FALSE MEMORY SYNDROME FOUNDATION NEWSLETTER

JANUARY/FEBRUARY 2006 Vol. 15 No. 1

Dear Friends,

We plunge into 2006 with ever-expanding support for the positions of the FMSF. On page 3 you will find Richard McNally, Ph.D.'s "Folklore of Buried Memories," a succinct "op ed" piece summarizing the science of recovered memories. It has appeared in numerous newspapers around the world and would be excellent to give to people who are not familiar with the subject.

Two longer articles in this Newsletter serve as examples of the mixed scientific acceptance of recovered memories as we begin the 15th year of the Foundation. The first is by FMSF advisor Harrison Pope, Jr., M.D., and the second is from a recent decision by Judge Sandra L. Dougherty of Nebraska.

In the first piece, Dr. Pope critiques an article by New Zealand's John Read, Ph.D., who with his colleagues (including Colin Ross, M.D.) claimed that childhood trauma can cause schizophrenia. Read et al. write: "Recent large-scale general population studies indicate the relationship is a causal one, with a dose-effect."[1] Pope's critique is an encore of the outstanding series of articles that he wrote for this Newsletter in the mid-90s that eventually became the book *Psychology Astray: Fallacies in Studies of "Repressed Memory" and Childhood Trauma*, (Upton Books, 1997). Pope carefully explains the problems of trying to show that one thing actually causes another, and then he shows the weaknesses of the Read et al. arguments.

If the name John Read sounds familiar, perhaps it is because the last time we wrote about him (in 2000) it was in the context of his leading a futile movement to have the New Zealand Psychological Society rescind its invitation to Elizabeth Loftus, Ph.D., to be a featured speaker at its conference. He complained of her work that: "No one will disclose abuse for fear of being disbelieved." [2] Read has been a strong supporter of the accuracy of recovered memories. In their zealous belief that past trauma is the cause of so many of life's current problems, Dr Read and colleagues were lured into making claims that exceed the evidence. It is very difficult to assign past trauma as a cause to current problems, whether schizophrenia or anything else.

The other longer piece illustrates well, on the one hand, that there is abundant evidence for how people may come to believe in things that have not happened, and, on the other hand, that there are still many professionals who ignore the science and cling to the old beliefs about trauma and recovered memories. It consists of excerpts from Judge Sandra L. Dougherty's decision after a recent pre-trial (Daubert) hearing in Nebraska to determine whether expert testimony about recovered memories can be presented in evidence.

The experts who testified for the defense at this hearing in the District Court of Douglas County were Elizabeth Loftus, Ph.D., Harrison Pope, Jr., M.D., both FMSF advisors. Bessel van der Kolk, M.D., testified for the plaintif f, a man who claimed that he had only recently recovered memories of being abused by a priest at Boys Town. Judge Dougherty ruled that the plaintiff could not present expert testimony that he suffered from repressed memories, noting that van der Kolk had not proved that such a diagnosis is scientifically valid. Although much of the information in Dougherty's decision is familiar to Newsletter readers, we think that it is valuable to see how someone new to the subject perceives the arguments and evidence.

Minnesota attorney Patrick Noaker represented the plaintiff in the case. After the Dougherty decision, Noaker withdrew a claim of repressed memories in a similar case against Boys Town, saying that he expected the same result from another Daubert hearing that had been scheduled to be held in federal court.[3] According to attorney James Martin Davis, who represented Boys Town in the case, Noaker may have dropped the repressed-memory claim because he did not want to lose again. Davis noted that Noaker has

In this issue...

repressed-memory cases around the country, and if he were to have a ruling against him in federal court, it would help establish a precedent against the claims in other cases.

The Dougherty Daubert decision is one of a series of pre-trial hearings that we have reported in the Newsletter over the years. Although the majority of opinions have supported the FMSF positions, not all have. Following are some examples of other pre-trial Daubert hearings on admissibility of experts to testify about recovered memory:

Barrett vs. Hyldburg, North Carolina 1998; Carlson vs. Humenansky, Minnesota, 1995; Doe vs Archdiocese, Louisiana, 2003; Doe vs. Maskell, Maryland, 1995; Engstrom vs. Engstrom, California, 1995; Logerquist vs. Danforth, Arizona, 1996; Mensch vs. Pollard, Washington, 1998; New Hampshire v. Hungerford, New Hampshire, 1995; Rhode Island vs. Quattrocchi, Rhode Island, 1999; Shahzade vs. Gregory, Massachusetts, 1996.

Because these are pre-trial hearings, they are not generally available on the web. Within the next few months, we expect to have several posted on the Foundation web site: www.FMSFonline.org.

In this Newsletter issue, we give brief mention to several new papers and books that may be of interest to readers. Space limitations precluded greater description.

We are pleased to see the appearance of the first book to pull together the disparate literature on false memories: *The Science of False Memory,* by C.J. Brainerd and V.F. Reyna (Oxford University Press). *The Science of False Memory* draws on the now-extensive false-memory literature that is scattered in various journals and book chapters in many different fields such as cognitive psychology, developmental psychology, neuroscience, psychotherapy, sociology, anthropology and criminology. It pulls them together in one place and provides a much-needed authoritative overview of the subject. Brainerd and Reyna, who are both members of the Psychology Department at Cornell University, have made many significant contributions to the false-memory research and have been involved in a number of high-profile legal cases. *The Science of False Memory* is a scholarly book, and although it is not as easy to read as is *ABDUCTED: How People Come to Believe They Were Kidnapped by Aliens* by Susan A. Clancy (Harvard University Press), it is extremely significant in bringing clarity to the memory wars.

The letters from readers in this issue provide a snapshot of many family situations. Sometimes your letters bring joy and sometimes great sadness. Two letters this month ask for help, and we hope that some readers will respond. The tragedy of the memory wars has been the wanton and needless destruction of families. Sadly, even if the memory wars were to be resolved tomorrow, families will still be trying to pick up the pieces.

In the next issue we will write about the Gray vs. Dr. Powers case in Pennsylvania in which another former patient struggles to reclaim her life after bad therapy. In addition, we will tell the story of Kyle Zirpolo who was one of the accusers in the McMartin Pre-School trial and who now says that his allegations were lies. The next issue will bring you up to date on the Outreau case in France in which wrongly accused people received an apology not only from the Justice Minister but also from President Jacques Chirac. There just was not enough space to include all these stories this month.

We thank you for your generosity to our annual appeal and for your kind words of support and encouragement. We have come a long way together in 15 years.

Pamela

1. Read J., van Os, J., Morrison, A.P., Ross, C.A. (2005). Childhood trauma, psychosis and schizophrenia: a literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica,112*, 330-350.
2. Radio New Zealand. (Aug 7, 2000). Dr. John Read interviewed by Kim Hill.
3. Ruggles, R. (2005, December 10). Suit drops repressed-memory claim. *Omaha World-Herald*, B1.

"It felt ridiculous to be digging around in my past when I knew there was no serious trauma there, and my gut feeling told me that my depression was not related to anything that had ever happened to me.

"But try explaining this to a therapist and they assume that either you are in denial, or you have simply repressed the bad memories.

"This is impossible to refute because you cannot prove the contrary—luckily for the therapist—since trying to remember what you've repressed can keep you in therapy for years."

Virginia Ironside (2005, November 19). She's one of Britain's top agony aunts.... *Daily Mail* (London), p. 26.

special thanks

We extend a very special "Thank you" to all of the people who help prepare the FMSF Newsletter. *Editorial Support*: Janet Fetkewicz, Howard Fishman, Peter Freyd, Members of the FMSF Scientific Advisory Board and Members who wish to remain anonymous. *Letters and information*: Our Readers.

"I really regret losing my sanity for so many years, and if I had it to do all over again, I wouldn't do any of it."

"Roseanne, actress, on her behavior in the early 1990s—including her claims that she had been sexually abused by family members."
Notebook. (2004, April 19). *Time*, p. 19.

Folklore of Buried Memories

Richard J. McNally

How victims remember trauma is the most controversial issue facing psychology and psychiatry today. Many clinical trauma theorists believe that combat, rape, and other terrifying experiences are seemingly engraved on the mind, never to be forgotten.

Others disagree, arguing that the mind can protect itself by banishing memories of trauma from awareness, making it difficult for victims to remember their most horrific experiences until it is safe to do so many years later. While acknowledging that trauma is often all too memorable, these certain clinical trauma theorists assert that a condition known as "traumatic dissociative amnesia" leaves a large minority of victims unable to recall their trauma, precisely because it was so overwhelmingly terrifying.

However, these clinical trauma theorists do not argue that "repressed" or "dissociated" memories of horrific events are either inert or benign. On the contrary, these buried memories silently poison the lives of victims, giving rise to seemingly inexplicable psychiatric symptoms, and therefore must be exhumed for healing to occur.

This is no ordinary academic debate. The controversy has spilled out of the psychology laboratories and psychiatric clinics, capturing headlines, motivating legislative changes, and affecting outcomes in civil lawsuits and criminal trials.

Whether individuals can repress and recover memories of traumatic sexual abuse has been especially contentious. During the 1990s, many adult psychotherapy patients began to recall having been sexually abused during childhood. Some took legal action against the alleged perpetrators, often their elderly parents. While complaints against parents, based on allegedly repressed and recovered memories of abuse, have declined, those against large institutions, such as the Catholic Church, have increased.

Strikingly, both advocates and skeptics of the concept of traumatic dissociative amnesia adduce the same studies when defending their diametrically opposed views. But it is the advocates who misinterpret the data when attempting to show that victims are often unable to recall their traumatic experiences.

Consider the following. After exposure to extreme stress, some victims report difficulties remembering things in everyday life. Advocates of traumatic amnesia misconstrue these reports as showing that victims are unable to remember the horrific event itself. In reality, this memory problem concerns ordinary absentmindedness that emerges in the wake of trauma; it does not refer to an inability to remember the trauma itself. Ordinary forgetfulness that emerges after a trauma must not be confused with amnesia for the trauma.

Consider, too, that one symptom of posttraumatic stress disorder is an "inability to recall an important aspect of the trauma." This symptom, however, does not mean that victims are unaware of having been traumatized.

Indeed, the mind does not operate like a video recorder, and thus not every aspect of a traumatic experience gets encoded into memory in the first place. High levels of emotional arousal often result in the victim's attention being drawn to the central features of the event at the expense of other features. Incomplete encoding of a trauma must not be confused with amnesia—an inability to recall something that did get into memory.

Moreover, a rare syndrome called "psychogenic amnesia" is sometimes confused with traumatic amnesia. Victims of psychogenic amnesia suddenly lose all memory of their previous lives, including their sense of personal identity. Occasionally, this sudden, complete memory loss occurs after severe stress, but not invariably. After a few days or weeks, memory abruptly returns. In contrast, the phenomenon of dissociative amnesia supposedly entails victims' inability to remember their traumatic experiences, not an inability to remember their entire lives or who they are.

Several surveys show that adults reporting childhood sexual abuse often say that there was a period of time when they "could not remember" their abuse. Claims of prior inability to remember imply that they had attempted unsuccessfully to recall their abuse, only to remember it much later. Yet if these individuals were unable to remember their abuse, on what basis would they attempt to recall it in the first place?

Most likely, they meant that there was a period of time when they did not think about their abuse. But not thinking about something is not the same thing as being unable to remember it. It is inability to remember that constitutes amnesia.

Research conducted in my laboratory on adults reporting histories of childhood sexual abuse provides a solution to this bitter controversy. Some of our participants reported having forgotten episodes of nonviolent sexual abuse perpetrated by a trusted adult. They described it as having been upsetting, confusing, and disturbing, but not traumatic in the sense of being overwhelmingly terrifying. Failing to understand what had happened to them, they simply did not think about it for many years.

When reminders prompted recollection many years later, they experienced intense distress, finally understanding their abuse from the perspective of an adult. These cases count as recovered memories of sexual abuse, but not as instances of traumatic dissociative amnesia. That is, the events were not experienced as traumatic when they occurred, and there is no evidence that they were inaccessible during the years when they never came

to mind.

Sexual abuse is not invariably traumatic in the sense of being overwhelmingly terrifying. Of course, it is always morally reprehensible, even when it fails to produce lasting psychiatric symptoms.

Richard J. McNally is a professor of psychology and director of clinical training in the department of psychology at Harvard University. He is the author of *Memories of Trauma*, Harvard University Press, 2003.

□

Does Childhood Trauma Cause Schizophrenia?

A critique of Read J. et al. (2005). Childhood trauma, psychosis and schizophrenia: a literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica*,112, 330-350.

Harrison Pope, Jr., M.D.

Read and colleagues have recently published a review article suggesting that there is an *association* between psychotic disorders (such as schizophrenia), or specific psychotic symptoms (such as delusions and hallucinations), and a history of childhood trauma [1] However, the fact that two conditions are *associated* does not permit the conclusion that one condition has *caused* the other. For example, the sunset is much more closely associated with having dinner than with having lunch—but it does not follow that eating dinner will cause the sun to set. Therefore, even if we grant that there is an association between psychosis and childhood trauma, we still have the burden of demonstrating that it is a *causal* association.

If A is associated with B, how would we go about demonstrating that A *caused* B? First, we must agree on some definition of what is meant by "cause." When I use the word "cause" here, what I mean is that A falls into the pathway of events that leads to the development of outcome B. In other words, if A does not happen, then B will not occur—or at least the chances of B will be significantly reduced. Clearly, the definitive way to test for such causality is to take two identical groups of people and randomly subject half of them to A, while ensuring that the other half is not subjected to A, and then to follow them over a period of time to see how many members of each group develop outcome B. If the individuals who were subjected to A display a much higher incidence of B on follow up, then one can reasonably conclude that A is a causal factor. This type of study is known as a randomized controlled trial.

Now clearly, it would be completely unethical and unreasonable to perform a study in which a scientific investigator deliberately randomized one group of people to receive childhood trauma, while another group did not. Therefore, in actual practice, the best that one can do is to perform a prospective study in which one takes one group of people who are documented to have been abused as children, and another group of people who are otherwise identical—coming from equally dysfunctional families, having inherited equal genetic risks for major psychiatric disorders, having been subjected equally to all manner of other adverse life events—but differing from the first group *only* in that they were not victims of childhood abuse. One would then follow these two closely matched groups to see if the group that experienced abuse went on to develop more psychiatric disorders (for example, more psychotic symptoms or a higher incidence of schizophrenia) than the otherwise-similar group that was not abused.

But even this type of study would be very difficult to do, because people who were abused in childhood are likely to have suffered a wide range of other misfortunes. In other words, childhood abuse rarely happens in isolation; people who have experienced it usually have had numerous other bad things happen as well. They may have grown up in dysfunctional families where they were subject to many other adverse influences, over and above actual abuse *per se*. Also, parents or relatives who abuse children are likely to have psychiatric disorders themselves, and they may pass the genes for these psychiatric disorders on to the child. Thus, children who have been abused may also have inherited genes predisposing them to major depression, bipolar disorder, schizophrenia, alcohol dependence, or other major psychiatric disorders—genes that might have caused them to develop these disorders even if they had suffered no adverse childhood experiences at all. Finally, these children may have suffered many other adverse life events over the years—again not representing abuse events *per se*, but still negatively affecting their development. So the challenge in a prospective study would be to somehow find a matched group of individuals who had identical adverse experiences, save for the one fact that they had not specifically been a victim of childhood abuse. To perform a prospective study with such matching would be extremely time-consuming and expensive.

In short, as the above discussion demonstrates, it is a very difficult proposition to demonstrate that childhood trauma *causes* specific disorders, because it is extremely difficult and expensive to do a properly designed *prospective* study, particularly with the dicey problem of trying to find non-abused comparison subjects who were matched in every possible respect. It would be much easier, and much less expensive, if you could test the role of causality using a *retrospective* design, in which we took people suffering from various psychiatric disorders and simply asked them about their past history of childhood trauma, rather than laboriously seeking out matched

groups and following them over years of time. Is there a way to test causality using retrospective methods?

There have indeed been many retrospective studies that attempted to test for causality, including some that have been very careful to try to eliminate confounding variables. For example, there have even been some studies that have looked at twins who grew up in the same family, and where one twin recalled being abused and the other did not. Presumably, since these twins experience similar family backgrounds, they would have been equally exposed to other adverse experiences—which would help to "isolate" the effects of abuse as opposed to the effects of other aspects of growing up. But such studies are still vulnerable to confounding variables, because there may have been differences in the adverse experiences of the two twins. Also, if the twins are fraternal twins, rather than identical twins, the abused twin may have inherited different genetics from the non-abused twin. Finally, and perhaps most importantly, retrospective studies are relying upon the *recall* of the subjects as to whether they were abused and in what way—and recall, it turns out, can be very fallible.

Graphic evidence of the fallibility of recall comes from two recent studies, one by Cathy Widom and her colleagues [2] and one by Raphael and colleagues [3]. Both of these studies relied on a long-term longitudinal database of more than a thousand individuals, about half of whom were documented through court records to have been victims of childhood abuse, and the other half of whom were deliberately chosen as otherwise similar non-victims. The authors of both studies located and interviewed these individuals some 20 years after the time of their documented abuse. Raphael et al. interviewed the subjects about their history of pain syndromes, and Widom et al. asked about alcohol and substance abuse. In both studies, it turned out that the individuals with documented abuse did not exhibit any higher prevalence of pain syndromes or alcohol and substance abuse problems than the comparison subjects who had been chosen because they had no documented abuse. In other words, the prospective data showed no evidence that childhood abuse played a *causal* role in causing pain syndromes or alcohol and substance abuse later on in adulthood. But then, the investigators in both studies performed an interesting experiment: without revealing their knowledge of the subjects' prior documented histories of abuse (or lack thereof), they simply asked their adult subjects whether or not they had been abused. When they then looked at subjects' *retrospective self-reports* of childhood abuse, as opposed to relying on the prior records of the subjects' *documented* childhood abuse, the numbers suggested that childhood abuse was strongly and significantly associated with the development of pain syndromes and alcohol and drug abuse in adulthood. In other words, if one had done this study and relied simply on subjects' retrospective self-reports, taking them at face value, one would have erroneously concluded that childhood abuse had a very powerful association—and perhaps a causal association—with these adult syndromes, even though the prospective data showed no such association at all!

Now of course one might argue that there were many subjects in the studies who had genuinely been abused, but that abuse had been secret and never reached the court system where it became documented. One might also argue that individuals with documented abuse, leading to a court conviction of the abuser, would have been less traumatized than individuals with undocumented abuse (and who therefore had no similar "closure" on their trauma)—and that therefore the prospective comparison based on documented cases alone might underestimate the association between abuse and adult pathology. However, if childhood abuse really did play a causal role in adult pain syndromes or adult alcohol or substance abuse—even a slight causal role—then it would be very hard to believe that in a huge statistical sample like this, with more than 500 abuse victims and more than 500 comparison subjects, there would be *no* detectable association at all between documented abuse (abuse so severe that it resulted in an actual court conviction of the abuser) and subsequent adult psychopathology. At the very least, these studies suggest that we should be extremely wary of any studies relying on subjects' retrospective self-reports, because this might lead to inflated estimates of the actual association between childhood trauma and adult psychopathology.

Given all of the methodological hazards enumerated above, how can Read and colleagues argue that childhood abuse plays a *causal* role in the development of psychotic symptoms or psychotic disorders. Upon reading their review, they appear to have advanced only two major arguments that the association is a causal association. First, they point out that several studies have shown a striking association between the severity or extent of childhood abuse and the subsequent severity or frequency of psychotic syndromes in adulthood; in other words, people who reported more severe levels of childhood abuse also demonstrated higher levels of hallucinations or other such psychotic symptoms in adulthood. In short, there is a "dose-response relationship" between trauma and psychosis. But does this observation allow us to infer that A causes B? It does not. Suppose that we do a study in which we ask people to estimate the total amount of time that they have spent carrying a cigarette lighter in their pocket or their purse prior to the age of 30, and we then assess these

people for their incidence of lung cancer by the time that they reach age 70. We find a dramatic association: the more prolonged and more extensive that one's "lighter-carrying history" becomes, the higher the odds that that person will develop lung cancer later on. In other words, there is a very striking dose-response relationship between lighter carrying and cancer. Could we then conclude that carrying a cigarette lighter causes lung cancer? Obviously not—because carrying a lighter simply is an indication that one is exposed to cigarettes, and it is the cigarettes that cause lung cancer. By analogy, a more severe or extensive history of childhood abuse may be simply an indication that one is exposed to a higher level of bad things—bad genetics, bad biological influences, bad environments, or whatever—it is these that cause psychotic syndromes, not the abuse itself. In other words, a strong dose-response relationship doesn't allow us to conclude anything about causality, one way or the other.

The second argument of Read and colleagues appears to be that the association between childhood trauma and psychotic syndromes seems to persist even in some studies that have controlled for other potential confounding variables, such as age, sex, ethnicity, presence of other psychiatric disorders, and even family history of psychiatric disorder. Therefore, these authors seem to imply, if one is to control for all of these other possibilities, then childhood trauma must be a causal factor. But once again this reasoning is hazardous and may be false. To take our cigarette example above, suppose that we compared carriers of cigarette lighters with non-carriers, and carefully controlled for age, level of education, sex, ethnicity, family history of lung cancer, family history of all other types of cancer, personal history of cancer, personal history of other serious medical conditions, urban versus rural residence, use of alcohol, use of other drugs of abuse, and several other variables. Even with all these adjustments, we would of course still find that carrying a cigarette lighter is significantly associated with the later development of lung cancer—*because we have still failed to control for the critical confounding variable, namely smoking cigarettes*. In short, since it is very difficult to think of all the possible unmeasured confounding variables that might exist, it is almost impossible to control for all of them, and hence it is very difficult rule out the possibility that other things are playing a causal role, rather than the variable that we are measuring.

The example of carrying a cigarette lighter may seem artificial or frivolous—but mistakes like this happen in real scientific research all the time, sometimes even in sophisticated studies in the most respected journals. For example, in the early days of the AIDS epidemic, before the HIV virus had been discovered, many studies were conducted to try to find out the cause of this mysterious disease. It was concluded that inhaled nitrites (so-called "poppers"—a drug popular with gay men during sexual activity) were almost certainly the cause of AIDS, because users of "poppers" were much more likely to develop AIDS than men who did not use them–and this relationship persisted even after adjusting for a wide range of potential confounding variables. Of course, we now know that AIDS is caused by a virus, and that "poppers" have no causal role at all. The reason for the false conclusion of these early studies was that users of "poppers" were much more likely to engage in receptive anal intercourse than men who did not use "poppers"—and this particular sexual practice was by far the most efficient method for transmitting the HIV virus. In fact, the erroneous conclusion that "poppers" caused AIDS has now become a classic example, used in the teaching of epidemiology students, to show that one can mistakenly infer causality, because one *thinks* that one has adjusted for all the important confounding variables in the association between A and B. [4] So in short, it would hazardous to conclude, purely on the basis of available studies at this time, that childhood trauma can somehow *cause* psychotic disorders in adulthood. Such a conclusion might prove to be just as erroneous as concluding that inhaling a "popper" could cause you to get AIDS.

1. Read, J. et al. (2005). Childhood trauma, psychosis and schizophrenia: a literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica*, 112, 330-350.

2. Widom, C. et al. (1999). Childhood victimization and drug abuse: A comparison of prospective and retrospective findings. *J Consulting Clinical Psychology*, 67, 867-880.

3. Raphael, K.G. et al. (2001). Childhood victimization and pain in adulthood. *Pain*, 92, 283-293.

4. See for example Vandenbroucke JP & Pardoel (1989). VPAM: An autopsy of epidemiologic methods: the case of "poppers" in the early epidemic of the acquired immunodeficiency syndrome (AIDS). *Am J Epidemiol*, 129, 457.

Dr. Pope is a professor of psychiatry at Harvard University Medical School and directs a biological psychiatry laboratory at McLean Teaching Hospital. He is the author of *Psychology Astray* and he is a member of the FMSF Scientific Advisory Board.

□

"By the mid-1980s the idea was to sometimes liposuction people's memories out of their brains. It was a bad idea, bad therapy and I don't recommend it.

"It's not the therapist's job to help patients remember anything—and to do so invites the most traumatized among them to simply invent a memory to satisfy the therapist.

"Treating a false memory as a true memory can be a very, very, very bad thing. Why? Because most of these recovered memories involve crimes such as a child saying they had been abused by Dad. Also, an individual then receives therapy for what did not occur."

John Briere. Quoted in Du Chateau, C. (1998, September 9). Recovered memory or just a giant con trick? *New Zealand Herald*, A13.

Some Recent Research of Interest

Geraerts, E. Smeets, E., Jelicic, M. van Heerden, J., Merckelbach, H. (2005). Fantasy proneness, but not self-reported trauma is related to DRM performance of women reporting recovered memories of childhood sexual abuse. *Consciousness and Cognition, 14(3)*, 602-612.

The authors found that individuals reporting recovered memories of CSA are more prone than other participants to falsely recalling and recognizing neutral words that were never presented. The finding held even when trauma-related material was involved. Correlational analysis revealed that fantasy proneness, but not self-reported traumatic experiences and dissociative symptoms were related to false recall and false recognition. This research expands the work of Clancy, Schacter, McNally, and Pitman (2000).

* * *

Storbeck, J. & Clore, G. L. (2005). With sadness comes accuracy; With happiness, false memory. *Psychological Science, 16(10)*, 785-791.

Two experiments showed that affect (positive or negative mood) can influence the encoding processes that are believed to lead to the production of false memories. Negative affective cues reduced the false memory effect.

The authors suggest that positive affect can be expected to benefit performance on tasks requiring relational processing. In relational processing people tend to see connections and focus on global rather than local aspects of what they see, and they process incoming information in relation to currently accessible concepts. On the other hand, negative affective cues seem to result in predominantly item-specific processing. The authors noted that individuals in negative moods resist the influence of accessible scripts and focus on local rather than global aspects of what they see and that they process incoming information independently of currently accessible concepts.

* * *

Park, L., Shobe, K.K., Kihlstrom, J.F. (2005). Associative and categorical relation in the associative memory illusion. *Psychological Science, 16(10*, 792-797.

The authors purpose was to learn more about the kinds of associations that underlie the associative memory illusion. A number of recent memory studies have relied on a task that asks people to study a list of words. The illusion takes place when subjects "remember" words that were not actually in the list. The results showed that strongly related items elicit false recollections at the same level of categorization as the studied items. For example the words banana and apple are related on a horizontal level because they are both examples of fruit. But the words fruit and banana are related on a vertical level because a banana is a kind of fruit. The results suggest that associated links are related in a horizontal rather than vertical categorization.

□

Authoritative Book on the Science of False Memories

The Science of False Memory
Oxford Psychology Series # 38.
C.J. Brainerd and V.F. Reyna
Oxford University Press, 2005

The Science of False Memory draws on the now-extensive false memory literature that is scattered in various journals and book chapters in many different fields such as cognitive psychology, developmental psychology, neuroscience, psychotherapy, sociology, anthropology and criminology. It pulls them together in one place and provides a much-needed authoritative overview of the subject.

Part I covers the history of the science of false memory, reviews the different methods that have been used to study false memory and discusses research regarding age changes in false memory and theories that have been used to explain and make predictions about false memory. Part II reviews the basic science of false memory, including theoretical explanations of false memory and laboratory research with adults, adolescents and children. Part III covers the applied science of false memory, discussing false memory in criminal investigations, both with children and adults, as well as in psychotherapy, including recovered memories of previous lives. Part IV considers emerging areas for experimentation.

This book should be on the desk of any person who may deal with possible false memories: research and clinical psychologists, police investigators, lawyers, judges, social workers and psychiatrists.

□

Other New Books

Destructive Trends in Mental Health: The Well-Intentioned Path to Harm.
R. H. Wright and N. A. Cummings (Eds.)
Routledge, 2005

The authors consider that special interest groups have used faulty science to promote political agendas, and they cover a variety of subjects including recovered memories. Accessible to the general reader.

* * *

Benchbook in the Behavioral Sciences: Psychiatry, Psychology, Social Work.
D. Lorandos and T. W. Campbell
Carolina Academic Press, 2005

This book should be on the desk of any people in the legal professions who must deal with the behavioral sciences.

□

"The most painful thing anyone can do to her loved ones is to remove herself from their lives without giving them any say."

Carolyn Hax, Syndicated Columnist
July 13, 2001, Tell Me About It
Albuquerque Journal, D5.

LEGAL CORNER

Excerpts from the:
ORDER
IN THE DISTRICT COURT OF
DOUGLAS COUNTY, NEBRASKA
Doc. 1024 No. 743

JOHN DOE, TODD S. RIVERS, a married man, in his sole and separate right, Plaintiff,
vs.
FATHER FLANAGAN'S BOYS HOME. a Nebraska Corporation, and JAMES E. KELLY, Defendants.

* * *

(Todd Rivers claimed that he suffered from repressed memory and that was the reason for his delay in filing a lawsuit alleging that he had been sexually abused when he was a child at Boys Town. On August 18, 19 and September 30, 2005, a Daubert hearing was held to determine whether Rivers would be allowed to present expert testimony concerning the phenomenon of repressed memory and the symptoms of child sexual abuse. On November 28, 2005, the court ruled that Rivers could not present expert testimony that he had repressed memories of abuse. Following are excerpts of Judge Dougherty' opinion. The complete decision will be posted on the FMSF web site: www.FMSFonline.org)

Part 1: Judge Dougherty's summary of the expert testimony. Harrison Pope, M.D. and Elizabeth Loftus, Ph.D. testified for the defense; Bessel van der Kolk, M.D. testified for the plaintiff.

* * *

"At the hearings on the Motions in Limine, the parties presented expert testimony regarding the concept of repressed memory."

* * *

"Dr. Pope is a professor of psychiatry at Harvard University Medical School and directs a biological psychiatry laboratory at McLean Teaching Hospital, where he has an appointment as a psychiatrist. Dr. Pope has an extensive curriculum vitae, has written approximately 250 peer-reviewed papers, seven books, and many other publications. His scientific stature is significant, e.g. he is listed among the top 250 psychiatrists and psychologists in the world by the Institute of Scientific Information and is listed among the top 250 or 260 neuroscientists in the world and one of only 37 scientists in the world who is on both of those lists. One of Dr. Pope's specialties is the study of the methodology of scientific research and the critique of scientific studies and their findings.

"Dr. Pope stated that the studies and articles that purport to establish the existence of repressed memory do not meet the methodological standards for valid scientific research. According to Dr. Pope, many of the studies confuse ordinary forgetting with repression. Dr. Pope stated that in his opinion, the phenomenon of repression and subsequent memory recovery does not exist. Dr. Pope defined a repressed memory as follows: "that you could have some sort of traumatic experience and then be literally unable to remember it" and that the memory becomes unavailable to consciousness as opposed to simply forgetting it. Dr. Pope stated that no scientific study has ever established or proved the existence of repressed memory after excluding known causes of amnesia. Dr. Pope stated that the retrospective studies that purport to prove the existence of repressed memory contain flaws such as: (a) erroneously assume forgetting a traumatic event equals a repressed memory; (b) inadequate corroboration of original traumatic events; (c) failure to exclude biological causes of amnesia; (d) no validation of the method for assessing amnesia; and (e) failure to exclude amnesia for secondary gain. According to Dr. Pope, there is no known error rate on any of the studies on repressed memory and that one needs an error rate to establish the scientific validity of the study. Dr. Pope challenged the majority of the studies relied upon by the Plaintiff because they were based on retrospective reminiscences in which people were only asked whether they remembered if they forgot.

"Dr. Pope opined that the concept of repressed memory is highly controversial, that there is no agreement or consensus among scientists, and therefore, no general acceptance for the theory of repressed memory within the relevant psychiatric community. Dr. Pope sent out a questionnaire to a random sample of board certified American psychiatrists and received a response from 80% of them. Of those responding, only 35% thought that repressed memory (dissociative amnesia) should be included as an official diagnosis in the DSM-IV without reservations and that an additional 40% thought that it could be a "proposed" diagnosis."

* * *

"Dr. Pope minimized the inclusion of dissociative amnesia in the DSM-IV as a disorder. Dr. Pope stated that the DSM-IV is not a scientific journal and is not peer-reviewed. Dr. Pope testified that even if there really was such a thing as a repressed or recovered memory, that to a reasonable degree of psychiatric certainty, one cannot evaluate the accuracy of retrieved memories without corroborating evidence."

* * *

"According to Dr. Pope, a 1994 paper published by the American Medical Association stated "considerable controversy has arisen in the therapeutic community over the issue of repressed memory and experts from varied professional backgrounds can be found on all sides of the issue." Dr. Pope also stated that a 2000 position paper from the American Psychiatric Association stated, "some patients have later recanted their claims of recovered memories of

abuse" and that in 1994 the American Psychiatric Association stated, "it is also possible to construct convincing pseudo memories for events that never occurred". Dr. Pope also noted that the Royal College of Psychiatrists stated in 1997: "Memories of events that did not occur may develop and be said with conviction." According to Dr. Pope, these statements from a variety of professional organizations established that there is no general acceptance within the scientific community concerning the theory of repressed memory and the accuracy of recovered memories."

* * *

"The Defendants also presented the expert testimony of Dr. Elizabeth Loftus, Ph.D. Dr. Loftus is a distinguished Professor of Psychology at the University of California-Irvine and a specialist in memory. She has authored or co-authored twenty books and 400 articles. Dr. Loftus was elected to the National Academy of Sciences in 2004 and the Royal Society of Edinburgh in 2005 and received the Grawemeyer Award in 2005. She is the top ranked female on a list of 100 most influential psychologists published by the Review of General Psychiatry. She has been engaged in doing research on memory distortion since the 1970's.

"Dr. Loftus agreed that the concept of repressed memory is so controversial that one could not possibly say it was generally accepted within the scientific community of psychologists and cognitive psychologists. Dr. Loftus stated that there is no good scientific support for the notion today. Dr. Loftus co-authored an article in 1994 which Plaintiff contends is one of the studies that proves the existence of repressed memory. Loftus disagreed that the article proved repressed memory exists. Dr. Loftus stated that it is not known what the participants in the study meant when 19% of them stated that for a period of time they forgot their childhood sexual abuse and then the memory returned. Dr. Loftus stated that when the study was done, she thought there might have been evidence for repression but that in 15 years of efforts since then it still had not been scientifically proven that repression exists. In 1996 Dr. Loftus published her article "The Myth of Repressed Memory", which discussed how false memories are created, planted, or suggested. Dr. Loftus also studied cases where dreams and dream interpretation had the result of changing people's memories and creating false memories."

* * *

"Dr. Loftus, in her 30 years of research, had never found anything to prove the existence of repressed memory. Dr. Loftus did not believe there was any credible scientific support for the existence of repressed memory. Dr. Loftus also opined that there was no evidence that Rivers had a repressed memory. Dr. Loftus did acknowledge that she did not treat patients and had no special expertise in childhood development."

* * *

"Dr. Loftus stated that the DSM-IV is used for communication and diagnosis and includes language that proved how controversial the concept really was. Dr. Loftus testified that fewer people believe in the concept today because of the research and studies and because of the hundreds and hundreds of recanters and retractors. Dr. Loftus also testified that many mental health professionals had been sued for planting false memories of abuse, which led to some changes in how therapists conducted their therapy."

* * *

"Plaintiff presented the expert testimony of Dr. Bessel van der Kolk, M.D. Dr. van der Kolk has an M.D. from Harvard, and is Board Certified in Psychiatry. He is currently a Professor of Psychiatry at Boston University and the Medical Director of the Trauma Center in Boston. Dr. van der Kolk is involved in a major way with the National Child Traumatic Stress Network, which is a network of universities and clinics that concentrate on the treatment of traumatized children. The Trauma Center in Boston specializes in the treatment of traumatized children and adults. Dr. van der Kolk teaches neuroscience, about trauma, and general clinical evaluation and treatment to residents in the Boston University Medical School. Boston University is involved in significant research involving trauma. Dr. van der Kolk is a treating psychiatrist, seeing patients on a regular basis.

"Dr. van der Kolk is the author of 120 to 130 peer-reviewed articles, mainly about trauma. Dr. van der Kolk stated that the issue of memories that come up and disappear is well documented in the war literature, starting with World War I. Dr. van der Kolk treated Vietnam War veterans at the Veteran's Administration and got interested in the memory processes of traumatized individuals. He also stated that the article about Holocaust victims who were traumatized also established that those victims had large gaps in their memories. When Dr. van der Kolk left the Veteran's Administration and returned to Harvard, he began to study the relationship between current diagnoses and the histories of childhood trauma. In his opinion, every study of sexually traumatized people found a certain number of people forgot the memory of the abuse. Dr. van der Kolk believed that it is such a "given" that there do not need to be any more studies done to establish the existence of repressed memory. Dr. van der Kolk co-authored "Traumatic Stress" and was involved with the publication of "Post-Traumatic Stress Disorder", a monograph published by the American Psychiatric Press. Dr. van der Kolk is a distinguished life fellow of the American Psychiatric Association.

"Dr. van der Kolk testified that

repressed memory is listed as a diagnosis in the DSM-IV and that it was listed in the DSM-III. For Dr. van der Kolk, the inclusion of repressed memory or dissociative amnesia as a diagnosis within the DSM-IV meant that it was the consensus of his professional organization that repressed memory exists and is generally accepted within the psychiatric community. According to Dr. van der Kolk, all studies of sexually abused people found examples of repressed memory. Dr. van der Kolk testified that it was no longer a valid question to ask whether repressed memory exists.

"Dr. van der Kolk summarized his opinion of the results of certain studies Plaintiff claims prove the existence of repressed memory.

"According to Dr. van der Kolk, the studies done by Briere and Conte, Williams, Burgess, Elliott and Briere, Dalenberg, Chu and Goodman all found that a percentage of sexually abused people had forgot their trauma or had no memory of their trauma for a period of time. On cross-examination, Dr. van der Kolk acknowledged that the conclusion of the Goodman article was that "these findings do not support the existence of special memory mechanisms unique to traumatic events, but instead imply that normal cognitive operations underlie long-term memory for a child of sexual abuse." Dr. van der Kolk also acknowledged on cross-examination that the American Medical Association statement upon which he relied in part for his opinions, also included the following statement: "The AMA considers recovered memories of childhood sexual abuse to be of uncertain authenticity, which should be subject to external verification." According to Dr. van der Kolk, within the clinical psychiatric/psychology community there is no controversy and that the concept of repressed memory is generally accepted within that community. Dr. van der Kolk also stated that the studies relied upon by the Defendants told us nothing about repressed memory since, according to him, none of them was the study of childhood sexual abuse and in one-half of them memory wasn't even tested."

* * *

Part 2: Judge Dougherty's discussion and conclusions.

Whether the Reliability of Repressed and Recovered Memory Can Be or Has Been Tested.

"The testimony at the hearing established that there is no empirical test that will demonstrate the existence of repressed memory and the reliability of a recovered memory. However, it should be noted that it would not be possible to ethically conduct a laboratory test on human subjects that created a traumatic event for the purpose of testing the subject's future memory or memory loss or memory recovery of the traumatic event. Accordingly, based upon the testimony and evidence presented at the hearing in this case, the Court finds that the reliability of a repressed and then recovered memory has not been tested adequately to establish the reliability and accuracy of such a theory."

* * *

Whether the Reliability of Repressed Memory and Recovered Memory Has Been Subjected to Peer-Review and Publication.

"The evidence at the hearing before this Court established that the studies were retrospective studies, and many were based on reports by victims that were not corroborated. Many of the studies did not distinguish ordinary forgetting from repression and only asked the subjects if they remembered if they forgot the abuse. Many of the studies failed to exclude alternative reasons for victims saying they forgot the abuse, such as: lying about the traumatic event, lying about forgetting about the traumatic event, having a false or pseudo memory about the abuse possibly suggested or implanted by another. One study done by Dr. Femina did a follow-up study on subjects who had denied sexual abuse when they were initially interviewed. Dr. Femina found eight of the eighteen subjects and all eight of them admitted that they had always remembered the abuse and had simply not disclosed it at the time of the original interview.

"The evidence presented in this case establishes that the case studies relied upon by Rivers contain limitations and methodological flaws.

"The Williams study, for example, purports to prove that one-third of the 129 women studied forgot their childhood molestation. However, Williams failed to conduct follow-up interviews in order to determine, why, in fact, the women did not report the previously documented abuse. The lack of follow-up interview calls into question the study's conclusions about repressed memory. Thus, the Williams study does not conclusively validate the repressed memory theory but does, however, provide some support for the theory that a number of individuals who were exposed to documented childhood trauma were not able to recall all memories of the abuse. But the Williams study presents no support for the other aspect of the debate between the scientists, which is whether repressed memories are susceptible to accurate and therefore, reliable recall. Further, the studies relied upon by Dr. van der Kolk do not provide a scientific basis for concluding that repressed memories can be accurately and truthfully recovered.

"Dr. Loftus herself was involved in an early study that Plaintiff claims supports their position. In that study, 19% of the subjects answered that they forgot their abuse for a time and that later the memory returned. However, in the article, the authors pointed out that the responses were ambiguous and that they didn't know how to account for the proportion of non-abused people who "remember" abuse. The evidence

presented demonstrates that there are numerous peer-reviewed articles and publications on both sides of the debate within the scientific community concerning the phenomenon of repressed and recovered memory. Thus, this Court finds that while the theories of repressed memory and recovered memory have been subjected to peer-review and publication, the results of those scientific articles are mixed and do not conclusively establish the existence of repressed memory and the reliability of recovered memory."

* * *

Whether the Reliability of the Theory of Repressed and Recovered Memory has an Established Rate of Error.

"Rivers did not present any evidence or testimony specifically on the issue of an established error rate. For a scientific study to be methodologically sound, it is important to have a small error rate or at least to know the error rate so one can interpret the results. Implicit in Dr. van der Kolk's testimony was the theme that known or potential error rates cannot be applied to the behavioral sciences such as psychology and psychiatry. During closing arguments, Rivers' counsel referred to the inclusion of dissociative amnesia as a diagnostic criteria in the DSM-IV and the Dalenberg study when discussing the error rate factor.

"Defendants, on the other hand, pointed to the results of the Femina study, which did a follow-up interview with subjects who had previously stated that they had forgotten their childhood abuse and all those found admitted that they chose not to disclose the abuse and had not really forgotten it. Defendants also presented evidence showing that there have been a number of "false" or pseudo memories and that numerous cases exist where people claim to have repressed and recovered memories and later recanted or retracted those memories as false or implanted during therapy or hypnosis. Based upon the evidence presented at the hearings, the Court finds that there is no known error rate regarding the reliability of repressed and recovered memories or in the studies presented by Rivers."

* * *

Whether the Reliability of Repressed and Recovered Memories is Generally Accepted Within the Relevant Scientific Community.

"At the hearing the Court was presented with Dr. van der Kolk's testimony that the theory is generally accepted within the psychiatric community and Dr. Pope's testimony that the theory is not generally accepted within the psychiatric community and Dr. Loftus' testimony that the theory is not generally accepted within the psychological community. The evidence at the hearing demonstrated that a major debate exists within the scientific community as to the theory of repressed and recovered memory. Some scientists like Dr. van der Kolk, worked with patients who experienced trauma and who had memory problems or gaps when attempting to remember the trauma. For those clinical psychiatrists, their clinical experiences provide all the proof they need to establish the existence of repressed or recovered memories. According to clinical psychiatrists, such as Dr. van der Kolk, repressed memory is included in the DSM-IV and the World Health Organization Category of Disorders because it is a clearly recognized theory by the psychiatric community.

"However, there is another well-recognized group of scientists, such as Dr. Pope, a psychiatrist, and Dr. Loftus, a psychologist, who believe that the concept is so controversial that there is no consensus of scientific professionals on the existence of repressed memory and/or the reliability of recovered memory."

* * *

"The fact that repressed memory or dissociative amnesia is listed as a diagnosis in the DSM-IV does not alone establish that the reliability of repressed memory and recovered memory is generally accepted by the relevant scientific community. One only has to look at the cautionary language contained within the DSM-IV, the APA Position Paper, and the AMA Position Paper to see that considerable scientific controversy exists concerning these issues. The DSM-IV states "there is currently no method for establishing with certainty the accuracy of such retrieved memories in the absence of corroborative memories." The APA position paper (1993) appears to support the existence of repression but does not seem to distinguish between lack of conscious awareness, or choosing or trying not to remember, or ordinary forgetting. The APA further acknowledged that it is not known how to distinguish memories based on true events from those derived from other sources and that there is no completely accurate way of determining the validity of reports in the absence of corroborating evidence. In addition, the American Medical Association stated that the existence of repression is highly controversial and that recovered memory reports are unreliable without corroboration.

"Based upon the evidence presented, the Court finds that the theory of repressed memory and recovered memory has not gained general acceptance in the psychological and psychiatric communities."

* * *

"Further, even if repressed memory exists, scientists are in agreement that the reliability of recovered repressed memories is unknown and the accuracy of recovered memory testimony cannot be determined without corroborating evidence."

* * *

"Thus, this Court was presented with no evidence that there is any medical or scientific proof to support a cor-

relation between certain symptoms and a diagnosis of sexual abuse. No evidence was offered by Plaintiff that such an opinion is generally accepted within the scientific community, that it has been peer-reviewed, and tested and has a known error rate. Accordingly, the Court finds that Plaintiff has not met its burden of proof under the Daubert/Schafersman test and Plaintiff will be precluded from offering testimony that certain symptoms, characteristics, or behaviors are consistent with a diagnosis of sexual abuse, that Rivers possesses the symptoms, characteristics, and behaviors of a person who was physically or sexually abused as a child, or that Rivers was physically or sexually abused as a child while at Boys Town."

* * *

"IT IS HEREBY ORDERED, ADJUDGED AND DECREED that the Defendants' Motion in Limine No. 1 regarding repressed memory shall be sustained and that Defendants' Motion in Limine No. 2 shall be sustained."

Sandra L. Dougherty
District Court Judge

□

Another Daughter Returns

My husband died in July and was buried with full military honors. When the ceremony was over, I saw that one of my two still-lost daughters was there. I went over to her to thank her for coming, and I put my hand on her shoulder. She suddenly went down to her knees and pleaded for forgiveness for all the harm and pain she had caused. I took her in my arms and we both just bawled.

She started to say something, but I stopped her and told her that she did not have to say anything, that she was forgiven. I told her I had been involved in all the research done on the subject and all that mattered was to love each other. So the terrible grief of the loss of my dear husband and the wonderful return of another daughter happened at the same time. This was the first time I cried for a long time.

Our older daughter has been back with us for about seven years now and still expresses her feelings of guilt. She is dealing with that guilt by giving me lots of attention. For the past seven years, whatever I have wanted, she will do. The other non-accusing siblings don't think this is right because she has never explained her accusations. Unfortunately, these are the siblings who never got involved with learning about FMS. There is nothing I can do about that, but I think that this daughter's close care of me is melting them gradually. I am optimistic that they will accept her because she treats them the same way. Another reason I think that the siblings will come to accept their sister, even without a retraction, is because of the teenage grandchildren from all the families who want to know each other.

The youngest daughter is now alone in her belief but still very stubborn. She has learned to hypnotize herself. I believe that she was actually abused by a neighbor when she was a child because when I spoke to her about it she responded as I had myself when I had been abused as a young person. But her accusations were not about that likely real event. I know what real abuse is like and the results of growing up with it. It was always in my thoughts with no chance of forgetting. It invaded my marriage. Here I am 79 and it pervades me still. I had at one time learned to live with it until my children brought it all back.

A mom

□

Getting to Know Family

One of my grandsons is now 18 and he has contacted me and the rest of the family. He says that he wants to get to know his family. I think that he was about 1 year old the last time I saw him. He said that now that he is 18, his mom can't stop him from getting to know us. He is flying across the country to see us for Christmas and we are helping him with the ticket. We will see what happens?

A happy grandmother.

□

Help Needed

Do you have any suggestions for me? My daughter detached herself from me, her family and friends, going on 10 years now. I still have no idea of what to do. I do send holiday cards as I was advised to do and I periodically have a private detective check on her to see if she is well. When something happens in the family, I send a short note, hoping it will cause a spark of interest. But there is nothing.

Does anyone else still have this situation or has anyone solved this stalemate? I would appreciate any advice that Newsletter readers have to offer.

A mom

□

How Can Our Situation Be Helped?

For some time my wife and friendly daughter have maintained polite relations with my accusing daughter (my presence forbidden), and I have even been in company with that daughter and her family at birthday parties of my friendly daughter's children.

The accusing daughter decided a couple of years ago that she would no longer attend the birthdays if I was present. I was and she didn't come.

My wife has been attending the birthday parties of the accusing daughter's children. At the last, my wife mentioned me. Now, several weeks later, she received a letter disinviting her from the next child's party because she had mentioned "the perpetrator you live with."

I am pretty weary of all this and mostly feel sorry for her. It's almost like believing in ghosts. Is there help for our family?

A dad

Web Sites of Interest

comp.uark.edu/~lampinen/read.html
The Lampinen Lab False Memory Reading Group, University of Arkansas

www.exploratorium.edu/memory/
The Exploratorium Memory Exhibit

www.ctnow.com/memory
Hartford Courant memory series

www.tmdArchives.org
The Memory Debate Archives

www.francefms.com
French language website

www.StopBadTherapy.com
Contains phone numbers of professional regulatory boards in all 50 states

www.IllinoisFMS.org
Illinois-Wisconsin FMS Society

www.ltech.net/OHIOarmhp
Ohio Group

www.afma.asn.au
Australian False Memory Association

www.bfms.org.uk
British False Memory Society

www.geocities.com/retractor
This site is run by Laura Pasley (retractor)

www.sirs.com/uptonbooks/index.htm
Upton Books

www.angelfire.com/tx/recoveredmemories/
Locate books about FMS
Recovered Memory Bookstore

www.religioustolerance.org/sra.htm
Information about Satanic Ritual Abuse

www.angryparents.net
Parents Against Cruel Therapy

www.geocities.com/newcosanz
New Zealand FMS Group

www.werkgroepwfh.nl
Netherlands FMS Group

www.falseallegation.org
National Child Abuse
Defense & Resource Center

www.nasw.org/users/markp
Excerpts from *Victims of Memory*

www.rickross.com/groups/fsm.html
Ross Institute

www.hopkinsmedicine.org/jhhpsychiatry/perspec1.htm
Perspectives for Psychiatry
by Paul McHugh

www.enigma.se/info/FFI.htm
FMS in Scandanavia - Janet Hagbom

www.ncrj.org/
National Center for Reason & Justice

www.lyingspirits.com
Skeptical Information on Theophostic Counseling

www.ChildrenInTherapy.org/.
Information about Attachment Therapy

www.traumaversterking.nl
English language web site of Dutch retractor.

www.quackwatch.org
This site is run by Stephen Barrett, M.D.

www.stopbadtherapy.org
Contains information about filing complaints.

www.FMSFonline.org
Web site of FMS Foundation.

Legal Web Sites of Interest

•www.caseassist.com
• www.findlaw.com
• www.legalengine.com
• www.accused.com

Elizabeth Loftus

www.seweb.uci.edu/faculty/loftus/

The Rutherford Family Speaks to FMS Families

The video made by the Rutherford family is *the* most popular video of FMSF families. It covers the complete story from accusation, to retraction and reconciliation. Family members describe the things they did to cope and to help reunite. Of particular interest are Beth Rutherford's comments about what her family did that helped her to retract and return.

Available in DVD format only:
To order send request to
FMSF Video, 1955 Locust St.
Philadelphia, PA 19103
$10.00 per DVD; Canada add $4.00;
other countries add $10.00
Make checks payable to FMS Foundation

Recommended Books

Remembering Trauma
Richard McNally

Science and Pseudoscience in Clinical Psychology
S. O. Lilienfeld, S.J. Lynn, J.M. Lohr (eds.)

Psychology Astray:
Fallacies in Studies of "Repressed Memory" and Childhood Trauma
by Harrison G. Pope, Jr., M.D.

ABDUCTED
How People Come to Believe They Were Kidnapped by Aliens

Susan A. Clancy
Harvard University Press, 2005

A very readable book recommended to all *FMSF Newsletter readers*. Chapter 3, "Why do I have memories if it didn't happen?" will be of particular interest.

In an article in the British press about her research, Clancy wrote:

"We've all been seeing aliens for more than 50 years.... Preparing this article, I showed 25 people a picture of an alien and Tony Blair: all recognized an alien, fewer than half recognized Tony Blair."

"The trick to creating false memories is to get confused between things you imagined, or read, or saw, and things that actually happened."

"For almost all abductees, the seed of their belief is a question.... 'Why did I wake up in the middle of the night terrified and unable to move?' 'Why are these odd moles on my back?' 'Why do I feel so alone?' 'Why am I different from everyone else?' 'Why are my relationships so bad?' Questions generally lead to a search for answers...and our search is limited to the set of explanations we have actually heard of."

"For better or worse, being abducted by aliens has become a culturally available explanation for distress—whether that distress comes from work, relationships or insecurity."

"Many of us have strong emotional needs that have little to do with science—the need to feel less alone in the world, the desire to be special, the longing to know that there is something out there, something bigger and more important than you watching over you."

October 22, 2005, *The Express*, p. 45.

FMSF BULLETINBOARD

CONTACTS & MEETINGS - UNITED STATES

ALABAMA
See Georgia
ALASKA
Kathleen 907-333-5248
ARIZONA
Phoenix
Pat 480-396-9420
ARKANSAS
Little Rock
Al & Lela 870-363-4368
CALIFORNIA
Sacramento
Jocelyn 530-570-1862
San Francisco & North Bay
Charles 415-984-6626 (am); 415-435-9618 (pm)
San Francisco & South Bay
Eric 408-738-0469
East Bay Area
Judy 925-952-4853
Central Coast
Carole 805-967-8058
Palm Desert
Eileen and Jerry 909-659-9636
Central Orange County
Chris & Alan 949-733-2925
Covina Area
Floyd & Libby 626-357-2750
San Diego Area
Dee 760-439-4630
COLORADO
Colorado Springs
Doris 719-488-9738
CONNECTICUT
S. New England
Earl 203-329-8365 or Paul 203-458-9173
FLORIDA
Dade/Broward
Madeline 954-966-4FMS
Central Florida - Please call for mtg. time
John & Nancy 352-750-5446
Sarasota
Francis & Sally 941-342-8310
Tampa Bay Area
Bob & Janet 727-856-7091
GEORGIA
Atlanta
Wallie & Jill 770-971-8917
ILLINOIS
Chicago & Suburbs - 1st Sun. (MO)
Eileen 847-985-7693 or Liz & Roger 847-827-1056
Peoria
Bryant & Lynn 309-674-2767
INDIANA
Indiana Assn. for Responsible Mental Health Practices
Pat 260-489-9987
Helen 574-753-2779
KANSAS
Wichita - Meeting as called
Pat 785-738-4840
KENTUCKY
Louisville- Last Sun. (MO) @ 2pm
Bob 502-367-1838
LOUISIANA
Sarah 337-235-7656
MAINE
Rumford
Carolyn 207-364-8891
Portland - 4th Sun. (MO)
Wally & Bobby 207-878-9812
MASSACHUSETTS/NEW ENGLAND
Andover - 2nd Sun. (MO) @ 1pm
Frank 978-263-9795
MICHIGAN
Greater Detroit Area
Nancy 248-642-8077
Ann Arbor
Martha 734-439-4055
MINNESOTA
Terry & Collette 507-642-3630
Dan & Joan 651-631-2247
MISSOURI
Kansas City - Meeting as called
Pat 785-738-4840
St. Louis Area - call for meeting time
Karen 314-432-8789
Springfield - Quarterly (4th Sat. of Apr., Jul., Oct., Jan.) @12:30pm
Tom 417-753-4878
Roxie 417-781-2058
MONTANA
Lee & Avone 406-443-3189
NEW HAMPSHIRE
Jean 603-772-2269
Mark 802-872-0847
NEW JERSEY
Sally 609-927-5343 (Southern)
Nancy 973-729-1433 (Northern)
NEW MEXICO
Albuquerque - 2nd Sat. (BI-MO) @1 pm
Southwest Room -Presbyterian Hospital
Maggie 505-662-7521(after 6:30pm) or Sy 505-758-0726
NEW YORK
Westchester, Rockland, etc.
Barbara 914-922-1737
Upstate/Albany Area
Elaine 518-399-5749
NORTH CAROLINA
Susan 704-538-7202
OHIO
Cleveland
Bob & Carole 440-356-4544
OKLAHOMA
Oklahoma City
Dee 405-942-0531 or
Tulsa
Jim 918-582-7363
OREGON
Portland area
Kathy 503-655-1587
PENNSYLVANIA
Harrisburg
Paul & Betty 717-691-7660
Pittsburgh
Rick & Renee 412-563-5509
Montrose
John 570-278-2040
Wayne (includes S. NJ)
Jim & Jo 610-783-0396
TENNESSEE
Nashville
Kate 615-665-1160
TEXAS
Houston
Jo or Beverly 713-464-8970
El Paso
Mary Lou 915-595-3945
UTAH
Keith 801-467-0669
VERMONT
Mark 802-872-0847
VIRGINIA
Sue 703-273-2343
WASHINGTON
See Oregon
WISCONSIN
Katie & Leo 414-476-0285 or Susanne & John 608-427-3686
WYOMING
Alan & Lorinda 307-322-4170

CONTACTS & MEETINGS - INTERNATIONAL

BRITISH COLUMBIA, CANADA
Vancouver & Mainland
Lloyd 250-741-8941
Victoria & Vancouver Island
John 250-721-3219
MANITOBA CANADA
Roma 204-275-5723
ONTARIO, CANADA
London
Adriaan 519-471-6338
Ottawa
Eileen 613-836-3294
Burlington
Ken & Marina 905-637-6030
Waubaushene
Paula 705-543-0318
QUEBEC, CANADA
Chertsey
Mavis 450-882-1480
AUSTRALIA
Evelyn everei@adam.com.au
BELGIUM
werkgr.fict.herinneringen@altavista.net
ISRAEL
FMS ASSOCIATION fax-972-2-625-9282
NEW ZEALAND
Colleen 09-416-7443
SWEDEN
Ake Moller FAX 48-431-217-90
UNITED KINGDOM
The British False Memory Society
Madeline 44-1225 868-682

Deadline for the MARCH/APRIL Newsletter is February 15**.** Meeting notices **MUST** be in writing and should be sent no later than **two months before meeting**.

1955 Locust Street
Philadelphia, PA 19103-5766
Phone: 215-940-1040 Fax: 215-940-1042
mail@FMSFonline.org www.FMSFonline.org
ISSN # 1069-0484
Pamela Freyd, Ph.D., Executive Director

Do you have access to e-mail? Send a message to
pjf@cis.upenn.edu
if you wish to receive electronic versions of this newsletter and notices of radio and television broadcasts about FMS. All the message need say is "add to the FMS-News". It would be useful, but not necessary, if you add your full name (all addresses and names will remain strictly confidential).

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

The FMSF Newsletter is published 6 times a year by the False Memory Syndrome Foundation. The newsletter is mailed to anyone who contributes at least $30.00. It is also available at no cost by email (see above) or on the FMSF website: www.FMSFonline.org

Your Contribution Will Help

PLEASE FILL OUT ALL INFORMATION
PLEASE PRINT

__Visa: Card # & exp. date:_____

__Discover: Card # & exp. date:_____

__Mastercard: # & exp. date:_____

(Minimum credit card is $25)

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

Signature: _____

Name: _____

Address:_____

State, ZIP (+4) _____

Country: _____

Phone: (_____)_____

Fax: (_____)_____

Thank you for your generosity.