squelched, painful issues never discussed. Heading the list of taboo subjects was the stillbirth of a baby that happened when I was about four years old. Fifteen years later, that childhood event returned to haunt me. I got pregnant with my first serious boyfriend, and went through a hellish abortion. Even though I was living at home and going to university, I managed to keep the abortion secret from my parents. I tried to ignore my anguish, in vain, just as my parents had tried to ignore the stillbirth long ago. But my guilt, anger and misery festered. By the time I was 38, I was a walking time bomb. My therapist unwittingly lit the fuse.

It wasn't easy making up with my parents. For help, I turned to a new psychiatrist, a woman recommended by my general practitioner. I was on her waiting list for a year. But finally, with her support, I was able to put to rest my haunting "memories." She asked me if I recalled any molestation as a child, and I recalled two incidents. One

occurred in a movie theater; I was about seven, and a man sitting next to me put his hand on my knee. The other occurred when I was 12 or so, at the beach near my aunt's summer cottage; a man insisted I touch his penis. Both times, having been brought up to do what I was told, I complied. But I never told a soul, thinking I'd done something shameful. My psychiatrist suggested that since these two incidents were clear in my mind, it was unlikely I had repressed other memories of abuse by my mother.

That weight lifted. I did some belated maturing, and learned to recognize my feelings, communicate my needs and clarify my expectations. I began to understand that my depressions were likely caused by guilt and unexpressed anger at my mother, not sexual abuse. Deep down, I felt I'd failed her. Just as important, I felt she'd failed me -- first, because of my sibling's death (I hated being an only child) and second, because I hadn't been able to confide in her about the abortion.

Over the past few years, I've opened up to my mother, telling her the secret I'd kept all those years, and the change in our relationship has been dramatic. No longer mystified by my moods -- and no longer worried that I blame her -- my mother feels more relaxed when we're together. Unencumbered by guilt, I now trust that she loves me, even knowing the "worst," the parts I kept hidden. We've recaptured some of the closeness we enjoyed when I was a small child.

It's been a relief to find out I wasn't the only troubled woman to seize upon sexual abuse as an explanation for everything that was wrong with my life. Hearing about other women with stories like mine, and speaking with mothers, fathers and siblings who have been falsely accused, has helped me understand a very difficult period in my life.

NOTICE - Ohio Families

Families in Ohio continue to be very active in informing all professionals who have any role in mental health about the devastation of FMS. They are finding that health insurance companies are interested in the problem. The Director of the Financial Investigations Department of Blue Cross and Blue Shield of Ohio, for example, expressed concern about how the issue of FMS may be affecting policyholders and whether there might be another issue in the effectiveness of state oversight of mental health counseling. He noted that Blue Cross and Blue Shield has a Financial Investigations Department that investigates healthcare fraud and other abuses. Anyone with information regarding questionable claims submitted to Blue Cross and Blue Shield of Ohio should call the BCBSO fraud hotline at 1-800-553-1000.

Grandchildren

We have had our first report of a grandchild (16 years old) asking to live with the accused grandparents. This raises two questions many grandparents have asked: (1) What model is presented to children when they see their parents cut off contact as a way to deal with issues? (2) What will happen in families when children reach an age to

make their own decisions? "What goes around, comes around," said one grandmother.

Canadian Grandparents Rights Association
Westminster Highway #10-8291
Richmond, BC V6X 1A7
Canada

Grandparents Rights - National Office
Ethel Dunn, Executive Director
137 Larkin Street
Madison, WI 53705

Bernardin Case

The accusations against Cardinal Bernardin have been news around the world and have helped focus interest on basic issues: (1) the nature of memory and repression and (2) the standard of practice in psychotherapy.

We thought that the following information reported by Andrew Greeley in the *St Louis Post-Dispatch*, January 26, 1994 was relevant.

"Larry Yellin, a reporter for Channel 32 News in Chicago, decided to investigate the background of Michelle Moul, the therapist who worked with Cook before he leveled his accusations.

"In two copyrighted reports Yellin presented the following facts:

"Moule received a degree in industrial planning from Syracuse University in 1980 with a minor in psychology. For much of the decade following her graduation, she seems to have operated a print shop and a delicatessen.

"Moul acquired a master's degree in applied psychology from Santa Monica University, a weekend institution (not accredited by the Middle States accrediting organization) in Philadelphia that conducts classes in hotel rooms. The president of Santa Monica told Yellin there was absolutely nothing about hypnotism in any of the school's programs. Moul is not licensed to practice psychology by the State of Pennsylvania.

"Yellin could find no record of supervised clinical experience."

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4 issues a year. \$12.00

**FMSF MEETINGS
FAMILIES & PROFESSIONALS
WORKING TOGETHER**

FUTURE MEETINGS

**NATIONAL FMSF PROGRAM
Memory and Reality
June 3-5, 1994
Kansas City**

Speakers will include members of the FMSF Advisory Board. Sessions will be held Friday through Sunday noon to be followed with a public lecture Sunday afternoon.

**MIDWEST REGIONAL MEETING
May 21-22, 1994
Michigan State University
LANSING, MI**

APA

American Psychiatric Association
ANNUAL MEETING
Doubletree Hotel
PHILADELPHIA, PA
Wednesday, May 25, 1994
2-5:00 pm Seminar Speakers:
Drs. Green, Lief,
McHugh, Singer

UNITED STATES

Call the contact person listed for time and location of meeting.

key: (MO) = monthly

ARKANSAS

LITTLE ROCK
Al & Lela (501) 363-4368
Spring Meeting - Saturday, March 26

CALIFORNIA

CENTRAL COAST
Carole (805) 967-8058

NORTH COUNTY ESCONDIDO
Joe & Marlene (619) 745-5518

RANCHO CUCAMONGA GROUP
Marilyn (909) 985-7890
1st Monday, (MO) - 7:30 pm

SAN JOSE-SAN FRANCISCO BAY AREA
Jack & Pat (408) 425-1430
Last Saturday, Bi-Monthly,

VALENCIA

Jane & Mark (805) 947-4376
4th Saturday (MO) 10:00 am

COLORADO

DENVER
Roy (303) 221-4816
4th Saturday, (MO) 1:00 pm

FLORIDA

SOUTH FLORIDA
Esther (407) 364-8290
Every Thursday, 1:30 pm at SIRS

FLORIDA STATE MEETING
being planned for April 23-24, 1994
Call Esther/Bernie (407) 364-8290

INDIANA

INDIANAPOLIS AREA (150 mile radius)
Gene (317) 861-4720 or 861-5832
Nickie (317) 471-0922 (phone & fax)
Bernice (219) 753-2779

IOWA

DES MOINES
Saturday, April 16, 9am -3pm
Call for reservations:
Betty/Gayle (515) 270-6976

KANSAS

KANSAS CITY
Pat (913) 238-2447 or
Jan (816) 276-8964
2nd Sunday (MO)

KENTUCKY

LEXINGTON
Dixie (606) 356-9309

MAINE

FREEPORT
Wally (207) 865-4044

MARYLAND

ANNAPOLIS AREA
Carol (410) 647-6339
1st Sunday, bi-monthly

MICHIGAN

GRAND RAPIDS AREA - JENISON
Catharine (606) 363-1354
2nd Monday (MO)

Michigan Information Newsletter
P O Box 15044, Ann Arbor, MI 48106
(313) 461-6213
Meeting notices & state topics

MINNESOTA

Terry & Collette (507) 642-3630

OHIO

CINCINNATI AREA
Bob (502) 957-2378

MISSOURI - See KANSAS

NEW ENGLAND

CHELMSFORD, MASSACHUSETTS
Jean (508) 250-1055
2nd Sunday (MO) 1:00 pm

NEW JERSEY (SOUTH) - See PENNSYLVANIA

OHIO

CINCINNATI
Bob (513) 541-5272 for meeting info
&
2-day workshop featuring FMS Debate

PENNSYLVANIA

WAYNE, PA
Jim & Joanne (215) 783-0396

TEXAS

CENTRAL
Nancy & Jim (512) 478-8395

HOUSTON

Jo or Beverly (713) 464-8970
Saturday, March 19, 1-5 pm

VERMONT & UPSTATE NEW YORK

BURLINGTON, VT
Elaine (518) 399-5749
Tuesday, March 8, 1994 - 7 pm

WISCONSIN

Katie & Leo (414) 476-0285
To participate in a phone tree.

CANADA

BRITISH COLUMBIA

VANCOUVER & MAINLAND
Ruth (604) 925-1539
Last Saturday (MO) 1:00-4:00 pm

VICTORIA & VANCOUVER ISLAND

John (604) 721-3219
3rd Tuesday (MO) 7:30 pm

MANITOBA

WINNIPEG
Joan (204) 257-9444
1st Sunday (MO)

ONTARIO

TORONTO
Pat (416) 445-1995

AUSTRALIA

Ken Goodwin 08-296-6695

NEW ZEALAND

Dr. Goodyear-Smith
tel 0-9-415-8095
fax 0-9-415-8471

UNITED KINGDOM

Affiliated Group
Adult Children Accusing Parents
Roger Scottford (0) 225-868682

To list a meeting: Mail or fax information to Nancy two (2) months in advance of meeting date, i.e., for April newsletter, send by Feb 26th. Standing meetings will continue to be listed unless notified otherwise by contact.

PROFESSIONAL ARTICLES:

- __513 Dawes, R.M. (1993) "Prediction of the future versus an understanding of the past: A basic asymmetry." *American Journal of Psychology*, Vol. 106, No. 1, pp. 1-24. [\$4.00]
- __562 Loftus, E.F. & Rosenwald, L.A. (1993) "Buried Memories Shattered Lives." *ABA Journal*, November 1993, pp. 70-73. [\$1.00]
- __574 Passantino, R. & Passantino, G. (1992) "Hard Facts About Satanic Ritual Abuse." *Christian Research Journal*, Winter 1992. [\$2.00]
- __592 Wakefield, H. & Underwager, R. (1993) "A Paradigm Shift for Expert Witnesses." *Issues in Child Abuse Accusations*, Summer 1993, 3: 156-167 [\$3.00]

MAGAZINE & NEWSPAPER ARTICLES:

- __080 "Victims, All? Recovery, co-dependency, and the art of blaming somebody else," David Rieff. *Harper's Magazine*, October 1991 [\$3.00]
- __095 "Oedipal Wrecks," E. Fuller Torrey. *The Washington Monthly*, January/February 1992. [\$3.00]
- __173 "False memory group looks into abuse that never happened," John Lyons. *Winnipeg Free Press*, December 7, 1992. [\$1.00]
- __245 "Total Recall Versus Tricks of the Mind," by Gayle Hanson. *Insight*, May 24, 1993. [\$2.00]
- __285 "Falsely Accused," by Anne Bayin. *Homemaker's Magazine*, September 1993 [\$1.00]
- __287 "Haunted Dreams: real or implanted?" by Mark Smith. *Houston Chronicle*, September 12, 1993. [\$1.00]
- __288 "Why does nobody run herd on therapists?," by Pierre Berton. *The Toronto Star*, September 18, 1993. [\$1.00]
- __291 "I Forgot to Remember to Forget," by Wes Eichenwald. *The Boston Phoenix*, October 15, 1993. [\$2.00]
- __292 "Multiple Personalities: the Experts are Split," by Chi Chi Sileo. *Insight*, October 25, 1993. [\$2.00]
- __293 "The Unknown Freud," by Frederick Crews. *The New York Review of Books*, November 18, 1993. [\$3.00]
- __294 "Defining Deviancy Up," by Charles Krauthammer. *The New Republic*, November 22, 1993. [\$1.00]
- __295 "Memories of Abuse," by Glenn Kessler. *Newsday*, November 28, 1993. [\$2.00]
- __296 "Trial by Accusation," Review & Outlook commentary. *The Wall Street Journal*, December 1, 1993. [\$1.00]
- __297 "Child Abuse, Suppressed Memory, and Coercion," by Dr. X. *Whole Earth Review*, Winter 1993. [\$2.00]
- __298 "Family gets blamed for everything," commentary by Kathleen Parker. *Orlando Sentinel*, December 31, 1993. [\$1.00]

Criminal Lawyers' Association Conference***The Abuse and Misuse of Science:
Recovered Memories***

November 5-7, 1993 Toronto

Contact Alan D. Gold, Barrister, 20 Adelaide Street East, Suite 210, Toronto, On M5C 2T6, 416-368-1726, fax: 416-368-6811

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FMS Foundation

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February 8, 1994

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False Memory Syndrome Foundation
3401 Market Street, Suite 130, Philadelphia, PA 19104-3315

Information Update
February 1994

The Foundation is making every effort to keep records up to date and to plan future research. To help us do so, please complete the short questionnaire below and return it at your earliest convenience.

Name: _____

Address: _____

City State Zip (9 digits, if possible)

Check this box if the above is a new address.

Note: The following personal information will be kept confidential. Your name or your answers to the questions below will not be released without your written permission below. The Foundation may report statistical data based on information provided but will not compromise confidentiality.

Your relationship to the accuser:

Mother Father Sibling Grandparents Other _____
specify

Who is accused ?

Mother Father Sibling Grandparents Other

Did the accusations include Satanic Ritual Abuse (SRA) ?

Yes No Don't Know

Has the accuser been diagnosed as having:

Multiple Personality Disorder (MPD)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Schizophrenia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Epilepsy or other disease of the central nervous system	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Eating disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Post Traumatic Stress Disorder (PTSD)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Bipolar Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Other, please specify _____			

Are you currently in contact with the accuser ?

Yes No

Has the accuser made any attempt to re-enter the family ?

Yes No

Has the accuser retracted the accusations ?

Yes No

Has any kind of legal action been initiated against the accused on the basis of repressed memories ?

Yes No Don't know

Do we have your permission to give your first name and telephone number only to a person in your state who may call you to let you know what is happening in the state, invite you to area meetings and bring up Foundation related issues? Please check the option and sign.

Yes, you have my permission to give my first name and telephone number to a contact person in my state. _____

signature

No, you do not have my permission to give my first name and telephone number to a contact person in my state. _____

signature

Thank You

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