

FMS Foundation Newsletter

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July 6, 1994

Dear Friends,

Will the FMS phenomenon find its place in history as the Recovered Memory Mistake? Therapy for space alien abduction! Therapy for past lives! On June 16, the American Medical Association's Council on Scientific Affairs issued a statement about recovered memories. The full text of the statement is reprinted in this newsletter. In addition to reasserting the AMA 1984 position on the limitations of hypnosis, the new statement specifically questions "recovered memory therapy."

"The AMA considers recovered memories of childhood sexual abuse to be of uncertain authenticity, which should be subject to external verification. The use of recovered memories is fraught with problems of potential misapplication."

The AMA statement also states what it considers the most questionable areas:

"Most controversial are those "memories" that surface only in therapy and those from either infancy or late childhood (including adolescence)"

When we read this, we decided to review the data we have collected from a survey conducted from March 1992 through August 1993.

We asked accused people at what age the accuser alleged the abuse began. In a sample of 399 surveys, 90 did not answer this question. Not every accused person knows all the details of the terrible things he or she allegedly did. Of the 309 completed responses, 54% of the accusers claimed to have recovered memories from 3 years or younger. 34% claim to have recovered memories from age 2 or younger.

We asked families at what age the accuser claimed the alleged abuse ended. From the sample of 399 surveys, 160 families did not answer this. Of the 239 who did answer, 60% said that the accuser claimed that the abuse continued after the age of 11 but s/he had not been aware of it until memories were "recovered" in therapy.

Doesn't that indicate at the minimum that the reports to the FMS Foundation should be examined? The accused are asking for investigation. It is the accusers, their therapists, and the state licensing and monitoring boards that refuse. To accuse and then refuse to provide any forum to examine the accusations is "guilt by accusation." It is this behavior that leads to use of the term "witch hunt."

Recovered Memory Therapy is a "closed-system" of logic. The insurance diagnosis associated with RMT is Post Traumatic Stress Syndrome, one of the only diagnoses that has a "stressor," a cause, associated with it. To make the diagnosis, a doctor must know that a trauma occurred. Yet "recovered memory" therapists characteristically note that the patient, "shows all the signs of abuse" and from the patient's behavior

"predicts backwards" to show that the abuse must have happened. No one can fail to have been abused, abducted by aliens or have past lives using this logic. With such logic there is no way to show that any report is ever false. This way of thinking is not scientific.

If any other medical product had more than 13,000 complaints it would be taken off the market and examined. If a new drug is developed, it is tested and the benefits and risks are evaluated. There are no mechanisms for doing this for a therapy product.

This month we received reports of a new therapy for finding trauma memories. Therapists can get continuing education credit for learning a technique of "wagging their fingers in front of the patient's face," (*Philadelphia Inquirer*, 6/26/94). This is called Eye Movement Desensitization and Reprocessing. There are no independent studies to show that this is an effective or a safe therapy. There is no sound scientific theory on which it is based. Instead, personal testi-

monials of the inventor and of committed clinicians are used to sell this therapy. This is the way a new therapy is introduced and marketed. Is this process in the best interest of the public? We have letters from families whose accusing children "recovered memories" using EMDR.

Retractors: For the past two months, we have received at least one phone call a day from someone telling us that he or she had been a "Recovered Memory Therapy" (RMT) patient. These calls are in addition to the letters and calls from accused families whose child has returned and retracted, or returned without mentioning the accusations. In the office, we feel a shift may just be beginning.

We have been asked to take over "The Retractor" newsletter — at least for now. "The Retractor" was started by Melody Gavigan two years ago. Through the help and insights Melody provided in this well-written quarterly newsletter, many former RMT patients began to understand their own therapy experiences. Melody is ready now to put the therapy experiences behind her and "get on with her life." She, along with other former RMT clients have told us that they want to be ordinary members of FMSF, to join in the effort to stop what is wrong and to try to change things so this terrible mistake will never happen again. If there is one request that is common, it is that they not be labeled.

While former RMT clients have special insights and needs, a common immediate concern now predominates: how to reconcile families that have been so savagely torn apart. Accused parents are trying to reach their children; former RMT patients are trying to reach their parents and extended family. When they do connect, then what? Until now, a major focus of FMSF has been on trying to find ways to get a wedge of reason into thinking systems that were 'closed.' This is happening with the help of thousands of caring professionals, the media, and the willingness of retractors to speak out.

Inside

AMA Report

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International Conference

Memory and Reality: Reconciliation

CoSponsored by The False Memory Syndrome Foundation
and The Johns Hopkins Medical Institutions
Baltimore, MD December 9, 10, 11 1994

Registration form enclosed.

We know all too well that the majority of families are still desperate, wondering if this nightmare can have an end for them personally, wondering how to help speed its end. The beginning shift of calls suggests that there is hope, but it does not yet say that we can change our expectations.

What is the reason that people move away from RMT therapy? Callers tell us that something they read in the paper or heard on television caused them to rethink their own experience. They sometimes say that a question or suggestion from a friend or relative or therapist who had read something was a trigger to rethinking. In this newsletter, we reprint a letter from a "Male Retractor from BC" whose "recovered memories" did not involve a therapist. The description of his struggle to come to terms with his own experience may help us all understand how the "recovered memory mistake" could have happened.

Child abuse is unconscionable. Ignorance and carelessness in dealing with issues of child abuse, however, will only undermine efforts to help children. Our culture bought into a therapy model that works well for substance abuse but then imposed the model on other situations and it took on a life of its own. There was a mistake. People make mistakes and cultures make mistakes. We can work together to learn from the mistake. We can work together to solve it. Nothing less will do.

But they [i.e. False Memory Syndrome Foundation] argue that often the accusations are false even if the accusers believe them to be true. They also note that these accusations are frequently encouraged by therapists who are untrained or don't have credentials, but who make a living as abuse specialists. The members of the group insist in strong and aggrieved terms, that as parents accused falsely of despicable acts they also have rights, both legal and moral, and deserve not only a hearing but also protection from false charges.

Walter Reich, M.D., 1994
"The Monster in the Mists"
New York Times Book Review, May 15

Pamela

Death of Nicholas Spanos

It is with deep regret that we inform readers of the death of one of the world's great hypnosis researchers, Nicholas Spanos, Ph.D., Professor of Psychology at Carleton University in Ottawa, Canada. Dr. Spanos died in a private airplane crash on June 7, 1994.

Nick Spanos left as his legacy an important body of research. Much of his recent work in hypnosis focused directly on issues related to FMS and space-alien abduction. One study, for example, concluded that people who claim to see flying saucers or have close encounters with extraterrestrials are ordinary folks with normal imaginations, (*Journal of Abnormal Psychology*, 102, 4, 624-632, 1993). Dr. Spanos was outspoken in his criticism of some current uses of hypnosis to "recover memories," and his articles and letters to the editor on this topic hold a special place in our library.

In honor of Nicholas Spanos, we can hold to the high standards of science and scholarship for which he earned the respect of his colleagues.

Our Critics, Hypnosis, FMSF Advisory Board. The death of Nick Spanos focused our attention on his work and on its role in the

development of understanding of memory processes, especially through work in hypnosis. We began to wonder if perhaps it was a lack of this kind of understanding that has led our critics to say what seemed to us very silly things (i.e. that FMSF has a "slick" media campaign, that FMSF has paid the media to write favorable articles, that the members of the media who do write favorable articles come from dysfunctional families, etc).

It was Franz A. Mesmer who first brought what is now called "hypnosis" to the attention of the medical profession. "Animal magnetism," as it was named by Mesmer in the late 18th Century, was thought to be some special state and that the behavior he observed in patients was the result of mechanistic forces, agencies, or mental processes that resulted in special or automatic responses. Indeed, in this century, the fundamental issue that has grounded research in hypnosis has been whether it is a "special state" or whether it falls on a continuum of waking functioning. One of the strengths of the FMSF Advisory Board, one of the reasons that people in the media and the professions have taken FMSF so seriously, is that scientists who fall into

differing camps on fundamental issues about hypnosis have joined to express the same concern about the "misuse" of hypnosis for "refreshing memory."

Nick Spanos put forth a body of research suggesting that the behaviors that were seen in hypnosis were not the result of some special state. He argued that they were instead the result of "cognitive-behavioral" responses. People, he suggested, respond in ways that fulfill the task requirements and the expectations of the researchers. "People are going to look to authority figures, such as the therapist, to see if they're treating this as though it really happened. People start thinking maybe it's true, start imagining what if it were true," (*Ottawa Citizen*, June 8, 1994). Spanos's body of research is built on the theoretical work and perspective of Theodore Sarbin, a member of the FMSF Advisory Board.

The body of work of Martin Orme, on the other hand, a member of the FMSF Advisory Board, argues that hypnosis is a special "trance" state. That does not mean that research from Orme's perspective ignores task requirements. Indeed, it was Orme who coined the term, "demand characteristics of social domains" which helped to sharpen the issues, boundaries, and theoretical perspectives of research in hypnosis.

The tension, the differing perspectives about hypnosis, are the very real and exciting processes of science as it progresses. In the effort to provide

convincing evidence and arguments, researchers are expected to produce careful and controlled experiments that are published. Clinical evidence is not ignored. Rather it is the starting point from which research questions are generated. While clinical evidence is important and necessary when working with people, it is not sufficient. We can be misled by clinical observations as the debacle of Facilitated Communication has recently shown us. Open debate, discussion, argument, presenting of data — this is what is expected in science. If someone makes a claim, he or she is expected to show the evidence for the claim.

Those who claim that there exists a process of "robust repression" such that decades worth of selected memories can be blotted out have the burden of proof. To put people in prison now, to destroy families now, because a study next year might have the proof? Claims that "the definitive study" is just about to appear are the hallmark of "belief systems" not science.

Selling Pseudoscience: We can contrast the vitality and excitement that propels real science with the methods used to promote "pseudo" science. Carl Sagan spoke to that issue at a June meeting of CISCOP (Committee for the Scientific Investigation of Claims of the Paranormal) in Seattle. Nick Spanos had also been scheduled to speak.

Why is it that so many people come to believe and have faith in things for which there is no evidence — such as Facilitated Communication. One of the talks at the CISCOP meeting was entitled, "How to sell pseudoscience." It was presented by Anthony Pratkanis, Ph.D. whose research has been on claims of "subliminal audio tapes." As you read the list, consider "recovered memory therapy." What parts of it are real science? What parts are pseudoscience?

1. Create a phantom. (Create an unavailable goal that looks real or attainable.)

2. Set a rationalization trip. (Get a person to commit to the cause as soon as possible. Then the person will want to prove himself or herself right, thus escalating the commitment.)

3. Manufacture source credibility. (An authority figure or guru will put an end to questioning. What right does a mere novice have to question the authority?)

4. Establish a "granfallon." (Create a group which will control the social reality. It is very common to create enemies or scapegoats.)

5. Use self-generated persuasion. (Ask the person to "imagine" what it would be like, etc.)

6. Construct vivid appeals. (Use case studies rather than statistics.)

7. Use pre-persuasion. (Define the situation and expectations.)

8. Use heuristics and commonplaces. (Ready made responses that cover any questions can eliminate discussion.)

9. Attack opponents through innuendo and other character assassination. (Make reference to a "vague they." **Innuendo can:**

- change the discussion by moving it from issues to character;

- raise a glimmer of doubt about the character;

- can be very chilling because the person attacked comes to question whether the challenge is worth the bother.

How does a person know that memories of abuse were false?

This is a question that we have asked former patients on a survey conducted by the FMS Foundation.

Ideally, research endeavors should steer the direction of clinical practice for all health care professions. When practice responds to research data, the health and welfare of the public are more effectively protected. Conversely, when practitioners ignore research, they reduce themselves to the status of charlatans and faith-healers — and even more alarmingly, they jeopardize the welfare of their patients.

Terence Campbell, Ph.D. (1994)
 "Psychotherapy and Malpractice Exposure"
 American Journal of Forensic Psych, 12 (1)

For many, this is a difficult question to answer because the "experience" of a memory can be impossible to describe. The idea of "proving" that a recovered memory is false is, in many cases, just as complex as proving a continuous memory is objectively true.

Many retractors report that at some time during their memory recovery process, they not only started to question their memories, but also came to a turning point at which they gathered the courage to look for corroboration or evidence for their memories of sexual abuse. What they found (or did not find) convinced them that their memories were false. Memories often did not "fit" with reality. Sometimes very concrete information disconfirmed their memories. Some retractors talk about physical evidence (pregnancies, scar tissue, etc.) that would have been available if their memories were accurate. In other cases, retractors described a sense of discordance with reality in their false memories.

Retractors have also commented on the character of their false memories. Some describe a blurring between fantasy and reality in their memories and a sense that their memories for the abuse simply did not "fit." These false memories are often described as not "feeling" like other memories (even other traumatic memories) or not making sense. Retractors often say that unlike other memories, their false memories kept "growing" during therapy, with more and more detail and embellishment.

Quite a few retractors can compare their false memories of abuse to their memories for real abuse they suffered as children and always remembered and have a sense that there is a real difference between these memories.

Finally retractors often say that they can tell their memories of abuse are false by the change in their life since they came to this realization. Many describe a sense of peace and comfort with their decision that their memories were false and a sense of well-being that they missed while entrenched in the memory recovery process.

Reduced Charges

As more people have started to question, parents have been told that the terrible "memories" were a metaphor for feelings of abuse. Parents have been told that the family was "dysfunctional." Charles Whitfield, M.D. is often cited as the expert on dysfunctional families. Whitfield is one of the most outspoken critics of FMSF saying that ninety-eight percent of the families that contact the Foundation are guilty. Whitfield's checklist has been used to confirm sexual abuse. Below is a Whitfield checklist. It may help some readers understand the basis for the new charges:

"Recovery Potential Survey"

Charles Whitfield

from *Healing the Child Within* (1987)

(Directions tell readers to circle word that most applies to how you truly feel. Circling "occasionally," "often" or "usually" to any of the questions, may indicate reader is an adult child of a dysfunctional family.)

Never, Seldom, Occasionally, Often, Usually

1. Do you seek approval and affirmation?
2. Do you fail to recognize your accomplishments?
3. Do you fear criticism?
4. Do you overextend yourself?
5. Have you had problems with your own compulsive behavior?
6. Do you have a need for perfection?
7. Are you uneasy when your life is going smoothly? Do you continually anticipate problems?
8. Do you feel more alive in the midst of a crisis?
9. Do you care for others easily, yet find it difficult to care for yourself?
10. Do you isolate yourself from other people?
11. Do you respond with anxiety to authority figures and angry people?
12. Do you feel that individuals and society in general are taking advantage of you?
13. Do you have trouble with intimate relationships?
14. Do you attract and seek people who tend to be compulsive?
15. Do you cling to relationships because you are afraid of being alone?
16. Do you often mistrust your own feelings and the feelings expressed by others?
17. Do you find it difficult to express your emotions?
18. Do you fear any of the following: •losing control? •your own feelings? •conflict and criticism? •being rejected or abandoned? •being a failure?
19. Is it difficult for you to relax and have fun?
20. Do you find yourself compulsively eating, working, drinking, using drugs, or seeking excitement?
21. Have you tried counseling or psychotherapy, yet still feel that "something" is wrong or missing?
22. Do you frequently feel numb, empty, or sad?
23. Is it hard for you to trust others?
24. Do you have an over-developed sense of responsibility?
25. Do you feel a lack of fulfillment in life, both personally and in your work?
26. Do you have feelings of guilt, inadequacy or low self-esteem?
27. Do you have a tendency toward having chronic fatigue, aches and pains?
28. Do you find that it is difficult to visit your parents for more than a few minutes or a few hours?
29. Are you uncertain about how to respond when people ask about your feelings?
30. Have

you ever wondered if you might have been mistreated, abused, or neglected as a child? 31. Do you have difficulty asking for what you want from others?

LESSON OF THE LEVY CASE

Adapted from articles in the *Globe and Mail*
(May 1994) Paula Tyroler

One day last spring, Harold Levy, a Toronto Star journalist and a lawyer, was arrested as he was driving to visit his mother.

"Police cars surrounded him on a public street — as if he were the most dangerous bank robber," said Alan Gold, Levy's lawyer. "His arrest was the most astonishing thing I have ever heard of, cameras were there to video tape the arrest."

Mr. Levy was charged with nine offenses, all based on recovered memories. At his bail hearing, the Crown sought to have him held in custody, but bail was set at an astonishing \$200,000.00.

Subsequently Mr. Levy suffered through "the year from hell."

This year, as dramatically as it had begun, the case fell apart. The young woman, whose identity cannot be revealed, and who had made allegations that Mr. Levy had sexually assaulted her with knives and been bottles from a very young age until quite recently, recanted!

She is devastated and regrets the whole thing. She feels that she was strongly influenced by a network of therapists, social workers and legal authorities. According to her lawyer, she now blames her therapists for encouraging her to "recall" events that never happened.

Did the Crown apologize to Mr. Levy for his ordeal? Not a chance! On Friday, April 29th, Crown counsel Christine McGoey, said that the crown had "very reluctantly" decided not to proceed with the charges.

"Sexual assault cases based on false memories have become so frequent that there ought to be a public inquiry into the way they are conducted," proclaimed lawyer Alan Gold.

Mr. Levy, who will return to the Toronto Star and resume his career said, "I want to use all my legal and journalistic skills to assure that in the future, people will not be charged in cases like this without a fair and thorough investigation."

"The lesson of the Levy case," said the young woman's lawyer, "is that prosecutors must exercise greater caution when dealing with allegations that arise from therapy sessions."

FMSF needs your help

The Foundation needs the active support of all concerned professionals and families. We cannot continue to operate without your contributions.

FROM OUR READERS

Therapist Not Needed to Recover Memories

I have been moved by the account of Laura Pasley in her article "Misplaced Trust" (*Skeptic* 2(3), May) to give you an account of my own seduction into the false memory hysteria and subsequent retraction. Laura's account of the process of ever-expanding stories of recovered abuse memories, "Each week we sat in a group and the stories were enough to make a strong stomach sick...one woman might have a flashback one week about her parents or someone else in the family and then the next week another one would have a similar memory come up...[i]t was not long before my own flashbacks got even more bizarre."

My experience departs from the norm in two respects: (1) my induction into the realm of false memories took place without a therapist as such, and (2) I am a male. I believe my experience indicative of a process that, once an irrational hysteria such as this gains momentum, it begins to show up in more generalized areas outside formal treatment milieus. Here is my story.

In the late 1980's, in the face of numerous personal issues I didn't feel were being helped by traditional psychotherapy, I began to attend one of the "anonymous 12 Step" groups, Adult Children of Alcoholics (ACA). These meetings are, as you probably know, run on a model similar to Alcoholics Anonymous or Alanon, but with a significant difference: there is an explicit emphasis on intense personal self-exploration which parallels, and perhaps in some ways exceeds, the format of group psychotherapy. In my case, these intense explorations seemed to be increasing my psychological distress, but I was assured by other members that "you have to get worse before you get better...giving up your denial is going to put you in touch with the pain of the damaged child within, etc. etc." I had also heard in a tape of Charles Whitfield, author of the book *Healing the Child Within*, stating that it is a normal consequence of the healing that one's self-esteem would plummet before it was rebuilt on a healthier foundation. I bought all these reassurances and was determined to throw myself into the work of the group to achieve a "recovery" from my problems.

I began to attend meetings at least once a week, all the while sinking into greater and greater turmoil; I also avidly read all the then current books by the various people such as Whitfield, Bradshaw, etc. So, when some ACA members announced that they were forming a special, closed time-limited intensive group structured around the workbook "The 12 Steps for Everyone", I was quick to join. These new meetings were longer (3 hours) than the standard ACA meetings and every attempt was made to encourage "work" on each member's part to the greatest degree possible; an elaborate phone network was established, and between meetings we all agreed to use the workbook format to engage in intensive autobiographical writing, the "searching and fearless moral inventory" prescribed by step 4 of 12 steps. In the first two weeks I wrote over 180,000 words in my desperation to see this effort work for me. I spent

This accusation is so remote and impossible that it seems pitiful that she could believe anything so preposterous. Nevertheless, we have been devastated, angry, and now just sad and numbly accepting of the situation.

A Mom and Dad

endless hours on the phone between meetings with other group members; these conversations were often punctuated with tears, various formulaic exhortations from the program, particularly surrounding the Catch-22 notion of "denial" the underlying assumption was that the real truth lay buried in repressed memories but that to avoid the pain of their devastating truth we all habitually relied upon various cover thoughts and behaviors that collectively comprised our "denial." It seemed that any new insights that came about from this self exploration which were undramatic or contained elements of mitigation of circumstances, were quickly adjudged to be just another layer of denial. To demonstrate "progress" I found myself making more and more dramatic and condemning interpretations of my recollections of the past, for which I was rewarded by the group for showing "the courage to heal."

Then at one of the meetings, during a "guided meditation" that followed a very intense session of dramatic "sharing" by several of the group, one woman let out a blood-curdling shriek followed by her collapsing on the floor in hysterical sobbing, yelling, "No, no, oh my God, no, not again, I'm just a little girl." This was followed by a halting, wide-eyed description by the woman of someone sexually molesting her as a child. At this point, one of the more self-assured members of the

group who had gradually assumed an unacknowledged but distinct role as leader, rushed to her side and said such things as "you are in a safe place now, don't lose it, there is more, take a look at it, tell us, don't be afraid, we're all here to protect you, let it out, face it, deal with it, etc." For the remainder of the evening and much of the subsequent meeting, this woman proceeded to recall more and more lurid details of her having been molested not only by her father but by other males from her neighborhood. Then another woman in the group suddenly broke down and said that something the first woman had said had triggered in her the recall of a scene of being sexually molested. During all this I was becoming more and more uncomfortable and upset. Then suddenly I had a vague recollection of some kind in which I seemed to recall being held in a dark place by a person whom I couldn't identify who was molesting me as a young boy.

Now with three people all sobbing and competing for the group's attention, the meeting broke up in chaos, with assurances all round that there would be a great deal of mutual support by phone and in person until the next scheduled meeting. At the next meeting, three people advanced various excuses why they couldn't honor their commitment to complete the group's work; the spell was broken. There was never another meeting.

Meanwhile I was still deeply bothered by the vague memory, which was more of a feeling than anything else. So, I sought out a person who offered "hypnotherapy" (an unlicensed person whose 'credentials' consisted of a mail-order diploma as it turned out). Sure enough, under the probing of this "hypnotherapist", I began to fill in details of

the supposed molestation. The one thing I couldn't conclusively get clear was the identity of the perpetrator. I eventually concluded that it must have been my grandfather, although I never did have a clear mental picture of him. Still, I was plagued by uncertainty as to the details that I had "remembered" in the hypnotic trance. Later I began to change details, as to where, what and who was involved. My ACA colleagues warned me that I couldn't face that it was my grandfather, and that denial was reasserting itself.

Nonetheless, some tough-minded part of me allowed me to begin to question this sink hole of non-sequitur reasoning, so I pulled back from the meetings to get some distance from the influences. At this point it is important to note that I had in fact experienced an attempted molestation as a young boy, by a chef in my father's restaurant who had exposed himself to me and grabbed me; I was able to quickly squirm free of his grip and flee. While frightening and creepy at the time, I don't believe that experience was particularly traumatic, and it isn't something that was repressed; I hadn't thought about it for years, but it was certainly an ordinarily accessible memory. I began to realize that I had taken the uncomfortable feelings I had experienced from that episode with the chef and amplified them in response to the hysteria and group pressure to recall something truly horrible to account for my adult "dysfunction." When the two women in our group were successful in gaining all the group's attention and solicitation following their dramatic recalling of sexual molestation, in retrospect I can see how I would have been motivated to become part of the process by coming up with "memories" of my own, based upon a real but essentially trivial incident.

I tried going to a few more ACA meetings, but with my new perspective, I began to see clearly the extent to which there was an irrational cult atmosphere with people continually absorbed by their personal problems and the group process, but without any indication that they were truly becoming healthier individual if anything they seemed to be less in control of their lives and morbidly dependent of the group.

Still, it wasn't until I began to receive material from the FMSF that I was able to completely dispel those lingering doubts as to whether my conclusion was the right one, so powerful is the concept of "denial" to undermine one's confidence of one's own conclusions.

So, there you have it; slightly unusual, but it fits the pattern. Use it as you'd like, if at all.

Retractor from Victoria, BC

Don't Ignore A Daughter Who is Here

I need to get something off my chest that happened over Mother's Day. My husband and I have been spending a lot of time on the weekends with my parents because we know that it makes them happy when we are there. This particular weekend, Mother's Day weekend, we sent my mother a card but it had not arrived by Mother's Day. I told

her it was in the mail and that was fine. We did not buy her anything because we were going to take her out to brunch because she always cooks for us when we are there. My mother said that would be too many people to take out and that we could cook her a nice breakfast at home. We had a good weekend.

On Tuesday I called her. She was crying and said I didn't love her and was inconsiderate because I had not gotten her anything for Mother's Day. I was so upset. I think that she is mad at my sister who made the accusations and cut off and that she is taking the anger out on me. Every Mother's Day is getting worse.

I am a little bitter at this point. I think this has gone on long enough, four years. I wish my mother and father

could just get on with their lives instead of thinking she is going to make a remarkable recovery and come flying home. I don't think that will happen and I don't think I should have to take the brunt of my mother's angry feelings.

A Sister

It would take more time than I have here to express it all, but the bottom line is that my own feeling of relief that she no longer sees me as a perpetrator is minor compared to my joy that she is emerging from a black hole and will have a chance now for a fuller family life instead of a bitter future based on false memories.

A Dad

Investigation

Several weeks ago, a group of families went to our state representative. We told him our stories and our concern about a local mental hospital, part of a very large chain of private hospitals. We asked if he could investigate. He assured me that he would if we could give him evidence that the hospital received state money.

I called the hospital and told them a "story" about my mother who was in depression and possibly needed professional help. I explained that my mother was on Medicare. We were told that was "not a problem" as they had many Medicare and Medicaid patients. She added that Medicare pays 190 days of inpatient care, and unlimited outpatient care five (5) days a week between the hours of 9 AM and 3 PM. She also said "Mom" would be evaluated by her (the R.N.) and not a doctor. She then went on to tell me what type of care she would need, probably extensive inpatient at first. This was simply astounding to me that a nurse would be making these decisions at what would be a very critical time in the treatment.

The representative will initiate action.

A Dad

Mother's Day

Fantastic news!! I had a call from our daughter on Mother's Day...after almost 19 months of separation.

Hearing the familiar voice say—tremulously—into the phone, "Happy Mother's Day," I thought I would drop dead of shock and joy. What a thrill!

She said I'd been in her dreams a lot lately, that it was very hard not to have a family, that she realized how much she loved us and missed us. She said she was really sorry she had hurt us, that she had done what she had felt she had to do at the time. She said she had not wanted to hurt us. She said she realized now she must have hurt us terribly and she was truly sorry. She begged our forgiveness. What a Mother's Day gift.

A Mom

A Debate Over Bulimia and Abuse

By Daniel Goleman - May 31, 1994

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While an earlier generation of therapists was criticized for minimizing the lasting psychological impact of their patients' childhood traumas, a current crop of therapists is coming under attack for telling patients that their symptoms indicate they must have suffered a childhood trauma, which they have buried.

If the patient cannot come up with such a memory, these therapists help them out with methods that include hypnosis, visualization and even sodium amytal, the so-called "truth serum," actually a short-acting barbiturate that induces an intoxication during which people talk with fewer inhibitions. While no one can say how common these practices are, such methods are "a sure-fire way to implant false memories," said Dr. Elizabeth Loftus, an expert on memory at the University of Washington.

Among the symptoms often considered by these therapists to be a sign that a person was sexually abused in childhood is bulimia. In the recent California case in which Gary Ramona was awarded \$500,000 after a jury found that psychotherapists had talked his adult daughter into falsely remembering childhood sexual abuse, bulimia was the problem for which she had sought treatment. In that case, before setting out to find the daughter's repressed memory of sexual abuse through the use of sodium amytal, the daughter's psychiatrist had told her that 70 to 80 percent of bulimics have been sexually abused.

Those figures are disputed, however, by an article in the current issue of *The American Journal of Psychiatry* reporting that women suffering from bulimia show no higher rates of childhood sexual abuse (ranging from fondling to intercourse), than to women in the general population.

The study, conducted by Dr. Harrison Pope, a psychiatrist at McLean Hospital in Boston, compared childhood sexual abuse rates for 91 women from the United States, Brazil and Austria. He found that American women who came for treatment of bulimia reported a rate of childhood sexual abuse of 24 percent, compared with 36 percent for the general population.

Those who cling to the idea that repressed sexual abuse is the cause of bulimia and a host of other problems may not be swayed by one study. Other studies have found higher figures of fully recollected sexual abuse among women seeking psychiatric help. Dr. Loftus, in an article to be published in *The Psychology of Women Quarterly* later this year, found that of 105 women in a clinic for substance abuse, 54 percent recalled childhood sexual abuse, with "abuse" being more broadly defined than in Dr. Pope's study to include, for example, having been the victim of someone sexually exposing themselves. But of those who reported childhood sexual abuse, only 19 percent said they "forgot" the abuse for a period before remembering it again.

"At the moment we do not have the means for reliably distinguishing true memories about the guilty from false memories about the innocent," said Dr. Loftus in a paper at the annual meeting of the American Psychological Association last August in Toronto. "We cannot get to the truth

about the past by remembering alone. Until we can it seems prudent to be cautious about how one goes about piercing some presumed amnesiac barrier."

Suggestibility Research

From "Recovered Memories": Recent Events and Review of Evidence: An Interview with Harrison G. Pope Jr., M.D.

in *Currents in Affective Illness*, Vol XIII, (7), July 1994.

Both Elizabeth Loftus and Richard Ofshe "have demonstrated that it is possible to "implant" false memories. Loftus was able to convince a group of persons that, as children, they had become lost in a shopping mall, when in fact that had not happened. Ofshe was able to convince a man who had been accused of satanic ritual abuse that he had forced his son and daughter to have sex with one another...One of the striking findings in psychological research over the last fifty years is that even intelligent and sophisticated people can be highly suggestible. The now classic experiments in social psychology, such as the Asch experiment, the Milgram experiment, and the Rosenthal experiments, have demonstrated that, regardless of intelligence or education, people can be extraordinarily vulnerable to suggestions under the pressure of peers or authority.

In the classic type of Asch experiment, you come into a room and are asked to estimate the lengths of two line segments on a screen. At first, the other members of your group agree with you — that line A, for example, is longer than line B. But then, all at once, the other group members (who are, unbeknownst to you, paid stooges), begin to say that line A is shorter than line B, even though your eyes tell you the opposite. Many people in that situation will bow to group pressure and see the shorter line as the longer one, even though it contradicts the evidence of their senses.

The Milgram experiment is even more dramatic. In that experiment, each subject was induced to deliver what he or she thought were electric shocks to another subject in a "learning" experiment. The intensity of the "electric shocks" gradually increased to the point where the "learner" was screaming in pain. After the "300-volt" level, the "learner" (who was on the other side of an opaque screen) stopped responding entirely; yet, when told by the experimenter that "the experiment requires you to continue," many subjects continued to deliver "450-volt shocks" to another person under the experimenter's authority. The finding was so striking that Milgram and colleagues thought it might be due to the influence of the prestige of the setting (Yale University); yet, when they moved their offices to a building in Bridgeport, Connecticut, where there were no trappings of academia, they replicated their findings.

Rosenthal found that an investigator could bias other investigators who were working for him to produce results that were congruent with his expectations; he found that even the subtlest of cues could alter his subjects' responses. The findings of these and other experiments in social psychology suggest that we humans have an almost humiliating degree of suggestibility, and that the forces of suggestion, of peer pressure, and of authority — all of

which occur in individual psychotherapy and in group psychotherapy — may have profound influences, or at least influences that are greater than most of us would like to believe.

LEGAL CORNER

If you have questions or concerns to be answered in the Newsletter, please send them to Legal Corner, care of James Simons at FMSF.

Analysis of the Ramona Decision, Part II

Jim Simons, J.D., Practicing Attorney
with comments from FMSF Staff

The verdict is in and the news is mixed. The Ramona Trial Court judge recognized the right of a third party plaintiff to bring suit in a false memory case and allowed the case to proceed to the Jury. At the same time, the jury verdict did not include any award for damages for emotional distress. It should be noted, however, that California law requires a cap on pain and suffering/emotional distress associated with medical malpractice cases. Thus, the potential for recovery for emotional distress presented only a fraction of the \$8 million award sought. A Judgment awarding \$475,000¹ to Gary Ramona is due to be entered by the Court on July 11, 1994. At present, it is unknown whether either side will seek a new trial or appeal the decision. The July 11 date marks the beginning of the period during which either side may file post trial motions and give notice of appeal. Depending on whether a motion for new trial is filed, the deadline could extend until mid-September.

The jury verdict which was returned on May 13, 1994, answered eight questions having to do with determining liability and amount of damages. The jury found that the Defendants in the case, therapist Marche Isabella, Richard Rose, M.D., and Western Medical Center - Anaheim, were negligent in providing health care to Holly Ramona by implanting or reinforcing false memories that her father had molested her as a child.² The jury also found that all Defendants had responsibility in causing Gary Ramona to be confronted with the accusation. Of the total negligence (100%), the jury assigned responsibility in the following manner: 5% to Gary Ramona, 40% to Ms. Isabella, 10% to Dr. Rose, 5% to Western Medical Center-Anaheim, and 40% to all other persons. Although the jury stated that Gary Ramona had suffered damages due to the negligence of the Defendants, they awarded him nothing for past or future "discomfort, fears, anxiety and other mental and emotional distress." The Jury did award Gary Ramona \$250,000 for past lost earnings and \$250,000 for future lost earnings caused by the Defendants' negligence.

1. This amount represents the original \$500,000 award reduced by the 5% comparative liability assigned to Mr. Ramona by the Jury.

2. Defendants' legal team argued vigorously to have the first question read "implanted AND reinforced." This point will likely constitute grounds for future argument.

In civil trial, the burden of proving the case is on the Plaintiff. The order of business at a trial is that Plaintiff goes first in presenting evidence which will prove the elements of his claims. After the Plaintiff completes presentation of all his evidence, the Defendants then show the jury (and the Court) the evidence they contend disproves the plaintiff's case, or which will, in some cases, excuse the Defendants' actions. Before the Defendants put on their case, however, the usual procedure is for the Defendants to move for a directed verdict. This takes place out of the sight and hearing of the jury and allows the Defendants to make the legal argument that the Plaintiff has not presented enough evidence to prove the elements necessary to carry the case to the jury. The Judge can then rule on each of the Defendants motions for directed verdict, and some or all of the Plaintiff's claims can be disposed of in this manner. If the Judge allows a directed verdict on a certain claim, the Defendants do not have to present evidence on that issue and the matter is not presented to the jury for decision. In addition to other points which come up during the trial, any of the motions for directed verdict could become the source of a claim of error by the party against whom the Court ruled and could form the basis for an appeal or a request for a new trial.

Not surprising, at the half-way point in the Ramona trial, the Defendants moved for a directed verdict on four issues. All of them were denied by the Judge.³ The Defendants first moved for a directed verdict on the issue of the intentional infliction of emotional distress. The Court denied that motion and ruled that based on the (Plaintiff's) evidence presented thus far in the trial, the jury could find a reckless course of conduct by all the Defendants and that recklessness (and not deliberate intention to cause emotional distress) is legally sufficient to conclude intentional infliction of emotional distress.

Second the Court refused to grant the Defendants' motion based on the contention that no claim could be recognized for Gary Ramona's lost wages. The Judge held that the jury could find that confrontation of Mr. Ramona with the false memories could have caused him to lose everything, including his employment — and that it was not necessary for one of the Defendants to have told Mr. Ramona's employer about the accusations against him.

Taking the remaining issues out of order (as did the Court), the fourth point was raised by the hospital which sought a directed verdict on the issue of liability connected with statements in the record by a hospital employee. The Court refused to allow the hospital to escape the jury's scrutiny regarding liability of the hospital based on the negligent acts of its employees as an agent acting on behalf of the hospital.

The third issue presented by Defendants for directed verdict was the question of whether a father may maintain a lawsuit against his daughter's therapist. In explaining his reasons for allowing the lawsuit to continue, the Judge specifically ruled that Gary Ramona was not a patient of any of the Defendants — and that he did not need to be a patient in order to have standing to pursue his lawsuit. The

3. The reasons given by the Judge in deciding each point are recorded in the transcript of the trial.

trial court held that a duty existed under California law which allowed Gary Ramona standing to sue the Defendants in this case. In an extended explanation, the Judge stated that he was following California law based on prior rulings by the California Supreme Court.⁴ The Judge cited Molien v. Kaiser Foundation Hospitals (27 Cal. 3d 916, 167 Cal. Repr. 831, 616 P.2d 813, California Supreme Court, 1988) as controlling. The Judge stated that Mr. Ramona could be considered a "direct victim" of Defendants' negligence based on the similarity between the facts in Ramona and the facts in Molien. In Molien, a doctor instructed the patient, whom he had wrongly diagnosed as having syphilis, to tell her husband so that the husband could be checked and treated also. The result was the break-up of the marriage. The Molien Court recognized the husband's right to sue the doctor. The Court noted that Gary Ramona had been summoned to a meeting with his daughter's therapist and confronted with a certain diagnosis, a diagnosis which the Jury could find to be incorrect and therefore negligent. The diagnosis resulted in the break-up of Mr. Ramona's family.

In discussing the obligation of the trial court to follow the precedent set forth by the California Supreme Court, the Judge made it clear that the duty of the trial court was not to legislate a change in the law. If the California Supreme Court desired that the Molien decision should be overruled, then the California Supreme Court must say so. The Court noted that the California Supreme Court had an opportunity to overrule Molien in a recent case but had not done so.⁵ The Court also noted that the Court of Appeals for the First District of California had twice refused to issue a pre-trial ruling on the issue and that a final determination could come post-trial on appeal. The trial court stated that consideration of public policy issues was reserved to the higher courts in California.

The Court's remarks concerning public policy identified the underlying question at issue in the Ramona case — and indeed in any false memory case — whether allowing a right of action to a third party is in the public interest. Public policy is a principle of law which holds that no person can lawfully do that which has a tendency to be injurious to the public or is against the public good. thus, out of consideration of the public good, the Court could issue a ruling which will serve the best interest of the community. Gary Ramona argues that such public policy had already been set by the Molien court's recognition of a direct victim right of action. The Defendants argues that so many restrictions and exceptions had been attached to the "direct victim" theory that it no longer existed.

4. Rulings by the California Supreme Court are binding on all lower courts in the state. However, specific facts in a case may allow a lower court to indulge in interpretation of the higher court's decision thereby giving rise to exceptions or variations on the ruling.
5. Although the Judge did not cite the case by name, Burgess v. Superior Court 2 Cal., 4th 1064, 9 Cal Rptr. 2d 615, 831 P.2d 1197 (1992), was the most recent opportunity for the California Supreme Court to rule on the matter. The Court reaffirmed the "direct victim" theory.

Tied up with consideration of whether a public policy right of action exists is the question of how (or whether) the public interest is served by recognition of such a right. Arguments pro and con can be broken down into a multitude of persuasive topics, all of which purport to prove that the consequences of a particular choice will be the most beneficial to society as a whole. As the Ramona and other cases unfold, refinements will occur but certain predictable arguments will be repeated in every case. A few examples which readily come to mind are: Individual therapist's right to deliver therapy services without interference by non-patients vs. Community interest in protecting its members from quackery; Right of clients to engage in the brand of therapy of their choice vs. Right of innocent persons not to be falsely accused; Responsibility of the profession to police its own ranks vs. Right of an injured party to insist on redress when the profession fails to do so; Economic costs of allowing lawsuits to function as avenue of redress for injury vs. Absence of viable alternative for injured third party to be heard; Placing blame on therapist who held no personal animosity toward third party vs. Unfairness of nonetheless requiring the third party to bear his injury alone; Reluctance to opening the door to unconventional causes of action vs. Confidence that the courts and juries can weed out unmeritorious claims. This list is by no means exhaustive and will continue to grow, but the underlying question remains the same: Is the current practice of confrontation based on nothing more than "recovered memory" morally right and if not what should be done about it?

In regard to the Ramona case itself, rarely can either side in a lawsuit claim total victory. While some may wish Ramona had been awarded millions for his emotional distress, the fact is he got a favorable verdict from a jury. This was the first case of its type to go to a full-scale trial. Many lawyers around the country now feel that the door is open to seek truth and redress in our court system for the unscientific and negligent conduct of some therapists.

FMSF Budget

We think it appropriate that we inform you of the financial situation of the Foundation. We operate on a fiscal year ending February 28. For the year ended February 28, 1994, our expenses were approximately \$740,000 and our revenue approximately \$680,000. The deficit was funded from our bank balance which stood at approximately \$30,000 on March 1, 1994, the start of our current year. Audited financial statements of the Foundation will be available for inspection at the offices of the Foundation upon completion of our audit.

In the year ended February 28, 1994 approximately \$225,000 of our revenues were derived from dues, fees and subscriptions. The balance was represented by contributions from families and Foundations. Our budget for the current year, ending February 28, 1995 is \$850,000.

TYPEWRITER NEEDED

We need a typewriter for the office. If you have one in good condition that you can spare, please call Valerie at 215-387-1865 before August 20. Thanks

**American Medical Association
June 16, 1994
REPORT OF THE
COUNCIL ON SCIENTIFIC AFFAIRS
CSA Report 5-A-94**

Subject: Memories of Childhood Abuse
Presented by: Yank D. Coble, Jr, MD, Chair
Referred to: Reference Committee D
Peter W. Carmel, MD, Chair

The adoption of Substitute Resolution 504, A-93, created new policy on memory enhancement methods used in cases of possible childhood sexual abuse. The policy states "The AMA considers the technique of 'memory enhancement' in the area of childhood sexual abuse to be fraught with problems of potential misapplication (AMA Policy Compendium, Policy 515.978). The resolution also directed the Council on Scientific Affairs to investigate the issues surrounding memory enhancement. This report addresses those and related issues.

The resolution was adopted in response to concerns about the growing number of cases in which adults make accusations of having been abused as children based solely on memories developed in therapy. In many cases, the accusations are made against the parents of the accuser, although others, such as members of the clergy, teachers and camp counselors, have been targets of allegations. Questions have been raised about the veracity of such reported memories, one's ability to recall such memories, the techniques used to recover these memories, and the role of the therapist in developing the memories.

The general issues have come to be referred to under the umbrella term "repressed memories" or "recovered memories." Both terms refer to those memories reported as new recollections, with no previous memories of the event or circumstances surrounding the event, although some "fragments" of the event may have existed. Considerable controversy has arisen in the therapeutic community over the issue, and experts from varied professional backgrounds can be found on all sides of the issue. At one extreme are those who argue that such repressed memories do not occur, that they are false memories, created memories, or implanted memories, while the other extreme strongly supports not only the concept of repressed memories but the possibility of recovering such memories in therapy. Other professionals believe that some memories may be false and others may be true.

Most controversial are those "memories" that surface only in therapy and those from either infancy or late childhood (including adolescence). Concern about and interest in repressed memories is widespread, and the topic is covered in both the professional literature and the lay press. Word of the AMA's interest in the issue resulted in well over 100 letters asking the AMA to address the needs of falsely accused individuals.

The Board of Trustees of the American Psychiatric Association (APA) recently issued a statement "in response to the growing concern regarding memories of sexual abuse." In part, the statement says:

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. (Statement of the APA Board of Trustees, adopted December 12, 1993)

Related AMA Policy

The AMA has numerous policies related to child abuse, including sexual abuse, and about violence in general. Two policy statements are of particular importance. Policy 515.976, adopted at the 1993 Annual Meeting, encourages physicians to be alert to the mental health consequences of interpersonal and family violence. Council on Scientific Affairs Report B (A-93), which developed this policy, thoroughly discussed these consequences, including possible long-term adverse effects. There is considerable evidence that victims of child abuse are found in mental health treatment settings in large numbers. (1)

Also relevant is Policy 80.996, adopted in 1984, which discusses the use of hypnosis in refreshing recollection. The entire policy states:

The AMA believes that (1) With witnesses and victims, the use of hypnosis should be limited to the investigative process. Specific safeguards should be employed to protect the welfare of the subject and the public, and to provide the kind of record that is essential to evaluate the additional material obtained during and after hypnosis; (2) A psychological assessment of the subject's state of mind should be carried out prior to the induction of hypnosis in an investigative context, and informed consent should be obtained; (3) Hypnosis should be conducted by a skilled psychiatrist or psychologist, who is aware of the legal implications of the use of hypnosis for investigative purposes; a complete taped and/or precise written record of the clinician's prior knowledge of the case must be made; complete videotape recordings of the pre-hypnotic evaluation and history, the hypnotic session, and the post-hypnotic interview, showing both the subject and the hypnotist, should be obtained; (4) Ideally, only the subject and the psychiatrist or psychologist should be present; (5) Some test suggestions of known difficulty should be given to provide information about the subject's ability to respond to hypnosis; (6) The subject's response to the termination of hypnosis and the post-hypnotic discussion of the experience of hypnosis are of major importance in discussing the subject's response; (7) Medical responsibility or the health and welfare of the subject cannot be abrogated by the investigative intent of hypnosis; and (8) Continued research should be encouraged.

This policy was developed as part of CSA Report K (I-84), which addressed several aspects of hypnosis and memory. The report concluded that new information is often reported under hypnosis, and that while the information may be accurate, it may also include confabulations and pseudomemories. Moreover, the Council concluded that hypnosis-induced recollections actually appear to be less reliable than non-hypnotic recall. That statement remains an accurate summary of the empirical literature.

Neither the AMA nor the Council has studied other aspects of memory enhancement, such as amytal or age regression. A forthcoming review of amytal concludes that it has no legitimate use in recovered-memory cases. (2) Rigorous scientific assessments of other methods of memory enhancement are not available.

Legal Concerns

To some extent, current concerns about repressed memories can be traced to the lawsuits filed by accusers, particularly those filed against parents. Numerous such lawsuits have been filed by accusers, and it is of course difficult to disprove accusations regarding events that are alleged to have taken place many years or even decades earlier. Over the past few years, a number of states have adopted laws that have affected such litigation. Illinois, for example, has just extended the time allowed in which to file a suit; previously lawsuits could not be filed after the accuser had attained the age of 30. On the other hand, California has recently adopted laws under which a plaintiff cannot prevail in the absence of evidence beyond the recovered memories.

From a therapeutic perspective, such lawsuits might be deemed valuable in helping an abuse victim retake or reassert control of his or her life. Restoring control to the victim is a widely recognized part of therapy. (1) At the same time, public policy may require standards of proof that must be met before allowing suits based on recovered memories to be filed or result in judgments against the accused.

Therapeutic Issues

Of particular interest in this issue is the role of the therapist in developing new memories. It is well established for example that a trusted person such as a therapist can influence an individual's reports, which would include memories of abuse. Indeed, as the issue of repressed memories has grown, there have been reports of therapists advising patients that their symptoms are indicative – not merely suggestive – of having been abused, even when the patient denies having been abused. (3) Other research has shown that repeated questioning may lead individuals to report events that in fact never occurred. Unfortunately, the dynamics that underlie an individual's suggestibility are only beginning to be understood.

Notwithstanding these findings, other research indicates that some survivors of abuse do not remember, at least temporarily, having been abused. While some research relies on self-identified survivors of abuse and consequently

begs the question of repressed memories (see for example Briere and Conte (4), other research is based on cases in which childhood sexual abuse was documented. Williams, (5) for example, reports that more than one-third of women in a group of known victims failed to report victimization 17 years later; most of those who did not report the abuse appear to have been "amnesic for the abuse." (p 20) There are other instances in which recovered memories proved to be correct.

In short, empirical evidence can be cited for both sides of the argument. While virtually all would agree that memories are malleable and not necessarily fully accurate, there is no consensus about the extent or sources of this malleability. The issue is far from settled, and under such circumstances, therapists should exercise care in treating their patients, maintaining an empathic and supportive posture. Due diligence for and reference to the Principles of Medical Ethics, or other similar statements in the case of non-physician therapists, should be given high priority. In some cases, a second opinion should be considered.

Conclusions and Recommendations

The AMA has a long history of concern about the extent and effects of child abuse. Child abuse, particularly child sexual abuse, is under recognized and all too often its existence is denied. Its effects can be profound and long-lasting. (6) The Council on Scientific Affairs recommends that the following statements be adopted and that the remainder of this report be filed:

1. That the AMA recognize that few cases in which adults make accusations of childhood sexual abuse based on recovered memories can be proved or disproved and it is not yet known how to distinguish true memories from imagined events in these cases.
2. That the AMA encourages physicians to address the therapeutic needs of patients who report memories of childhood sexual abuse and that these needs exist quite apart from the truth or falsity of any claims.
3. That Policy 515.978 be amended by insertion and deletion to read as follows: The AMA considers recovered memories the technique of "memory enhancement" in the area of childhood sexual abuse to be of uncertain authenticity, which should be subject to external verification. The use of recovered memories is fraught with problems of potential misapplication.
4. That the AMA encourage physicians treating possible adult victims of childhood abuse to subscribe to the Principle of Medical Ethics when treating their patients and that psychiatrists pay particular attention to the Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry.
5. That Policy 80.996, which deals with the refreshing of recollections by hypnosis, be reaffirmed.

References

1. Herman J.L. Trauma and Recovery, New York: Basic Books; 1992.
2. Piper A Jr. "Truth Serum" and "Recovered Memories" of

sexual abuse: A review of the evidence. *J Psychiatry and Law*. In press.

3. Loftus E.F. The reality of repressed memories. *American Psychologist*. 1993; 48(5):518-537.

4. Briere J, Conte J. Self-reported amnesia for abuse in adults molested as children. *J Traumatic Stress*. 1993; 6(1):21-31.

5. Williams L.M. Adult Memories of childhood abuse: Preliminary findings from a longitudinal study. *The APSAC Advisor*. 1992; 5(3):19-21.

6. Council on Scientific Affairs. Mental health consequences of interpersonal and family violence. Implications for the practitioner. CSA Report B (A-93).

Williams Study

The Williams study mentioned in the AMA report "involved interviews with 100 women, mostly African-American. These women, 17 years earlier, were girls aged infant to 12 years old when they were brought to a city hospital emergency department for treatment and collection of forensic evidence related to childhood sexual abuse (even when there was no physical trauma present). The sexual abuse ranged from sexual intercourse (in about a third of the cases) to fondling (also about a third of the cases). Without revealing the true purpose of the follow-up interview, the women were asked about childhood experiences with sex to elicit the sexual abuse victimization. The results showed that 38% were amnesic for the abuse or chose not to report it. The bulk of the nonreports were thought to be attributed to women who did not remember rather than chose not to report. This conclusion was warranted in part because many of the women were willing to report other sexual victimizations, although not the one in the hospital record."

"The 38% figure has been taken as evidence for the prevalence of repression, but this conclusion is unwarranted. Recall that the girls were ages infant to 12 when their reported abuse happened. Thus, for some percentage of victims, the abuse would have happened so early in life, before the offset of childhood amnesia, that as adults they would not be expected to remember the experience no matter whether it was abuse or some other experience." (Loftus, Polonsky, and Fullilove, 1994).

A study by Femina and colleagues (D.D. Femina and associates, *Child Abuse and Neglect* 14:227-231) "also conducted follow-up interviews on a group of individuals

with documented histories of sexual or physical abuse. Interestingly, precisely 38 percent gave a history on follow-up that was discordant with the documented history. But Femina and colleagues, unlike Williams, went back and found 11 of those patients for a second follow-up interview; in the second interview (which they called the "clarification interview"), they confronted their subjects with their known histories of abuse to find out why their first interviews had been discrepant. Eight of that 11 were known to have been abused and had denied it during the first interview; during the second interview, all eight of those individuals acknowledged that they remembered the abuse but had elected not to tell the interviewer about it the first time. If that is generally true, it suggests that the failure of some of Williams's patients to disclose the abuse on interview may reflect the fact that the patient elected not to tell the interviewer about it, and, since they were not confronted, it cannot be concluded that they had forgotten the abuse." (Pope, 1994).

Pope reminds us that "a series of Federal Government-sponsored investigations during the 1960's and 1970's looked specifically at why people don't disclose events on interviews. There were, for example, studies where interviewers went to see people who were known to have been in motor vehicle accidents, and, in the course of interview, asked them about their history of motor vehicle accidents. In one study, thirty percent of the individuals who were known to have been in a motor vehicle accident nine to 12 months earlier did not disclose it on interview. These were people who had not lost consciousness during the accidents and had no biological reasons for having forgotten. In other studies, thirty to 40 percent of people failed to disclose a doctor's office visit that had occurred just within the preceding few weeks. One wouldn't claim that they had repressed the memory; they just didn't tell the interviewer. In other studies in this series, twenty to 50 percent of people failed to disclose to the interviewer a hospitalization they were known to have undergone 10 to

12 months previously. The fact that many people do not disclose life events to interviewers, even when those events have occurred weeks to months earlier, would argue that a 38 percent non-disclosure rate, for an embarrassing event that had occurred 17 years earlier, would be consistent with what one would predict. It is not necessary to posit repression to explain William's finding." (Pope, 1994).

Loftus, Polonsky, and Fullilove (1994). "Memories of Childhood Sexual Abuse." *Psychology of Women Quarterly*, 18, pp. 67-84.

Pope, H. (1994) "Recovered memories: Recent events and review of evidence." *Currents in Affective Illness* XIII (7).

Can I Trust My Memory?
A Handbook for Survivors with
Partial or No Memories
of Childhood Sexual Abuse
by Joan Spear, M.S.W., L.C.S.W.
Hazelden, 1992

"It is particularly frustrating and painful if you have no memories but just a strong sense from present-day problems that you were sexually abused as a child. This is like trying to come to terms with something that seems like a figment of your imagination."

"Sexual abuse is any kind of touching, talking, or innuendo that is forced upon someone in a way that feels invasive, repulsive, or embarrassing."

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Call person listed for meeting time & location.
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NEW HAVEN AREA
George 243-2740

FLORIDA

DADE-BROWARD AREA
Madeline (305) 966-4FMS
DELRAY BEACH PRT
Esther (407) 364-8290
2nd & 4th Thursday (MO) 1:00 pm

ILLINOIS

CHICAGO METRO AREA (South of the Eisenhower)
2nd Sunday (MO) 2:00 pm
Roger (708) 366-1056

INDIANA

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

IOWA

DES MOINES
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

LOUISVILLE

Bob (502) 957-2378
Last Sunday (MO) 2:00 pm

MAINE - AREA CODE 207

FREEPORT
Wally 865-4044
3rd Sunday (MO)

MARYLAND

ELLCOT CITY AREA
Margie (410) 750-8694

MASSACHUSETTS / NEW ENGLAND

CHELMSFORD
Jean (508) 250-1055

MICHIGAN

GRAND RAPIDS AREA - JENISON
Catharine (616) 363-1354
2nd Monday (MO)

MINNESOTA

ST. PAUL
Terry & Collette (507) 642-3630

MISSOURI

ST. LOUIS AREA
Mae (314) 837-1976 &
Karen (314) 432-8789
3rd Sunday (MO) 2:00 pm
Retractors support group also meeting.

NEW JERSEY (So.) - See PENNSYLVANIA (WAYNE)**NEW YORK - UPSTATE**

ALBANY AREA
Chuck (518) 273-5242
Elaine (518) 399-5749
Tuesday, July 19, 1994, 7:00 pm

OHIO

CINCINNATI
Bob (513) 541-5272

OKLAHOMA - AREA CODE 405

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

PENNSYLVANIA

HARRISBURG AREA
Paul & Betty (707) 761-3364
PITTSBURGH
Rick & Renee (412) 563-5616
WAYNE (includes So. Jersey)
Jim & Joanne (610) 783-0396
No meetings until September
2nd Saturday (MO) 1:00 pm

TEXAS

CENTRAL TEXAS
Nancy & Jim (512) 478-8395
DALLAS/FT. WORTH - See "STATE MEETINGS"
HOUSTON
Jo or Beverly (713) 464-8970

VERMONT & UPSTATE NEW YORK

BURLINGTON
Elaine (518) 399-5749
Monday, July 11, 1994, 7:00 pm

VIRGINIA - See "STATE MEETINGS"**WASHINGTON, DC - See "STATE MEETINGS"****WEST VIRGINIA - See "STATE MEETINGS"****WISCONSIN**

Katie & Leo (414) 476-0285

CANADA**BRITISH COLUMBIA**

VANCOUVER & MARLAND
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

OTTAWA
Eileen (613) 592-4714
TORONTO
Pat (416) 445-1995

AUSTRALIA

Ken & June, P O Box 363, Unley, SA 5061

NEW ZEALAND

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

UNITED KINGDOM

The British Falae Memory Society
Roger Scottford (0) 225-868682

...

Meeting Notice Deadline

Monday, August 15 for September
Newsletter.

Attention: All Downstate Illinois Members
As of July 1st, Bob and Mary will no longer
be state contacts for Southern Illinois. They are
seeking one or more persons to be contacts for
their area, which includes area codes 618,
217, and 309.

Bob and Mary are willing to assist their re-
placement(s) and get them started on the right
foot. Please call them at (217) 463-3840 after
5:00 pm.

RECENT ADDITIONS TO BIBLIOGRAPHY

MAGAZINE & NEWSPAPER ARTICLES:

- 060 "When it's time for a patient to find a way out of therapy," 20Nov88; "Therapists and clients views on leaving therapy," 12Jan89, D. Sifford. *The Philadelphia Inquirer*. [\$2.00]
 174 "Some law suits simply therapy," Claire Bernstein. *London Free Press*, December 21, 1992. [\$1.00]
 265 "Of Memory and Emotion," Daniel Reisberg. *Reed College Magazine*, June 1993. [\$1.00]
 292a "Real or Imagined?" David McKay Wilson. *The Reporter Dispatch*, October 20, 1993. [\$1.00]
 298 "It's time society put the inner child to bed," K Parker. *Orlando Sentinel*, December 31, 1993. [\$1.00]
 298a "Seeking help and finding anguish," by B. Ordine. *The Philadelphia Inquirer*, February 27, 1994. [\$2.00]
 298b "Pandora's Memory," by Sarah Jones. *The Monthly*, March 1994. [\$1.00]
 299 "The Lost Daughter," by John Taylor. *Esquire*, March 1994. [\$3.00]
 301 "Dark Memories," by Paul Wood. *The News-Gazette*, March 6, 1994. [\$3.00]
 302 "Are Secrets Locked Inside?" and "Military controls my mind, woman says, by Carol Gentry. *St. Petersburg Times*, March 6, 1994. [\$3.00]
 303 "Was It Real or Memories?" by Kenneth Woodward, et al. *Newsweek*, March 14, 1994. [\$1.00]

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PROFESSIONAL ARTICLES:

- 540a Gardner, R.A.. (1992) "Belated Realization of Child Sex Abuse by an Adult" *Issues in Child Abuse Accusations*, Fall, Vol. 4, No. 4: pp 177-195. [\$5.00]
 543a Hedges, L. E. (1994) "Taking Recovered Memories Seriously." *Issues in Child Abuse Accusations*, Vol. 6, No. 1: pp 1-31. [\$5.00]
 567 Merskey, H. (1992) "The Manufacture of Personalities: The Production of Multiple Personality disorder." *British Journal of Psychiatry*, Vol. 6, No. 1: pp 1-31. [\$5.00]

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July 6, 1994

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Memory and Reality: Reconciliation
Scientific, Clinical and Legal Issues of False Memory Syndrome
 December 9, 10 & 11, 1994
 Stouffer Harborplace Hotel, Baltimore, Maryland
 REGISTRATION FORM

Please print or type

first name	middle initial	last name/degree
		()
social security number*	specialty	area code/daytime telephone

mailing address _____

city	state	zip + 4 code
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*for our office records, please _____ Fax # if available _____

List additional family members attending the conference:

first name	last name	first name	last name
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Please, circle your selection in the REGISTRATION FEE SCHEDULE below and mail to: Office of Continuing Medical Education, Johns Hopkins Medical Institutions, Turner 20, 720 Rutland Avenue, Baltimore, Maryland 21205-2195. Include check payable to Hopkins/False Memory.

or
 Fax to (410) 955-0807

For Credit Card Registration

___ VISA ___ MASTERCARD Card # _____ Expiration Date _____

Name _____

as it appears on card; please print

Signature _____ Date _____

REGISTRATION FEE SCHEDULE				
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Space limited. Register early.

HOTEL ACCOMMODATIONS. Make your reservations **DIRECTLY WITH THE HOTEL.** Specify that you are attending the False Memory Syndrome meeting to receive the special room rate of \$115.00 single/double. After November 15, 1994, reservations will be accepted only on a space-available basis. **Stouffer Harborplace Hotel, 202 East Pratt Street, Baltimore, Maryland 21202, (410) 547-1200, (410) 539-5780 FAX.**

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