Reconstructing the Past:
Trauma, Memory and Therapy

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Reconstructing the Past: Trauma, Memory and Therapy

Warwick Middleton

Objective: To provide an overview of the phenomena of recovered memories and also false memories of past traumas illustrated by clinical vignettes, historical observations and statements by representative writers/researchers.

Conclusions: The questions concerning the recovery of memories of trauma, do not readily reduce to simple dichotomies. Whatever the terminology applied, be it repression, dissociation, or forgetting, humans have a capacity to not consciously know about aspects of their traumas for extended periods of time. The nature of memory is reconstructive. Memory is not a digital recording that provides for a totally accurate replay. Multiple factors including the age at which traumas occurred, the relationships to the person responsible, or the nature and extent of the traumas influence what will be accessible to memory. In regard to these patients who describe recovered memories, lack of regard to therapeutic boundaries is a factor that is particularly likely to be associated with poor outcomes for patient and therapist alike. Compounding such difficulties on the part of some therapists are limitations in training and ignorance about the complex nature of traumatic memory.

Key words: abuse, dissociation, false memory, recovered memory, repression, trauma.

INTRODUCTION:

Yudofsky and Hales observed that, “The brain function that is conveniently conceptualised as memory, is central to almost every facet of clinical psychiatry. The modification of Descarte’s dictum, ‘I think, therefore I am,’ to, ‘I remember, therefore I am’, is not an extreme departure (pg 661).” This is congruent with Rubins’ (1985) observation that, “Autobiographical memory is the source of our sense of self: the feeling that we are the same person with the same personality over time (pg 39).” Janet (see van der Kolk et al, 2001) pointed out around a century ago that instead of being routinely integrated into neutral narrative memory, trauma persists as subconscious fixed ideas.

Spiegel, Frischholz and Spira (1993) observed, “Memory, whether present, absent or disordered, has been at the heart of psychiatry and psychotherapy from the beginning. ‘Hysterical symptoms are residues’ was Freud’s early dictum. His equally famous prescription for psychotherapy, ‘where id was there ego shall be,’ was a way of saying that the process of psychotherapy involved bringing that, which has been forgotten or unrecognised into conscious awareness. Indeed, the notion of the unconscious is inseparable from the problem of memory (pg 747).”

Published in 1920, W.H.R. Rivers’ book “Instinct and the Unconscious” includes a description of the case of “a medical man aged thirty-one, who from childhood has suffered from a dread of being in an enclosed space, and especially of being under conditions which would interfere with his speedy escape into the open (pg 170).”

“When I saw him first his earliest memory of this dread went back to the time at age 6 he slept with his elder brother in what is known in Scotland as a box-bed… He would lie in a state of terror, wondering if he would be able to get out if the need arose….
His next memory bearing on his phobia is being taken to see some men descending the shaft of a coal pit. There came to him at once the fear that were he going down something might happen to prevent his getting out,… He would not travel by the tube-railway, and remembers his horror when on one occasion he had to do so,…

During boyhood he had occasional attacks of sleeplessness, loss of appetite, and inability to work… He was told that the cause of his trouble certainly lay in some forgotten experience of childhood of a sexual nature. When he related his dreams they were invariably interpreted by means of symbolism of a sexual character…. This process of so-called psycho-analysis had no result which satisfied the patient. On the contrary, after two months of it his sleep became so disturbed and his general condition so much worse that he gave up the treatment…. As soon as he had recovered sufficiently he joined the R.A.M.C. and went to France. When he reached the front he had to live and work in dugouts and was at once troubled by the dread of the limited space, and especially by the fear that he might not be able to get out if anything happened. His dread was greatly stimulated on his first day in a dug-out when, on asking the use of a spade and shovel, he was told that they were to be used in case he was buried…. After two attacks of trench-fever his dread was greatly accentuated and increased to such an extent as to make his life almost unendurable…. He was advised by his commanding officer to consult the A.D.M.S., who sent him into hospital…. When he came under my care he had been sleeping very badly in spite of hypnotics. He had been having terrifying dreams of warfare from which he would awake sweating profusely and think that he was dying…. It was only when I explained to him my views concerning the exaggerated interest in sex shown by Freud and his disciples that he learnt for the first time that forgotten experiences of other than a sexual kind might take a part in the production of nervous states….

A few days later he dreamed of being in France, and of being chased by someone into a deep hole in which his pursuer killed a rabbit in place of himself, and threw it into a pond covered with scum….

Three nights later he had another dream. As he lay in bed thinking over the dream, there came into his mind an incident dating back to three or four years of age which had so greatly affected him at the time that it now seemed to the patient almost incredible that it could ever have gone out of his mind, and yet it had so completely gone from his manifest memory that attempts prolonged over years had failed to resuscitate it. The incident was of a kind which convinced him at once that the long-sought memory had been found. Unfortunately his interest in the regained memory was so great that the dreams which suggested it was completely forgotten and all attempts to recall it were unavailing.

The incident which he remembered was a visit to an old rag-and-bone merchant who lived near the house which his parents then occupied. This old man was in the habit of giving boys a halfpenny when they took to him anything of value. The child had found something and had taken it alone to the house of the old man. He had been admitted through a dark narrow passage from which he entered the house by a turning about half-way along the passage. At the end of the passage was a brown spaniel. Having received his reward, the child came out alone to find the door shut. He was too small to open the door, and the dog at the other end of the passage began to growl. The child was terrified. His state of terror came back to him vividly as the incident returned to his mind after all the years of oblivion in which it had lain. The influence, which the incident made on his mind, is shown by his recollection that ever afterwards he was afraid to pass the house of the old man, and if forced to do so, always kept to the opposite side of the street.
Ten days later...as he lay in bed thinking over his dream and its possible antecedents, he found that he was saying to himself over and over again the name “McCann”. He could not at first remember that he knew anyone so called, but it suddenly flashed on his mind that it was the name of the old rag-and-bone merchant in whose house he had been terrified. .

It seemed possible that these thoughts, recalled in consequence of thinking over dreams, might be purely fictitious. It might be that in his intense desire to find some experience of childhood which would explain his dread, the patient might have dreamed, or thought of, purely imaginary incidents which had been mistaken for real memories. Luckily the patient’s parents are still alive, and on inquiry from them it was learnt that an old rag-and-bone merchant had lived in the neighbourhood in such a house as the patient remembered and that his name was McCann. Until they were told some twenty-seven years later they had no idea that their child knew anything of the old man or had ever entered his house... If it had not been for the independent confirmation of his parents the whole memory might have been dismissed as fictitious, but their evidence makes it clear that we have to do with the revival of a genuine memory (Rivers, WHR, 1920, pg 170-177).

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Henry Krystal (1993) who for decades has written about “massive psychic trauma”, makes the point that there are sometimes large areas of a person’s traumatic past that are blocked out in extraordinary ways. He illustrates with the following vignette:-

“Recently, I had an opportunity to work with a ‘juvenile’ concentration camp survivor who was fortunate in having had a course of psychoanalytic treatment back in the 1960’s. He felt quite satisfied with the progress he had made at the time. He came to see me at this time because of acute panic reactions. I noticed that he did have alexithymic characteristics, and that a few years ago his oppressor/partner got greedy and allowed the patient to buy him out. Not too long afterward, the patient became convinced that he could succeed on his own and he developed severe anxiety mixed with depression and other physiological aspects of emotions. He responded well to a small dose of imipramine, and we spent some time talking about his affect tolerance and health maintenance problems. He related that as a public service, he was giving talks to high school students about the Holocaust. He finally brought himself to confess to me that he had still, untouched by his analysis or with me, a total amnesia for the events of 1942-45, although by talking to fellow survivors, reading, and other sources he has reconstructed the story which he still cannot recall directly (pg 852).”

Just over a century ago Pierre Janet observed:-

“Forgetting the event which precipitated the emotion... has frequently been found to accompany intense emotional experiences in the form of continuous and retrograde amnesia (as quoted by van der Kolk, 1996) (pg 285).”

Typifying the older literature concerning combat amnesia, Sargant and Slater (1941) reported that of 1000 consecutive admissions to a field hospital following the evacuation from Dunkirk, 144 of the men had significant amnesia for their trauma. Those with the most ‘severe’ war stress were more likely to have amnesia for combat than those with ‘moderate’ stress. Congruently Henderson and Moore (1944) reported a 5% amnesia rate for combat related events in the first 200 of their war-related cases admitted to a military hospital for psychiatric reasons.
Grinker and Speigel in 1945 observed that some combat veterans had “total amnesia, including both events on the battlefield and the patient’s previous life”, and that “memory for part of the battle experience may be retained, with a gap involving the actual precipitating traumatic factors and the events that followed. The majority of patients make persistent attempts to recover their lost experiences (pg 10).”

A modern account of battlefield amnesia is one elaborated by Zahava Solomon (1993) concerning Yossi, a 21 year old platoon sergeant in an elite parachute unit at the time the Yom Kippur War broke out.

“He fought with the commandos and then in the ‘Chinese form’ battle, notorious among Israeli soldiers for its slaughter. He remembered little of the course of the battle, but feelingly recounted a gruesome incident in which the head of a soldier, still bearing its helmet, came flying from an adjacent trench into his own,... In the course of battle, 8 out of his 30 men were killed. Except for himself and another platoon commander, all the commanders in his company were killed; not a single squad commander survived. Yossi’s position of responsibility made the bloodshed even worse for him. As he explained it, it was he who had to urge reluctant soldiers to fight; then, when he tried to save the situation, his request for permission to retreat was turned down.

Yossi was finally evacuated to a hospital in Israel, riddled with shrapnel in his hands and legs. In addition, he suffered from amnesia – remembering almost nothing, not even how to read...(pg 197-198).”

Solomon describes Yossi as experiencing ongoing severe Post Traumatic Stress Disorder symptomatology, affective instability and depression. His memory loss persisted and he had to learn to read again. She describes how in the subsequent Lebanon war,

“Yossi did not function from the very beginning..... When they came under heavy Katushya bombardment, he felt ‘on the verge of exploding’. Eventually, he was saved by routine home leave, from which he refused to return to duty.”

“For a month, he stayed at home just lying around, smoking cigarettes, and drinking coffee. He did not bathe or shave, talk to his wife, or look at the son who had been born the year before.... Constantly enraged, he would scratch the walls with his nails. He had terrible dreams in which his Yom Kippur War experiences ‘all came back in a huge onslaught.’ He was finally referred to an IDF mental health clinic after he cursed and threatened to shoot the army representative who had been sent to bring him his military recall order (pg 198-199).”

Within forensic settings claims of amnesia for a criminal act are common with some 20-40% of criminals denying recall of their alleged crime. Whilst there may on occasion be a medical cause identified such as an alcoholic blackout, epileptic seizure or a psychotic paramnesia, more commonly the mechanism of dissociation is invoked and an association with depressed mood demonstrated (Kopelman, 1987a). Underlying the density of psychogenic amnesia commonly seen for very traumatic events is the oft reported finding of complete amnesia associated with homicides. Multiple studies have found it in 30-40% of cases (Kopelman, 1987b) whereas amnesia is rarely found in non-violent crime. One particular circumstance associated with amnesia is in homicide cases in which the victim is closely related to the offender, the offence is unpreameditated and it takes place in a state of high emotional arousal (Taylor & Kopelman, 1984).
CONTEMPORARY CLINICAL CONTEXTS:

She was a 27 year old single woman, a health worker with no previous history of psychiatric treatment who however was highly avoidant of intimate relationships with men. She was moved by suicidal ideation and feelings of increasing unease to present herself for hospitalisation. Once admitted, she seemingly became more disturbed, at times walking around clutching a doll, earning a description of severe “borderline” behaviour before having a series of “fits” that resulted in her transfer to the neurology ward of another hospital. Whilst her “fits” were noted to be almost certainly pseudoseizures, she caused mystified concern when she suddenly slammed her right arm back into a wall with such force that she fractured it, though afterwards could offer little explanation for what occurred. That evening, she was transferred to another psychiatric unit from which she left suddenly the following morning to take herself to a car park from which she jumped, falling approximately two stories and sustaining further fractures. Afterwards she had complete amnesia for the jump. She had no history of any past episodes of equivalent self injury.

It was at this juncture that she was seen by the author. It is important to emphasise that this lady in contacts with psychiatrists in the weeks prior to her acute presentation, had been able to clearly give a history of extensive physical, sexual, and emotional abuse in an extremely disturbed family in which an idealised sibling had suicided. Whilst there were gaps in her memory, she was fully aware of having been made a ward of the State and of having had multiple foster placements, the majority of which were abusive.

Seen regularly over the days following her jump from the carpark there was a progressive recovery of memory for the events leading up to, and surrounding the jump. The state approximating “la belle indifference” that was in evidence in the period immediately following her jump, gave way at times to marked anger and anxiety that were responded to by allowing her to ventilate, and by addressing issues of safety and pain relief. As she began to spontaneously recover memories for her jump, she also experienced intense flashbacks to elements of her childhood abuse that previously she had not been consciously aware of. She became aware that her idealised dead brother had also severely abused her, with an instance of particular severity being an occasion when as a child she was walking on a bush track and he approached her sexually. She resisted and he responded by throwing her over a high embankment, resulting in her fracturing an arm – her right (with the height of her fall from the carpark approximating that of her fall over the embankment).

Equally traumatic for her was the associated return of memories of this same brother sexually abusing her in her bedroom, their mother opening the door, looking in, and then closing it. She would experience as an auditory hallucination, the sound of her mother’s receding footsteps symbolising for her the totality of her abandonment. Whereas previously she had rationalised that her mother cared for her and had not intervened because she did not know about the ongoing abuse, this was no longer sustainable.

What had precipitated this dramatic process, leading to acute decompensation, and the traumatic recovery of childhood memories incorporating re-enactment, emotional outpouring and a series of flashback experiences including traumatically based hallucinations? Was it therapist suggestion, the regressive use of hypnosis, or some form of psychological manipulation? It was none of these: the index event precipitating the unravelling of defences and the overwhelming impact this engendered was a chance meeting the patient had with one of her past foster mothers, who had been party to her abuse and who had recently moved into her neighbourhood.
Re-enactment without conscious links to the prior trauma is central to the repetition-compulsion dynamic. By way of further example Bessel van der Kolk (1989) describes treating a Vietnam veteran “who had lit a cigarette at night and caused the death of a friend by a Viet Cong sniper’s bullet in 1968. From 1969 to 1988, on the exact anniversary of the death, to the hour and minute, he yearly committed ‘armed robbery’ by putting a finger in his pocket and staging a ‘hold-up’, in order to provoke gunfire from the police. The compulsive re-enactment ceased when he came to understand its meaning (pg 391).”

A middle-aged man known to the author was involved in an industrial accident in which several people were killed or injured. He harboured marked guilt regarding his actions, and in a dissociative state for which he had no subsequent memory, lacerated much of his body, covering himself with blood, representing a deep symbolic expression of the unresolved feelings that tormented him and which became much less evident following his full exoneration by a coronal enquiry.

His face was lined, tanned, not without signs of humour, but gaunt nonetheless. He was an ex-regimental sergeant-major whose stated presenting problem to the author was difficulty in controlling outbursts of anger and the repeated experience of flashbacks to his Vietnam experience of nearly a quarter of a century earlier. Until that year he was emphatic that he had never previously experienced flashbacks. Such was his defensive structure, which incidentally had allowed him to stay in the army until the late 1980’s, that until he had experienced them himself, he had regarded flashbacks as “an urban myth”. Despite close bonds to soldiers he served with, he had assiduously avoided attending any reunions. It was when he met up with one of those with whom he fought that for the first time he experienced what he described as the “scary, frightening” phenomena of being “transported to another place.” His exact spontaneous account of this was: “Everything came back with so much clarity. I could see things I hadn’t thought of for years. My mind has an inbuilt safety mechanism. I’ve never remembered much about Vietnam. A lot of my tour over there, I’m totally blank on... I remember just isolated incidents. The whole lot seems a blur...”

A decade on he has close and regular contact with many fellow veterans, and he has explored the nature of, and the emotions to, his emotionally deprived and abusive childhood and the dynamics of his following his father into army service and ultimately achieving a higher rank embodied in the persona of the impregnable, hard drinking toughness of an RSM. He has lived through periods of marked somatization including experiencing intense pain identical in quality and distribution to that associated with carrying a full combat pack. Yet, whilst he knows there were many occasions in which he would have seen the bodies of fellow Australian soldiers killed in combat, he has to this day no visual memory of such a scene.

She was a 17 year old female adolescent, in the throes of attempted separation from an environment in which her two parents, although maritally separated, retained extremely enmeshed relationship styles. Aspects of her extensive trauma, exemplified by her torture at the hands of a church youth group leader might seem barely believable were not salient facts confirmed by Police and the consistent accounts of two other patients quite independently seen on subsequent occasions by the author. Her reported abuses at the hands of this man included being locked in the back of cars, held underwater, burnt with cigarettes, or being locked in a garage where he would strip her and then hold an activated circular saw
near her face or genitals, before sexually abusing her. Variations in this pattern of abuse was carried out with a number of other girls. Finally uncovered, he offered an oblique largely uninformative apology to his church congregation and shortly afterwards wrote suicide notes to the church and his wife before virtually cutting off his own head with the same saw he had used to terrorise victims. Police confirmed the method of suicide.

In another instance of well-documented trauma this adolescent, in front of multiple witnesses, was forcibly abducted against her will by a van full of extreme fundamentalists, who in the process of chanting things like, “We take you in the name of the Lord”, managed in the ensuing struggle to dislocate her knee. Her mother’s explanation for this, an extrapolation of the one previously used repeatedly, that of, “She bruises easily,” was along the lines of, “She dislocates easily…”.

On one occasion, the author actually spoke by phone with one of this patient's self-proclaimed exorcists who had moved interstate following the collapse of what he described as his “spiritual warfare school”. In rather hushed tones, he described how the patient had been inducted into a coven at the age of four, had participated in human sacrifices and perverse sexual rituals and had been promoted to the position of “high priestess of the devil”. When it was pointed out that at the age of four she was actually living 1000 km away from the location of the coven that she was presumed to be a member of, this did not seem to shake his conviction. In point of fact there has never been a shred of actual evidence that linked this person to any satanic cult, though in the perverse environment in which she was raised – that of extreme fundamentalism and sadistic perversion, she was repeatedly exorcised in the belief that her dissociative defences represented demonic possession.

This highly intelligent young woman who with treatment did very well, married, became a mother and returned to her career, demonstrated the phenomena of eidetic imagery that extended also to the spoken word. She could report in precise detail the content of conversations occurring more that half a lifetime previously.

A highly dissociative patient, along with well-corroborated accounts of multiple traumas she also demonstrated the phenomena of “false memory”. In her particular case it would seem likely that the occasion of cessation of actual ongoing abuse by her principal abuser, (allied as it was to the dynamics of her ambivalent attachment), occasioned such a void that an alter state was created to fulfil the role of the absent abuser/parental attachment figure, and this alter state was responsible for severe self-mutilation which in other states was remembered as being caused in a recent attack by her primary abuser. As her ego states became more integrated and as she was able to strengthen her boundaries, the nature of her false memories became apparent to her, but her true memories remained.

For more detailed historical cases of the recovery of memories of trauma see Appendix 3.

THE WIDER CONTEXT:

From the late 1980’s one can trace the emergence of clinical and social polarisations concerning memories of trauma, the “recovery” of memories of past trauma (particularly dealing with child sexual abuse), the emergence of individuals claiming to have been ritualistically or satanically abused (or even abducted by aliens) and the frequent linking of such phenomena to individuals diagnosed with Dissociative Identity Disorder (D.I.D), the validity of which was likewise an issue in further polarisations.
At one level the extent of controversy was surprising – after all there had been a century in which amnesias for all sorts of traumas (particularly those occurring on the battlefield) had been documented. (The diagnostic significance of amnesia for trauma was well embedded in the 1980 DSM-III diagnostic criteria for Post Traumatic Stress Disorder.)

Yet at another level the incipient fireball was not surprising – society was attempting something that had never been achieved before – progressively exposing to public gaze traumas that despite earlier attempts, had returned to, or remained in darkness. By the 60’s there was emerging awareness of the human response to disaster. In 1962 Kemp et al. described the “battered child” syndrome. By the 70’s society was beginning to grapple with the syndromes of Vietnam Veterans, whilst at the same time feminist writers and researchers were challenging decades old rationalisations about Oedipal phantasies and hysterical mendacity. In 1981 Judith Herman published “Father Daughter Incest”. In 1986 Russell published “The Secret Trauma: Incest in the Lives of Girls and Women” a large scale epidemiological study on incest and other childhood sexual abuse. Society’s confrontation with the extent of child incest (Russell’s study suggested 16% of American females had been incestuously abused, 4.5% by their father) was to be joined by confrontations concerning the extent of abuses perpetuated in state or church institutions, the extent of child abuse perpetrated by members of the clergy, and the extent to which sexual boundaries are violated by health professionals.

Herman and Schatzow (1987) reported that 74% of their patients in a series of women reporting childhood sexual abuse, whether the memories of the abuse had always been accessible or had been recovered through the course of therapy, had memories which could be supported by corroborating evidence they had gathered, and that a further 9% were supported by statements of others that indicated a strong likelihood that the accounts were correct. Essentially similar findings to those of Russell were reported by Draijer in The Netherlands (see Herman, 1992).

In the early 90’s the world witnessed the apocalyptic destruction of the Branch Davidian stronghold in Waco Texas, the Swiss massacre of the Solar Temple cult complete with evidence of the sacrifice of infants, the unleashing of genocide in Rwanda in which over some 800,00 people were hacked to death with machetes etc. and the extraordinary physical and sexual brutalities carried out on a large scale in the name of ‘ethnic cleansing’ in an ostensibly civilised European region that in its recent past had been host to the 1990 Winter Olympics. The massacre of 15,000 in Srebrenica in Bosnia by forces loyal to the genocidal Serbian psychiatrist, Radovan Karajec was in time to be overshadowed by a full scale ethnic cleansing campaign in Kosovo later in the decade, in which bands of paramilitary led by killers such as Arcan ventured into the field for expeditions of rape and killing before returning to Slobodan Milosevic’s Belgrade to celebrate in night clubs.

Growing ever more bold and deadly Al-Qaeda’s terrorist strikes in the 90’s found a new zenith on September 11, 2001, to be followed by coordinated subway bombings in Madrid and London while affiliated terrorists bombed Saudi Arabia, Bali, Djakarta, Egypt, India and Bali for a second time. Meanwhile ‘a coalition of the willing’ looked progressively more tied down than ever in a very unstable Iraq, a magnet for international terrorists and suicide bombers, being as it is, an arbitrarily constructed country of longstanding deep tribal, ethnic and religious divisions. The forces bringing democracy to Iraq also brought the sorts of interrogation processes showcased to the world through the digital camera images of the treatment of prisoners at Abu Ghrain prison, possibly the worst public relations disaster for the American military since the Mai Lai massacre in Vietnam.

Starting from the early 80’s increasingly public and increasingly numerous scandals involving Catholic and other priests sexually abusing children entered public consciousness. In the March 20, 1993, issue
of ‘America’, the Jesuit magazine, the noted sociologist, Rev. Andrew M Greeley, using data from the Chicago archdiocese as a statistical baseline, estimated that 2,500 priests, or some 6% of the U.S. Catholic clergy had abused 100,000 children in the last generation (Berry, 2000). By 2002 the epicentre of the scandal involving the American Catholic Church hovered over Boston. In a cover story, Time Magazine openly asked the question, “Can the Catholic Church survive?” Writing in Time, Andrew Sullivan in March 2002 stated, “In the past month, it has been revealed that more than 70 priests in the archdiocese of Boston – out of a total of less than 700 – have been accused of the sexual abuse of children. That’s 1 in 10. Worse, when evidence of these crimes has come to light, the church hierarchy has done everything in its power to hush it up, pay secret damages to the victims and, in many cases, do nothing but reassign pedophile priests to other parishes, where they can commit abuse again. In one of the worst cases, that of the Rev. John Geoghan, the church hierarchy had responded to clear evidence of his depravity by moving the now defrocked priest around for almost two decades – as he continued his pattern of molestation of minors. Last week he was sentenced to nine to ten years for indecent assault and battery (pg 39).” By the end of 2002 the most senior American priest, Cardinal Law had resigned from heading the Archdiocese of Boston while an increasingly restive flock simultaneously grieved, expressed outrage at the rampant unchecked paedophilia in the Catholic clergy exemplified by the serial predating abuses of Fr. Porter, Fr. Geoghan, Fr. Birmingham, Fr. Shanley etc. etc., sued the Church, or alternatively tried to save it from itself. A $85 Million (US) settlement to sex abuse victims was negotiated in 2003 by the Boston Archdiocese which has some 2.1 million Catholics (Schreiner, 2005). By December 2004 new records were being reached in the value of law-suits settled by the Church when a suite of suits against the Roman Catholic Diocese of Orange was settled for $100 Million U.S. (Flaccus, 2005), only to be eclipsed by a subsequent $120 Million U.S. settlement in the relatively small Roman Catholic Diocese of Covington Kentucky. In June 2005 (Schreiner, 2005) it was reported that in the diocese’s most recent public report it was stated that there had been 205 allegations against 35 priests, nearly 10% of the 364 priests who had ever worked for the diocese. Of the 35 accused priests, 16 were dead, 5 had been defrocked and 14 had been permanently removed from ministry but remained priests.

Writing in May 2005, Alexaxandra Stanley observed, “Retirement worked wonders. When Cardinal Bernard F. Law led a memorial mass for Pope John Paul II in St. Peter’s Basilica last month, it was as if his long tenure as archbishop of Boston had been unblemished, his resignation under pressure in 2002 forgotten.

Even the cardinal seemed to have banished unpleasant memories. When the ABC anchor George Stephanopoulos veered from the topic of John Paul II’s legacy to ask the former archbishop if he thought he could have done more to address the problem of pedophile priests, Cardinal Law looked as if he had been slapped. ‘You know, I, I don’t know that this is a time to be reflecting on that issue,’ The cardinal replied stiffly, before adding that of course he deplored his and others’ failures.”

In the same month that Stanley wrote her piece, a Los Angeles Times editorial on the Catholic Church sex abuse scandal opined, “The new pope is unlikely to bring more transparency to the issue. Three years ago, he said the whole scandal was a ‘planned campaign’ by the news media to discredit the church.”

Writing in 2003, David Finkelhor, a modern pioneer in the child abuse field observed that prior to the clergy abuse scandal in the Catholic Church backlash concerns seemed to be the major focus in the media. Prominent in the backlash of course was the contention that no one really forgets child sexual abuse and the associated corollaries prominently endorsed by the False Memory Syndrome Foundation etc. “But, then ensued, to almost everybody’s surprise, a year full of the most credible child
maltreatment stories. Gone are the images of overzealous investigators, mendacious children, and a child protection system threatening the integrity of families. Back are images of fiendish predators, intimidated children and a message that state child protection mandates need to be expanded to penetrate some still recalcitrant corner of our society (Finkelhor, 2003, pg 1225).

Finkelhor (2003) cautioned against polarising and stereotyping. He credited the scandal with re-alerting parents of the need to talk to children about sexual abuse and the risk of such abuse occurring at the hands of people known to and respected by children and their families and he pointed to the way in which the scandal had further de-stigmatised sexual abuse and lowered the barriers to disclosure. Finkelhor observed that the scandal had put organizations and administrators on notice about “their affirmative responsibilities for dealing with problematic employees in a responsible way (pg 1226)”, however he cautioned that “the clergy abuse scandal reinforced and compounded many of the most insidious stereotypes about sexual abusers and child molesters. The offenders were routinely referred to as pedophiles, implying a sexual attraction to prepubertal children, a paraphilic disorder, a person with multiple victims, and a compulsion to offend. In fact, the majority of the priest offenders were not pedophiles. Very few readers got a sense of the spectrum of offenders who were involved. People like Father Porter and Father Geoghan who had many victims were prominently featured, but the reality that most of the accused had one or a couple of victims got lost. The notion that there is a wide spectrum of abusers was much more apparent when the public conversation included many instances of incestuous fathers and abusive grandfathers, but in the context of priest abuse, this was harder to convey (pg 1226).”

By December 2006, when the Los Angeles Archdiocese offered a $60 million settlement as part of the still unfolding clergy – sexual abuse scandal, there was a perception that the money was but a precursor to the nation’s most costly abuse payout (Leovy & Garrison, 2006). “Victims and their advocates staged public news conferences and spoke about the abuse with a frankness that would have been unthinkable 20 years ago.” In prefacing their story, Leovy and Garrison stated, “Joelle Casteix [Southwest regional director of Survivors Network of Those Abused by Priests] knew something had changed when she saw sexual abuse by priests spoofed on ‘The Simpsons’. In one episode, the animated residents of Springfield lapsed into awkward silence in the presence of a Catholic priest. Nothing more was needed to get across a dig at the church scandal.”

The December 2006 sexual abuse settlement that was announced resolved all current civil claims involving molestations that occurred during Cardinal Roger M. Mahony’s 20 year tenure as head of the Roman Catholic Archdiocese of Los Angeles. Pringle and Guccione (2006) reported, “But it leaves unanswered for now the biggest questions raised by the scandal: how the cardinal and other church officials handled molestation complaints against priests, and whether the archdiocese will bear any criminal responsibility for their actions. Mahony has acknowledged leaving 16 priests in the ministry after parishioners complained about inappropriate behaviour with children... The cardinal has released truncated summaries of those cases but the full accounts reside in confidential files that the archdiocese has withheld. Mahony waged a years-long battle to keep the files from a county grand jury, finally losing before the U.S. Supreme Court.” Most of the priests accused of sexually abusing children during Mahony’s watch face additional civil claims.

On 16th January 2007, the ‘Frontline’ documentary “Hand of God” was broadcast by PBS on U.S. television. It was based around the story of Paul Cultrera, a former altar boy in Salem, Mass. Alessandra Stanley writing in the New York Times described her impressions of the film made by Paul Cultrera’s younger brother, Joe.
“Paul Cultrera wasn’t destroyed or unhinged by the actions of Father Joseph Birmingham, a priest who was accused of molesting scores of boys before his death in 1989. ‘It’s not the story of my life,’ he says. ‘It’s a thing that happened to me.’”

Mr Cultrera kept his secret for 30 years before going public. His story, which relates in a restrained, matter-of-fact tone, is not told in self-defense, nor is it just an expression of hurt and anger. ‘Hand of God’ is a stinging denunciation of the Catholic Church, but it is also a celebration of the family that survived the ordeal and was in some ways strengthened by it...

When he finally talk about what happened, he finds he is supported by his family and deserted by his church. He was particularly embittered by the way the officials like Bishop John B. McCormack of Manchester, N.H., protected his abuser.

At one point Joe Cultrera films the outside of the church building for the documentary until the priest comes out and puts his hands on the lens to stop him.

When Joe Cultrera explains what his film is about, the priest turns icy. ‘Sir, if you think you’re going to make me feel bad about this,’ the priest says, ‘you’re not.’ They later learn that he is Bishop Richard Gerard Lennon, an auxiliary bishop who temporarily took over the archdiocese after Cardinal Law stepped down (Stanley, 2007).

Congruent with the dynamic of avoiding or refusing responsibility are the utterances of convicted pedophile, Rev. Charles Sylvestre, interviewed by the Ontario Crown Attorney, Paul Bailey whilst in the penitentiary where he was serving time for sexually abusing 47 girls between the ages of 8 and 15 over a period of 30 years in the five parishes across southwestern Ontario. Roberta Pennington of the Can West News Service reported: -

“In an effort to dispel the myth that pedophiles suffer a ‘mere moral failure’, Bailey presented excerpts from his conversation with Sylvestre that shows the disgraces priest’s mental illness, or ‘distinct psychological pathology.’

When speaking to Bailey of the young girls he molested, Sylvestre talked as though the children conspired to have him abuse them.

‘These girls that came over there every day, they planned it,’ Sylvestre told Bailey. ‘I could hear them talking and they’d come in and sit on a chair and their skirt would be up to their crotch. Well, it was kind of attracting.’

Sylvestre said he knew what he was doing ‘was a sin,’ but thought his actions would be forgiven through confession (Pennington, 2007).”

Simultaneously with the unfolding of clergy abuse was increasing appreciation of sexual abuses occurring in psychotherapy. Holroyd and Brodsky in a survey of 1,000 psychologists in 1977 found that 12.1% of male, and 2.6% of female psychologists admitted having had sexual relationships with patients. Gartrell et al. in 1986 in a survey of 5,574 psychiatrists found 7.1% of male, and 3.1% of female psychiatrists reported sexual relationships with patients. Studies that included figures for therapist’s sexual involvement with former patients produced higher percentages e.g. Pope et al. (1987) found that 3.6% of the male sample of psychologists admitted to having had sexual relations with a
client but that 14% reported having had sex with a former client. (For female psychologists, the percentages were 0.4% and 8% respectively.)

Given the vastly more focussed attention from professional organisations it would probably be unproductive to attempt such surveys today, but the list of health professionals (including psychiatrists) being deregistered for the sexual abuse of patients continues to build. (Since the beginning of the 90’s at least 9 Queensland registered psychiatrists have been deregistered or relinquished the right to practice in the context of breaches of sexual boundaries with patients, the most recent being in 2005.)

However, up to the present time prosecutions involving therapists accused of sexually abusing/exploiting patients and/or demonstrating unusual boundary dynamics continue to occur with unending regularity. Differing accounts of what actually happened, plus differing perspectives on the meaning of actions whose occurrence are not in dispute, strongly reinforce a need for sound boundaries and for not doing in one’s practice, what it would be hard to clinically justify to a cross-section of one’s respected professional peers. Factual memory and the assigning of meaning are different processes. In January 2007, a leading Perth psychologist Bruce Beaton 64 was tried in court following his earlier arrest when police set up secret recordings of him with his 22-year-old alleged victim on the phone and also placed a hidden camera in the woman’s bag during one of their appointments.

Reporting the case in The Australian on January 24th, 2007, Alana Buckley-Carr stated,

“ The District Court was told yesterday that police, waiting outside Mr Beaton’s office in 2005, intervened after hearing whipping noises coming from inside. Mr Beaton, an expert in treating patients with eating disorders, has pleaded not guilty to allegations he sexually assaulted and humiliated the patient in 2005 during a number of therapy sessions.

Giving evidence yesterday, the woman, now 24, said Mr Beaton told her bulimia was about control and she needed to learn discipline.

‘I’d have to obey every order that he gives and present myself the way he says,’ the woman said. She said she was often told to take her clothes off during her therapy sessions but when she refused to remove her underwear she was beaten with a wire coathanger. She said he had asked her about boyfriends, relationships and her sexual fantasies.

Prosecutor Amanda Forrester said police became involved after the woman made a complaint, the day after being forced to lie naked on a couch in Mr Beaton’s Fremantle clinic, where he performed sex acts on her (pg. 7).”

The jury watched the tape on which Mr Beaton is heard calling the woman, his “delicious” submissive while she calls him “master”. She was seen on the tape wearing a dog collar and swearing an oath to offer her body to him in order “to become a better person” (Guardian Unlimited, 2007).

The Australian reported on February 2nd, 2007 that Mr Beaton was acquitted in his jury trial. During the trial it was revealed that the woman has suffered from bulimia for 10 years and had many problems including drug use, self-harm and being sexually abused at age nine. Mr Beaton’s explanation for his language which included calling the woman his “delicious submissive” whom he wanted to have a taste of, was that he was mirroring his patient’s behaviour in order for her to trust him. He also admitted telling her to masturbate while having sexual fantasies that did not include violence. The woman had accused Mr Beaton of making her wear a dog collar, whipping her with a wire coathanger and a home-
made cat-o-nine tails, giving her oral sex and digitally penetrating her. Acquitted on the sexual assault charges Mr Beaton was convicted of contempt of court for refusing to name the colleague who he claimed to have consulted with for advice on how to treat a condition known as BDSM (bondage, discipline and sadomasochism). Mr Beaton declared his career was destroyed. (Buckley-Carr, 2007).

On the same day that Mr Beaton’s acquittal on sexual assault charges in Perth was prominently reported in the national press, as if to underline the frequency with which otherwise highly qualified and experienced therapists can at times do things which seem devoid of boundaries and common sense, a Melbourne psychiatrist was portrayed on page 2 of the Melbourne Age in handcuffs following his arrest triggered by his taking a loaded hand-gun, sourced from a criminal contact, into a district court (Oakes & Cooke, 2007). Other photos published showed the doctor’s wife being led away in handcuffs as well as a selection of the weaponry they had collected, which was subsequently explained in terms of defending themselves from an underworld hit that it was claimed was being organised by Dr Gelb’s ex-wife. The following day The Age made it a cover story titled, ‘The shrink, his wife, a pistol and the ex’. (Harrison & Butcher, 2006). In opposing bail on 5th February, 2007 for Dr Gelb on the grounds of unacceptable risk Senior Constable Bailey stated in court that Gelb claimed a criminal had revealed to him that there was a kill contract out on him and had demanded $5,000 to stop the hit. “He said Gelb claimed he was given the hand-gun by a criminal, one of three he befriended who later became his patients – including one that attended his wedding (Butcher, 2007, pg 4).”

Despite commissions of inquiry on institutional abuses and even a NSW Royal Commission on paedophilia, the extent of paedophilia in society is glimpsed by the 2,000 arrests in Australia in 2004 as a result of an international law enforcement initiative in tracing individuals using the internet to trade in, or distribute child pornography and by news items reporting the arrest of paedophiles who have amassed documented lists of victims, the numbers of whom for many are staggering. When the Queensland paedophile, Geoffrey Dobbs was arrested in 2003 (as a result of leaving a tape in video equipment that he placed for repair at a Melbourne shop), documentary evidence in the form of photos and tapes indicated that he’d accumulated at least 300 child victims over 30 years (Watt & Keim, 2003).

In The Netherlands, in May 2006 a political party was formed by Dutch paedophiles which set out to win support for its campaign to legalise sex with children. The Brotherly Love, Freedom and Diversity party (Partij voor Naastenliefde, Vrijheid en Diversiteit) has been campaigning for a cut in the age of consent from 16 to 12 and the legalisation of child pornography and sex with animals. Party chairman Marthijn Uittenbogaard told a news conference in September 2006, “What we think is really going on is that people are afraid of the emancipation of children. It is the adults who do not allow the child to have these contacts.” His party was quoted as saying it wanted to lift the taboo on paedophilia, which it said had intensified since the 1996 Marc Dutroux child abuse scandal in neighbouring Belgium. According to their official statement, accessed on their website (31st May 2006) the PNVD's platform aims to maximize diversity and liberty. They propose allowing individuals, from the age of 12, to vote, have sex, gamble, choose their place of residence, and use soft drugs. Hard drugs would be legal at 16. They also intend to eliminate marriage in the law, permit public nudity anywhere in the country, make railway travel free, and institute a comprehensive animal rights platform. The treasurer of PNVD, Ad van den Berg (then 43), was convicted in 1987 for molesting an 11-year old boy. He was fined and given a suspended prison sentence (Court refuses to ban Dutch pedophile party, AP article). After Van den Berg’s background became known in June, he was chased from the trailer park where he lived in the city of Oostvoorne (Corder, 2006).
Numerous studies dating from the early 80’s have demonstrated that between 40% and over 70% of psychiatric in-patients, when enquiry is made, will give a history of childhood sexual and/or physical abuse (Husain & Chapel. 1983; Enslie & Rosenfeld, 1983; Mills et al. 1984; Bryer et al. 1987; Jacobson & Richardson, 1987; Craine et al. 1988; Swett et al. 1990.) Similar trends have been reported with psychiatric outpatients (Jacobson, 1989). Read et al. (2004) compared 40 studies published between 1984 and 2003 that examined the prevalence of child abuse among female psychiatric in-patients and among outpatients where at least half the patients were diagnosed with a psychosis. Collectively the studies included 2,396 subjects. In 50% there was a history of child sexual abuse, in 29% there was a history of incest, and in 48% a history of child physical abuse. No less than 69% had a history of either sexual or physical abuse, while 35% had a history of both. Read et al. also compared 25 studies complete between 1987 and 2003 that examined the prevalence of child abuse among male psychiatric in-patients and outpatients where at least half the patients were diagnosed with a psychosis. Collectively there were 1,356 subjects of whom 28% had a history of child sexual abuse and 7% had a history of incest. 515 gave a history of child physical abuse, while 60% had a history of sexual or physical abuse and 19% had a history of both.

In his book, “Schizophrenia: Innovations in Diagnosis and Treatment” Colin Ross plausibly confronts the genetic model of schizophrenia. By way of a broader perspective, he points out that in the last four decades of the twentieth century, “for every study on the relationship between child abuse or neglect and schizophrenia, there were thirty on the biochemistry of schizophrenia and forty-six on its genetics (pg 63).” Based on existing genetic research which indicated that monozygotic twin concordance for schizophrenia is only around 28 per cent, Ross states the obvious – that it is impossible that schizophrenia has a predominantly genetic aetiology and thus its causes must be primarily environmental. Ross cites one of the rare studies on the genetics of schizophrenia that included an evaluation of families adopting the offspring of mothers with schizophrenia. Tienari (1991) found that only 4 per cent of the children raised by healthy adoptive families became severely psychotic compared with 34 per cent of the children raised by ‘disturbed’ adoptive families.

Oliver in 1993 reported what until then had been an issue largely avoided: the transgenerational effect of childhood abuse. He, on the basis of much longitudinal research, estimated that a third of child abuse victims will abuse their offspring and a further third remain at risk of doing so.

Much earlier research regarding sexual offenders and their pattern of abusing victims was grossly distorted by assuming they were more or less telling researchers the truth. Ahlmeyer et al. used polygraphy on a group of 36 convicted sex offenders who had admitted to, on average, two sexual assaults each. After the polygraph test, the inmates had disclosed an average of 165 victims per offender. Anna Salter in her book on sexual predators (2003) makes the point that fewer than five percent of sex offenders are ever apprehended. She describes one offender, a Mr Saylor who before being incarcerated at age 30 had amassed eleven male rape victims, one female rape victim and approximately 1,250 male molestation victims.

“One child’s family, by no means atypical, simply said to their son, ‘John loves you, John wouldn’t do anything to hurt you. There must be some mistake.’ Mr Saylor told me the child made no mistake at all. It took almost twenty years and well over a thousand child victims before a single allegation stuck (Salter 2003, pg 27).”

In July 2005 the San Jose Mercury News reported on the case of Dean Schwartzmiller, a 64 year-old plasterer awaiting trial on charges that he sexually abused two boys. “It is the discovery by police of seven cryptic journals – containing more that 36,000 entries of boys he longed for or molested – that
has staggered authorities,... In five states over 35 years, Schwartzmiller has been arrested on more than 80 counts of child molestation involving at least 13 boys. He was convicted on nine of those counts, and four were eventually overturned by appeals courts. His journals suggest much more; he may turn out to be one of the most prolific child molesters in the country’s history (Reed & Chang, 2005)."

One does not have to invoke controversies over ‘recovered memory’ to know that society frequently does not want to know about the reality of childhood trauma and how it is perpetrated. Pope (1994) quotes some of the least subtle examples which came from the courts:-

“...A judge declined to convict two adult men of raping an 8-year-old girl because she was, in the judge’s opinion ‘a willing participant’ (Judge Urged to Resign’, 1985, p. A6).

* A judge refused to confine an individual who plead no contest to sexual assault of a 16-year-old girl because rape, according to the judge, is a ‘normal’ reaction to the girl’s ‘provocative clothing’ – ie, blue jeans, a blouse over a turtle neck sweater, and tennis shoes (A Woman’s a Sex Object’, 1977, p.2).

* A judge took a 5-year-old girl’s ‘character’ into account in discounting the responsibility of the 24-year-old man who sexually assaulted her. According to the judge, she was ‘an unusually sexually promiscuous young lady. No way do I believe that [the adult] initiated the sexual contact (‘Unbelievable’ 1983, p. F2), (pgs 38-39).”

Writing in the San Francisco Chronicle (2005) Jane Ellen Stevens observed, “The reality is that only 10 percent of child molesters are strangers to those they abuse (6 percent for children under 6 years old). About 30 to 40 percent are family friends or trusted adults. Typical child sex abusers –50 to 60 percent- are fathers, stepfathers, uncles, grandfathers, and brothers. (The percentage of women who sexually abuse is low.)…”

Because family members rarely make it into the criminal justice system, researchers stumble along in the dark to characterise their behaviour. But individual cases range from violent rapes to intercourse in the name of ‘sex education’.

When caught, their excuses are often preposterous, like this one cited in a research study by psychiatrist Gene Abel: ‘Yes, I penetrated my 6-year-old daughter, but it was an accident. I was coming out of the shower. I slipped on the soap, and my penis accidentally went into her vagina’.

What leads so many men to molest their own children or the children of their friends? The cause ‘is a profound puzzle for all of us,’ says clinical psychologist Ray Knight, President of the Association for the Treatment of Sexual Abusers... What’s certain is that most people who are abused sexually at a young age do not become child molesters. There are simply too many victims.”

As Judith Herman (1992) amongst others, points out, society’s countertransference to the victim of trauma goes along one or other predictable paths including denial that the trauma ever happened, admitting that it happened but then claiming the victim’s account is exaggerated, admitting that it happened but at the same time blaming the victim for having caused it, or acknowledging that it happened, but in effect ordering the suppression of it in that as it was long ago, nothing positive can come of ‘bringing up all that stuff now’, the advice being, ‘Put it behind you’, ‘Live in the present’, ‘Get on with life’ etc.
Congruent with the above themes Anna Salter (2003) was moved to state, “The history of psychology in the past one hundred years has been filled with theories that deny sexual abuse occurs, that discount the responsibility of the offender, that blame the mother and/or child when it does occur, and that minimises the impact. It constitutes a sorry chapter in the history of psychology, but it is not only shameful, it is also puzzling. Hostility toward child victims and adult women leaks through this literature like poison (pg 57).”

When the weight of community authority reached a critical mass such that the extent of abuses perpetuated against the least powerful, most readily shamed and discredited, and least protected began to be exposed, it was inevitable that forces previously residing below society’s surface would erupt through the transferences, projections, identifications, denial, combative self-protection, hate, over compensations and the excesses of group and victim dynamics that would make it likely that for an extended period, there would be more heat than light. Researchers such as Matthew H. Erdelyi (1996) found that a hitherto uncontroversial area of cognitive laboratory research concerning remembering and forgetting was suddenly on the frontline in a war zone. What have been described as “the memory wars” which gathered steam in the early 90’s in North America saw acrimonious divisions, multiple law suits, the establishment of journals (e.g. “Treating Abuse Today”) and organisations (such as The False Memory Syndrome Foundation) formed by groups on either side of the debate, the airing of sensational TV documentaries, the picketing of therapist’s offices, and the production of numerous tomes, some polemical (e.g. Ofshe and Watters (1994), Wakefield and Underwager (1994)), some written by laboratory memory researchers (e.g. Erdelyi 1996, Schacter 1996) and others by therapists (e.g. Alpert, 1995, Courtois, 1997).

Celebrated law cases involving the ‘recovery’ of material previously claimed to have been forgotten gained particular prominence as they went to appeal or were taken up by the public media (e.g. the case of George Franklin who was initially convicted on the evidence of his daughter that he’d murdered a child, or the case of Ramona v Isabella in which a father was given standing to sue the psychotherapists of his adult daughter on the grounds of negligence, with the daughter testifying on behalf of her psychotherapists – see Magner & Parkinson, 2001.)

Such cases frequently failed to reach endpoints where there was reasonable community consensus. A number of prominent therapists/researchers were sued. Dr Bennett Braun had two lawsuits against him settled (Shobe & Schooler, 2001). Dr Judith Peterson (2001) who was also prominent in the trauma and dissociation field and had headed an in-patient unit was charged with mail fraud on the basis of mailed patient accounts crossing state postal borders. She had the case against her dropped, when a juror dropped out and the state used this as a basis for discontinuance (Peterson, 2001).

A psychiatrist, Diane Humenansky was sued for malpractice by six former patients, who made a variety of allegations (e.g., Hamanne v. Humenansky, 1995), including that they had received treatments, such as ‘recovered-memory therapy’, that implanted false memories of sexual abuse by family members and of Satanic cults. In the initial trial Humenansky testified that she did not believe that patients could recover false memories of sexual abuse. Following two multi-million dollar awards to the first two plaintiffs, Humenansky’s insurance carrier arranged out-of-court settlements with the remaining four. The Minnesota Board of Medical Practice found that Humenansky had engaged in unprofessional conduct and that she had displayed professional incompetence (Brainerd & Reyna, 2005).

Whilst powerful societal dynamics have on the one side seen sceptics of recovered memory portrayed as the protectors of paedophiles and on the other side have seen attempts to virtually outlaw
psychotherapy, those that were objective were always appreciative that most of the issues in contention wouldn’t reduce to simple dichotomies and that what might apply in one individual case might not be readily generalised.

Briefly listed below are a sampling of the questions central to the divisions.

1. Is it possible for someone to truly “forget”, repress, dissociate or otherwise not have access to the memory of a significant past trauma?

2. Are memories of traumatic events qualitatively different from memories of other events?

3. To what degree are the results of studies involving suggestion and the subsequent remembering of essentially non-traumatic events, generalisable to how truly traumatic events are remembered?

4. To what degree have therapists’ poor technique (e.g. overt use of suggestion) or inappropriate use of adjuncts to therapy e.g. hypnosis, chemical abreactions, age regression etc. contributed to the production of “false memories” in patients?

5. Has there ever been, or are there, legions of “recovered memory therapists”?

6. Is it plausible that a few lines in some popular books were responsible for precipitating recovered memories of past abuse by large numbers of individuals?

7. What is the status of so-called recanters, those who having claimed to remember being abused, now claim they weren’t? And what of recanters who then revert to their original claims?

8. Are those individuals “recovering” memories of improbable or impossible events such as elaborate satanic rituals, alien abduction, birth trauma or past life experiences indicative of widespread therapeutic incompetence?

9. How can one be sure that an individual has truly “forgotten” an event rather than simply not had occasion to think about it? Can someone accurately remember that they previously forgot something?

10. In the larger scheme of things, in terms of overall reports of, or convictions for child sexual abuse, how frequently is the issue of “recovered” memory a significant factor?

11. If previously forgotten memories are recovered, are they as accurate as memories for trauma that have never been forgotten?

12. Are diagnostic entities such as dissociative disorders, valid or rather an iatrogenic artefact of misguided therapists with erroneous notions imposing such beliefs on suggestible patients?

The polarisations, the proliferation of law suits involving questions of recovered memory, and a climate of professional anxiety in the 90’s saw one professional mental health body after another formulate position statements regarding recovered memories. Even in trying to formulate short statements based upon the existing literature some groups remained deeply divided e.g. in 1993 the American Psychological Association formed a six-member working group to analyse the evidence about recovered memory. The group consisted of three eminent psychotherapists with a principal focus on
child sexual abuse (Laura Brown, Christine Courtois and Judith Alpert), and three eminent experimental psychologists involved with memory research (Elizabeth Loftus, Stephen Ceci and Peter Ormstein). Five years later, unable to reach consensus on many of the issues before them, the three clinicians on one hand and the three memory researchers on the other, had issued their conclusions in different publications in a point – counterpoint exchange (see Alpert et al. 1996).

The British Psychological Society’s statement of 1995 exemplified a cautious handling of issues at a time that law suits involving ‘recovered memory’ were peaking in the USA. The British Psychological Society stated, “Forgetting of certain kinds of trauma is often reported, although the nature of the mechanism or mechanisms involved remains unclear”, and that, “While there is a great deal of evidence for incorrect memories, there is currently much less evidence on the creation of false memories (pg 173) (see Knapp and Van de Creek, 1997).”

A more comprehensive statement by the American Psychiatric Association had been published in 1993. A sampling of many salient conclusions in their document include the following:-

“Psychiatrists should maintain an empathic, non-judgmental, neutral stance towards reported memories of sexual abuse. As in the treatment of all patients, care must be taken to avoid prejudging the cause of the patient’s difficulties, or the veracity of the patient’s reports (pg 156) (see Knapp and Van de Creek, 1997).”

“Children and adolescents who have been abused cope with the trauma by using a variety of psychological mechanisms, in some instances, their coping mechanisms result in a lack of conscious awareness of the abuse for varying periods of time (pg 154) (see Knapp and Van de Creek, 1997).”

“Psychiatrists should vigilantly assess the impact of their conduct on the boundaries of the doctor/patient relationship. This is especially critical when treating patients who are seeking care for conditions that are associated with boundary violations in their past (pg 157-158) (see Knapp and Van de Creek, 1997).”

Echoing perhaps the stance of the American Psychiatric Association, the Royal Australian and New Zealand College of Psychiatrists position paper (1998) on the question of recovered memories of trauma was likewise a document less inherently conflicted than that of the British and American psychological societies /associations.

Adopted in 1996 and amended in 1998 the RANZCP Clinical Memorandum emphasised the extent of physical and sexual abuse of children, the harmful nature of such abuses, and that “memory of such abusive experiences may be absent for considerable and varied periods of life and may be recalled under any of a variety of circumstances, including as a vicissitude of undergoing psychiatric treatment for (at least initially) apparently unrelated reasons.” The document emphasised “that psychiatrists, while supporting the clinical interests of the patient, maintain a position of neutrality in the consulting room – no matter what personal views they may have formed. This is no different from the stance which psychiatrists must take on many other matters raised by patients.”

In 1994 the Australian Psychological Society reprinted their 1986 guidelines relating to recovered memories which included the advice that “psychologists should inform any client who recovers a memory of abuse that it may be an accurate memory of an actual event, may be an altered or distorted memory of an actual event, or may be a false memory of an event that did not happen (pg 181) (see Knapp & Van de Creek, 1997).
The last decade has seen substantial efforts to provide clearer answers to the sorts of questions posed above, though the background landscape shows the scars. As of July 1998, 803 claims arising from recovered memories filed in the USA had resulted in litigation (633 were civil suits), while as of October 1998, 139 malpractice claims had been filed against therapists by their former patients relating to allegations of therapists “implanting” false memories. By 1998 third parties, such as a patient’s relative, had filed 152 malpractice suits against therapists on the grounds of claimed damage arising from “false allegations” (McNally, 2003). High profile cases have included Burgus v Braun et al., 1997 in which Dr Braun formed the belief that his patient who he had diagnosed with Multiple Personality Disorder was involved in a cult that participated in satanic ritual abuse (Ofshe & Watters, 1994; Shobe & Schooler, 2001). Burgus claimed that hypnosis and drug therapy were used to help her recover memories which included being a high priestess in a satanic cult that practiced human sacrifice and cannibalism, being sexually abused by numerous men, as well as abusing her own two sons and of being Catherine the Great in a past life (Ofshe & Watters, 1994).

Ofshe and Watters (1994) state; “As her satanic rank grew [Burgus’] importance to Braun also appeared to increase. Several times when he attended conferences to make presentations on MPD, she would accompany him. When reporters wanted to talk with an MPD patient, he often asked [her] if she would be interviewed. During one conference, at Braun’s encouragement [Burgus] gave a presentation on her history and the story of her treatment. During this time she also appeared on the local television news series with Braun (pg 238).”

Pendergrast (1997) opined, “Braun was clearly fascinated and moved by his clients’ bizarre revelations. Sometimes he would cry with Burgus. Other times, he apparently became sexually aroused during her lurid descriptions of sexual assaults, according to Burgus. With the encouragement of Braun and Sachs, Burgus eventually came up with memories of lit torches being pushed inside her, being buried for days on end, and having to eat the body parts of two thousand people a year (pg 160-161).”

Patricia Burgus’ civil suit against Braun was finally settled for $10.6 million. Another suit against him was settled under confidential terms (Shobe & Schooler, 2001). His medical licence was suspended by the state of Illinois for 2 years. In 2001, he was expelled from both the American Psychiatric Association and the Illinois Psychiatric Association after being found to have provided incompetent medical treatments and to have violated ethical standards (Brainerd & Reyna, 2005). Yet highly publicised individual cases at both ends of the recovered memory/false memory continuum may principally prove that some individuals have difficulties appreciating boundaries and are capable of quite unobjective responses. They selectively focus on information that may have dubious veracity, but which nevertheless reinforces their very particular belief system, a phenomena not unknown in many areas of science, let alone in religion or politics.

By way of forming a perspective on the relative importance of cases based on recovered memory Bessel van der Kolk (1994) examined the Massachusetts Department of Social Services records for 1993 (the same year that Burgus filed her civil suit against Braun). They confirmed sexual abuse in 2,149 children. More than 200 men were jailed for sexual offences against children, and 278 were put on probation. In the law library, van der Kolk could locate only 5 Massachusetts’ cases over the previous 3 years where adults had taken an alleged abuser to court after recovering traumatic memories. All were convicted, with one of them being James Porter a notorious former Catholic priest who was thought to have molested at least 155 children and who remains currently incarcerated. Many of his accusers had suffered from years of amnesia of the abuse.
THE NATURE OF MEMORY AND THE EFFECTS OF TRAUMA ON IT:

Hyman and Kleinknecht (1999) make the point that “remembering is always a creative process. People construct recollections out of the contents of the mind to meet the needs of the current context (pg 181).” All memories are reconstructions. It was a romantic notion tied to the pioneering work of the Canadian neurosurgeon Wilder Penfield in the 50’s, that electrical stimulation of the exposed temporal lobe would produce a detailed and accurate replay of seemingly long-forgotten events when unchanging neural imprints were isolated. Daniel Schacter (1996) observes; “If we could just figure out a way to find the unchanging neural imprints that our brains preserve forever, Penfield thought, we could remember or even relive everything we have ever experienced. Maybe the passing of time does not, after all erode or erase the brain’s recordings of past events; it might merely wreak havoc with our ability to replay our dusty old records (pg 77).”

The roots of the notion that memory works like a digital recorder that can be accessed to accurately replay past events is particularly derived from Penfield’s work, yet of Penfield’s 520 patients only 40 who received temporal lobe stimulation reported any mental experience that could be possibly recognised as memories (Schacter, 1996). Penfield relied only on the patient’s perception that the experience represented a long lost memory. One patient remembered being at a particular lumberyard, yet asserted that it was a place she had never visited (Knapp & Van de Creek, 1997). In the absence of corroboration it is difficult to accurately identify the phenomena Wilder elicited in this small minority of his patients. Penfield had only his patient’s perceptions that the experience was a long lost memory (rather that a fantasy or hallucination).

In order to better orientate the reader to the debate concerning memory, a brief overview is useful.

Whilst memory has been subject to many different classifications, speaking generally, three principal means of dichotomising memory are identified. These are intrinsic (implicit) and extrinsic (explicit), short-term and long-term, and verbal and non-verbal (Trimble, 2000). Explicit or declarative memory refers to the ability to consciously recall facts and to be able to formulate a narrative of events. Implicit memory (also known as non-declarative or procedural memory) refers to having the behavioural knowledge of an experience without the ability to consciously recall it. We may know how to swim but have no explicit recollection of learning this skill. Similarly a developmentally traumatised individual may adopt characteristic avoidant body postures or be affectively triggered by particular environmental cues e.g. certain words, sounds or smells without an understanding of the basis for such reactions.

Recognition is a sense of familiarity experienced when current experience activates a memory of an object or event encoded previously in memory, while recall involves the conscious reconstruction of a previous experience in response to a current cue or elicited without external prompting.

Short-term memory refers to the use of a limited storage capacity (in the order of seconds), used to repeat directions or dial a telephone number. Long-term memory includes any memory that falls outside short-term memory. Semantic memory is for words and facts and in the absence of damage to the left temporal lobe tends to remain stable through adulthood (Trimble, 2000).

Difficulties encountered in defining a memory as either lost or recovered may involve consideration of one of the following:
- Infantile amnesia refers to that period of life, starting from birth for which there is no accessible explicit memory. There is no evidence that events prior to age 2 can be recalled in narrative forms. Infants and young children do however retain and process information and may demonstrate implicit memory responses to events they cannot describe. Among adults in Western cultures, the average age of earliest memory is age 3 to $3\frac{1}{2}$ years (Bauer, 2004).

- Whilst humans can demonstrate remarkable memory abilities e.g. in being able to distinguish individual faces from the many thousands we have contact with, we tend to struggle with source attribution (Schacter, 1996) e.g. we will instantly recognise a face on the street, but removed from their usual setting, we may have difficulty placing the person. (“I know, I know him, but from where?”)

- When an individual has a sudden intense onset of remembering, they may subjectively but incorrectly believe that they had previously forgotten the experiences. Schooler et al (1997) proposed that some cases of recovered memory may be appropriately viewed as discovered memory.

Pertinent details of documented events may be remembered inaccurately despite the conviction of the rememberer. Mike Scrafton undertook a lie detector test and went on national television in 2005 seemingly convinced that he had had three telephone conversations with the Australian Prime Minister dealing with the veracity of the so-called “children overboard” allegations. Whatever the points of disagreement about the content of what was said, it was proven that contrary to Scrafton’s initial certainty there had only been two phone calls. When John Dean gave testimony concerning conversations he had with Richard Nixon, Robert Haldeman and other principals in the Watergate cover-up, his recollections seemed so extraordinarily detailed that he came to be known as the human tape recorder (Schacter, 1996). Yet when Nixon’s secret tapes were made public it became evident that Dean’s memories were not particularly accurate. Despite his confident presentation he rarely if ever recalled the verbatim content of conversations and frequently failed to remember correctly even the general gist of a conversation.

On occasions individuals recover memories for experiences for which there is no corroborative evidence. The claims can seem improbable or virtually impossible. In the late 80’s and early 90’s a substantial number of patients described recovering memories of satanic ritual abuse which often included reports of ritual sacrifice, cannibalism and murder (Ross, 1995). In the USA where most such claims were centred, not a single case came to light for which there was any hard evidence. The FBI agent Ken Lanning (1992) investigated over 300 cases of claimed satanic cult abuse without finding corroborating evidence for a single one. This does not prove that some isolated example(s) of satanic abuse could never have happened, though it does suggest that although sections of humanity are capable of absolutely gruesome behaviour, it is virtually impossible to keep a lid on conspiracies involving large sections of a community in which individuals are regularly being murdered. Serial killers characteristically operate alone (e.g. Ted Bundy, Ivan Milat, John Glover) or in close partnership with a single individual (e.g. Henry Bianchi and his cousin, Ted and Rose West). It can at times be challenging to remain receptive and open-minded about accounts that are representative of mankind’s capacity for extreme cruelty, whilst at the same time avoiding the temptation to uncritically accept uncorroborated accounts of gruesome things, essentially on the basis that an individual said it with conviction and that it is a trauma seemingly no worse than different, but proven abuses (such as the Holocaust, the killing fields of Cambodia, the genocide of the Tutsi’s in Rwanda or ethnic cleansings throughout the former Yugoslavia). (See Appendix 4.)
Since the time of Pierre Janet it has been recognised that characteristic responses people have to major traumas include tendencies to re-experience or remember the trauma, whether by intrusive thoughts, flashbacks or dreams, as well as tendencies to avoid thinking about the trauma (van der Kolk et al, 2001). So successful are many individuals in their avoidance that they develop partial or complete amnesia for the trauma.

When in the late 80’s reports began to appear concerning allegations made by individuals that they had been satanically ritually abused, Frank Putnam was one of those researcher / clinicians who strongly cautioned against going beyond the boundaries of verifiable data. Reflecting on the social phenomena of satanic ritual abuse (SRA) allegations in 1997, Putnam stated, “From my perspective, the best example of the creation of clinically and legally significant pseudomemories involves allegations of satanic ritual abuse (SRA). Such allegations are defined here as claims that a vast, international, multigenerational conspiracy is practising religious worship of Satan or the devil through rituals involving sex, death, torture, incest, human sacrifice, cannibalism, and necrophilia. With the exception of a few isolated ‘copycat’ incidents, there is no credible evidence that SRA is occurring or ever has occurred (pg. 124).”

Putnam goes on to observe that allegations of SRA occur within a much larger social context than just the therapists’ offices. “In fact, there are plenty of examples where therapists are not involved in the process. SRA allegations are spawned in social networks composed of all manner of individuals, including police officers, journalists, and religious fundamentalists. There is a reverberating rumour circuit that generates, propagates, back-propagates, amplifies, and self-affirms SRA allegations,.. The field of child abuse and neglect is particularly prone to this process, because it encompasses so many different disciplines that have little in common except for a focus on child maltreatment (pg. 124).”

Contrary to the speculations of critics of trauma therapy who at the peak of the SRA controversy were contending virtually every therapist who diagnosed MPD (DID) immediately embarked on a process of implanting pseudomemories of SRA, in fact few MPD (DID) patients made SRA allegations and subsequent to the early/mid-nineties new SRA allegations have become rare. In 1997 Sariganian and Putnam (see Putnam, 1997) found that only 4% of dissociative patients in an outpatient treatment sample reported such experiences, down from the 8.5% of MPD patients reported three years earlier in a personal series by another prominent researcher in the dissociative disorder field (Coons, 1994). In the U.K. the British False Memory Society found that allegations of SRA were rare (Andrews, 1997). In our series of 62 DID patients who had been assessed between 1993 and 1997, there were only two who had made SRA allegations (Middleton & Butler, 1998). Both of these individuals had a long contact with mental health services with demonstrably severe symptomatology that predated any emergence of SRA allegations.

Concerning the proposal that was for a time vigorously pursued i.e. that there were legions of recovered memory therapists creating MPD and implanting false memories of SRA, it is salient to consider the very grounded observations of Frank Putnam (1997).

“In the course of a general practice, therapists will occasionally encounter individuals who make such claims. This should not be construed as evidence that the therapists are responsible for the patients raising these claims in therapy. Critics who boldly tell others what is happening in therapists’ offices where they have never actually been are guilty of the same fallacy as those few therapists who regale training workshop audiences with gory details of satanic black masses that they have never seen. Both are telling others about something that they believe is going on; however, neither has ever seen it happen, and neither has any hard proof that it has ever happened (pg 125)…”
“The cruel paradox, with respect to the ‘false-memory’ debate, is that a person must have been severely traumatized to have the kinds of dissociative memory dysfunctions that increase susceptibility to acquisition of pseudomemories (pg. 127).

Van der Kolk noted in 1996 that amnesias for traumatic experiences, with delayed recall for all or parts of the trauma, have been documented in the literature after natural disasters and accidents; war-related traumas; kidnapping, torture and concentration camp experiences; physical and sexual abuse; and committing murder. A general population study by Elliott (Elliott & Briere, 1995; Elliott, 1997) showed that virtually all categories of severe traumas produced victims with complete amnesia (the one exception being witnessing the death of one’s child). A history of complete memory loss was most common among victims of child sexual abuse (20%). Additionally a substantially higher proportion of victims had significant amnesia for particular details of their traumas. Of the 505 who completed the survey, 72% reported some form of trauma and of these 32% reported delayed recall of the event. This phenomena was most common among those who observed the murder or suicide of a family member, sexual abuse survivors and combat veterans. The severity of the trauma was predictive of memory status whilst the most commonly reported trigger for recall of the trauma was some form of media presentation such as a TV show or movie (54%), whereas psychotherapy was the least commonly reported trigger (14%).

Writing in 1996 van der Kolk stated, “For reasons that are not at all clear [compared with other traumas], childhood sexual abuse seems to result in the highest degree of total amnesia prior to memory retrieval (pg 285).” It was in addressing the issue that van der Kolk raised that Jennifer Freyd embarked on a line of research that became formalised as Betrayal Trauma Theory (Freyd, 1996; Freyd et al, 2001), a theory that incorporates not only the effects of a trauma per se but examines the way the relationship between an abuser (who is also an attachment figure) and their victim will impact on how childhood sexual abuse is remembered. Unlike the other traumas van der Kolk refers to, ongoing childhood sexual abuse is frequently incestuous or the perpetrator is a trusted adult well known to parental figures. Betrayal trauma theory positions psychogenic amnesia as an adaptive response that functions not so much to reduce immediate suffering but to promote long term survival by not rupturing attachment to a figure vital to development. If the betrayer is a primary caregiver, it is particularly important that the child does not stop behaving in such a way that will inspire attachment. For a child to withdraw from a caregiver on which he/she is dependent would further threaten his/her life, both physically and mentally. Thus the trauma of child abuse necessitates that knowledge about the abuse be blocked from those mental mechanisms that control attachment and related behaviours. The information that gets blocked may be partial (for instance, blocking emotional responses only), but for many partial blocking will lead to a more profound amnesia.

In a prospective community study Williams (1994) found that among a sample of 129 adult women whose childhood histories of sexual abuse were documented by medical and social service records, 38% failed to recall these events at a follow-up interview 17 years later. In fact Williams’ study is one of numerous studies of varying methodology that have found that a significant proportion of adults who report a trauma history also describe a period of time when they did not recall the experience with the rates of reported forgetting in the case of child sexual abuse ranging from approximately 12% (Williams, 1995) to 77% (Roe & Schwartz, 1996) depending on the study. Included within this range, Loftus et al (1994) reported 19% of subjects experiencing total amnesia prior to memory retrieval.

When viewed from an interpersonal and attachment perspective, the ambivalence about the parent/abuser relationship and the ambivalence about the traumatic memories that underpin it, leads not
unnaturally to the phenomena of accuser/recanter cycling where the individual trying to individuate, makes an accusation, only to recant when faced with the prospect of losing the only parental attachment figures he/she has. Kluft (1999) points out in his naturalistic study of the memories of 19 patients with DID, that some patients recanted and rescinded several times.

Extreme effort after meaning has been employed at times to try and somehow explain away the phenomena of recovered memories of past trauma with explanations ranging from, “nobody really forgets a major trauma” though they may choose not to think about it, through to the presumption that if someone reports recovering such a memory, it must somehow be a result of the over use of suggestive techniques in poorly conducted therapy. The most contentious area has always been with respect to recovered memories of childhood sexual and other abuse. The issue of amnesias occurring in combat veterans has never generated similar discord.

In response to the controversy of recent years a growing number of cases have been published documenting in meticulous detail individual circumstances in which early trauma is well documented and in which a period of amnesia for the traumas is likewise well documented, followed by the recovery of memories of the traumas e.g. Duggal and Stroufe (1998) report the case of a young woman who happened to be a subject in a prospective longitudinal study from early childhood on. Background information concerning the family had been obtained prior to any report of sexual abuse. Four and half years into the study Child Protection Officers and Police were called in following the child (“Laura”) reporting sexual abuse. (Her parents were divorced and she was in joint custody.) It was further noted by her mother at the time that her child would cry, tantrum, and have nightmares when she went to stay with her father. Around the time the child reached 3rd Grade, it was documented that she had told a friend that she had been sexually abused, a case-note that was to constitute the last childhood record of memory for the trauma.

By age 16 in response to direct questions regarding past sexual abuse “Laura” indicated in a written response that she’d never been sexually abused. A similar response at the 17 year assessment was obtained. At 18 years and 10 months “Laura” discussed her memory of abuse openly in a structured interview administered by a research assistant who was blind to Laura’s previous history. In response to a question regarding previous experience of any physical, sexual or other abuse, Laura indicated that in the previous few months she had memories about being sexually abused as a child by her father. The memories had returned progressively over a 1-2 week period culminating in explicit memories of her father sexually abusing her, occurring during a conversation with a teacher. Afterwards Laura went to a friend’s house where “she thought she heard her father’s voice. She noted, ‘I totally went into shock all over again, just like screaming ‘get him away from me’” (pg 315).”

Laura’s father never denied that she’d been sexually abused. A child therapist who saw “Laura” initially after the involvement of Child Protection had met her father at various times. He stated that if Laura had experienced sexual abuse, it had been perpetuated by somebody else, adding the qualification that if he had done it, then it had occurred while he was on drugs and he had no memory of it.

Williams (1995) and Dalenberg (1996) both found that there were no significant differences in the reliability of continuous and recovered memories, with the latter reporting a 75% accuracy for both.

The clinical account of “Laura” is typical of corroborated cases of the recovery of memory, the existence of which some writers have denied or portrayed as being extremely rare. To counter such arguments Assoc Prof Ross Cheit launched The Recovered Memory Project in August 1997 which
takes the form of a web site (www.RecoveredMemory.org) that includes a growing archive of corroborated cases of recovered memory of trauma that at the last update included 96 cases. Listed individually, a typical entry on Cheit’s web archive of corroborated recovery memory could be, “Marilyn Van Derbur’s recovered memories of child sexual abuse (revealed publicly in Denver, Colorado, May 1991). Her memories were corroborated by her sister, Gwen Mitchel, who had continuous memory of similar abuse and who long thought she ‘was the only one’ sexually abused in the family. Fawn Germer, ‘Ex-Beauty Queen’s Sister Acknowledges Father Molested Her, Too.’ Rocky Mountain News, May 11, 1991:6.” Marilyn Van Derbur, an intelligent and articulate woman, had been the 1958 Miss America. The sexual abuse she and her sister experienced at the hands of her father and of her recovery of memories of that abuse at age 24 is documented in substantial detail in Terr’s (1994) book, “Unchained Memories” and in her own 2004 book, “Miss America By Day” (see Appendix 4).

At the age of 40 Marilyn Van Derbur asked to meet with her father and spoke with him for the first time about his abuse of her. The first thing her father did when she broached the topic was to excuse himself for a brief time, go upstairs and return with a handgun. Her father was to tell her, “If I had known what it would do to you, I never would have done it.” (Marilyn was to subsequently find out that her father’s sexual abuse of other children continued until his death.) Their conversation over, Marilyn’s father reached into his pocket and lay the gun in his open palm. “He looked me right in the eye and said, ‘If you had come in any other way, I would have killed myself.’ His message was very clear, ‘If you are even thinking about reporting me, take a look at the consequences’ (Van Derbur, 2004).”

Speaking to an audience of therapists at a conference on child abuse and neglect in 1994, Ross Cheit spoke of his own well documented recovered memories of abuse, demonstrating in doing so the factors survivors contend with in speaking on the record. “There was a time less that a year ago when I thought I could never speak publicly about what I am going to say today. And my reluctance I think, is testimony to the power of denial, the burden of shame, and the unsympathetic attitude that is displayed towards all too many adults who speak about being sexually abused as children. But it is clear to me that this topic demands public attention, that silence is part of the problem (pg 181)” (quoted in Freyd, 1996).

(Ross Cheit, who is now an associate professor of political science at Brown University was sexually abused as a boy by William Farmer, the administrator of a summer camp he attended. At 36, having recovered memories of the abuse he sought to find out if there had been others Farmer sexually abused. He located 55 people who had attended the same camp during the same period. Within a month, he found a man who completely verified his experience. Another told Cheit that Farmer had tried to get him into his sleeping bag once but he didn’t get in because he realised the man was naked. A few days later Cheit received a letter from the man saying, “I feel really sheepish. What I told you the other night wasn’t true. I did get into the sleeping bag. I just wish that the other story were the true one.”)

Somewhere in the late 80’s laboratory memory researchers, many without significant clinical experience, found that the area of memory research which hitherto had been calm, industrious and largely uncontroversial was suddenly at the epicentre of intense controversy, though the tools to resolve it could not easily be shaped.

It was established that young children subjected to suggestive interrogation can frequently alter parts of a testimony (Hyman & Kleinknecht, 1999), it was established that via presenting information with conviction that some individuals can be convinced that they remembered some non-existent event that
could have been mildly distressing, however in laboratory research there was no ethical way in which to measure the responses of individuals who someone had tried to convince were severely traumatised, when they were not, or to actually traumatisate people and measure the process of how they remembered it. As van der Kolk et al. (2001) point out, “For ethical reasons, not scientific ones, the extreme terror and helplessness that precede the development of PTSD simply cannot be replicated in [a laboratory] setting… Hence it appears inescapable that to study the nature of traumatic memories one must study the memories of people who have actually been traumatised (pg 12).”

Van der Kolk et al. make the salient points that clinicians working with traumatised individuals “found themselves confronted with unexpected observations : incoherent memories of ‘isolated, non-verbal, sensory, motor, and emotional fragments’ (pg 13)” that they then tried to make sense out of. “Initially, the constructs of repression and dissociation were the best they could find. It is not that pioneering students of traumatic memory ignored laboratory evidence… It is just that when it came to delayed recall and the fragmentary nature of many traumatic memories, clinician-scientists encountered a conceptual void in the laboratory memory research literature. Laboratory scientists had studied memories for events they had created under controlled conditions, and thus had never encountered fragmentary traumatic memories (pg 13-14).”

Whilst it has for a long time been recognised that some deeply traumatised dissociative individuals will on occasion have memories for traumas that can be shown to be false or which alternatively are highly unlikely to be true, these memories frequently coexist with memories of traumas that can be corroborated. Indeed when one looks at studies that made a focus of obtaining corroborative evidence of abuse in patients with DID, in the great majority it can be obtained. Kluft (1999) summarises six such studies involving collectively 125 patients with DID/DDNOS. Confirmation of abuse was obtained for 115 of the patients (92%). In the only Australian series of DID patients published (Middleton & Butler, 1998) (N=62 + 10 with incomplete data), corroborating evidence was available for some 29%. While this was not a forensic investigation there was little however to distinguish patients whose abuse was corroborated e.g. by an admission from an abuser, Police records etc. from those where such material was not readily available. (Many patients reported on in this series were seen for one-off assessment without there being any opportunity for follow-up.) Generally speaking, individuals don’t adopt a life characterised by high levels of suicidality, self-harming, eating problems, sexual dysfunction, affective instability, drug/alcohol abuse and chronic sleep-disturbance etc. unless there is a very good reason for it.

Exemplifying van der Kolk et al’s comments on the nature of traumatic memories, among patients mentioned in the Australian Series, were individuals who were highly agitated yet virtually mute for the first years of therapy, who unconsciously and chronically adapted extremely defensive body postures, who took years to walk through an office doorway without almost overwhelming anxiety or who exhibited extreme avoidance in making eye contact. At least 5 (possibly more) of the 62 patients who were the principal focus of the 1998 report (plus the 10 for which there was incomplete data) are known to be dead, three via suicide and one other via high risk behaviours indicative that DID, so frequently linked with the recovered memory debate, very much needs to be recognised as a serious mental illness.

In dealing with dissociative patients in which there are complex patterns of symptomatology occasioned by trauma and equally complex defensive structures in response to it that on occasion include amnesias, misinterpreting a present circumstance via the perspective of the past, or using fantasy or an affinity with paranormal themes to create alternate realities, it is plausible that clinical ignorance combined with narcissistic over-confidence would produce poor therapy. Knapp and Van de
Creek (1997) make the point that lower levels of training amongst therapists appear to lead to poorer quality of treatment for patients, citing as an example, the psychotherapist who “helped” Stephen Cook recover untrue memories of abuse by the respected, if controversial, Cardinal Bernadin (see Berry, 2000). Lindsay and Read (1995) suggested from equally anecdotal reports that the extreme cases of negligence in respect of dealing with recovered memories came from untrained and unlicensed professionals. Berliner and Briere in 1999 had some sympathy for the proposition that on the part of the therapists “certain beliefs and practices create the conditions under which vulnerable patients may come to believe, falsely, that they had been abused in childhood”. They continue, “Therapists beliefs that are considered problematic include the following assumptions: that sexual abuse is the source of psychological symptoms, that many victims do not recall their experiences, that remembering is necessary for effective treatment, and that memory is relatively impervious to influence (pg 11).” Citing so-called memory enhancement techniques such as the suggestive use of hypnosis, guided imagery, bibliography or other therapeutic strategies (e.g. age regression) in which patients are encouraged to think about or imagine possible abuse experiences, they however qualify any potential concern about such practices by pointing to the paucity of empirical data regarding the extent to which such practices actually lend to pseudomemory production. Briere, in 1992 expressed the opinion that “although part of the outcry regarding incompetent therapists who ‘implant’ false memories of abuse is undoubtedly specious, it is also true that some very bad ‘therapy’ in this area is being done by individuals with insufficient training, experience, and/or psychological stability (pg 292).”

Lindsay and Read (2001) state, “A century of research on eye-witness suggestibility effects and other memory errors demonstrates that people sometimes experience illusory recollections of events that did not really occur. Research indicates that false memories are most likely when suggestive influences are strong and concern an event or time period that is poorly remembered (pg 80).” They make the points that “many of the same conditions that would probably assist an individual in recovering essentially accurate memories (e.g. use of guided imagery to mentally reinstate context, encouragement to work at remembering and not to be critical or doubtful about the historical accuracy of whatever comes to mind) would also promote illusionary memory experiences (pg 81),” and that “it is easier to create false memory reports regarding a peripheral detail in a passively witnessed event than to create false memory reports regarding a dramatic life event (pg 81).”

AUTOBIOGRAPHICAL MEMORY AND SELFHOOD:

It is impossible to know who we are unless we can remember where we’ve come from (Middleton, 2005). We are defined by the journey that thus far has brought us to here. The more readily we can access the past that shaped us, the more that we can own and share with those we trust the feelings and vulnerabilities that have accrued from our life experience, then the more likely it is that we will be empathically receptive to others. The less we have ‘no go’ zones in terms of what has happened to us or the feelings associated with such events, the more likely it is that we will have assembled functional personal boundaries, affective stability, healthy self-esteem and be self-activated enough to aim high in the pursuit of love, work and play. The capacity to remember, and the capacity to process pain lie close together.

BOUNDARIES AND MEMORY:

Though not prominently conceptualised as such, the issues concerning patient’s memories and how they are dealt with by health professionals probably have more relevance to the paradigm of boundaries than to any other (Middleton, 2005). If the boundary issues relating to memory were better appreciated and more integrated into practice, it is very probable that much of the anguish in recent years would
have been less intense, though a societal polarisation concerning recovered memories was probably historically inevitable, given past societal polarisations over female voting rights, civil rights for blacks, or confronting paternalism or ‘in house’ solutions to abuse and neglect in varied contexts and settings.

A therapist could perhaps be defined in part as a trained professional with whom one shares memories and the thoughts and feelings that go with them. The therapist is thus the custodian of pieces of another’s life, but more particularly of a person who has been hurt or deprived by past experiences.

A therapist fails to exercise appropriate boundaries with respect to a patient’s memories, recently recovered or otherwise, where therapy is not protected by a therapeutic frame that provides consistency, states responsibilities on behalf of both parties, and which is used in pursuit of a clearly conceptualised and defined therapeutic goals (which usually involves some variation on achieving or returning to a balanced life).

Appropriate boundaries are not being exercised where the pursuit of memories or the production of prolonged regressed or incapacitated states associated with the articulation of such memories is used as a rationale for bending other boundaries in order to better “assist the patient” e.g. appointments become longer and/or more frequent or are scheduled as the last one in the day, there is increasing phone contact out of hours, visits by the therapist to the patient’s home (or vice-versa) begin to occur etc.

A therapist fails to exercise appropriate boundaries with respect to a patient’s report of past traumas by making it apparent that such discussion is unwelcome, but conversely also fails to exercise appropriate boundaries by indicating an enthusiastic acceptance of the historical accuracy of such accounts even when objectivity indicates otherwise. Whilst in many instances, in the absence of corroborative evidence, a therapist may not be ever totally sure of the historical accuracy of some particular account, nevertheless, the desirability of truthfulness in personal dealings, and in the conduct of therapy is an important emphasis to convey.

A respect for boundaries means acknowledging patients’ right to their defences, not urging them to take pre-emptive legal action against presumed abusers or inducing them into other actions that have more to do with the therapists’ identifications, projections, or self-promotion needs than their patient’s welfare. Therapists need to avoid exploitive ness e.g. by compromising their therapist role such that their principle task is that of social advocate, abuse crusader, biographer, researcher or forensic investigator. The therapeutic alliance will not be sustained where the principal focus of the therapist is not actually the treatment of the patient. Sound boundaries include providing the patient with balanced and factual information on the nature of trauma and remembering and demonstrating appropriate tolerance for ambiguity and uncertainty. An acknowledgment that something may or may not be true can allow patients to safely discuss an issue at the same time as maintaining a capacity for creating distance if overwhelmed or unsure.

Therapy is not particularly about the therapist. When therapists fail to provide a therapeutic frame that is safe and does not involve coercion or feelings of obligation in fulfilling a therapist’s agenda regarding one’s memories, it is highly likely that multiple other boundary problems will be emerging that will further undermine the therapy. This is not to imply that the therapist should ever forget their humanity, rigidly enforce some narrow notion of therapeutic neutrality, or fail to consult common sense and the hard-won lessons of clinical experience. Every patient and situation is in some ways unique. A wide appreciation of the spectrum of boundary issues and the differences between boundary violations that damage/exploit the patient, and carefully justified boundary crossings made to support and empower the patient, is a fundamental requirement. [Gabbard (2000) speaking from an analytic
perspective defined boundary crossings as “Benign and even helpful, countertransference enactments that are attenuated, occur in isolation, are subject to analytic scrutiny, and extend the analytic work in a positive direction (pg 2071).” He defined boundary violations as “Egregious enactments that are often repetitive, not subject to analytic scrutiny, pervasive, and harmful to the patient while also destroying the viability of the analysis (pg 2071).”

**RECOVERED MEMORY AND THE STATUS OF DISSOCIATIVE IDENTITY DISORDER**

Issues concerning the recovery of memories of trauma have frequently been attributed by those critical of the concept of recovered memories of trauma to a focus by therapists on a diagnosis of multiple personality disorder (or dissociative identity disorder). Typical of this line of thinking is that of Mark Pendergast (1998).

“The events usually unfold as follows. First, a young woman enters therapy for depression or some other complaint. Her therapist encourages her to see her family as dysfunctional, and herself as victim of ‘emotional incest’. Soon, she reads self-help recovery books and retrieves memories of physical incest by one family member. Then, as her memories flow more easily, she names other perpetrators. Finally, she recalls ritual abuse, is diagnosed with MPD, and often winds up heavily drugged and suicidal in a psychiatric ward (pg 180).”

In her book, “Trauma and Recovery” Judith Herman (1992) states, “Traumatised people are frequently misdiagnosed and mistreated in the mental health system. Because of the number and complexity of their symptoms, their treatment is often fragmented and incomplete. Because of their characteristic difficulties with close relationships, they are vulnerable to be re-victimised by care givers. They may become engaged in ongoing, destructive interactions in which the medical… system replicates the behaviour of the abusive family (pg 123).” Congruent with Herman’s work on Complex PTSD the entity of ‘Disorders of Extreme Stress Not Otherwise Specified’ (DESNOS) was incorporated into the DSM-IV under the ‘Associated Features and Disorder Section’ (APA, 1994, pg 488).

van der Kolk (1996) detailed the evolution of the categories of symptoms included as proposed criteria for DESNOS.

The proposed criteria for DESNOS published in this book in 1996 (pg 203) are:-

A) Alterations in regulating affective arousal
   1. chronic affect dysregulation
   2. difficulty modulating anger
   3. self-destructive and suicidal behaviour
   4. difficulty modulating sexual involvement
   5. impulsive and risk-taking behaviours

B) Alterations in attention and consciousness
   1. amnesia
   2. dissociation

C) Somatization

D) Chronic characterological changes
1. alterations in self-perception: chronic guilt and shame; feelings of self blame, of ineffectiveness, and of being permanently damaged
2. alterations in perception of perpetrator: adopting distorted beliefs and idealizing the perpetrator
3. alterations in relations with others:
   a. an inability to trust or maintain relationships with others
   b. a tendency to be revictimized
   c. a tendency to victimize others

E) Alterations in systems of meaning
1. despair and hopelessness
2. loss of previously sustaining beliefs

DSM field trials found that people who had been traumatised at an early age tended to have problems in all of these categories, such that these apparently disparate problems tended to occur together in the same individuals. van der Kolk states, “Trauma affected a whole range of core psychological functions: regulations of feelings; thinking clearly about what had happened in the past and was currently happening; ways in which feelings are expressed by the body; and people’s views of themselves, strangers, and intimates. The older the victims were, and the shorter the duration of the trauma, the more likely they were to develop only the core PTSD symptoms; the longer the trauma, and the less protection, the more pervasive the damage. The field trials confirmed that trauma has its most profound impact during the first decade of life, and that its effects become less pervasive in the more mature individuals: overwhelming experiences clearly had a different impact on people at different stages of development. Early and prolonged interpersonal trauma resulted, not in non-specific character changes, but in the psychological problems captured in the DESNOS syndrome.”

Writing in 2005, van der Kolk and Courtois state that since the complex PTSD/DESNOS diagnosis was first conceptualised (Herman, 1992) and studied more that a decade ago, at least 30 research studies have provided some support for this construct. They state, “The effects of the decision not to include DESNOS as a distinct diagnosis have been for-reaching. Subsequent treatment outcome research has focussed almost exclusively on PTSD symptomatology as described in the DSM-III and DSM-IV (APA, 1980, 1994); posttraumatic problems not captured in the PTSD criteria, including affective, anxiety, dissociative and somatoform disorders, as well as substance abuse, have generally been referred to as ‘comorbid conditions’, issues secondary to the core posttraumatic psychopathology…

For a substantial proportion of traumatised patients, PTSD symptoms capture but a small part of their difficulties. A review of treatment outcome studies demonstrates that the typical subject who is screened out of PTSD studies due to their multiple comorbid conditions may well be the typical patients seen in mental health care settings (Spinazzola, Blaustein, & van der Kolk, 2005) (pg 386).”

Adult survivors of severe ongoing developmental trauma satisfy DSM-IV criteria for multiple psychiatric entities. Colin Ross in his book, “The Trauma Model: A Solution to the Problems of Comorbidity in Psychiatry”, states that, “When the index disorder is Borderline Disorder, Post Traumatic Stress, or Dissociative Identity Disorder, the norm is a high level of comorbidity.” He points out that only a tiny minority of affected individuals have such a disorder in pure form, with no diagnosable comorbidity. Demonstrative of this he presents data on 379 patients with the index diagnosis of Borderline Personality Disorder and 107 individuals with the index diagnosis of Dissociative Identity Disorder. Comorbidity rates are shown in the Table reproduced below which is presented on page 35 of his book.
**Lifetime Comorbidity in Borderline Personality Disorder (BPD) and Dissociative Identity Disorder**

<table>
<thead>
<tr>
<th>Disorder</th>
<th>BPD (N=379) %</th>
<th>DID (N=107) %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood</td>
<td>96.3</td>
<td>97.2</td>
</tr>
<tr>
<td>Anxiety</td>
<td>88.4</td>
<td>89.7</td>
</tr>
<tr>
<td>Posttraumatic Stress</td>
<td>55.9</td>
<td>80.0</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>64.1</td>
<td>65.4</td>
</tr>
<tr>
<td>Borderline Personality</td>
<td>100.0</td>
<td>56.3</td>
</tr>
<tr>
<td>Eating</td>
<td>53.0</td>
<td>38.3</td>
</tr>
<tr>
<td>Somatoform</td>
<td>10.3</td>
<td>43.9</td>
</tr>
<tr>
<td>Dissociative</td>
<td>-</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The only missing data from the Table is the prevalence of dissociative disorders in the borderline group. As in both studies the SCID (a structured interview, utilising DSM-IV diagnostic criteria) was used to assess comorbidity, and as the SCID does not make dissociative diagnoses, there is one piece of missing data in the first column. Dr Ross points out that given the highly similar patterns of comorbidity in BPD and DID populations, attempts at differentiation of etiological models for the two disorders are unlikely to be productive.

Borderline Personality Disorder and DID have extremely high comorbidity with a range of disorders. The nature of such comorbidity is well illustrated in the data my colleague Dr Jeremy Butler and I published on 62 individuals fulfilling diagnostic criteria for Dissociative Identity Disorder (1998). 71% fulfilled full DSM-III-R criteria for Somatization Disorder. 94% of the whole series fulfilled DSM diagnostic criteria for a past or current episode of major depression. 73% fulfilled diagnostic criteria for Borderline Personality Disorder. Of those specifically questioned with DSM-III-R criteria for PTSD, 90% satisfied diagnostic criteria. 39% had previously had or continued to have, problem drinking. 24% gave a history of extensive street drug use.

It needs to emphasised, that any study that has specifically enquired about a history of childhood trauma in patients satisfying diagnostic criteria for Borderline Personality Disorder (BPD), has found very high percentages of such patients reporting it. A typical study is that of Herman, Perry and van der Kolk (1989). More than half of the sample of patients with Borderline Personality Disorder had histories of severe physical or sexual abuse starting before the age of six. Only 13% of the subjects did not report childhood histories of trauma, though half of this 13% were amnestic for most of their childhoods, making their reports unreliable. Only a small proportion of BPD patients, as was the case with this study, do not seem to have a trauma history. This study demonstrated high correlations between having been sexually abused, particularly in early life, and self-mutilation and suicide attempts. The younger the patients were when they were abused and neglected, the more likely they were to engage in self-mutilation and other forms of self-harming. Similar abuse histories in BPD patients have been found in multiple other studies.
It also needs to be stated that meeting diagnostic criteria for BPD means one is existing within a
spectrum of life threatening illness. Michael Stone (1989) demonstrated that hospitalised patients with
BPD who also have clinical depression have an 18% rate of completed suicide in long-term follow up.

Importantly, in addition to the dissociative disorders the construct of dissociation is explicitly
represented in the DSM-IV-TR diagnostic criteria for both Borderline Personality Disorder and for Post
Traumatic Stress Disorder.

The DSM-IV-TR (2000) description of the diagnostic features of Borderline Personality Disorder
includes the following passages:-

“There may be an identity disturbance characterised by markedly and persistently unstable self-image
or sense of self (Criterion 3). There are sudden and dramatic shifts in self-image, characterised by
shifting goals, values, and vocational aspirations. There may be sudden changes in opinions and plans
about career, sexual identity, values and types of friends. These individuals may suddenly change from
the role of a needy supplicant for help, to a righteous avenger of past mistreatment. Although they
usually have a self-image that is based on being bad or evil, individuals with this disorder may at times
have feeling that they do not exist at all” (pg 707).

“During periods of extreme stress, transient paranoid ideations or dissociative symptoms (e.g.
depersonalisation) may occur (Criterion 9), but these are generally of insufficient severity or duration to
warrant an additional diagnosis. These episodes occur most frequently in response to a real or
imagined abandonment. Symptoms tend to be transient, lasting minutes or hours. The real or perceived
return of the care giver’s nurturance may result in a remission of symptoms” (pg 708).

The DSM-IV-TR description of the diagnostic features of Posttraumatic Stress Disorder includes the
following passages:-

“In rare instances, the person experiences dissociative states that last from a few seconds to several
hours, or even days, during which components of the event are relived and the person behaves as
though experiencing the event at that moment (Criterion B3). These episodes, often referred to as
‘flashbacks’, are typically brief but can be associated with prolonged distress and heightened arousal”
(pg 464).

“This avoidance of reminders may include amnesia for an important aspect of the traumatic event
(Criterion C3). Diminished responsiveness to the external world, referred to as ‘psychic numbing’ or
‘emotional anaesthesia’ usually begins soon after the traumatic event” (pg 464).

Critics of the diagnosis and treatment of DID, never seem to present any data on the outcome of
individuals who are in the DESNOS spectrum and/or who meet diagnostic criteria for DID but receive
a treatment protocol they endorse.

There is a voluminous scientific literature on the manner in which adult survivors of severe childhood
trauma demonstrate marked comorbidity when the pervasive effects of their development are described
in DSM-IV terms. By way of emphasising the likelihood of actual comorbidity in a patient diagnosed
with Borderline Personality Disorder, it is worth again quoting from the DSM-IV-TR (2000).

“Premature death from suicide may occur in individuals with this disorder, especially in those with co-
occurring Mood Disorders or Substance-Related Disorders. Physical handicaps may result from self-
inflicted abuse behaviours or failed suicide attempts. Recurrent job losses, interrupted education, and broken marriages are common. Physical and sexual abuse, neglect, hostile conflict, and early parental loss or separation, are more common in the childhood histories of those with Borderline Personality Disorder. Common co-occurring Axis 1 disorders include Mood Disorders, Substance-Related Disorders, Eating Disorders (notably Bulimia), Posttraumatic Stress Disorder and Attention-Deficit/Hyperactivity Disorder. Borderline Personality Disorder also frequently occurs with the other personality disorders” (pg 708).

In looking at the issue from the perspective of D.I.D., DSM-IV-TR states, “Reports by individuals with Dissociative Identity Disorder of a past history of sexual or physical abuse are often confirmed by objective evidence. Furthermore, persons responsible for acts of physical and sexual abuse may be prone to deny or distort their behaviour. Individuals with Dissociative Identity Disorder may manifest posttraumatic symptoms (e.g., nightmares, flashbacks and startle responses) or Posttraumatic Stress Disorder. Self-mutilation and suicidal and aggressive behaviour may occur. Some individuals may have a repetitive pattern of relationships involving physical and sexual abuse. Certain identities may experience conversion symptoms (e.g., pseudoseizures) or have unusual abilities to control pain or other physical symptoms. Individuals with this disorder may also have symptoms that meet criteria for Mood, Substance-Related, Sexual, Eating, or Sleep Disorders. Self-mutilative behaviour, impulsivity, and sudden and intense changes in relationships may warrant a concurrent diagnosis of Borderline Personality Disorder” (pg 527).

The complexities of DID, BPD and the other trauma-spectrum conditions that group together under the DESNOS umbrella become much more understandable when viewed from an evolutionary and attachment perspectives. Indeed the long term effects of lack of safety and insecurity of attachment permeate DSM-IV diagnostic criteria for BPD while the need to find a way of preserving a life-sustaining attachment to a primary care giver, who is also a serial perpetrator, is frequently at the core of the childhood genesis of DID, an adaptation that in time evolves frequently into an adult state characterized by maladaptive elaborations of conflicted internal parts. The cost of childhood survival exacts a high cost further down the line, ranging from living with chronic life-threatening mental illness on the one hand, to doing the hard, and sometimes painful work of reconnecting with and integrating that which (including traumatic memories) has been dissociated.

As recently as November 2006, the eminent Frans de Wall, Professor of primate behaviour at Emory University in Atlanta, Georgia stated, “We have the distinction of going where no species has gone before. Whether we make good use of that distinction depends on human nature and the way we choose to organise our societies... This is why we need a deeper understanding of nature, and this can be achieved only if the social sciences replace their ideology-laden, fragmented approach with objective science grounded in a unitary theory of behaviour. There is only one such theory around, which is why I predict that 50 years from now every psychology and sociology department will have Darwin’s portrait on the wall (quoted in Penrose, 2006, pg 37).”

Derived from published observations of acutely traumatised individuals dating back to World War I as well as clinical observations of patients with dissociative disorders Nijenhuis and co-workers developed the theory of structural dissociation of the personality, such that posttraumatic disorder involve two dissociative structures, an “apparently normal” part of the personality (ANP) focussed on functioning in daily life, preservation of the species, and avoidance of traumatic memories, and, the “emotional” part (EP) charged with defence from major threat to the integrity of the body (Nijenhuis, 2003). The responses of traumatized DID patients while remaining as ANP and EP were explicitly tested in a symptom provocation study using positron emission tomography (PET). As hypothesized
the ANP and EP when each were exposed to emotionally neutral personal memories did not demonstrate significant differences in regional cerebral blood flow (rCBF), physiological reactivity, and subjective measures (affective and sensorimotor reactivity). However major differences emerged between the psychobiological responses of ANP and EP to trauma scripts that only the EP regarded as personal memory (Nijenhuis, 2003). Without here detailing the many areas of difference Nijenhuis concluded that integrative failure with respect to bodily cues, which may play a central role in basic forms of consciousness, is related to dysfunction of the temporal, parietal, and occipital association areas. It has been repeatedly found that traumatized and dissociative patients have smaller total brain volume, corpus callosum, frontal lobes and hippocampus. In 1999 Tsai et al (See Adler. 1999) reported functional magnetic resonance imaging studies of a patient with DID, one whose hippocampal volumes were less than half the usual means, while the volume of her other brain structures was within the normal range. To see whether switches between identified personality states were different from the effects of imagination or effort, on occasions the subject was asked to imagine being a named 8-year old girl. Switches between personality states were accompanied by marked changes in activity in the hippocampus and in the surrounding temporal cortex. When the subject pictured as the imagined eight-year-old, rather than a real alter ego, her brain activity did not change. Intriguingly, it appears that successful psychotherapy for DID results in actual macroscopic changes to the brain. In three studies Ehling, Nijenhuis, and Krikke (Nijenhuis, 2003) assessed the hippocampal volume of women with florid DID, dissociative disorder not otherwise specified (DDNOS), and matched physically and mentally healthy controls. Women with florid DID had about 25% less hippocampal volume bilaterally than controls and those with DDNOS had about 13 % less. Hippocampal volume was strongly correlated with validated measures of dissociation, posttraumatic stress symptoms, and cumulative trauma reporting. Women who were rigorously assessed as having recovered from DID had 9% (left-sided) and 18% (right-sided) more hippocampal volume than florid DID cases.

Whilst traumatized (and non-traumatized) individuals on occasions give descriptions of events that are not historically accurate (Middleton, DeMarni Cromer & Freyd, 2005), a comprehensive reading of the scientific literature concerning DID would lead to the conclusion that for such patients the underreporting of trauma is more likely than over-reporting. Lewis et al. (1997) reported on the objective documentation of child abuse and long-standing marked dissociation in 12 murderers with DID who were being held on death row. Given the particular circumstances it was possible to amass large quantities of collateral history and to review many relevant documents that predated the offences (frequently by many years). Corroboration of symptoms of DID were obtained from relatives, police records/tapes, friends, housemates, mental health records, ex-girlfriends, old hand written documents/letters, acquaintances, social service records etc. Lewis et al. were able to document long-standing dissociative symptoms in all 12 subjects and to obtain objective evidence of extreme abuse in 11 of them. The 12 murderers were unaware of their psychiatric condition. In every case, three or more outside sources provided independent evidence of subject’s marked changes in voice, demeanour, and behaviour, and in 11 cases abuse was also verified objectively. Lewis et al. state, “What is more, contrary to the popular belief that probing questions will either instil false memories or encourage lying, especially in dissociative patients, of our 12 subjects, not one produced false memories or lied after inquiries regarding maltreatment. On the contrary, our subjects either denied or minimized their early experiences. We had to rely for the most part on objective records and on interviews with family and friends to discover that major abuse had occurred.”

Whilst critics of D.I.D. have characterised it as a culture bound phenomena, created by social forces and overzealous North American D.I.D. enthusiasts (i.e. iatrogenesis) many such criticisms dated from a time that predated the publication of the many clinical series reports and D.I.D. prevalence studies from around the world (see Dorahy & Middleton, 2005). Conspicuously absent from such critiques of
D.I.D. are references to the empirical studies, which have examined the validity of D.I.D. as a psychiatric entity e.g. the review by Gleaves, May and Cardeña (2001) on the validity of D.I.D. in which they found D.I.D. was not only a valid psychiatric condition, but one with the mass of empirical data accrued on its existence over the past quarter century. The evidence for its validity was greater than several well-accepted psychiatric conditions. Aside from USA and Canada reports on large series of patients meeting diagnostic criteria for D.I.D. have been published from Australia, The Netherlands, Turkey, South America, Germany, Japan, China and Norway. As of 2004 there were 24 countries in the world from which there have been scientific publications describing patients diagnosed with D.I.D. (Ross 2004). Many of these studies have employed the Structured Clinical Interview for DSM-IV-Dissociative Disorders (SCID-D) (Steinberg 1995), or the Dissociative Disorders Interview Schedule (DDIS) (Ross 1989, 1997), two structured interviews with high levels of validity and reliability in the detection of dissociative disorders including D.I.D.

The widely used Dissociative Experiences Scale (DES) whilst not a diagnostic instrument is a most useful screening instrument and measure of the different forms of dissociative phenomenology (Bernstein & Putnam 1986, Van Ijzendoorn & Schuengel, 1996). Ross (2000) pointed out that ‘the operational meaning of dissociation is based on the same rules and procedures that are applied to the measurement of anxiety, depression or psychosis and is supported by over 100 data-based peer-reviewed publications using the DES, and numerous publications using the DES, DDIS and SCID-D (pg 372).”

Ross (2000) observed that “the inclusion of a disorder in DSM-IV-TR represents the authoritative judgement of the relevant scientific community. It is therefore within the standard of care to make that diagnosis…. For a disorder to appear in DSM-IV-TR, there can be no conclusive scientific proof available in the literature that it lacks acceptable reliability and validity (Ross 2000, pg 384).”

Historically, the first cases of D.I.D. in the medical literature date from Eberhardt Gmelin’s description of what he labelled as an “exchanged personality.”

“In 1789, at the beginning of the French Revolution, aristocratic refugees arrived in Stuttgart. Impressed by their sights a twenty-year-old German young woman suddenly ‘exchanged’ her own personality for the manners and way of a French-born lady, imitating her and speaking French perfectly and German as would a French woman. These ‘French’ states repeated themselves. In her French personality, the subject had complete memory of all that she had said and done during her previous French states. As a German, she knew nothing of her French personality. With a motion of his hand, Gmelin was easily able to make her shift from one personality to the other (Ellenberger 1970, pg 127).”

Interest and clinical understanding in the diagnosis grew until the early 1900’s. (Morton Prince published ‘The Dissociation of a Personality’ in 1905.) However with Freud’s public and definitive renunciation of his ‘seduction’ theory in 1905 and with the associated focus on oedipal complexes and the associated repression of id-based sexual desires, the horizontal model of mind which had dominated psychiatric theory and practice, and which better explained D.I.D., was replaced by Freud’s topographical (vertical) model of mind. As is often the case when scientific paradigms change, the phenomena studied as part of the old paradigm cease to be a central focus and attention is redirected towards phenomena explained by the new paradigm (Kuhn, 1970) and once a paradigm is accepted humans change their mind set only with extreme reluctance.

Anthony Reading (2004) observed, “Unlearning something we have previously learned is much more difficult than learning something new, especially if it means having to modify an existing model. This
may explain why we generally like to read books that confirm our beliefs and associate with people who share our views (pg 28).” Haldane (quoted in Calvin 1996) described the four stages of acceptance of a scientific theory as being “(1) This is worthless nonsense, (2) This is an interesting but perverse point of view, (3) This is true, but quite unimportant, (4) I always said so.”

The 1970’s saw feminist writers attain a critical mass and the era witnessed a renewed interest in the study of D.I.D. coinciding with a focus on incest, child abuse, sexual assault, wife battering and other forms of interpersonal trauma (as well as the trauma-induced symptomatology of Vietnam veterans). Following the dissociative disorders being liberated from hysterical neurosis and gaining independent status in DSM-III, the empirical study of D.I.D. proliferated. It is hardly surprising that clinical awareness of D.I.D in the modern era principally arose in North America. Between 1987 and 2001 North America was responsible for 64% of the world’s scientific publications on psychological trauma (Bedard et al., 2004).

Pierre Janet, the late 19th, early 20th century French philosopher and psychiatrist, who developed the most advanced theory of dissociation of his time, in one of his later papers, reviewing his life’s work, commented that after the death of Jean Charcot in 1893 “hysteria patients’ (the condition which D.I.D. was subsumed under) seemed to disappear because they were now designated by other names. It was said that their tendency towards dissimulation and suggestibility made an examination dangerous and interpretations doubtful. I believe these criticisms to be grossly exaggerated and based on prejudice and misapprehension, and I am still under the illusion that my early works were not in vain and that they have left some definite ideas (pg 127, 1930).”

D.I.D. is identified by criteria that define dissociative phenomena including amnesias, yet it is a ‘condition’ that rarely occurs as other than a component of a complex trauma condition that usually incorporates, PTSD, the diagnostic criteria of which also includes amnesia. Complex trauma is characterised by the multiple way memories of traumas intrude as flashbacks, reenactments, somatic symptoms or internalised commentaries and by the multiple ways trauma and memories of trauma are avoided e.g. by dissociation, numbing, avoidance of reminders, using drugs and alcohol, or distancing via denial or intellectualisation.

Patients with D.I.D. rather than being viewed as having multiple personalities are probably more helpfully conceptualised as having something less than one (Spiegel et al., 1993), the product of an enduring state where full autobiographical memory has been lost. Colin Ross observes that the literature on D.I.D. is heading inevitably in the direction of a general trauma model of psychopathology, something that will produce a paradigm shift out of the two dominant schools of thought of 20th century psychiatry, the psychoanalytic and the biomedical-reductionist (see Ross, 2000).

CONCLUSIONS:

At the latter end of a period which reached its zenith in the mid-90’s in which there were numerous allegations regarding the excesses of so called “recovered memory therapists” who it was frequently claimed adhered to the Freudian notion of “repression” as a core principle of their apparent misguided and outdated endeavours, it is actually difficult to find any therapists who define themselves principally as practicing “recovered memory therapy”. McNally observed in 2003, “As far as I can tell, no one practicing psychotherapy today endorses this term as descriptive of what they do (pg 3).” It was also hard to find many writers in the field of trauma and memory who placed particular emphasis on the entity of “repression” as the principal construct used to explain the complex phenomenology and
amnesias frequently seen, particularly in those who lived through severe emotional, physical, and sexual traumas during formative developmental years and where commonly their abuser was simultaneously a vital attachment figure for which there was no ready substitute. The term “repression” uncomfortably straddles many meanings (e.g. denial, suppression, spacing out, traumatic amnesia, resistance, unawareness etc., see Freyd, 1996), whilst being derived from a theoretical model that is essentially unprovable. 

Dissociation, whether it is viewed as a single construct or as a collection of related mechanisms is something that has been intensely observed, operationalised, measured with refined, reliable and valid instruments, and is a construct deeply embedded in the diagnostic criteria of a range of DSM-IV (1994) disorders, including naturally, the dissociative disorders, but also PTSD and Borderline Personality Disorder.

It has been a long time since psychiatry and psychology has witnessed a more acrimonious dispute than that focussed on the phenomena of recovered memories of past (usually childhood) traumas and related issues. Polarisations on both sides of such a conflict speak more about counter-transference than objective scientific analysis and a willingness to incorporate salient facts and arguments that might depart from personal theoretical stances for which there was an initial emotional valance. Around a decade on from when the controversies reached their peak we are left to ponder a world in which the proven widespread paedophilic abuses of children by clergymen have created major financial and legitimacy crises for mainstream Christian churches, where enquiry after enquiry has documented decades of widespread severe child abuse in state and church orphanages, where such senior and ceremonial figures as the Cardinal of Boston or the Governor-General of Australia have been forced to resign from their positions because of how they handled past allegations of child abuse in their precincts and where Police operations worldwide have netted approximately 100,000 individuals (including in 2004 over 2,000 in Australia) using the internet to buy or distribute pictures of children being sexually abused. In 2002 the Catholic Archdiocese of Boston settled with 52 plaintiffs by agreeing to pay $85 million (US) (Flaccus, 2005). In December 2004 the Catholic diocese of Orange agreed to the single largest clergy abuse settlement in history up to then ($100 million US) in resolving 90 lawsuits, though nationally some 800 clergy abuse lawsuits remained pending.

It was inevitable that society would act out polarisations as if the issues of trauma and memory could be reduced to a series of simple dichotomies for which there were universal (and presumably self-evident) correct answers. Human psychology is much more complex. In keeping with numerous studies that have documented the extent of child abuse in our societies, and taking account of the ways developing children compartmentalise their abuse in order to eke out as much growth as possible in barren or abusive environments, it stands to reason that partial or complete amnesia for repetitive childhood traumas in particular would be common. Given that memory is an imperfect reconstructive phenomena it is understandable, particularly when dealing with dissociated/fragmented individuals, that false memories can appear, though as the smoke clears it is apparent that taken overall false memories have never represented the sort of clinical and societal problem that true memories of trauma represent (including those, rejected, unheard or unspoken). Illustrative of societal unwillingness to know, as recently as 1980 (Sadock), the most authoritative comprehensive text book of psychiatry in the world stated that accurate figures of the incidence of incest were difficult to obtain but nevertheless referenced a 1955 study reporting an incidence of one case per million population...

The single most important factor, it is suggested, in avoiding the over-identification, generalisations, polarisations, and extrapolations that are not supported by available data, is the thorough understanding about, and application of, sound therapeutic boundaries when one is a privileged custodian of other
people’s memories as they work on achieving a future. Having sound boundaries in therapy allows the focus to move to the equally important goal of having sound boundaries in science.

Just as two of the principle symptom clusters of PTSD (as defined in DSM-IV) relate to persistent re-experiencing phenomena (e.g. intrusive recollections, distressing dreams) and persistent avoidance of trauma related stimuli (e.g. detachment, avoidance of thoughts or reminders) the apparent paradox for both therapists and scientists is that traumatic memories are both the least forgettable and the most forgettable of all memories. (Freyd, 1996, Middleton, DeMarni Cromer & Freyd, 2005).

Appendix 1:

A Longitudinal Sampling of Writers on Recovered Memories of Trauma.

“False memories are by no means rare occurrences in most of us... Most people, probably, are in doubt about certain matters ascribed to their past. They may have seen them, may have said them, done them, or they may only have dreamed or imaged they did so... The most frequent source of false memory is the accounts we give to others of our experiences. Such accounts we almost always make both more simple and more interesting than the truth. We quote what we should have said or done rather than what we really said or did; and in the first telling we may be fully aware of the distinction. But ere long the fiction expels the reality from memory and reigns in its stead alone. This is one great source of the fallibility of testimony meant to be quite honest... It is next to impossible to get a story of this so accurate in all its details, although it is the inessential details that suffer most change (pg 373-374).”

William James, 1890

“The detestable terms ‘railway spine’ and ‘railway brain’ are still employed by a number of authors, but apparently more with the object of clearly indicating the general classification of the cases they report than with the idea that they are proper scientific designations. It would do much toward finally settling the status of the topic if these terms, as well as the words ‘concussion’ and ‘hystera’ were finally dropped,... It is somewhat strange that the very important symptom, amnesia, partial or total, as a result of shock, has received no attention in the numerous papers of the last three years (pg 3).”

E.C. Sequin, 1890

“The necessary condition for the (pathogenic) operation of ideas is, on the one hand, an innate—that is, hysterical-disposition and, on the other, a special frame of mind. We can only form an imprecise idea of this frame of mind. It must resemble a state of hypnosis; it must correspond to some kind of vacancy of consciousness in which an emerging idea meets with no resistance from any other — in which, so to speak, the field is clear for the first corner. We know that a state of this kind can be brought about not only by hypnotism but by emotional shock (fright, anger, etc.) and by exhausting factors (sleeplessness, hunger, and so on) (As quoted in Breuer & Freud, 1895, pg 215).”

P.J. Moebius, 1894

“The longer we have been occupied with these phenomena the more we have become convinced that the splitting of consciousness so striking in the familiar classical cases under the form of ‘double
conscience’ is present to a rudimentary degree in every hysteria and that a tendency to such
dissociation, and with it the emergence of abnormal states of consciousness (which we shall bring
together under the term ‘hypnoid’) is the basic phenomena of this neurosis. In these views we concur
with Binet and the two Janets, though we have had no experience of the remarkable findings they have
made on anaesthetic patients (pg 12)”

Josef Breuer & Sigmund Freud, 1895

“Doubts about the genuineness of the infantile sexual scenes can, however, be deprived of their force
here and now by more than one argument. In the first place, the behaviour of patients while they are
reproducing these infantile experiences is in every respect incompatible with the assumption that the
scenes are anything else than a reality which is being felt with distress and reproduced with the greatest
reluctance (pg 204).”

Sigmund Freud, 1896

“In one instance, the brother… of his own accord… confirmed for me… [sexual abuse] scenes of this
kind from their later childhood and the fact of sexual relations dating further back. Another time it
happened that two women whom I was treating had as children had sexual intercourse with the same
man, when certain scenes had occurred in which all three took part. A particular symptom which
could be traced to these childish experiences had been developed in both cases and bore witness to this
common experience (pg 201-202).”

Sigmund Freud, 1896

“Unfortunately, my own father was one of these perverts and is responsible for the hysteria of my
brother (all of whose symptoms are identifications) and those of several younger sisters. The frequency
of this circumstance often makes me wonder (pg 230-231).”

Sigmund Freud, 1897 (See Masson, 1985)

“In the hysterical patient suggestibility is the dominant quality or, more exactly, autosuggestibility.
She - I say ‘she’ because the woman is subject to these symptoms – lives in a world of dreams and in
the graver cases… the mental trouble amounts to an hysterical delirium… These patients are experts
in the art of putting the stamp of reality, not only on their sensations… but on the phantoms created by
their most flagrant imaginations (pg 172-173).”

Paul Dubois, 1905

“Similarly, B IV described the New Haven escapade – at least, as much of it as belonged to B1 and
herself, but nothing of Sally’s part. At first, her memory was very hazy, but by taking her through each
step in succession, and by allowing her to think hard she recalled the events. On a previous occasion,
before she used her ‘mind-fixing’ process, she could not recall this adventure, this memory in contrast
with her amnesia, seemed paradoxical.

Here was evidence of quite an extensive memory of the life of B1, showing apparently that division of
personalities was not as complete as previous observations had seemed to indicate. At the time, the
contradictory evidence was puzzling. Later, she confessed the trick. When she appears to the onlooker
to be in deep though she was, in reality, in a condition of abstraction (pg 254-255).”
Morton Prince, 1905

“Children’s declarations before the law are, for the truly experienced knower of children, downright null and hollow, absolutely worthless and without significance, all the more insignificant and all the more hollow the more often the child repeats the declaration and the more determined he is to stick to his statements... Frequently there is no question of the ‘seduction’ of children. But rather the instigation derives in the first place from children themselves (pg 220).”

Ivan Bloch, 1909 (See Masson, 2003)

“Psychiatrists saw the effects of battle on the human mind and recorded them with wonderful eloquence. War horrified, appalled, yet also excited them. It provided an extreme environment, a laboratory in which every theory could be tested literally to destruction; war shattered the mind, but in an intellectually absorbing way. These conflicting emotions pervade the medical literature; even as the doctors record the horrors, they marvel at the way the mind refracts and mediates them. A soldier admitted to Maida Vale Hospital in London in January 1915 had completely lost his memory after being blown up by a shell at Ypres in October 1914. He had been sent first to a hospital in Manchester and now spoke with a Lancashire accent. But under hypnosis, he regained his memory, and, in the soft burr of his native Wiltshire, described ‘with very manifest expressions of emotions’ the ‘horror of a bombardment by explosive shells.’ But when he came out of hypnosis, he could remember nothing and talked again in a Manchester accent. Try as they would, the doctors were unable to re-unite his two personalities. After 25 ‘sittings’ he was discharged, a case of ‘lost personality’ (pg xvii-xviii).”

Ben Shephard (quoting A. Feiling, 1915), 2000

“It is a general rule that when a person passes from a condition of extreme dissociation to the normal state there is a tendency for amnesia to supervene for the previous dissociated state (multiple personalities, epileptic and hysterical fugues, hypnotic and dream states, etc). Likewise in everyday life it frequently happens, when the dissociation effected by emotion results in an extremely retracted field of consciousness, that, after this emotional state has subsided and the normal state has been restored, memory for the excited retracted state, including the action performed, is abolished or impaired. Even criminal acts committed in highly emotional states (anger, ‘brain storms’, etc.) may be forgotten afterwards. In other words, in the normal state there is in turn a dissociation of the residua of the excited state. The experience of this latter state are not lost, however, but only dissociated in that they cannot be synthesised with the personal consciousness and thereby reproduced as memory (pg 508-509).”

Morton Prince, 1916

“The origin of the symptoms... is to found in the intense emotion of fear caused by the shell expulsion, of which they are the objective physical manifestations...

The attempted repression and control of the fearful emotion at its inception brings about a splitting of the mind [what Janet called ‘dissociation’] which appears later as an amnesia of greater or lesser extent, often involving other losses of function also, such as dumbness, deafness, tremulousness and paralysis (pg 50).”

William Brown, 1918 (as quoted in Shephard, 2000)
“Independently, growing out of dissatisfaction with the practical use of hypnotism, a third line of approach was taken by the Viennese physician, Sigmund Freud. It had been found by earlier workers that hypnotism was often the means of reaching experience which had been so completely forgotten that by no effort of the will could it be recalled. Working in conjunction with Breuer, Freud found the process of bringing these buried memories to the surface led to the disappearance of hysterical symptoms of long duration, and the two authors founded upon this experience a theory of hysteria according to which its symptoms are the indirect expression of old mental injuries (traumata), especially those of early childhood.

Later, Freud found that the buried memories which manifested themselves in this morbid manner could be brought to the surface more securely and with greater therapeutic efficacy, though less expeditiously, without the aid of hypnotism. By means of his method of free association, starting as a rule from clues provided by dreams, Freud was led to formulate a theory of the unconscious and an elaborate scheme of the mechanism by which it is related to acts upon the conscious. In the course of this work Freud was led to the conclusion that the mental experience which had been cut off from the general body of consciousness was nearly always connected with sex. His work, and still more that of his disciples, came to deal so exclusively with sexual factors that the general body both of the medical profession and the laity refused to give this movement the attention it deserved (pg 125-126).”

W.H.R. Rivers, 1919 (Reprinted 1927)

“In many cases, however, in which the obliteration is due to mental shock or other physical factor, the experience which is inaccessible to the consciousness of the subject under the usual conditions of memory has been recovered in the hypnotic state or by the method of free association or has expressed itself, usually in a distorted form, in dreams. In some cases soldiers have lost the entire memory of their lives from some moment preceding a shock or severe strain until they have found themselves in hospital, perhaps weeks later, although during at least part of the intervening time they may have been to all appearances fully conscious and may even have distinguished themselves by actions on the field of which they have no recollection. Although these memories may remain for months or years quite inaccessible to memory when approached by the ordinary channels, they may be brought to the surface by means of hypnotism or by the method of free association (pg 14).”

W.H.R. Rivers, 1920

“I venture after the lapse of so many years to lift the veil of discretion and reveal the fact that Katharina was not the niece but the daughter of the landlady. The girl fell ill, therefore, as a result of sexual attempts on the part of her own father. Distortions like the one which I introduced in the present instance should be altogether avoided in reporting a case history.”

Sigmund Freud, 1924

“Before going further into the question of infantile sexuality I must mention an error into which I fell for a while and which might well have had fatal consequences for the whole of my work. Under the influence of the technical procedure, which I used at that time, the majority of my patients reproduced from their childhood scenes in which they were sexually seduced by some grown-up person. With female patients the part of seducer was almost always assigned to their father. I believed these stories, and consequently supposed that I had discovered the roots of the subsequent neurosis in these experiences of sexual seduction in childhood. My confidence was strengthened by a few cases in
which relations of this kind with a father, uncle, or elder brother had continued up to an age at which memory was to be trusted. If the reader feels inclined to shake his head at my credulity, I cannot altogether blame him; though I may plead that this was at a time when I was intentionally keeping my critical faculty in abeyance so as to preserve an unprejudiced and receptive attitude towards the many novelties which were coming to my notice everyday. When, however, I was at last obliged to recognise that these scenes of seduction had never taken place, and that they were only phantasies which my patients had made up or which I myself had perhaps forced on them, I was for some time completely at a loss. My confidence alike in my technique and in its results suffered a severe blow; it could not be disputed that I had arrived at these scenes by a technical method which I considered correct, and their subject matter was unquestionably related to the symptoms from which my investigation had started. When I had pulled myself together, I was able to draw the right conclusions from my discovery: namely, that the neurotic symptoms were not related directly to actual events but to wishful phantasies, and that as far as the neurosis was concerned psychical reality was of more importance than material reality (pg 33-34)."

Sigmund Freud, 1924 [1925]

“As we know from Breuer, hysterical symptoms can be resolved if, starting from them, we are able to find the path back to the memory of a traumatic experience. If the memory which we have uncovered does not answer our expectations, it may be that we ought to pursue the same path a little further; perhaps behind the first traumatic scene there may be concealed the memory of a second, which satisfies our requirements better and whose reproduction has a greater therapeutic effect; so that the scene that was first discovered only has the significance of a connecting link in the chain of associations. And perhaps this situation may repeat itself; inoperative scenes may be interpolated more than once, as necessary transitions in the process of reproduction, until we finally make our way from the hysterical symptom to the scene which is really operative traumatically and which is satisfactory in every respect, both therapeutically and analytically.”

Sigmund Freud, 1926

“Even children of respected, high-minded puritanical families fall victims to real rape much more frequently than one had dared to suspect. Either the parents themselves seek substitution for their lack of [sexual] satisfaction in this pathological manner, or else trusted persons such as relatives (uncles, aunts, grandparents), tutors, servants, abuse the ignorance and innocence of children. The obvious objection that we are dealing with sexual fantasies of the child himself, that is, with hysterical lies, unfortunately is weakened by the multitude of confessions of this kind, on the part of patients in analysis, to assaults on children (pg 288-289).”

Sandor Ferenczi, 1932 (See Masson 2003)

“What memory does not recall, the imagination tends to supply – unconsciously as a rule, half-conscious where bias or suggestion exists, and consciously in whole-cloth perjury. As memory fades, imagination retouches the details; where this is done unconsciously, therefore honestly, we are apt to recall what we think should have normally occurred, or, if personally involved, what we wish had occurred, or what, from suggestions now half-forgotten, we believe occurred....

The merest skeleton of fact, repeatedly told, bodies forth as a complete, truthful narrative, ‘ere long fiction expels reality from memory and reigns in its stead alone’ and ‘unconscious impressions’ blend with ‘conscious realities’, playing havoc with objective truth. This ‘filling-in’ of memory occurs so
unconsciously that it does not even affect the positive belief or manner of the witness…. Memory is more than the re-instatement of the original perception; it involves the interpretation of details, judgement, estimates, and the correlation of related incidents. Imagination and suggestion are twin-artists ever ready to retouch the fading daguerreotype of memory. Just as ‘Nature abhors a vacuum’, the mind abhors an uncompleted picture, and paints in the details, careless indeed as to whether the old picture is reproduced faithfully (pg 400-401.).”

D.S. Gardner, 1932-1933

“Almost all of my women patients told me that they had been seduced by their father. I was driven to recognise in the end that those reports were untrue and so came to understand that the hysterical symptoms are derived from phantasies and not from real occurrences….It was only later that I was able to recognise in this phantasy of being seduced by the father the expression of the typical Oedipus complex in women (pg 120).”

Sigmund Freud, Introductory Lectures of Psycholanalysis, 1933

“One of the tasks of psycho-analysis, as you know, is to lift the veil of amnesia which hides the earliest years of childhood and to bring to conscious memory the manifestations of early infantile sexual life which are contained in them. Now these first sexual experiences of a child are linked to painful impressions of anxiety, prohibition, disappointment and punishment. We can understand their having been repressed; but, that being so, we cannot understand how it is that they have such free access to dream-life, that they provide the pattern for so many dream-phantasies and that dreams are filled with reproductions of these scenes from childhood and with allusions to them (pg 28).”

Sigmund Freud, 1933

“Many cases of amnesia have been studied and reported in voluminous detail… Extensive amnesics are very apt to be associated with shocks of some kind… The shock may be an emotional disturbance or even a moral conflict… Cases not infrequently appear in which the patient can recall nothing of what took place during a period of several months or even years (pg 106).”

Clark Hull, 1933

“If the little girl were brought up from the first with the same demands and rewards, the same severity and the same freedom, as her brothers,… promised the same future, surrounded with women and men who seemed to her undoubted equals, the meanings of the castration complex and of the Oedipus complex would be profoundly modified. Assuming on the same basis as the father the material and moral responsibility of the couple, the mother would enjoy the same lasting prestige; the child would perceive around her an androgynous world and not a masculine world. Were she emotionally more attached to her father – which is not even sure – her love for him would be tinged with a will to emulation and not a feeling or powerlessness.”

Simone de Beauvoir, The Second Sex, 1949

"Where do these studies lead us? The facts of amnesia, without additional experiments, make abundantly clear that repression occurs, and that memories once lost can be recovered without relearning. While therefore experiments are not needed to establish the phenomenon of repression, they
may help us to delineate the precise circumstances under which repression occurs. Clarification of repression phenomena is today more important than establishing their genuineness (pg 290)."

E.R. Hilgard & G.H. Bower, 1966

“Our experiences after Dunkirk taught us the folly of trying to patch up soldiers and expect them to face again the stresses that had caused their breakdown. Our first thousand admissions included, for instance, more than one hundred and fifty men with acute hysterical losses of memory: a condition of the utmost rarity in peacetime. Sodium amytal, promptly injected, brought the memory back, often accompanied by overwhelming emotional release and a reliving of the forgotten experiences, but we found if these soldiers were sent back to full duty, fresh battle stresses would at once reproduce the former symptoms. So we decided to avoid the terrible chronic neuroses left over from World War 1 by arranging for nervously unstable patients to be discharged from the Army, hoping that they would make some sort of success in civil life (pg 89).”

William Sargant, 1967

Morselli in [1925] was struck by his patient’s apparent ignorance of the facts of life and by certain gaps in her memory: she could remember nothing about the weeks spent with her father in a place of which she could not recall the name.

Gradually, Elena recovered her forgotten memories at the cost of terrifying emotional abreactions. She remembered having been the victim of her father’s incestuous attacks (the reality of which was confirmed from other sources). Most horrifying for her was the memory of his attempts to put his tongue into her mouth. Her flight into a French personality was thus an attempt to repress the memory of her father’s ‘tongue’ and for his incestuous attacks in general (pg 139).”

Henri F. Ellenberger, 1970

“This model was originally worked out by Breuer and Freud in their ‘Studies in Hysteria’. On the upper line we put the hysterical symptoms, and on the lower the unconscious motivations that Breuer and Freud, following Charcot and Janet, found to be unconscious representations (or in the language of that time traumatic reminiscences). Suppose the symptoms S is on the upper line, and the traumatic reminiscence T is on the lower, the association between S and T is threefold. There is a hermeneutic relationship, the symptom is like the cypher in a known language that helps one to decipher the text in an unknown language. There is a relationship effect to cause, and thirdly there is a therapeutic relationship. S can be removed by exerting a certain manoeuvre on T, such as bringing it into awareness and abreacting it. The clinical interpretation, the scientific understanding, and the therapeutic removal of the symptoms thus almost coincide.

This is a development of what Janet and Breuer had found. Freud’s innovation was his dynamic concept of the relationship of S and T. T has a tendency to express in consciousness, but T is checked and held in the unconscious by means of an active force called repression. This inner conflict absorbs psychological energy that can be freed when the patient is cured of his symptoms (pg 497).”

Henri F. Ellenberger, 1970

“No one is ever made sick by his fantasies. Only traumatic memories in repression can cause the neurosis… Fantasies, in particular compulsive ones, are a symptom of the disease, never its cause.”
Robert Fliess, 1973

"Memories that may cause us great unhappiness if they were brought to mind often appear to be 'forgotten'. However, are they really lost from memory or are they simply temporarily repressed as originally suggested by Freud (1922)? Repression is the phenomenon that prevents someone from remembering an event that can cause him pain and suffering. One way that we know that these memories are repressed and not completely lost is that the methods of free association and hypnosis and other special techniques used by psychotherapists can be used to bring repressed material to mind and can help a person remember things that he has failed to remember earlier (pg 82)."

G.R. Loftus & E.F. Loftus, 1976

*Of a WWI veteran with ‘traumatic neurosis’.*

“His trench had been shelled, and he had been buried under earth and debris three times, without untoward effect. However, after the fourth such occasion, he came to but was mute, deaf, blind, with no body sense, and had to be fed with a dropper.

Body feeling returned within six months, and it took another six months for the sensory organs to regain their function. It was more that a year before he could read or write, and it is interesting to note that the latter ability was the last of all to return (pg 109-110).”

Abram Kardiner, 1977

“The war neuroses showed that defensive and adaptive manoeuvres were very different in character in that sometimes a defensive manoeuvre can destroy the adaptation of the entire ego. The key to the syndrome was that in response to a traumatic survival threat from the environment, the defensive shrinkage of the ego destroys the adaptive capacity of the entire organism. In other words, the trauma, causes the total ego to become disintegrated, which in turn leads to the breakdown of the ego’s systems of action. It is here that one sees the failure of the adaptive mechanisms such as denial, displacement, and so on described by Freud in his *Interpretation of Dreams*. The need to deny, to forget, to not see, is an attempt to break contacts with, to defend oneself from a dangerous and painful stimulus. But the adaptive manoeuvre fails and becomes maladaptive by depriving the individual of some or all of his effective coping devices. Hysterical blindness shuts off the pernicious scene, but unfortunately it blocks out everything else as well (pg 112).”

Abram Kardiner, 1977

“I had left the last hour feeling quite calm but somewhat intrigued by these new insights. But apparently the material having to do with my association with the female began to stir things up a bit, and I had a dream about a mask, from which I awoke with great apprehension. The dream stimulated very important associations which led to the discovery of a childhood phobia that I had had, namely, the fear of masks and clothed wax figures. Freud asked, ‘What was there about the mask that frightened you so?’ My first response was that it was the facial immobility, the lack of expression, the fact that it neither smiled or laughed, and that the face was immobile. I myself had had several dreams in which I could see myself in the mirror, and the face would not reflect my emotional expression; that is, I would smile or I would frown, but the expression in the mirror did not change.
Freud drew the conclusion that the possibility was that ‘the first mask you saw was your dead mother’s face.’ Now, this idea sent shivers through me when I first thought about it, but the circumstantial evidence from this dream and the associations led to the striking possibility that I had discovered my mother dead, while I was alone with her in the house.

I told Freud, ‘Well, if you wanted any evidence for the basis of identification with my mother, here it is. I was, in all likelihood, alone with her when she expired. There was also a superstition popular at the time that if you were with someone who died, you would breathe in the soul of that person, which was expelled with his last breath.’ When I returned to New York, my sister confirmed this. She was old enough to remember the events very accurately because she was at the time eleven years old, and she told me what had happened. She said that nothing unusual had happened on that day, because my mother was chronically ill and she was left home alone. I was with her, playing on the floor. Apparently, I wanted something and I shook her. She did not respond or answer, and I was frightened. When my sister came home for lunch, she discovered that my mother was dead and that I was alone in the room crying.

‘Well,’ said Freud, ‘it’s obvious from your associations that the mask represented your mother’s dead face. Therefore, all masks or wax figures were associated with death, and brought back the old terror (pg 61-62)’.

Abram Kardiner, 1977

“A twenty-five year old office worker was seen in the emergency room with an acute anxiety attack. She was pacing, agitated, unable to eat or sleep, and had a feeling of impending doom. She related a vivid fantasy of being pursued by a man with a knife. The previous day she had been cornered in the office by her boss, who aggressively propositioned her. She needed the job badly and did not want to lose it, but she dreaded the thought of returning to work. It later emerged in psychotherapy that this episode of sexual harassment had reawakened previously repressed memories of sexual assaults by her father. From the age of six until mid-adolescence, her father had repeatedly exhibited himself to her and insisted that she masturbate him. The experience of being entrapped at work had recalled her childhood feeling of helplessness and fear (pg 8).”

Judith L. Herman, 1981

"Oldham was riding in the back seat of a two-door car. When the car was stopped and the abduction began, his two friends in the front were somehow switched off. Oldham pushed the seat - and his companions - forward and got out with great difficulty. He walked on compelled as it were, towards a huge light, and later, after the abduction was over, struggled back into the rear seat past his 'suspended' friends. By the time their animation returned, David's memories of his UFO experience had vanished, and were not restored until he was hypnotically regressed years later (pg 107-108)."

B. Hopkins, 1981

“In a given patient [with Multiple Personality Disorder], one may find episodes of photographic recall, confabulation, screen phenomena, confusion between dreams or fantasies and reality, irregular recollection, and wilful misrepresentation. One awaits a goodness of fit among several forms of data, and often must be satisfied to remain uncertain (pg 14).”

Richard Kluft, 1984
“It has been … charged that [Freud] offered the concept [of the Oedipus Complex] as a kind of cover up when the earlier idea of traumatic seduction threatened to incriminate his own father. Aside from the forgettable Dr. Masson we have the remarkable volume of Marie Balmary (1979). This author, through ingenious dissection and reassembling of historical facts, comical allusions, artistic references, and the handling of other data …, elicits from Freud’s own words that what precipitated his rejection of the seduction theory was the death of his father and Freud’s anxious desire to keep repressed in himself his profound suspicions about the mysterious disappearance of his father’s second wife, which, in this narrative, appears to have been suicide following desertion – thus repeating the suicide of Chrysippus, the youth seduced and abandoned in the legend by Laius, the father of Oedipus.

I cannot imagine what the ultimate fate of this revision will be, or indeed any revisions … that seek to restore the hegemony of trauma over fantasy in the etiology of personality and its disorders. In the face of incontrovertible evidence – which we so far don’t have – that Freud introduced the Oedipus Complex for this ulterior purpose, would the concept lose its status as a hermeneutic rule? Just posing the question that way demonstrates its absurdity. It simply cannot be that all instances of the Oedipus Complex that have been derived during the past 80 years or so have existed only in the brainwashed minds of psychoanalysts and their unfortunate patients (pg 447-448)!”

S.A. Leavy, 1985

“Child sexual abuse is an intensely controversial, deeply divisive subject. It splits children from parents, mothers from fathers, and families from friends, neighbours and relatives. It divides social workers against psychiatrists, therapists against investigators, investigators against prosecutors, prosecutors against judges, judges against jurors, and every player against society itself. Any traditional or potential alliance is threatened, and every nascent distrust is exaggerated. Each question becomes a dispute and every answer an insult. Here in the midst of the flowering of twentieth century reasoning and scientific enlightenment is a neglected relic of mythic and superstitious issues almost untouched by mainstream adult consciousness (pg iii).”

Roland Summit, 1986

“Memories concealed for years have been discovered, but learning theory mandates that behaviours – and memory is a facet of behaviour – must be reinforced else they extinguish. In fact, these traumatic memories are repeatedly reactivated, often in nightmares, but in cryptic or disguised forms. Furthermore, chance contemporary encounters containing elements associated with the original event also frighten the person and provoke a flashback, a sudden trance, when the memory is relived only to be forgotten once again. Although there is not conscious awareness, these memories are not dormant. In a strange way, they are active and repetitive, producing symptoms. One patient led a double existence. During the day she was a competent administrator, but at night she would usually revert to her hypnotic world where childhood horrors were revisited and then forgotten. Patients with these problems have specific activators that in daily life revivify and perpetuate these occult memories although the victim recognises only anxiety, panic, depression, pain, or amnesia (pg 108-109).”

Eugene Bliss, 1986

“The majority of patients (64%) did not have full recall of the sexual abuse but reported at least some degree of amnesia… Just over one quarter of the women (28%) reported severe memory deficits. A strong association was observed between the degree of reported amnesia and the degree of onset and
duration of the sexual abuse. Women who reported no memory deficits were generally those whose abuse had begun and continued well into adolescence. Mild to moderate deficits were usually associated with abuse that began in latency and ended by early adolescence. Marked memory deficits were usually associated with abuse that began early in childhood, often in the preschool years, and ended before adolescence.

In addition, a relationship was observed between frankly violent or sadistic abuse experiences and the resort to massive repression as a defence (pg 5).

J Herman & E Schatzow, 1987

"The mechanism behind 'ordinary forgetting', although not explicitly stated in the discussion on recovered memories probably is decay, considering its implicit meaning, (i.e., information wears off in the course of time, as in Thorndike's 'Law of Disuse'). The trace decay hypothesis is based on Ebbinghaus's classical experiment (1885) on the forgetting curve which states that the amount lost is a function of time, which suggests that (Baddeley, 1976): '...the memory trace will spontaneously deteriorate over time, rather as a mark made in a pat of butter will gradually disappear in a warm room (pg 59)."

A.J. Parkin, 1987

"If you think you were abused and your life shows the symptoms, then you were. If you don’t remember your abuse, you’re not alone (pg 22)."

Ellen Bass & Laura Davis, 1988

“Survivors with the most severe memory deficits often describe almost complete amnesia for childhood but report experiencing jarring, recurrent, intrusive symptoms, particularly flashbacks and body sensations. And some survivors with complete amnesia develop acute symptoms of post-traumatic stress disorder when a recent experience (a family crisis, disclosure of other incest in the family, a TV show about incest, a sexual experience) triggers sudden, often overwhelming recall of the incest trauma (pg 29)."

Christine Courtois, 1988

"Salley, a college educated woman in her late 30's, presented in a suicidal state with classical symptoms of MPD. Her score on the Dissociative Experiences Scale was well over 40. She also met DSM-III-R diagnostic criteria for borderline personality disorder. She reported internal voices belonging to perceived autonomous internal self-states who reportedly were fighting with her for executive control of the body. When successful, they often were self-defeating or self-harming. She had grown up with harsh, disapproving Christian fundamentalist parents, and had renounced traditional religious dogma at an early age after observing hypocrisy in her church. While attending a private Christian school she became aware of a number of 'false-self parts' of her mind who alternatively would role play to meet the demands of her parents and others. Internally, she continued to flounder in the absence of a cohesive sense of identity or an acceptable ontological belief system.

In her 20's, Salley was attracted by the charismatic leader of a new age UFO cult whose dogma suddenly made sense out of her dissociative experiences. It was explained to her that the various internal parts represented simply cosmic detritus that through cult commitment would be shed prior to
the final harvesting of the chosen few who would join the leader in another dimension of the universe. Following this epiphany, Salley's internal system of alters reconfigured to organize around her newfound beliefs. Later while proselytising for the cult, she experienced UFO close encounters of the third kind, witnessing spacecraft land and aliens emerge (pg 213-214)."

George K. Ganaway, 1989

"Yet we are also at a point in time when we appreciate all too keenly the vicissitudes to which human memory is vulnerable (Wells & Loftus, 1984), especially when hypnotically refreshed or hypnotically recovered memory is in question (Orne, 1979; Pettinati, 1988). The more one presses for data, the higher is the likelihood that a number of powerful forces will make it possible for some inaccurate material to be reported. These phenomena seem well established in the laboratory situation, but controversy persists as to as to whether such findings hold for the material of genuine life events.

Dissociative disorder patients are highly hypnotizable as a group, and show many autohypnotic features. Is it not possible that we will find that clinicians and patients alike have unwittingly induced and repeated, or have simply misinterpreted such distortions, and unknowingly contributed to a contagious misperception that is giving rise to a modern legend with potential for untold damage?"

Richard P. Kluft, 1989

"My goal is rather to emphasize that within the medical tradition, the healer's education is what the sociologist Renee Fox has described as 'training for uncertainty,' to do the best one can in the absence of definitive knowledge. This is true for every known medical condition and psychopathology. When we forget this, we are vulnerable to entering an unacknowledged cycle of projective identification with our patients, taking their urgency into ourselves, and paralleling this process in our interactions with the patient and with others. We become unwitting extensions of our patients', urgent quest for premature certainty, and dissociate our awareness that the literature demonstrates that for all their imperfections, our knowledge base and our skills are sufficient to provide a reasonable quality of care for patients with complex dissociation disorders. We can perceive ourselves unnecessarily as depotentiated and deskilled. Our patients introject that, and the vicious cycle deepens.

The very stuff of therapy is fraught with uncertainties. Traumatized persons must come to terms with their pasts. However, their pasts are encoded in memory. Trauma distorts the memory process. Were past perceptions encoded accurately? How can we reconcile different alters' mutually contradictory accounts? Were the memories retained without contamination or alteration, or have they become adulterated? Has their retrieval been optimal, or has it occurred under circumstances that may possibly influence what is 'retrieved'? To what extent should we regard the possibility of contamination as a probability in the absence of data that points one way or the other (pg 178)?"

Richard P. Kluft, 1991

“The best course of action is by the child who realised the error of the accusations made, and recants and brings an action for malpractice, against the therapist. It would seem that there is a very real possibility that the parent could join in this action… Therapists, medical institutions and insurance companies will be seriously threatened by such actions.

False Memory Syndrome Foundation, 1992
“If you have memories that could not possibly have happened, first consider trickery designed to instil doubt. Ritual abusers combine sadism with intelligence. Some of the deceptions they devise are masquerading as aliens or famous people and then committing acts of abuse, staging a mock death of someone who later is clearly alive, using illusion, masks, and sleight of hand to perform ‘impossible’ movements or acts, and inducing hallucinations with drugs and hypnosis (pg 165).”

Renee Fredrickson, 1992

“It never happened; the victim lies; the victim exaggerates; the victim brought it on herself; and in any case it is time to move on and forget the past (pg 8).”

Judith Herman, 1992

“Programs that promote the rapid uncovering of traumatic memories without providing an adequate context for integration are therapeutically irresponsible and potentially dangerous for they leave the patient without the resources to cope with the memories uncovered (pg 184).”

Judith Herman, 1992

“Neither Freud, nor, to my knowledge, any other analyst, published a case wherein a woman, not psychotic, told of an incestuous relationship with the father and then in the course of treatment it turned out to be a fantasy (pg 968-969)!”

B. Simon, 1992

“Dr Masserman’s insurers have made four out-of-court settlements against him. He has also signed a consent order with the state of Illinios agreeing to give up his licence to prescribe drugs or practice any form of psychotherapy or medicine. Additionally, he has received notice of his suspension from the American Psychiatric Association and the Illinios Psychiatric Society for violating the principles of medical ethics. Nevertheless, Dr Masserman has denied all allegations that he is guilty of misconduct (pg 7).”

Barbara Noël with Kathryn Watterson, 1992

“No amount of external approval can ever substitute for inner acceptance, no matter how much uncertainty and incomprehensible pain such acceptance of self entails. If an honest relationship is to survive, then the ‘doubting’ therapists’ only alternative is to bear this uncertainly and to help the patient bear hers, hoping thereby to recall to them both a deeper experience of self-acceptance (pg 37).”

P. Genova, 1993

Asked “Is choosing paedophilia for you a responsible choice of the individual?”

“Certainly it is responsible. What I have been struck by as I have come to know more about and understand people who choose paedophilia is that they let themselves be too much defined by other people. That is usually an essentially negative definition. Paedophiles spend a lot of time and energy defending their choice. I don’t think that a paedophile needs to do that. Paedophiles can boldly and courageously affirm what they choose. They can say that what they want is to find the best way to love. I am also a theologian and as a theologian I believe it is God’s will that there be closeness and
intimacy, unity of the flesh, between people. A paedophile can say: ‘This closeness is possible for me within the choices I have made (pg 3-4).”

Ralph Underwager (Quoted in J. Geraci), 1993

“It would be nice if someone could get some kind of big research grant to do a longitudinal study of let’s say, a hundred twelve-year-old boys in relationships with loving paedophiles. Whoever was doing the study would have to follow them at five-year intervals for twenty years. This is impossible in the U.S. right now. We’re talking a long time in the future (pg 12).”

Hollida Wakefield (Quoted in J. Geraci), 1993

“The Philadelphia-based False Memory Syndrome Foundation (FMSF) reported in its July (Vol 2 Number 7) newsletter that psychologist and expert witness Ralph Underwager resigned from the FMSF advisory board because of what he claimed were potential ‘misinterpretations’ of an interview with his wife, Hollida Wakefield, and him that appeared in the Winter 1993 issue of Paidaka, the Journal of Paedophilia. Underwager’s resignation came shortly after Moving Forward questioned FMSF executive director Pamela Freyd about comments that he made in the interview.

News of Underwager’s resignation appeared on Page 7 of the FMSF Newsletter. Under the small headline ‘Controversial Article’, the organisation explained the resignation this way: ‘We were questioned recently about an interview that was given by Hollida Wakefield and Ralph Underwager for a Dutch journal concerned with pedophilia (Paidaka, 1993). Dr Underwager believes that parts of this interview could be misinterpreted to mean that on occasion he might be supportive of pedophilia when he definitely is not. Given that possibility of misinterpretation, he believes it is in the best interest of the False Memory Syndrome Foundation if he step aside [sic] from the Scientific and Professional Advisory Board…”

Wakefield, however, does not appear to be concerned about her decision to participate in the interview or about whether her printed remarks might be misinterpreted as well. Last month, Freyd told Moving Forward that Wakefield had not resigned her advisory board position. When asked if the organisation planned to take action against her, Freyd said ‘not at this time’ (pg 3).”

Lana R, Lawrence, 1993

“In contrast to repressed memories, dissociated ones are isolated into discrete periods of time lost from consciousness. The material kept out of consciousness in dissociation is usually intact rather than transformed, as in repression. What is kept out of awareness may be some traumatic episode. When the material is re-accessed, it bursts into consciousness with associated affect. By contrast repressed information is usually disguised in the form of condensed images or memories. Impulses are transformed into opposites, as in reaction formation, and so even when memory accesses material, this is only the beginning of the unravelling of its meaning… Typically, repression may occur as a response to a variety of chronic life stresses or as a reaction to warded off unconscious fears and wishes, rather than traumatic life events; extreme forms of dissociative amnesia occur in the aftermath of some kind of physical or sexual trauma (pg 747).”

David Spiegel, E.J. Frischholz, J. Spira, 1993
“We as psychiatrists must commit ourselves to the treatment of our patients based on rational, sound and scientific approaches. I am most concerned about the involvement of psychiatrists overseas, and increasingly within Australia, in the promotion of MPD and SRA and their treatments by techniques which only serve to perpetuate and amplify symptomatology and dysfunction. Perhaps it is time for our College to take a position on these issues. The extent to which bizarre beliefs can be legitimised by “professional” involvement has been illustrated over recent weeks in the pages of the Medical Observer, which reported that Dr John Mack, Professor of Psychiatry at the Cambridge Hospital, Harvard Medical School, has set up a treatment service for those who have reported being abducted by aliens. Their symptoms include phobias, unusual nightmares, disturbing perceptual phenomena and a variety of somatic problems. He uses hypnosis to access unremembered abduction experiences, and states that patients feel terror, rage and intense grief as a result of their memories. In his opinion, this validated the veracity of the emerging memories! Dr Mack has established support groups to assist abductees, branches of which are now operating in Australia. Need any more be said! I would value the comments of my colleagues (pg 708).”

Jerome Gelb, 1993

“False memory as the explanation for alleged abuse is an age-old theme: the accuser’s perception is faulty, her motives are impure or she is inherently (perhaps biologically) unreliable by virtue of a pathological tendency toward hysteria, suggestibility and autosuggestibility. The implication is that these people need to come to their senses and abandon their strange phantoms (pg 32),”

David Calof, 1994

“Ironically, some World War 1 era psychiatrists had observed that traumatised (‘battle fatigued’) soldiers developed dissociative symptoms (including amnesia and fugue states) similar to female hysterics. However, they only found it an interesting irony. While it was apparent to them the men’s symptoms had a traumatic etiology, they related the women’s symptoms to character, moral, or biological issues (pg 33).”

David Calof, 1994

“Child abuse is a minefield. Gary Ramona, who lost his $US 250,000-a-year ($A 350,000) job with a Californian winery, is suing his daughter’s psychotherapist, accusing her of implanting false memories of childhood sexual abuse. Inconsistencies have begun to emerge in the testimony of the daughter, 23-year-old Holly Ramona. And the evidence of her 22-year-old sister Kelli, that she believed Holly, was thrown out as hearsay…

Like most parents accused of incest, the Freyd’s claim that theirs was a happy, almost idyllic, family until it was wrecked by therapist-induced fantasies.

But in a lecture last August, at a hospital conference on false memory at Ann Arbor, Michigan, Jennifer ‘outed’ herself and her parents.

When he was nine, Peter had a sexual relationship with a male artist. ‘He was a pedophile; I was a kept boy,’ Peter had admitted. ‘I never repressed a thing. What happened is certainly abusive.’ By the early 80’s Peter had been admitted to hospital for treatment for chronic alcoholism.
‘For many years our family life was dominated by the dynamics of my father’s drinking,’ Jennifer says. ‘My father was an active alcoholic during most, if not all, of my childhood and that alcoholism was denied until after I was no longer in my parent’s house.’ Whether or not one believes Jennifer’s allegations, the picture that emerged of the Freyd’s home life from her lecture was one in which sexual boundaries were constantly blurred. When she was 11, Jennifer appeared in a play directed by her father, who taught her ‘how to kiss like a grown-up.’ He sat around the living room in a dressing gown with his genitals exposed, a habit which her mother described as ‘annoying.’

She cited visiting her father as a young adult, after giving him a present of a pin mould, a gadget that makes replicas of anything you rest on it, such as a hand, Peter Freyd showed his daughter how he made a replica of his penis and testicles (pg 13),”

Linda Grant, 1994

“There is reason to be concerned that some clinicians with less than optimal competence and/or sensitivity to appropriate cautions and potential risks may have led patients to believe that events that did not occur actually have transpired… There is equal reason to be concerned that some clinicians with less than optimal competence and/or sensitivity to appropriate cautions and potential risks may have led patients to believe that events that did occur actually have not transpired (pg 79).”

Richard Kluft, 1994

“I am considered an authority on the malleability of memory. I’ve testified in hundreds of court cases where a person’s fate depended on whether the jury believed the eyewitness’s sworn testimony and pointing finger of blame: ‘He’s the one.’ ‘I saw him.’ ‘He did it.’ I take the witness stand and speak my academic truths, cautioning the court that our memories are flexible and superimposable, a panoramic blackboard with an endless supply of chalk and erasers (pg 3).”

Elizabeth Loftus & Katherine Ketcham, 1994

“In seventeenth century Salem visions of witches in every shadow were in vogue; in the 1950’s, a Communist in every closet was all the rage; currently, allegations of sexual harassment are in style. In some social environments and in some workplaces a woman without her own story of sexual harassment is covertly pitied as unhappily repulsive; in denial, male co-workers, especially supervisors, become likely targets of false accusations. Equally popular in many circles are ‘recovered memories’ by troubled adults of fantasised childhood abuse by family and friends, and the ‘release’ of repressed ‘memories’ of more recent (imagined?) sexual attacks by advisers, therapists, supervisors, colleagues and ex-lovers (pg 68).”

Christine Masserman, 1994 (see Masserman, 1994)

“To give her every benefit of the doubt, Ms. Noël, having been relieved of a severe panic-depressive state, may have felt a surge of affection for her elderly, long-term therapist in the role of father – surrogate and, in a virtual fantasy, identified him with her own father, who she claimed had made what she interpreted as erotic advances during her childhood and adolescence. She herself later described this hallucinatory state to her examiners as one in which she was unable to distinguish between ‘dream and reality.’ However, she then rejected the admission as revealing her own guilty incestuous wishes and reverted, as she had during her therapy, to blaming her father as defensively as possible – e.g.,
witness Ms Watterson’s book, Ms Noël’s pursuit of TV shows, and the search for ever more public approbation (pg 82).”

Jules Masserman, 1994

“The options for those taking sides in this debate are quite unambiguous: the mind either has the ability to repress vast numbers of events, as described by recovered memory therapists, or it does not. The satanic cults, which have been reported by a substantial percentage of recovered memory patients and their therapists, either exist or have been created in therapy…. The therapy setting and the special techniques used either access life histories previously unknown to the patients, or these procedures create pseudomemories. Because of the clear nature of these positions, this professional debate is not likely to be settled amicably, or on some mutually agreed upon middle ground (pg 26).”

Richard Ofshe & Ethan Watters, 1994

“MPD proponents will sometimes go to extremes to discredit beliefs, memories, and experiences that are incompatible with the diagnosis, and replace them with those that are. Does the patient deny having been abused as a child? The proponent can say that MPD patients often attempt to hide their abuse histories. Does the patient fail to show evidence for other personalities? The proponent can say that patient has ‘secret MPD’ in which the other personalities do not emerge unless the host is alone. Does the patient deny having MPD? No problem – people can have MPD and not even be aware of it themselves. Does the patient fail to show any sign whatsoever of MPD? Not a problem either, because the essential core of the disorder is the presence of a mental structure – an ‘entity’ – which, curiously, remains obstinately invisible to all but those therapists who have the special ability to discern it (pg 9).”

August Piper, 1994

“One day I saw Eileen Lipsker entirely, completely happy. In February 1992, she and Elaine Tipton came to the Fairmont Hotel ballroom in San Francisco to explain the process of her memory return and her testimony at the trial [of her father George Franklin] to the American College of Psychiatrists. Afterward, the psychiatrists, including some of the most distinguished members of the profession in this country, crowded around Eileen. They believed her, they told her. They admired her. They felt intense compassion for her ideal (pg 60).”

Lenore Terr, 1994

“As a young Lutheran pastor, R.U. started a Lutheran parochial school in the Los Angeles area in the fall of 1952. He noticed a seven-year-old girl, quiet and shy, a slim, tall child with light brown hair. Some days she was not too clean and looked a bit shabby. R.U. took care of the playground to give a break to the teacher and, gradually, Denise began to spend time interacting with him. During morning recess on a day early in January, she said, ‘My daddy screws me.’ At that time there was no child protection system. The police were not interested.

“That afternoon he took Denise to her home, pointed his finger at the father and said, ‘You are the man!’ Nathan’s words to King David confronting him with his adultery with Bathsheba….The father was confronted by the elders in meetings and R.U. spent time advising the mother and father on their life, marriage, sexuality, and parenting (pg 1-2).”

Hollida Wakefield & Ralph Underwager, 1994
“Typically a client believes that these symptoms ‘happen to me’ and does not feel any sense of connection to them. Technically, this detachment is termed ‘dissociation’ and it is an understandable phenomena. No one consciously or deliberately chooses to be obese, to have rotten self-esteem. Similarly, no one consciously or deliberately chooses to be a survivor of sexual abuse. No one, on the surface, wants that for themselves. But in the same way that some people can build their lives around a pathological pattern (like binge eating or purging, or chronic depression) that hurts them and affects all of the things they do — career, relationships – an individual can build a life around being a survivor (pg 148).”

Michael Yapko, 1994

"Finally, Dr. Ofshe characterizes plaintiff's memories as a progress toward ritual, satanic cult images, which he states fits a pattern he has observed of false memories.

It appears to the court, however, that in this regard, he is engaging in the same exercise for which he criticizes therapists dealing with repressed memory. Just as he accuses them of resolving at the outset defining repressed memories of abuse and the constructing them, he has resolved at the outset to find a macabre scheme of memories progressing toward satanic cult ritual and then creates them."

Judge Dennis Yule, (Crook v. Murphy) 1994

“In sum, the literature on memory suggestibility offers little support for the story that is being circulated, the story that patients develop false memories of abuse as a direct result of therapists’ dredging, implanting, and creating. The story holds a great deal more complexity… There is no research that indicates that most mental health professionals working with adults who assert child sexual abuse do treatment that is suggestive and almost exclusively focussed on memory retrieval, with little attention to other therapeutic aims (pg 14).”

Judith L. Alpert, 1995

“For six weeks, a West Australian jury listened intently to such stories, trying to decide if they were true. The jury members heard two sisters… now aged 34 and 29, recount in horrific detail what they claimed were long-dormant memories of abuse by their father and other family members – memories of satanic abuse involving sodomy at age two, numerous incidents of either rape or torture through childhood and adulthood, and two forced abortions. Memories allegedly repressed for up to 30 years and then recovered through therapy (pg 62).”

Bettina Arndt, 1995

“Middleton and Butler appear not even to understand the issues that are of concern to the False Memory Syndrome Foundation – namely the request for scientific evidence for the claims about memory repression made by some clinicians, and for the use of techniques that carry the risk of high suggestibility such as hypnosis or sodium amytal… The FMS Foundation has never questioned the existence of the problem of child abuse. Child abuse is one problem and false memories acquired in highly suggestive situations is another. They are both problems that need to be solved but the kind of misleading information and mean-spirited personal attack by Middleton and Butler only add to the confusion – not to the solution.
In the United States, resolution to the problem is coming through the legal system. In the past few months, three important legal decisions have been made in cases in which the scientific acceptance of ‘repressed memories’ was the issue. In all three cases the decision rendered said there was no scientific evidence for repressed memories. In addition, former patients have begun to sue therapists for malpractice based on false memories. This month a former patient in Minneapolis was awarded $2.5 million by a jury.

Pamela Freyd, Executive Director FMS Foundation, Philadelphia, 1995

“The impact of ‘The Courage to Heal’ has been immense. It has been used in both civil and criminal court cases in America and in Australia. It was a catalyst for the formation in America and later in Australia and other Western countries of the False Memory movement.

On the other side, it has been extremely influential in the growth of incest support groups, in Victoria alone there are now over 60 such groups. Several months ago, in response to what they saw as the ‘aggressive media activism’ by the Australian False Memory Association, a group of child sex abuse victims in Sydney formed Advocates for Survivors of Child Abuse.

ASCA claims more that 300 members in Australia, while the False Memory Association claims a membership of about 100.

Both groups say they receive a constant flow of calls asking for help and advice. And lined up to support each group are psychologists, psychiatrists and lawyers. At issue is this question: can people repress, for decades, memories of horrific things that happened to themselves when they were children only to recall them either spontaneously, or more frequently, during counselling for other psychological problems.

The stories from both sides of this increasing fraught question are extremely harrowing.”

Michael Gawenda & Victoria Curvich, 1995

“We are ‘in it’ so to speak, deep. If you don’t believe me, check recent adjudications, not to mention multi-million dollar settlements, against therapists. The trouble we need to address, which is how to serve not only our own interests but also those of our clients, does not stem solely from the efforts of our major detractors in the false memory syndrome movement; it has been lurking in our field from the beginning. There is an urgent need for therapists to become sophisticated enough to provide treatment without presupposing that clients’ reports or ‘memories’ are in accordance with fact, and without assuming that only one/or even several/interpretation(s) can explain even the most suggestive symptoms or dreams.”

Nancy L. Horstein (President of the ISSD), 1995

“For the record, aside from seeing patients with severe childhood traumas, we have seen ex-combat veterans or those traumatised by disasters, armed robbers, etc. We have had clinical involvement with perpetrators of child abuse and the ex-spouses of perpetrators. We have seen some patients whose history of childhood trauma was unlikely to be accurate and have seen patients accused by a son/daughter of things they almost certainly did not do. One is impressed by the many similarities shared by these seemingly disparate groups, the need for care in not going beyond the data and in the exercising of appropriate boundaries (that include how memories are handled). It does not surprise us
that at times therapists get into serious trouble any more than it surprises us that at times extraordinary abuse can be perpetrated for decades without anyone intervening (pg 356)."

Warwick Middleton & Jeremy Butler, 1995

“The memories of Satanic ritual abuse survivors, if they are even partially real, pose a major challenge to our usual beliefs about human history and the cultural evolution of our race. I have met dozens of people who claim to have participated in ritual cannibalism, drinking of human blood, and human and animal sacrifice, and who believe themselves to be demon-possessed (pg 14)."

Colin A. Ross, 1995

“One would predict that severe childhood trauma would have a profound impact on memory. One would anticipate that severe psychosocial trauma would result in deletions, inversions, insertions, misreading, activations, and deactivations of memory, just as biological trauma does to the structure and processing of DNA. Disorders of memory are very common in survivors, and I would venture to say universal, once a certain threshold of severity and duration is exceeded. These disorders of memory should be viewed as an inevitable consequence of the trauma, and no more a reflection on the person’s character than is DNA pathology caused by biological trauma (pg 107).”

Colin A. Ross, 1995

"There has been much in the media that has led the press to say, 'If you print one view, you have to print the other. If you report a memory, you have to say it might be false, treating it as 50-50 chance,' but with none of the usual investigation. So I thought I would share with you a third force. It is neither the child nor the parent, the accuser not the accused, that is in question here, but the kind of third force that tangible investigation can bring forth.

I want to share a letter. The writer is the brother of the man who cofounded the False Memory Syndrome Foundation. He is writing to WGBH about a program called 'Divided Memories', which you may have seen, that was supposed to be an investigation of memory. This letter also went to Congress and to the press, so it's a public letter. It's just unfortunate that the press, as far as I know, didn't pick it up.

'Gentlemen: Peter Freyd is my brother. Pamela Freyd is both my stepsister and sister-in-law. Jennifer and Gwendolyn [their daughters] are my nieces.

There is no doubt in my mind that there was severe abuse in the home of Peter and Pam, while they were raising their daughters. Peter said (on your show, 'Divided Memories') that his humor was ribald. Those of us who had to endure it, remember it as abusive at best and viciously sadistic at worst.

The False Memory Syndrome Foundation is a fraud designed to deny a reality that Peter and Pam have spent most of their lives trying to escape. There is no such thing as a False Memory Syndrome. It is not, by any normal standard, a Foundation. Neither Pam nor Peter have any significant mental health expertise.

That the False Memory Syndrome Foundation has been able to excite so much media attention has been a great surprise to those of us who would like to admire and respect the objectivity and motives of people in the media. Neither Peter's mother (who was also mine), nor his daughters, nor I have wanted
anything to do with Peter and Pam for periods of time ranging up to more than two decades. We do not understand why you would 'buy' such an obviously flawed story. But buy it you did, based on the severely biased presentation you made of the memory issue that Peter and Pam created to deny their own difficult reality.

For the most part you presented very credible parents and frequently quite incredibly bizarre and exotic alleged victims and therapists. Balance and objectivity would call for the presentation of more credible alleged victims and more bizarre parents. While you did present some highly regarded therapists as commentators, most of the therapists you presented as providers of therapy were clearly not in the mainstream. While this selection of examples may make for much more interesting television, it certainly does not make for more objectivity and fairness.

I would advance the idea that 'Divided Memories' hurt victims, helped abusers and confused the public. I wonder why you thought these results would be in the public interest that Public broadcasting is funded to support.'

The letter is signed, William Freyd. Now please understand that, above all else, this is not about blaming, because if this letter is true, it means that this situation is probably a continuation of victimization and abuse that started in the past. But I hope that you will consider - as you do the work that is so important in depth and in understanding the possibilities - that you will also look at the reportorial investigative actualities, at the external facts, and try to take it all into account so that we can begin to stem this terrible underground river that is poisoning so much of our culture (pg 10-11)."

Gloria Steinem, 1995

“For all of us memory is a labyrinth that takes different turnings each time we come back to it. Moreover, whenever we return to our memory labyrinth we emerge with a slightly different view of what is actually there. Its treasures are inexhaustible and we can never find the same treasure twice, because we ourselves change constantly, as do our purposes in searching for memories (pg 1).”

Marea C. Teski & Jacob J. Climo, 1995

“As individual therapists continue to struggle against the activities of the FMS movement, the therapeutic community is slowly beginning to organise their resources. Is it too late? Will therapists be able to protect the mental health profession? Observers like Sherry Quick and Eric Marine certainly feel the outcome is uncertain. According to Marine, ‘These types of cases were basically nonexistent 1½ years ago. We’re dealing with a backlash in our society.’ Judith Peterson, PhD, a Texas therapist known for her work on the psychology of trauma and childhood sexual abuse, had never received a complaint, lawsuit or legal action in her twenty-six years of professional practice until 2½ years ago – the same time the FMSF was founded. Peterson reports, ‘Since then, I have been the victim of 12 lawsuits by ‘recanters’ and eight board complaints. Of the five board complaints resolved to date, I have not been found guilty of unethical or below standard practice (pg 13).”

Eva Doehr, 1995

"Some of us think that undue leniency, not undue attention, has been a more serious problem when it comes to sexist or racist judges. But even more serious are the structures, the procedures, even the very content of the law itself.
Take, for example, the remarkable case of Dr. Leo Pilo. In November, 1993, a complaint of sexual abuse of a patient was laid against Dr. Pilo at the Ontario College of Physicians and Surgeons. The former patient, now a woman of 38 - we'll call her D.M.M., as the court documents do - said that Dr. Pilo had sexually abused her for many years, between the ages of 9 and 19.

Dr. Pilo flatly denied the allegations. But his name was published in the news reports, and lo, four more women came forward, separately, to swear they had suffered the same types of abuse by Dr. Pilo.

Dr. Pilo changed his mind. In January ’94, he pleaded guilty to all charges, admitting that both D.M.M.’s evidence and the allegations of the other four were true. His medical license was permanently revoked.

D.M.M., who suffered debilitating emotional and physical problems in adolescence and adulthood, was told by the College that there was no money left in its fund for victims of abuse. So she sued Dr. Pilo in civil court.

The court case began in September ’95. And this time, Dr. Pilo denied the sexual assault - despite his previous admission to the College that he 'had engaged in manipulation of the clitoris and nipples' of his child and pubescent patients, 'watched while they undressed, made comments of a sexual nature, used a vibrator inside the vagina, stroked, hugged and kissed the patients, masturbated himself to orgasm,' according to the College's Discipline Committee. (And all that is a polite understatement.)

Polite Understatement

So why does Dr. Pilo now reverse his plea? Perhaps because he suffers from False Innocence Syndrome, a notorious condition (just invented by me) that afflicts guilty perpetrators of child sexual abuse.

To back his case, Dr. Pilo presented 'expert evidence' from several doctors, including Dr. Harold Merskey of London, Ont., a scientific advisory board member of the False Memory Syndrome Foundation.

Not surprisingly, Dr. Merskey opined that D.M.M. 'very likely' suffers from False Memory Syndrome. He had not, however, examined her. And I don't know if he had asked Dr. Pilo any very pointed questions either.

What is most astounding about this case is that although everyone in the courtroom presumably knew about Dr. Pilo's published confession, and though many other victims of his abuse had come forward with strikingly similar details of his sickening sexual molestations, none of this was allowed into court evidence.

The doctors, you see, enjoy the snug protective shelter of a new clause in the Regulated Health Professions Act, proclaimed on Dec. 31, 1993. The regulation states that 'no report, document, statement, order or decision, made in a proceeding at the college is admissible in a civil suit."

Judge Douglas Lissaman all but apologized to D.M.M.’s lawyer, Mark Edwards, for this incredible state of affairs. 'In some ways it is almost offensive to think that Mr. Edwards should not...be able to cross-examine the doctor if he gives evidence contrary to his position before the college,' the judge said in a ruling. 'But...I am sorry...I see no way around section 36(3).
The case is still undecided (pg K1)."

Michelle Landsberg, 1995

“Interestingly, the controversy recapitulates on a vast scale a crisis confronted almost a century ago by Sigmund Freud, in the solitary confines of his own clinical practice. And the emerging consensus, led by experimental psychology, confirms Freud’s much maligned (and often misrepresented) conclusions: unconscious memories can be recovered; unfortunately, some of the recollections are false, even if some of them are true, and even recollections tending to be true are typically garbled and overlaid by distortions (pg xiii).”

Matthew H. Erdelyi, 1996

“In my own case I lost the ability to choose privacy. Approximately eight months after I first presented betrayal trauma theory, my parents, in conjunction with Ralph Underwager and others, formed the False Memory Syndrome Foundation (FMSF). Before the organisation was formed, my mother, Pamela Freyd, had published an article presenting her version of family history under the name ‘Jane Doe’ (Doe 1991). The Jane Doe article, when circulated to my professional colleagues and to the media by my mother, made public allegations about my professional and personal life, at the same time that it helped spawn the false memory movement…

I was… uncomfortable with the way a distorted version of my story was being used by the FMSF and the media to create the impression that most adult women who recover memories of childhood abuse are deluded, unstable, or under the undue influence of others. In August 1993, two years after my mother’s Jane Doe article and a year and a half after the formation of the FMSF, I broke my public silence and, at a mental health continuing education conference in Ann Arbor, Michigan, presented my perspective on my family of origin and the formation of the FMSF…

Yet hardly a day goes by that my work is not interrupted by challenges to my integrity or attempts to derail my work. Sometimes these challenges are quite intrusive. Other times they are obtrusive; in 1994 an FMSF member picketed the front of the building in which I work.

This pattern of diverting attention from the message to the messenger has shown up in the academic and scholarly world at large… It emerges, too, when children and adult victims of sexual abuse who dare to attempt to communicate their experiences suffer attacks on their credibility. We see it in the current societal debate about recovered memories. This pattern is so pervasive and central that it ultimately demands explanation by the very theories that attempt to account for the psychological response to sexual abuse. If people who dare to speak about sexual abuse are attacked by those whom they have relied on and trusted, is it any wonder that unawareness and silence are so common (pg 198-199)?”

Jennifer Freyd, 1996

“The False Memory Syndrome – a condition in which a person’s identity and interpersonal relationships are centred around a memory of traumatic experience which is objectively false but in which the person strongly believes. Note that the syndrome is not characterised by false memories as such. We all have memories that are inaccurate. Rather, the syndrome may be diagnosed when the memory is so deeply engrained that it orients the individual’s entire personality and lifestyle, in turn
disrupting all sorts of other adaptive behaviours. The analogy to personality disorder is intentional. False Memory Syndrome is especially destructive because the person assiduously avoids confrontation with any evidence that might challenge the memory. Thus it takes on a life of its own encapsulated, and resistant to correction. The person may become so focused on the memory that he or she may be effectively distracted from coping with the real problems in his or her life.”

John Kihlstrom, 1996

“Sexual assault is a strange psychic hurricane in which the victims must, despite the evidence of uprooted trees and roofless houses, argue to the disbelieving that something happened (pg 34).”

Anna Salter, 1995

“Two social movements have taken center stage on this issue. One (hereafter referred to as the incest recovery movement, a somewhat loosely organised social phenomenon that has no central organising group or official leadership) was founded by adults who describe themselves as survivors of childhood sexual abuse; the other (hereafter referred to as the false memory movement, best represented by the False Memory Syndrome Foundation, which coined the concept of false memory syndrome and has taken active leadership on this issue) was founded by adults who describe themselves as having been falsely accused of committing such abuse. These social movements uncovered and crystallised controversies within the mental health field regarding the nature and effects of child sexual abuse, as well as the scientific basis and standards of care for clinical and forensic practice (pg 3).”

Kenneth S. Pope & Laura S. Brown, 1996

“This controversy is often thought of as a winner-take-all battle royal between advocates of recovered memories and proponents of false memories. I believe that we need to step back from the rhetoric, and recognise that this is an unfortunate oversimplification of an issue with many intermingled parts that need to be disentangled. Although it is likely that some therapists have helped to create illusory memories of abuse, it also seems clear that some recovered memories are accurate (pg 10-11).”

Daniel L. Schacter, 1996

“I don’t care if it’s true,’ asserted Ann’s therapist, Douglas Sawin. ‘What’s important to me is that I hear the child’s truth, the patient’s truth. That’s what’s important. What actually happened is irrelevant to me.’ Asked about the possibility that a client’s report is a delusion, Sawin did not flinch: ‘We all live in a delusion, just more or less delusionary’ (pg 263).”

Daniel L. Schacter, 1996

“A total of 25 studies on amnesia for child sexual abuse (CSA) now exist, all of which demonstrate amnesia in a subpopulation; no study failed to find it, including recent studies with design improvements such as random sampling and prospective designs that address weaknesses in earlier studies. A reasonable conclusion is that amnesia for CSA is a robust finding across studies using very different samples and methods of assessment. Studies addressing the accuracy of memories show that recovered memories are no more or less accurate than continuous memories for abuse (pg 143).”

A.W. Scheflin & D. Brown, 1996
"In December 1995, two women filed ethics complaints with the American Psychological Association (APA) against Elizabeth Loftus, PhD, regarding her published statements about two legal cases involving delayed memories of sexual abuse. Citing procedural considerations, however, the APA has declined to investigate the women's complaints.

Jennifer Hoult (a concert harpist living in New York) and Lynn Crook (a Washington State consultant) each filed separate complaints with the APA, alleging that Loftus mischaracterized the facts of their legal cases in published articles. Both women brought successful civil suits because of the sexual abuse that the fathers (and the mother, in Crook's case) perpetrated against them during their childhoods. At their trials, they presented corroborative evidence that met the requirements for judicial proof of their allegations.

Loftus serves on the Scientific and Professional Advisory Board of the False Memory Syndrome Foundation, Inc (FMSF). She also had been an active member of the APA since 1973, but she resigned in January 1996, shortly after the filing of the complaints. In a brief telephone interview with 'Treating Abuse Today'. Loftus confirmed her resignation from the APA, but she denied any knowledge of the ethics complaints. She also cautioned that 'Treating Abuse Today' should not state or imply that she resigned from the APA to avoid investigation of the ethics complaints.

When the ethic complaints were filed against Loftus, Jeffrey N. Younggren, PhD chaired the APA Ethics Committee. During his tenure in this position, Younggren appeared as an expert witness in many trials involving so-called 'false memory syndrome,' generally as a witness for accused perpetrators or against therapists accused of implanting 'false memories'. At the time Hoult and Crook filed their complaints, Younggren and Loftus were both working as expert witnesses on the same side of the same case. When asked about this coincidence, however, Loftus stated that she had no knowledge of the fact, because she worked on many cases simultaneously and didn't always know which expert witnesses were scheduled to testify in any particular case...

Both Hoult and Crook have contested the APA's decision. In a strongly worded letter of objection to Schroeder, Crook argued that APA policy clearly bars the resignation of a member under the scrutiny of the Committee. She asked that the APA immediately rescind Loftus's resignation and proceed with investigation of her complaint. Hoult asked for the same actions, as well as asking the Ethics Office to send her the procedures for filing an ethics complaint against the Ethics Committee (pg 71-72)."

"Confounding all this activity is the fact all psychotherapy, by encouraging self-directed attention, involves voluntary or involuntary recovery of memory. The distinction among repression, suppression, avoidance, and simple forgetting or redirection of attention is often hard to establish. Thus, many of the problems, fears, and recommendations about recovered memory overlap problematically with issues about psychotherapy itself. Hence any risk management guidelines for proper conduct should be constructed to leave appropriately conducted psychotherapy intact (pg 1404)."


"Our data also suggest that delayed recall of childhood trauma is often a process that unfolds over time rather than a single event, and that it occurs most commonly in the context of a life crisis or developmental milestone, with a trauma-specific reminder serving as the proximate cue to new recall. Psychotherapy was not implicated in the early stages of delayed recall in most cases. However, the
retrieval of traumatic memories, once begun, proved to be a powerful incentive for entering psychotherapy. Patients rarely sought treatment with a goal of recovering more memories; rather, they wished to gain more control over intrusive, involuntary reliving experiences and to make sense of the fragmented, confusing and disturbing, recollections they already had.

These data remind us that remembering autobiographical material is normally an active process, characterised by shifting emphases, changing interpretations, and repeated evaluation of the meaning of particular events in relation to an ongoing life narrative (pg 567).

J.L. Herman & M.R. Harvey, 1997

“Alongside reports of recovered memories of sexual abuse there have been growing numbers of cases of multiple personality disorder (also known as dissociative identity disorder). There seems to be little doubt that many of these cases are iatrogenically determined. Any spontaneous presentation of multiple personality disorder should be sympathetically considered but should not be made subject of undue attention nor should the patient be encouraged to develop ‘alter personalities’ in which to invest aspects of their personality, their fantasies or their current life problems. Psychiatrists should be particularly aware of the unreliability of the memories reported in these cases and of the close association both with prolonged therapy and with recovered memories of sexual abuse, particularly alleged satanic abuse. Since there is not [a] settled view of the validity of multiple personality disorder, and because of the very strong correlation with recovered memories of sexual abuse which is itself a disputed concept, there is a strong case for a consensus paper on multiple personality disorder based upon a substantial review of the literature (pg 665).

Royal College of Psychiatrists’ Working Group on Reported Recovered Memories of Child Sexual Abuse, 1997

“Many dissociative and posttraumatic symptoms respond well to therapies facilitated by hypnosis. Hypnosis is often a most useful modality with which to facilitate their restructuring and resolution. It would be a shame to throw the baby out with the bathwater by unduly restricting the use of hypnosis in traumatised populations (pg 42).

Richard Kluft, 1997

“Unfortunately, the controversy over repressed or false memories has been characterised by harsh rhetoric and outlandish claims on both sides of the debate. The antitherapy rhetoric in the ‘repressed memory war’ has often been unjustified and needlessly offensive. The attack on psychotherapy may have had a chilling effect on competent and conscientious professionals who want to provide legitimate services to survivors of childhood abuse (pg 131).

Samuel J. Knapp & Leon Van de Creek, 1997

"Although these sources of evidence do not conclusively demonstrate that Cheit himself was the victim of abuse, their implication of Farmer [the alleged perpetrator] as a sexual abuser clearly supports the possibility that he may have abused Cheit as well...It should be noted that the reporter who investigated this case was a friend of Cheit’s. While such an affiliation need not invalidate the evidence provided, it is possible that the evidence was not collected in a completely unbiased manner (pg 261)."

J.W. Schooler, M. Bendiksen & Z. Ambadar, 1997
George Franklin, the first person convicted of murder on the basis of repressed-memory testimony, is now suing his daughter, her therapists and San Mateo County law enforcement officers. The suit accuses the defendants of conspiring to manufacture evidence and present false testimony to support Franklin's adult daughter's claim. In 1989 Eileen Franklin said she suddenly recalled a repressed childhood memory of her father raping and murdering her playmate, 8-year-old Susan Nason of Foster City, 20 years earlier. Franklin spent $6^{1/2}$ years in prison before a judge overturned the conviction in 1995. He was released in July 1996.

A key defendant is University of California repressed-memory theorist Lenore Terr, whose testimony at the 1990 trial put her in the national spotlight. Psychologist Terr, author of ‘Unchained Memories,’ a book which was written about the case, is accused of conspiring with Deputy District Attorney Elaine Tipton to present false testimony about the accuracy of recovered memory, ‘without any basis in social science research,’ Franklin’s attorney, Dennis Riordan said.”

Daniel Vasquez, 1997

“The majority of contributors to this issue of Health Care Analysis discuss the notion of ‘recovered memory’ and the implications for therapists and patients of using it. There is little consensus between the discussants – Goodyear-Smith, Laidlaw and Large doubt that ‘traumatic childhood memories’ can be repressed. Bryant thinks the most pertinent question is not whether memory can be repressed but how ‘traumatic memories’ are encoded, Gavey accuses Goodyear-Smith et al. of ‘ideological motivation’ while Middleton and Butler report widespread ‘child sexual abuse’ and consequent amnesia.

Despite the range of opinions, it is pleasing to find so many academics and practitioners prepared to reflect publicly on this important issue. Sadly though, not all those whom the journal approached were so open-minded. We received various communications from senior professionals that may at best be described as not constructive, and at worst as downright belligerent. Here is a sample.…. ‘Please do not publish such drivel (a reference to the - Goodyear-Smith paper). Your request puts me in an awkward position. I am way behind getting my empirical research out, and yet, articles like the ones (sic) you may publish contain such dangerous misinformation that I am in a bind about whether to once again stop more urgent publications in order to again point out all the studies on actual traumatised people (rather than laboratory subjects), in which this phenomenon has over and over again been documented’ (from a Professor of Psychiatry) (pg 93),”

David Seedhouse, 1997

"The attempt to explain everything by one single mechanism is a good sign of the quack. In this regard, the women's movement has grossly over-emphasised the importance of sexual abuse with respect to mental illness. This is not to say that it is not important, but only that it has been greatly inflated beyond its true serious importance. In this respect, some caregivers are responsible for confusing the issues and their intemperate campaigning makes things far worse for the real victims. Because of the occurrence of recovered memories, because of the over-emphasis on minor degrees of sexual abuse, as if they were the same as major ones, because of widespread and over-reaching claims which put everything into one causal basket, it is probably harder now for genuine victims to be believed than they were before. The shame and disgrace of the inadequate treatment of victims today rests substantially with those who claim to be defending them (pg134-135)."
Some critics would contend that virtually every therapist who diagnoses MPD proceeds immediately to implant pseudomemories of SRA. In fact, few MPD patients make SRA allegations. For example, Coons (1994b) found that only 8.5% of his MPD patients made SRA allegations. We found that only 4% of dissociative patients in an outpatient treatment sample reported such experiences (Sariganian and Putnam, 1997). Indeed, even the British False Memory Society’s own survey found allegations of SRA were rare (Andrews, 1997) (pg 124).”

Frank W. Putnam, 1997

“The extreme false memory position” is best reflected in the writings of Elizabeth Loftus. Based on two decades of laboratory research on eyewitness suggestibility (the misinformation effect), Loftus has attempted to demonstrate that misleading post-event information can significantly transform the original memory for an event. She has interpreted these research findings to mean that memories for non-existent events can be ‘implanted’ or ‘erected’ and that individuals can be made to accept and believe with a high degree of confidence false memories for events that never happened. Whilst no research data on false memory creation in psychotherapy per se yet exist, Loftus has readily generalised her findings from eyewitness studies to psychotherapy (pg 41).”

Don Brown, A.W. Schefflin & D.C. Hammond, 1998

“For the most part, these participants lost memory for whole periods, recollecting neither traumatic events nor neutral or positive experiences. These descriptions are strikingly similar to Terr’s observation of pervasive amnesia for chronically traumatised children and suggest that the underlying mechanism for this kind of amnesia may not be repression of overwhelming experience or selective inattention to noxious events. Instead, the massive failure to integrate entire periods of childhood strongly suggests that intensely traumatic experiences may result in a different way of processing and storing information, supporting the notion that traumatic memory is different from ordinary memory. This model is consistent with the concept of dissociation, in which various mental contents exist in different states held separately from each other, adding evidence to the notion that traumatic amnesia may result from dissociative phenomena rather than the active psychoanalytic mechanism of repression (pg 69).”

James A Chu, 1998

“A backlash began to develop. As often occurs in situations where human ills cannot be easily solved, childhood abuse survivors were either disbelieved or characterised as being part of a ‘culture of blame.’ Even more devastating, a coalition of parents who had been alienated from their children or who had been sued for allegedly abusing their children joined with sceptical academics in the psychiatric and psychological community to form the False Memory Syndrome Foundation (FMSF). The FMSF has pursued a well-funded and highly publicised agenda to discredit many patients who report childhood abuse and the professionals who treat them; as a result, many professionals have been targets of lawsuits and had their reputations destroyed, and many of those who work with adult survivors of childhood abuse have lived in an atmosphere of fear and defensiveness (pg 2).”

James A Chu, 1998
[Describing an Australian series of 62 patients fulfilling diagnostic criteria for dissociative identity disorder.] “Prevalent were trance-like episodes (98%), derealisation (66%), depersonalisation (71%) and amnesia for extensive parts of childhood (90%). Regarding childhood amnesia, for one patient there were missing data, 4% of patients were unsure and one reported being previously amnestic. The one patient to deny having had amnesia for large parts of childhood had marked amnesia for later periods of life. At least 82% of patients had episodes of psychogenic amnesia, 31% had episodes of sudden unexpected travel and 11% had definite psychogenic fugues. At least 63% of patients reported one or more ‘out of body’ experiences. Forty per cent would, at times, write with either hand and 85% described writing things that could not be otherwise disclosed. Fifty per cent had imaginary companions as children. An even higher percentage (61%) described sleep walking (pg 799).”

Warwick Middleton & Jeremy Butler, 1998

“The events usually unfold as follows. First, a young woman enters therapy for depression or some other complaint. Her therapist encourages her to see her family as dysfunctional, and herself as the victim of ‘emotional incest’. Soon, she reads self-help recovery books and retrieves memories of physical incest by one family member. Then, as her memories flow more easily, she names other perpetrators. Finally, she recalls ritual abuse, is diagnosed with MPD, and often winds up heavily drugged and suicidal in a psychiatric ward (pg 180),”

Mark Pendergrast, 1998

"Attempts to understand how adults could come to report newly emerging memories about having experienced child sex abuse have become all but lost in a bewildering blizzard of conflicting terms and concepts. Such reported memories may be described as the result of repression, dissociation, implanting, motivated forgetting, directed forgetting, amnesia, betrayal trauma, retroactive inhibition, suggestibility, self-induced hypnotic trance states, personality disorder, thought suppression, retrieval inhibition, cognitive gating, biological protective processes, a clinical syndrome, and so on. These terms and concepts may be used without clear definition or scientific basis, and may foster pseudoscientific beliefs (pg 1160)."

Kenneth S. Pope, 1998

“Testimony that some subjects can be mislead or tricked into saying something happened when it did not is virtually useless for finding out whether a specific individual in a specific case was in fact so misled (pg 82),”

Jon Conte, 1999

The spark that galvanised the emergence of the false memory movement was the allegation and denial of sexual abuse within one middle-class professional family. In brief, in late 1990, psychology professor Jennifer Freyd accused her father, Peter Freyd, a mathematics professor, of having sexually abused her and denied her parents access to her children. Peter and his wife Pamela were highly distressed by the allegations, which Peter denied. The couple began to research information on abuse allegations (a search that put them in touch with the evolving professional and lay literature on repressed/recovered memories of abuse in adults and the controversies developing about false accusations of contemporaneous child abuse) and consulted with colleagues and therapists. In 1991, Pamela Freyd, a professional educator, anonymously published ‘How could this Happen? (Freyd 1991) in Issues in Child Abuse Accusations, a journal established by psychologists Ralph Underwager and
Hollida Wakefield, co-founders and active members of Victims of Child Abuse Laws who often testified for the defence in cases involving allegations of child abuse.

In this account of a mother’s confusion, shame, and rage, and her dawning belief that her daughter’s allegation were suggested by her psychotherapist on the basis of erroneous theorising and technique, can be found the initial impetus for and reasoning behind the false memory perspective. The article hit a nerve (pg 24-25).”

Christine Courtois, 1999

“Although the accusations made by their daughter Jennifer were made in private, in 1992 the Freyd’s (with Ralph Underwager and others) organised a public response by establishing and incorporating the False Memory Syndrome Foundation. They solicited and attracted a Scientific and Professional Advisory Board of eminent professionals, who immediately lent credibility and influence to the organisation and its message. On this board sat many cognitive scientists specialising in memory, some of them Jennifer Freyd’s professional colleagues. (Incredibly, the Freyd’s even asked Jennifer to serve as an advisory board member, ostensibly to keep communication open between them. She refused their invitation.).

Jennifer, in contrast to her parents, chose to keep her abuse allegations private. She publicly discussed them only once, at a professional conference in Ann Arbor, Michigan in August 1993, where she told her side of the story. She questioned why, as an established and credible adult as well as a respected scientist specialising in memory, her recollections and allegations should be given less credibility than her father’s denials, especially since he had acknowledged treatment for alcoholism during the year she believes the abuse occurred…. Other family members have spoken out in support of Jennifer’s contentions and charges but the Freyd’s maintain their innocence. The family continues to represent the poles of the controversy, Pamela and Peter in regarding Jennifer’s memories as false, and Jennifer in regarding her parent’s memories and denial as fake (pg 25-26).”

Christine Courtois, 1999

“Considerable controversy has surrounded the strategy of seeking information from collateral sources to substantiate or disconfirm recovered memories of abuse, especially abuse perpetrated by family members who are then accused of abuse (and possibly sued). Several false memory advocates have suggested that therapists have a duty to seek out corroborative information in all cases of recovered memories of abuse (McHugh, 1992) while other commentators have argued against this position (Brown et al., 1998). Still others have commented that seeking corroboration is not a strategy without risk. This was made evident in the Ramona case where attempts at corroboration were made by the defendant’s therapist but the interpretations they applied to the evidence were challenged in the malpractice lawsuit by the alleged victim’s father (Appelbaum & Zolteck-Sick, 1996) (pg 249).”

Christine Courtois, 1999

“Most patients who enter psychotherapy for help in dealing with a traumatic past do so because of what they remember, and not because of what they do not (pg 27).”

Mary R. Harvey, 1999
“There is a certain hypocrisy in the retractor claim that defendant therapists have allegedly implanted false memories. The plaintiff would like the court to believe that s/he was especially vulnerable to suggestive influences in the treatment rendered by the defendants that caused the development of false memories of abuse that never happened and/or a false dissociative disorder diagnosis that s/he never had. Yet in all 30 cases the plaintiff failed to report his or her vulnerability to post-therapeutic suggestive influences that might have been operative in the shaping of the retraction belief itself.

The most striking finding from our analysis was that significant post-therapeutic suggestive influences associated with the development of the retraction belief could be identified in every one of the 30 cases. Given that the medical record failed to document any pattern of allegedly therapeutic suggestive influences causing false abuse memories in the great majority of these cases... [t]he overwhelming conclusion from these data is that most retraction beliefs are not a function of the person correcting a previously distorted or mistaken recollection of personal history, but rather are the result of a complex pattern of systematic post-therapeutic suggestive influences (pg 687).”

A.W. Scheflin & D. Brown, 1999

“(I)nfluence by other patients and disaffected patients also played a significant role in the development of retraction beliefs in 20% of these cases. Mary Shanley’s deposition testimony… revealed that she had developed contact with other high-profile retractors who had also sued their therapists – Lynn Carl, Lucy Abney, Patricia Burgus and Laura Paisley. According to testimony, one of these retractors helped her prepare the ‘chronology’ of her treatment history for the law firm representing her (pg 689-690).”

A.W. Scheflin & D. Brown, 1999

“‘Cognito ergo sum.’ – ‘I think therefore I am.’ This phrase, written by the great French philosopher Descartes in 1637, still stands as perhaps the most widely quoted pronouncement in all of Western philosophy. One of the great biological lessons of the twentieth century… is that the statement is wrong and that it is wrong for two reasons. First, Descartes used this phrase to emphasise the separation he believed to exist between the mind and body. However, biologists now have every reason to believe that all the activities of the mind arise from a specialised part of our body: our brain....

There is, however, a second and larger sense in which Descartes’ original statement is wrong. We are not who we are simply because we think. We are who we are because we can remember what we have thought about…. [E]very thought we have, every word we speak, every action we engage in – indeed, our very sense of self and our sense of connectedness to others- we owe to our memory, to the ability of our brains to record and store our experiences.”

LR Squire & ER Kandel, 1999

“PTSD patients demonstrate a variety of memory problems including deficits in declarative [explicit/conscious] memory… and fragmentation of memories (both autobiographic and trauma related). PTSD is also associated with alterations in nondeclarative memory (i.e., types of memory that cannot be wilfully brought up into conscious, including motor memory such as how to ride a bicycle). These types of nondeclarative memories include conditioned responses and abnormal reliving of traumatic memories following exposure to situationally appropriate cues (pg. 798).”

J. Douglas Bremner, 1999
“When the qualifications of a therapist who had treated Cook became suspect, the young man said he could not trust his memory and withdrew the lawsuit against Bernadin, which should never have been filed. The second defendant, Ellis Harsham, was removed from his position as a chaplain and a settlement eventually negotiated with Cook. The Bernadin case was like a lightning rod. Almost overnight, the scandal of bishops harbouring child molesters was transmogrified into a collective media parable on false memory. The media prism filled with accounts of conflated stories planted in the minds of vulnerable clients by quack therapists; unprovable cases of Satanic conspiracies, a culture of victimimage shorn of rational bearings (pg viii).”

Jason Berry, 2000

“Freud was now faced with a problem. Why did so many female patients present with a complex array of symptoms and false memories of childhood sexual abuse? His answer? Repression. It is when repression theory is correct that the memories are false. Repression is an ego defence against unacceptable id drives which break through as false memories of incest. The false memories are an expression of oedipal desires to have intercourse with the father.

Repression theory, in this sense, is an ego defence against internal drives, wishes and conflicts. It has little or nothing to do with sensory input or external experience. Repression in this sense is an unnecessary postulate for the trauma model.

However, there is the second meaning of repression. Repression is also a defence against traumatic events. Memory, affect and cognition about the event are repressed into the unconscious, where they are inaccessible to conscious recollection. In this meaning, repression is a defence for coping with trauma and the events we assumed to be real. This second meaning of repression is incompatible with the repudiation of the seduction theory (pg 50).”

Colin A Ross, 2000

“There is no way to tell clinically whether a given recovered memory is true or false. The scientific facts cut both ways. Except for impossible memories, such as memory of being decapitated, there is no way to tell on clinical grounds whether a memory is true or false. One cannot conclude that a memory is false anymore than one can conclude it is true. There are no clinical criteria which can make the differentiation in either direction. This is also true of so-called continuously held memories.

Clinical criteria which cannot make the differentiation include: plausibility or implausibility; amount of detail; degree of narrative coherence; subjective conviction or disbelief in therapist or patient of the reality of the memory; similarity or dissimilarity of the memory to eternally confirmed or disconfirmed events; accompanying affect or physiological arousal; consistency or inconsistency from session to session; honesty or dishonesty of the patient; improvement or deterioration of the patient in any time frame; accompanying body language; similarity or dissimilarity to other patient reports; and presence or absence of secondary gain (pg 59).”

Colin A. Ross, 2000

In the winter of 1914/15 strange cases began to arrive at the hospitals and casualty clearing stations of the British Army in France. These soldiers were not wounded, yet they could neither see, smell nor
taste properly. Some were unable to stand up, speak, urinate or defecate; some had lost their memories; others vomited uncontrollably. Many suffered from ‘the shakes’.

One was a private soldier, aged 20, who had been moving from one front-line trench to another when he was caught in barbed wire. As he tried to disentangle himself he was ‘found’ by the German artillery. Immediately after one of the shells burst in front of him, his sight, he said, became blurred. Another shell, which then burst behind him gave him a greater shock, ‘like a punch on the head without any pain after it.’ The shell in front cut his haversack clean away and bruised his side. Crying, shivering and frightened that he was going blind, the private was led to a dressing station. Five days later he arrived at the Base Hospital at le Touquel where the Cambridge psychologist C.S. Myers was working. After ten days treatment he was evacuated to England.

That unknown private was the first recorded case of ‘shell-shock’ – one of three described by Dr Myers in an article of February 1915 in which he coined the term ‘shell-shock’... The experience of being shelled seemed to leave men blinded, deaf, dumb, semi-paralysed, in a state of stupor, and very often suffering from amnesia. Some could remember nothing between the moment of the explosion and coming to in hospital; others could remember nothing at all. A number of these patients also showed physical symptoms, such as extraordinary, unnatural ways of walking, that astonished the doctors who examined them in England (pg 1).”

Ben Shephard, 2000

“Pierre Janet (1889, 1919/1925) was the first clinician to clearly articulate differences between ordinary and traumatic memories. He described memories that were inaccessible to retrieval under ordinary conditions and beyond conscious control. The memories of his patients, he noted, consisted of sensory experiences, emotional states, intrusive recollections, and behavioural re-enactments. Janet wrote of memory fragments that were remembered with particular vividness, yet resisted integration into existing mental structures, leaving the person ‘incapable of making the necessary narrative which we call memory regarding the event (1919/1925)’. It is important to note, however, that Janet’s lucid descriptions were limited to the kinds of traumatic memories he could observe in his severely traumatised patients (pg 35).”

James Hopper & Bessel A van der Kolk, 2001

“There are some reasons to suggest that in the legal realm the middle ground on recovered memories has been found... There is a choice to be made between two uncomfortable positions. Either some innocent men will be the victims of the miscarriage of justice or some abused women will see their abusers walk free. The latter ... is extremely undesirable, but the former is intolerable (pg 65).”

Eilis Magner & Patrick Parkinson, 2001

“The Government appeared embarrassed by the fact that none of the recanters could point to any false memories that I ‘implanted’, and that many of their claims did not hold up to cross-examination. The Government also appeared embarrassed by Hudson’s performance on the stand and decided to end the trial immediately after the defence finished his cross-examination. The prosecutors told my defence attorneys that all of the other key ‘expert’ witnesses and the other three retractors that they were depending on, now refused to testify (pg 2).”

Judith A. Peterson, 2001
“Every contemporary study of traumatic memories has essentially corroborated Janet’s and Freud’s initial observations that traumatic memories persist primarily as implicit, behavioural and somatic memories, and only secondarily as vague, overgeneral, fragmented, incomplete, and disorganised narratives (pg 24).”

Bessel A. van der Kolk, James W. Hopper & Janet E. Osterman, 2001

“Social alters contain memories of severe traumas and rejections and have their own repertoire of defensive behaviours. Experiments have shown that adults who were traumatised as children are more susceptible to hypnosis, to group suggestions, to hysterical religious behaviour, and paranormal experiences. Dissociative disorders are what Winnicott called ‘the psychosis hidden behind the neurosis’. More organised and dissociated than just ‘false selves’, social alters differ from alters of multiple personalities in that they replace the usual denial by amnesia with denial by dissociation of emotional connections, maintained through group collusion. Even though one may be more or less conscious of the activities of one’s social [alter], the emotional connections between the two selves are missing. Thus, people can imagine they go to war or conduct genocide because of the chance appearance of a suitable enemy, never because of anything emotional happening in their own heads.

It is important to remember that a person’s social alter depends on the early amygdalin memory system, a repository for our dissociated traumas. Social alters do not include the more mature areas of the brain, those containing the developed self-consciousness necessary for empathy (pg 101-102).”

Lloyd De Mause, 2002

“At a more macroscopic level, cognitive scientists have also been hard at work in the study of memory storage and retrieval. At this time, there appear to be a few generally accepted principles that inform our understanding of memory processes: (1) many people do not have access to information about trauma for short-to-long periods of time, only to regain access to it at some later date. Currently, this debate seems to be focussed on what mechanism(s) account for these phenomena rather than the phenomena themselves’ (2) the accuracy of reports of traumatic memory is uncorrelated with the intensity, vividness or affect that accompany its re-accessibility; (3) the accuracy of reports of traumatic memory is not correlated with the ‘wildness’ (unlikeness) of the events reported; and (4) people may ‘remember’ events that never took place, and suggestibility (distributed as a subject variable rather than a general characteristic of dissociative process), malingering, factitious production, and a variety of personal needs and external influences (many of which may be post-therapy contacts) may play significant roles in this regard (pg 3).”

A Steven Frankel, President, International Society for the Study of Dissociation, 2002

“Doubts about the critical date. This expanded view of the evidential sufficiency of the eight studies rendered as supporting proof of the implantation of whole memories by Lofuts puts into better perspective how little credible evidence there was of whole memory implantation. Based on the evaluation of the full range of evidence, both unreported and known, I am drawn to the conclusion that the implanting of whole memories did not exist on an evidential basis in 1993.

There is a deceptive glamour about repeated admonitions on the hazards of therapy that are persuasive to some; however, Loftus’ admonitions are based on speculation and the ferment of strong conviction. The scenario laid out has yet to be scientifically tested (Brown, 1995).
As lucidly stated in a Law Review article (Vella, 198; p.93), ‘false memory syndrome is, at best, a pseudo-medical theory which does not have any credible body of scientific evidence to support it.’ From the perspective of good science, Loftus’ thesis of what transpires in therapy remains nothing more than speculative theory, yet her vision of therapeutic damage has carried considerable weight in the intervening years and has come to be sanctioned in the literature as if it were supported by science (Pope, 1996). Her views have become entrenched by uncritical professional acceptance and has fostered the dissemination of bad science. That many eminent scholars inadvertently accord false memory theory a veneer of credibility with legitimising speculation without applying the usual critical scrutiny to questionable theories and conclusions is illustrated in the following excerpts. Baron (1994; p. 233) elevates the article (Loftus, 1993), that for most part does not rise much above the level of speculation, to ‘an authoritative work in this field.’ Ofshe and Singer (1994; p 393) inform their audience that therapists ‘use group-processes, role-playing, leading questions to classify frankly speculative or confabulated scenarios as memory.’ McElroy and Keck (1995; p. 731) miscredit the article with novel treatments. ‘Recovered memory therapy is a psychotherapeutic treatment based on the premise that a variety of psychiatric symptoms and disorders are due to repressed memories of childhood sexual abuse.’ Read and Lindsay (1994; p. 410) labor under the misconception that the class project involving Chris is an appropriate reference point to argue that ‘suggestions can indeed give rise to false memories of traumatic life experience.’ They go on to claim that reviews such as the one by Loftus ‘have demonstrated false memories of autobiographic events under conditions that can be reasonably generalised to therapy situations’ (p. 413). These excerpts illustrate the importance of becoming intimately conversant with the literature before exercising scholarship in the area (p. 31-32).”

Frank Leavitt, 2002

“In America the largest amount of DID is diagnosed in connection with allegations of ritual satanist abuse, hence the discrediting of our inability to perceive the possibility of the one existing automatically precludes rational thinking about the other (pg 16).”

Valerie Sinason, 2002

“In the Anglo-European tradition, memory, self, and person are historically braided concepts. It is thus possible to attack or to undermine the selfhood and personhood of others by undermining them as rememberers. I contend that on some occasions when we challenge others as competent rememberers, our intent is to undermine them as persons due various forms of respect, by calling into question how well they can function cognitively (pg 27).”

Sue Campbell, 2003

“There is no reason to postulate a special mechanism of repression or dissociation to explain why people may not think about disturbing experiences for long periods. A failure to think about something does not entail an inability to remember it (amnesia) (pg 2).”

Richard J. McNally, 2003

“It never occurred to any analytic writer prior to the controversy over Freud’s views unleashed by my book to claim that psychoanalysis always maintained an interest in sexual abuse. Now analysts are claiming that it is now and has always been a major concern within psychoanalysis. But if we look at the journals, we do not find this to be so. The cumulative index of the authoritative Journal of the
American Psychoanalytic Association, more than 600 pages, contains the contents of the journal from its inception in 1953 through 1974 – thus the heyday of psychoanalysis and its influence – and has five columns devoted to the words Oedipus Complex. By contrast, the word abuse is not found in the index. Nor is there a single entry under sexual abuse…(pg 340-34).”

Jeffrey Moussaieff Masson, 2003

“Jan Hinchman knows all too well that people who have lied for decades about their offending would lie to her about being victimised as a child, so she compared the reports of abuse by child molesters who were not being polygraphed on their answers with a later group who was informed that they would have to take a polygraph after the interview. The group that was being polygraphed was also given immunity from prosecution for crimes previously unknown in order to take away one of the many reasons that offenders lie…

In a series of three studies, the offenders who claimed they were abused as a child were 67 percent, 65 percent, and 61 percent without the threat of a polygraph. With polygraph (and conditional immunity), the offenders who claimed they were abused as children were 29 percent, 32 percent, and 30 percent, respectively. The polygraph groups reported approximately half the amount of victimisation as children as the non-polygraph groups did (pg 73).”

Anna Salter, 2003

“Partisanship, in research or in court, is an antithetical to the development of science. The contamination effects of partisanship may be more readily visible in courtroom testimony, but they are more potentially dangerous if they undermine the fabric of scientific understanding. For this reason, the give-and-take that makes good science possible is an essential element for building a solid foundation of knowledge (pg 8).”

Alan W. Scheflin, 2003

“It is now common for people with ordinary life problems to seek help from counsellors or therapists. What is not well known is that therapy can sometimes make their situations worse. People are often told their symptoms, such as depression, will be helped if they recover so-called ‘repressed’ or ‘delayed’ memories.

Other promoters of false memories are some trendy self-help books, some emotional support groups, and parents caught up in bitter custody disputes. Such influences may cause false memories without the involvement of a counsellor.

Vivid, but false, memories can be created in such situations via a process related to ordinary imagination. The sufferer usually forms a solid belief that the memories are true. Curiously, the persuasion-induced ‘memories’ nearly always have sexual themes.

We often prefer not to think about bad experiences, thereby avoiding bad feelings. But there is no scientific evidence that we involuntarily repress traumatic memories such that they can emerge later as if for the first time. On the contrary, we find it difficult to forget really bad experiences.

Australian False Memory Association, 2004
“Memory is at times seemingly indelible and at other times frustratingly fallible. What is more... the same past experience can at one moment impinge upon consciousness unbidden and at another, elude deliberate attempts to recollect it (pg 1).”

Patricia J Bauer, 2004

“Real memories and false planted memories are, unfortunately, quite difficult to distinguish. Although some group differences have been found (e.g. real memories have more sensory detail), with repeated rehearsal false memories assume the qualities of true memories. Sadly, there is at present no reliable way to differentiate real from suggested memories without some form of independent corroboration (pg 560).”

Daniel M. Berstein & Elizabeth Loftus, 2004

“One afternoon Anderson told him about a possible new case. A man named Frank Fitzpatrick had called to say he was sexually assaulted by a priest, Father James Porter in Fall River, a hard-knocks city ninety minutes due south of Boston. At the time, he was twelve. For years he had put it out of mind, but in 1989 he began pester ing the church for accountability, without satisfaction. They wouldn’t tell him where Porter was in the priesthood or out, or even whether he was still alive. He was told to ‘leave it in the hands of the Lord’. On his own, Fitzpatrick- a private detective, it turned out – tracked down the defrocked priest in Minnesota, when he lived with his wife and children. Fitzpatrick notified police, who did nothing.

Frustrated, he placed an ad in his old hometown newspaper that read, ‘Do You Remember Father Porter?’ His misery needed company.

Six other victims called him (pg 206-207).”

David France, 2004

“In recent times the phenomenon of false memories has become popular, but it can be seen that at one level, all our memories are false. That is simply the way of the nervous system. In clinical practice, false memories present in a variety of settings, from confabulation to ‘recovered’ memories of child abuse to pseudologia fantastica (pg 121).”

Michael Trimble, 2004

“When I was asked if I ‘forgot’ my father coming into my room at night, and I say, ‘Yes’ I am not talking about the kind of forgetting Ben Bradlee recounted or the kind of forgetting we experience when we misplace our car keys. Although the words ‘forgot’, ‘repressed’, ‘split my mind’, and ‘dissociated’, are sometimes used synonymously in this book, I am writing about having no memory whatsoever of the experiences. That would mean Ben Bradlee would have had no memory of even being with Jackie Kennedy on that fateful day (pg 456).”

Marilyn Van Derbur, 2004

“Too often, when a child ‘tells’ her mother she does not believe her and blames her for lying and causing such trauma within the family. If charges are pressed against her father, the child is often blamed for causing him to go to jail, their loss of income and the shame that will be brought on all of
them. Her father rages at her for lying and other siblings side with their parents and blame her. What child would not recant? I understand why even adults recant. My mother said, ‘I don’t believe you.’ I was 53 when my story became public. A friend said, ‘Your poor mother. This must be so difficult for her.’ Another said, ‘Why did you want to ruin your father’s reputation?’ A columnist wrote, ‘What this really boils down to is one person’s word against another or in Marilyn’s case, her word against her father who is dead and cannot respond.’ For many people, I needed a sister to validate me. That stunned me. It still does. I understand why children and adults recant (pg 524).”

Marilyn Van Derbur, 2004

“Shanley’s accuser, now a 27-year-old firefighter, says he remembered in early 2002 that he’d been repeatedly raped and molested by the former priest from 1983 to 1989 at a Newton parish. Shanley’s lawyer has questioned the science behind repressed memory, also known as dissociative amnesia.

The condition is ‘not common, but it’s not at all rare’, said prosecution witness Dr James Chu, an associate professor at Harvard Medical School.

‘It really is more this repeated trauma that tends to be forgotten by some mechanism,’ Chu said.

Shanley’s accuser said he remembered the abuse after talking with Greg Ford a close friend who also accused Shanley of raping him at St Jean’s parish in the 1980’s.”

Associated Press, 2005

“Though individual researchers naturally incline toward their own explanations for the alien-abduction experience (it’s mostly sleep paralysis, said Richard McNally; it’s memory distortion, says Elizabeth Loftus; it’s fantasy-proneness, say Robert Bartholomew and George Howard), I would hope they’d be receptive to my multilevel synthesis of these disparate contributions. I am arguing that alien-abduction memories are best understood as resulting from a blend of fantasy-proneness, memory distortion, culturally available scripts, sleep hallucinations, and scientific illiteracy, aided and abetted by the suggestions and reinforcement of hypnotherapy. But this analysis is still insufficient for an understanding of the phenomenon. As the abductees themselves would say, ‘If you’re telling me it didn’t happen to me, that I made it up, why in God’s name would I want to?’

That’s the hardest question to answer. The experiences are terrifying, nightmarish. They take place in the dark when you’re alone and vulnerable. The alien creatures are repulsive, with vacant black eyes, long fingers, segmented bodies. They steal you away from all that’s safe and familiar, and then they probe and dig into your brains, nasal cavities, genitals, and intestines. Things are carved out of you, or embedded in you. Even if it seems reasonable to accept the explanatory equation presented above and acknowledge that false beliefs can be created, it’s difficult to understand why anyone would make up such ghastly things. David Jacobs, a leading researcher in the field, argues that abduction narratives ‘would be extremely difficult, if not impossible, to attribute to internally generated psychological fantasies.’ John Mack, in a memorable phrase, called the typical account ‘a self-destroying traumatic narrative.’ (pg 138-139).”

Susan Clancy, 2005

“And various versions of the unconscious, construed as the dissociated rumpus room or the locked ward of the mind, live happily on in our language. We have a super-ego to explain our guilt; an id to
cause our neuroses and ‘repressed traumatic memories’ to account for our bad behaviour; a collective unconscious to generate the symbolism of myths and dreams. And now we have brain states as well, to help us out when we are puzzled by ourselves; serotonin imbalance, frontal lobe dysfunctions and (my favourite) ‘minimal brain damage’ – so slight you cannot see it, but definitely there, or those kids would not be so unruly (sorry, ‘hyperactive’) (pg 339).”

Guy Claxton, 2005

“This attitude, born of the present culture of victim hood (sic), is at the heart of the present need to reconsider the process of justice in sexual abuse allegations, especially historic cases. That attitude goes on into the early pages of the report. The very terms of reference fail to address a central issue, which the Victorian Health Commissioner has recognised and is currently dealing with, and that is the training of psychologists, psychiatrists and counsellors in the matters of the discredited theory of repressed memories. This omission leaves a gaping hole in the inquiry, in that the source of many of the charges in these cases has not been recognised, again in what seems a political move to avoid challenging the victim hood (sic) of claimants to that title.

The section on the impact of sexual abuse specifically disregards information critical to understanding the topic which was given to the Inquiry by Citizens Against False Sexual Abuse Allegations (CAFSA) representatives. There is no mention at all of the study by Rhind, Trmovich & Braverman, which is the largest aggregation of results yet done on the impact of sexual abuse. The results of this study are that, contrary to what is claimed by researchers such as those that are selectively cited by the Inquiry the long-term effects of sexual abuse are not universally negative, they are most often neutral (and are rarely, regarded as positive). Aside from a brief mention of effects that ‘may or may not require treatment’ based on APS guidelines cited on p. 11, this is essentially brushed under the carpet such that the myth that long-term sequelae are invariably severe and widespread can feed the fear on which the present witch hunt is not dispelled, but thrives. The fact that the courts only ever see the ones where harm is alleged continues to travel in the judicial blind spot.”

Michael Cox (Immediate Past President CAFSA; Past President of the Australian False Memory Association) & Travis Gee (Scientific Advisor to CAFSA), 2005

“The allegations of sexual abuse were as bizarre as they were disturbing, involving violence and vampirism. They were levelled against a mother, father and a grandmother, first by their eldest daughter, then by all four children. The children were removed and the adults charged. The family was destroyed. And all on the basis of a psychotherapy technique based on digging up memories thought to be locked away in the minds of children, a technique that has since been largely discredited. This week the NSW Supreme Court found the mother and the grandmother in the case had been wrongfully arrested and had suffered malicious prosecution, and awarded them $165,000 in damages. The judge said the children’s claims were inconsistent and at times implausible. The case against the abusers was based on claims made during repressed memory counselling sessions. Called ‘false memory syndrome’ by its detractors, it is based on a belief that some traumatic incidents in a person’s past, often instances of sexual abuse, are so painful they are repressed in the memory, only to be ‘recovered’ in counselling sessions in later life…..

But the debate goes on, most recently in Victoria, where the Health Services Commissioner is conducting an inquiry into the syndrome…”

Jacqueline Maley, 2005
“Celebrity witness: In this case, Columbia made the bigtime, and not just because the CBS show ‘48 Hours’ was filming the trial for a future show.

Key defence witness Elizabeth Loftus is quite possibly the biggest celebrity witness to ever testify in Boone County.

She was involved on one capacity or another – as Crane deftly pointed out to the jury, in the Ted Bundy serial murder case, the case of The Hillside Strangler and the defence of O.J. Simpson, Michael Jackson and even Martha Stewart. Her speciality is child sex abuse cases, and as such, she appeared in recent cases brought against the Catholic Church and specific priests.

Loftus, who charges $450 an hour for her testimony, was paid $11,000 for this case. Her testimony, once Crane was through with her, wasn’t worth $11. Her research, though, is interesting.

The research psychologist plants false memories in people’s minds with the power of suggestion, convincing them, among other things, that they remember seeing Bugs Bunny at Disneyworld or that they enjoy strawberry ice cream when, in fact, they don’t.

A better trick would have been to plant a false memory in the defence lawyer’s mind that made him forget to call her to the stand.”

Tony Messenger, 2005

“Cornelia Rau’s case reminds us that psychiatrists and the police, between them, can get things horribly wrong. But, grim as her plight is, it tends to pale alongside other, run-of-the-mill and easily averted miscarriages of justice in Australia. The everyday horrors I have in mind are the shonky therapists recovering ‘repressed’ memories of sexual abuse, which have in turn triggered ill-considered police prosecutions and devastated hundreds of lives…. Regular readers of this column may well remember mention of Mike Cox. He’s and activist social worker in south-east Queensland who developed a passionate interest in recovered memories of sexual abuse after his daughter falsely accused him, then retracted the charge. He and Travis Gee, a research psychologist at the University of Queensland, have just made a chilling submission to Victoria’s Inquiry into the Practice of Recovered Memory therapy. The picture they paint is one of unrelieved gloom. As Cox puts it, ‘Therapeutic techniques known to be suspect or fraudulent since the late 1980’s are still being widely practiced and uncritically relied on by police ad prosecutors. A witch-hunt mentality has developed and it precludes many accused people getting a fair trial…

Cox and Gee’s submission has a lot of sensible things to say about systemic problems in the investigation and prosecution of people accused of paedophilia on the basis of recovered memories… Cox is a crusader and he has the Beattie Government in particular in his sights. But the other state governments have all been alerted to the issues and most continue to sit on their hands. As he says: ‘The tragedy of protracted inaction by the authorities has had an enormous social cost. The only responsible course of action now is to set up a national inquiry’ (pg 19-20).”

Christopher Pearson, 2005
The California Supreme Court will hear an appeal from the nation’s most controversial repressed memory debunker to determine if the psychologist can be sued for invasion of privacy and defamation.

The case involving Taus has dogged Loftus for many years. The story of ‘Jane Doe’ began in 1984 when David Corwin, M.D., videotaped his conversations with a 6-year-old girl at the centre of a child-custody suit. Taus claimed that her mother had inappropriately touched her during bath-time. The mother lost custody and visitation rights.

Eleven years later, Corwin, a psychiatrist, interviewed Taus again and the teenager was able to recall the alleged abuse. Corwin taped the interview and his subsequent article about the case was published in Child Maltreatment.

Loftus says she thought the case was ‘fishy’ and with the help of Melvin Guyer, Ph.D., J.D., of the University of Michigan, figured out where Taus lived and approached her family and friends to ask about her history. In an article in Skeptical Inquirer in 2002, Loftus wrote about the speculations of a social worker and Taus’s brother that the accusations of abuse had been invented as a weapon in the custody battle.

In 1999, however, Taus complained to the University of Washington that Loftus’ investigation had violated her privacy. The school’s Office of Scholarly Integrity seized the psychologist’s files. After a 21-month investigation, the school decided that Loftus was engaged in permissible research, but that she could no longer contact Taus’s mother without the school’s permission. Loftus was also ordered to take an ethics class. Instead, she resigned and accepted the position in California [University of California at Irvine].

Following the 2002 publication, Taus filed a lawsuit against Loftus and others claiming that personal information about her health and private life were obtained and published without her knowledge and consent and that defamatory remarks were made about her in public settings.

In fighting the lawsuit against her, Loftus’ argued that the case was of such scientific significance that her conduct was justified in order to refute it.

Both the trial and appeals court have denied Loftus’ effort to have the lawsuit dismissed. The Court of Appeals found that Taus had raised genuine issues and provided evidence that tends to support her claims.

Taus’s lawsuit is not the first time Loftus has found herself accused of alleged breaches of research protocols. Two ethics complaints were filed against her with the American Psychological Association, but she resigned from that organisation soon after the charges were made and, as a result, the APA was unable to investigate them.

John Thomas, 2005

“He can, indeed, pull a fact from his mental library as fast as a search engine can mine the Internet. He read Tom Clancy’s ‘The Hunt for Red October’ in one hour and 25 minutes. Four months later, when asked, he gave the name of the Russian radio operator in the book, referring to the page describing the character and quoting several passages verbatim. Kim began memorising books at the age of 18 months, as they were read to him. He has learned 9,000 books by heart so far. He reads a page in eight
to 10 seconds and places the memorised book upside down on the shelf to signify that it is now on his mental ‘hard drive’.

Kim’s memory extends to at least 15 interests—among them, world and American history, sports, movies, geography, space programs, actors and actresses, the Bible, church history, literature, Shakespeare and classical music. He knows all the area codes and zip codes in the U.S., together with the television stations serving those locales. He learns the maps in front of phone books and can provide Yahoo-like travel directions within any U.S. city or between any pair of them. He can identify hundreds of classical compositions, tell when and where each was composed and first performed, give the name of the composer and many biographical details, and even discuss the formal and tonal qualities of the music. Most intriguing of all, he appears to be developing a new skill in middle life. Whereas before he merely talked about music, for the past two years he has been learning to play it.

It is an amazing feat in light of his severe developmental problems—characteristics shared, in varying extents, by all savants. He walks with a sidelong gait, cannot button his clothes, cannot manage the chores of daily life and has great difficulties with abstraction. Against these disabilities, his talents—which would be extraordinary in any person—shine all the brighter. An explanation of how Kim does what he does would provide better insight into why certain skills, including the ordinary obscure skill of calendar calculating (always associated with massive memory), occur with such regularity among savants. Recently, when an interviewer offered that he had been born on March 31, 1956, Kim noted, in less than a second, that it was a Saturday on Easter weekend (pg 90).”

Darold A. Treffert & Daniel D. Christensen, 2005

“Psychology, like criminal investigation, presents a confluence of variables that, in light of laboratory research, have the potential to elevate patients’ tendency to make erroneous reports about the events of their lives. Those variables fall into two broad categories—namely, general attributes of the psychotherapeutic context that hold more or less universally and specific therapeutic practices whose use varies considerably from patient to patient and from therapist to therapist (pg 420).”

C.J. Brainerd & V.F. Reyna, 2005

“But our increasing understanding of memory and ways in which it can be manipulated might have profound effects beyond PTSD. The ability to block intrusive or traumatic memories may end some people’s nightmares. But what of memories that are merely undesirable rather than pathological?

Should humiliating, embarrassing or distressing episodes prompt us to swallow a liquor of forgetfulness? ‘People tend to think about memory-altering drugs as science fiction’, says Richard Glen Boire from the Center for Cognitive Liberty and Ethics in Davis, California. ‘Not true. These drugs will be available within five to 10 years and they will alter our lives entirely. In modulating a person’s memories, we are talking about nothing less than altering the central part of what it means to be a human being’ (pg 35).’

Gala Vince, 2005

Re: Michael J. Powel vs Carlo D. Fabbozzi, Superior Court for the State of Connecticut, Judicial District of Fairfield at Bridgeport, CV02-0393364S
A 47 year old Florida man, Michael J. Powel, won a $10.9 million dollar judgment in Connecticut Superior Court against a former maintenance worker for the Roman Catholic Diocese of Bridgeport, Carlo D. Fabbozzi. The jury agreed Powel was repeatedly molested by Fabbozzi when Powel was between the ages of 9 and 13. Fabbozzi, now 78, was in his mid-40s at the time. The abuse took place in the late 60s and early 1970s on church property and nearby.

Powel repressed his painful memories of the abuse by Fabbozzi until year 2000, only to regain these painful memories of abuse while recuperating from removal of a life threatening malignant brain tumor one year earlier. There are over 68 scientific studies supporting the existence of full or partial repression, otherwise known as dissociative amnesia, following trauma, like childhood sexual abuse.

Powel's account of the molestations was corroborated by the testimony of two other male victims. After initially defending the claims and invoking the fifth amendment privilege of self-incrimination as to his involvement in child molestations, Fabbozzi failed to appear at trial electing not to contest the claims. In July of this year, a jury of four men and two women, four jurors of whom were Roman Catholic, returned a verdict of $5 million dollars ($2 million economic, $3 million non-economic damages) and authorized the award of punitive damages. With the punitive damages, interest and costs, assessed by Judge Edward F. Stodolink, the judgment totals $10,937,538.80.

Press release, via Helen McGonigle, 2005

“The lawyer for defrocked priest Paul R. Shanley gambled that jurors wouldn't believe that the priest's accuser suddenly remembered sexual abuse from two decades earlier.

Defense attorney Frank Mondano was so confident in the strategy that the only witness he called was Elizabeth Loftus, a professor at the University of California at Irvine, who testified that false memories can be placed by psychotherapists in susceptible minds.

Even some lawyers who thought Shanley was guilty said Mondano might have succeeded in convincing the jury of seven men and five women that there were serious questions about the credibility of Shanley's accuser.

But the Middlesex County jury believed the accuser, and Mondano lost his gamble.

Patrick Kierce, a member of the jury that convicted Shanley, said he had no reason to doubt the 27-year-old accuser, who testified that Shanley repeatedly raped and fondled him at St. Jean the Evangelist Parish in Newton in the 1980s.

Kierce, who lives in Medford, said the accuser's emotional testimony struck him as ‘heartfelt.’

Kierce said that he would have liked to see Shanley take the stand and that the defense could have been stronger.

‘If they called more witnesses, it might have helped the case, you never know,’ Kierce said.

Two years ago, legal specialists predicted that the case against Shanley would hinge on the premise that his accuser had repressed traumatic memories of being sexually abused by the priest when he was 6 to 12 years old and only remembered the abuse in 2002, when he heard of news reports about Shanley.
The issue of recovered memories is a controversial one, pitting believers against critics who accuse psychotherapists of planting false memories.

Carmen L. Durso, who represented five men who settled lawsuits against the Catholic Archdiocese of Boston and attended Shanley's criminal trial, said a few hours before the verdict that he believed Mondano had sowed enough seeds of reasonable doubt for acquittal.

Mondano, Durso said, had mentioned that Shanley's accuser was in touch with a personal injury lawyer, who was preparing a class-action suit against the diocese, shortly after the young man claimed to have recovered his memories in early 2002. Mondano suggested that the man might have accused Shanley for financial gain.

Shanley's accuser was awarded $500,000 in a civil settlement with the archdiocese.

‘I've never been so happy to be wrong in my life,’ Durso said after the guilty verdicts. ‘This is vindication for a lot of people, not just the people who testified in this case, but for all the people who have been victimized by Paul Shanley.’”

Jonathan Saltzman, 2005

“In her 1997 memoir, Liz Mullinar says that as a child she was raped by a doctor and by her grandfather, but only remembered these incidents four decades later, while undergoing hypnosis. Of her family life she remembered ‘vague but happy memories’ of growing up with her five siblings in London and Wales. But in a 2003 interview with New Idea magazine, Mullinar said she now believed she was abused over a 15-year period by four men, including her mother’s chauffeur. More recently Mullinar has identified one of those men as her deceased father, Reverend Stephan Hopkinson.

When Katherine and David Blankley joined Mayumarri as volunteer co-ordinators late last year they became aware that Mullinar was now claiming that her father had been part of a pedophile network involved in torture and Satanism. David, who has 30 years’ experience working in child protection for the NSW Department of Community Services and other agencies, says he was disturbed that many people undergoing the centre’s healing program were ‘recovering’ memories that were very similar to Mullinar’s…

But only four months ago a clinical team from Dympna House, a government funded sexual assault counselling service in Sydney visited Mayumarri after hearing ‘unsettling’ reports. The Dympna House team determined that Mayumarri was working outside accepted International Society of Study of Dissociation guidelines and mandatory reporting requirements for child sexual assault.

According to Mayumarri’s financial records, the centre received more than $1 million between 2003 and 2005. Nearly half of that was in the form of government grants, with the remainder made up from donations, fundraisers and visitor fees. And although no major government grants have been made this year Mullinar is now forging links with established church groups and large charities such as Westpac Foundation in order to fulfil her ambition of making Mayumarri a national organization.

It’s a scale of success that has bemused some veteran child abuse professionals such as Freda Briggs, professor of child development at the University of South Australia. ‘She didn’t go to conferences, she didn’t present papers – she has no credibility in the field,’ says Professor Briggs, who believes Mullinar succeeded through a keen use of publicity and politics (pg 19-20).”
Richard Guilliatt, 2006

“Our tendency to confabulate – to believe a fictitious story or memory – is a serious concern when it comes to trusting an eyewitness.

How easily do our made-up stories become false memories? Maria Zaragoza of Kent State University in Ohio showed people an event on video and then asked them leading questions. When they did not have an answer – because the information just wasn’t on the tape – she encouraged them to make one up. People are very uncomfortable doing this, she says. They say they don’t know, and are just making up an answer, but a week later, more than half of the subjects report their false statements as true events.

Another experiment reveals that children behave in the same way in a real eyewitness situation. When asked to report how a maintenance man they had seen in a waiting room had broken something that he had not in fact touched, they said he didn’t break it, or that they didn’t see. They were then asked to make something up. A week later, many of the children believed their lies and would now willingly confabulate about the false situation. As with the adults, the effect was strongest when the questioner gave positive feedback, telling the person that their answer was correct.

Zaragoza says these findings have worrying implications for the way forensic interviews are conducted, particularly for the credibility of forced confessions.

Another controversial forensic technique is hypnosis. Its reliability was tested experimentally in the 1980s by psychologist Jane Dywan of Brock University in Ontario, Canada, at a time when hypnosis was increasingly being used, with little opposition to ‘refresh’ eyewitness memory. She showed people pictures and then tested their recall over the following days. After a week, she hypnotised the same people and asked them again what they could remember. They all ‘recalled’ more, but almost all the newly volunteered information was wrong.

Dywan says that hypnosis increases the focus of our attention and so increases the vividness and the ease with which information comes to mind. This may give us the sense of confident familiarity for false memories that we would normally only get with true ones. Hypnosis seems to interfere with our ability to judge what is real and what is not. Combine this confidence with increased recall, and you have set up a very dangerous situation, she says (pg 36).

Helen Phillips, 2006

"Scooter Libby, Vice President Dick Cheney's former chief of staff, has hired a renowned memory-loss expert to assist him with his legal defense. Harvard psychologist Professor Daniel L. Schacter tells NBC News he has been retained by Libby as a consultant. An official familiar with the Libby defense team confirms the news.

Schacter, who has been at Harvard since 1991 and who has a 29-page resume, is the author of 'The Seven Sins of Memory' and 'Searching for Memory: The Brain, the Mind and the Past'. His books offer explanations for the 'vulnerability of memory'. Schacter writes that if we are distracted as an event unfolds, 'we may later have great difficulty remembering the details of what happened.' Time of course weakens our memory. And, he writes, it is easy to 'unwittingly create mistaken -- though strongly held - beliefs about the past.'
Libby's lawyers hinted in court filings last week that memory loss will be 'central themes' of Libby's defense. Libby's lawyers write: '...any misstatements he made during his FBI interviews or grand jury testimony were not intentional, but rather the result of confusion, mistake or faulty memory.'

Libby's lawyers say that, during Libby's hectic days handling sensitive national-security matters, 'it is understandable that he may have forgotten or misremembered relatively less significant events. Such relatively less important events include alleged snippets of conversations about Valerie Plame Wilson's employment status.'

Libby has been charged with lying to investigators about his role in the disclosure of Valerie Wilson's role as a CIA operative. His trial is scheduled to begin in January 2007."

Jim Popkin, 2006

"With withering and methodical dispatch, White House nemesis and prosecutor Patrick J. Fitzgerald yesterday sliced up the first person called to the stand on behalf of the vice president's former chief of staff.

If I. Lewis "Scooter" Libby was not afraid of the special counsel before, the former Cheney aide, who will face Fitzgerald in a trial beginning Jan. 11, had ample reason to start quaking after yesterday's Ginsu-like legal performance.

Fitzgerald's target in the witness box was Elizabeth F. Loftus, a professor of criminology and psychology at the University of California at Irvine. For more than an hour of the pretrial hearing, Loftus calmly explained to Judge Reggie B. Walton her three decades of expertise inhuman memory and witness testimony. Loftus asserted that, after copious scientific research, she has found that many potential jurors do not understand the limits of memory and that Libby should be allowed to call an expert to make that clear to them.

But when Fitzgerald got his chance to cross-examine Loftus about her findings, he had her stuttering to explain her own writings and backpedaling from her earlier assertions. Citing several of her publications, footnotes and the work of her peers, Fitzgerald got Loftus to acknowledge that the methodology she had used at times in her long academic career was not that scientific, that her conclusions about memory were conflicting, and that she had exaggerated a figure and a statement from her survey of D.C. jurors that favored the defense.

Her defense-paid visit to the federal court was crucial because Libby is relying on the "memory defense" against Fitzgerald's charges that he obstructed justice and lied to investigators about his role in the leaking of a CIA operative's identity to the media. Libby's attorneys argue that he did not lie -- that he was just really busy with national security matters and forgot some of his conversations.

When Fitzgerald found a line in one of her books that raised doubts about research she had cited on the stand as proof that Libby needs an expert to educate jurors, Loftus said, "I don't know how I let that line slip by."

"I'd need to see that again," Loftus said when Fitzgerald cited a line in her book that overstated her research by saying that "most jurors" consider memory to be equivalent to playing a videotape. Her
research, however, found that to be true for traumatic events, and even then, only 46 percent of potential jurors thought memory could be similar to a videotape.

There were several moments when Loftus was completely caught off guard by Fitzgerald, creating some very awkward silences in the courtroom.

One of those moments came when Loftus insisted that she had never met Fitzgerald. He then reminded her that he had cross-examined her before, when she was an expert defense witness and he was a prosecutor in the U.S. attorney's office in New York.

Libby's defense team declined to comment.”

Carol D. Leonnig, 2006

“Traumatised clients often present with symptoms rather than with coherent verbal stories placed in time. Because traumatic ‘memory’ consists largely of reactivated, nonverbal memories, sometimes combined with incomplete narrative accounts, Janet suggested long ago that these memories are split off from conscious awareness and stored as sensory perceptions, obsessive thoughts, and behavioural reenactments. The individual apparently ‘remembers’ what happened through reliving these nonverbal iterations of the historical traumatic event or through mysterious physical symptoms that seem to have no organic basis. These non-verbal traumatic memories are ‘self-contained form[s] of memory that [do] not necessarily interact with general autobiographical knowledge’ Brewin (2001, p.376). Inaccessible to verbal recall, they typically remain unintegrated and unaltered by the course of time.

The lack of integration allows reminders of the trauma to trigger somatosensory fragments, causing detrimental effects on the client’s ability to modulate arousal and function in daily life. Because the trauma is not fully recollected as a coherent, autobiographical narrative, clients are unable to deal with the effects and implications of their memories by reflecting upon, discussing, or thinking about them. The memories remain unintegrated, and clients often become phobic of their contents. As a result, phase 2 work with traumatic memories is daunting for many clients and unnerving for their therapists, who fear that their clients will become overwhelmed and mired still further in their past (pp 234-235).”

Pat Ogden, Kekuni Minton & Claire Pain, 2006

“There has been much controversy over the veracity of recovered memories: Some can be corroborated, while others cannot (Hammond, 1998; Courtois, 1996b). Realization typically means the patient must accept the reality of what has happened to him or her. However, some survivors are unable to fully know cognitively what happened, but this need not impede full realization. One patient, who apparently had a preverbal traumatic experience, came up with a multitude of different scenarios, none of which she was sure were real. Yet, with the therapist’s reassurance that she could use these stories to heal without either of then making a judgement about their veracity, she said, ‘I know something bad happened to me. I was hurt and scared. I was completely overwhelmed. I didn’t get help when I needed it. That’s enough for me to know and move on.’ The therapists may never know the veracity of some memories, and should not be the one who decides on the objective truth. Nevertheless, the therapist may eventually develop a reflective belief on this matter, which sometimes needs to be shared with, rather than being withheld from, the patient (pg 331-332).

Onno van der Hart, Ellert Nijenhuis & Kathy Steele, 2006.
“Mark and Gail continued in sex therapy together, and the therapist recommended that Gail also begin individual therapy. It was several months into his individual treatment that Gail remembered and disclosed to her therapist the fact she had been a victim of incest perpetrated by her father for several years. As she remembered more and more of the details of that abuse, she recalled that her father had fondled her nipples, that she had from time to time found this very exciting, and that as the incestuous relationship progressed she had come to feel immense guilt over the fact that she was turned on by his touching (pg. 139).”

Ofelia Rodriguez – Srednicki & James Twaiite, 2006

“I’ve spent three decades learning how to alter people’s memories. I’ve even gone so far as planting entirely false memories into the minds of ordinary people — memories such as being lost in a shopping mall, cutting your hand on broken glass or even witnessing demonic possession as a child, all planted through the power of suggestion.

Psychological scientists have learned so much about planting false memories that some say we almost have recipes for doing so. But we haven’t seen anything yet. Over the next 50 years we will further master the ability to create false memories. We will learn more about who is more susceptible and what works with what kind of people. The most potent recipes may involve pharmaceuticals that we are on the brink of discovering.

In 2048, a descendant of George Orwell will write 2084, a book about totalitarian society in need of control. When we have mastered the false memory recipes, we will need to worry about who controls them. What brakes should be imposed on police, lawyers, advertisers? More than ever, we’ll need to constantly keep in mind that memory, like liberty, is a fragile thing.”

Elizabeth Loftus, 2006 (See Broks, pg 61).

“Then the tort lawyers got involved. Jane Doe filed lawsuit in her own name, Nicole Taus, the first time her identity was disclosed publicly. Ms Taus claims that Dr. Loftus invaded her privacy by investigating and reporting on Dr. Corwin’s study. She seeks compensation for alleged emotional stress – punitive damages.

The California Supreme Court, which heard arguments in December, should dismiss the case – and make clear that this kind of lawsuit will not be tolerated. The controversy over repressed memory is a matter of great public interest: and the U.S. Supreme Court, has repeatedly held, ‘speech concerning matters of public affairs is more than self expression; it is the essence of self government,’ occupying the ‘highest rung of the hierarchy of First Amendment values’. Tort lawsuits, especially those seeking punitive damages, can have an especially unconstitutional chilling effect. Indeed, the landmark decision, New York Times v. Sullivan, declared that ‘The fear of damage awards… may be markedly more inhibiting than the fear of prosecution under a criminal statute.’

Dozens of renowned scholars and scientists declared in a friend-of-the-court brief that ‘[p]ermitting personal lawsuits against scientists who investigate, locate and expose errors or misconduct in controversial research publications would have damaging effects in all areas of science.’ Such lawsuits could also threaten investigative journalism,…

Dr Loftus and her colleagues have already been embroiled in litigation for three years, and if the California Supreme Court allows the case against them to go forward, they will be forced to endure
invasive discovery and a long and costly trial, even if in the end they win. The damage to them will be serious – as will the threat to scientific research and a free press (pg. A12).”

Theodore J. Boutrous, Jr, 2007

“People with amnesia struggle to remember their past. They may also struggle to envision their future, according to a new study. Researchers have found that people with amnesia caused by damage to the hippocampus, a brain region intimately tied to memory, have difficulty envisioning commonplace scenarios they might reasonably expect to encounter in the future.

The findings challenge long-held views about function of the hippocampus and the nature of memory, says Lynn Nadel, a cognitive neuroscientist at the University of Arizona in Tucson. ‘The claim here is that the same system we use to remember the past we also use to construct possible futures,’ says Nadel.”


“The California Supreme Court sensibly ruled that the constraints of the law also apply to zealous researchers who may be eager to prove their theories with unethical or unlawful means.

Elizabeth Loftus is accused of misrepresenting herself to gain confidential information from the family member of a research subject. No institutional review board would approve such a method. No peer-reviewed scientific journal would publish an article whose data are derived from such a method.

Now the Supreme Court of California adds that such a method is not lawful. It is a victory for those who value ethics in the pursuit of scientific knowledge.”


Appendix 2:

Factors That May Play A Role In The Genesis Of False Memories In Dissociative Patients
(Derived from earlier papers – see Middleton, 1994 & 1995)

The factors listed are an amalgam of issues referred to in the dissociative disorders literature and personal clinical observations of substantial numbers of dissociative patients who had each experienced severe ongoing developmental traumas.

1. CONTINUATION OF CHILDHOOD FANTASY PRONENESS:

Severe dissociative disorders have their genesis in early childhood and are erected with childrens’ age related capacity to dissociate. Children of this age naturally have a capacity to create internal worlds, alternative realities and imaginary companions. Due to the need to maintain dissociative defences, such elements that usually would dissipate are maintained and may indeed be elaborated.
2. **LINKS BETWEEN CREATIVITY AND DISSOCIATION:**

Creativity, and by extension the use of metaphor, simile, symbolism, personification or dreamlike thought are central to the dissociative process. Symbols are frequently central to the content of dreams or hallucinations and given the propensity to experience multiple realities demonstrated by some patients, leakage or incorporation of creatively configured images or events becomes possible, leaving the patient at times uncertain about the source of authenticity of an apparent memory.

3. **REPETITION COMPULSION:**

The severely traumatised are destined to repeat aspects of their trauma and in some untreated dissociative patients the process can become like an endless feedback loop; trauma creates dissociatively based alter states, some of whom repeat aspects of the trauma invoking further dissociative defences and so it goes on. The repetition-compulsion can involve actual or symbolic ways of repeating the trauma, with at times traumas being repeated in intrapsychic ways associated with apparent memory.

4. **ALTERS RE-ENACTING PAST TRAUMAS:**

Here an alter based on an abuser and for which there is little or no co-consciousness, re-enacts in contemporary time by way of self-harm, aspects of abuse previously experienced, while other alters perceive and remember this as a continuation of abuse by a particular abuser. (On occasions the repetition-compulsion can involve an adult in flash-back mode revisiting traumas by inflicting on others, traumas first experienced as a child victim, themselves.)

5. **LACK OF TETHERING POINTS/SOURCE ATTRIBUTION ERRORS:**

Severely dissociative patients lack autobiographical memory and thus frequently can’t place an apparent memory in the context of defined tethering points or clearly defined chronological memory of events in the relevant time period. Such defined tethering points make it easier for non-amnestic patients to place an apparent memory of an event in the context of things that were happening before, at the same time, and after, and which allow for a quick internal corroboration process to operate to, for example, separate an internal image that first occurred in a dream, from one that was part of a remembered sequence of events.

6. **MERGED MEMORIES:**

Because with highly dissociative individuals memories are prone to be untethered, fragmentary or unidimensional (eg. visual without narrative, affect without visual etc.) it is particularly likely that like uncombined DNA such ‘pieces’ of memory may recombine in a manner that is not autobiographical and that such combinations may involve fragments derived from fantasy or dream life that in turn are spliced together such that they with a greater or lesser degree of metaphor portray central issues of trauma and abandonment.

7. **EXAGGERATION AS A DEFENCE:**

Many patients with D.I.D. have experienced severe traumas without any opportunity at the time to tell anyone who would either validate or protect them. Given the magnitude of their childhood abandonment, later in a safer therapeutic setting, for some patients it’s as if they operate on the premise
that no one will pay heed to any account unless it is embellished with gruesomeness, threat, or a sense of immediate crisis.

8. **FOCUSSING ON THE FASCINOMA AND NOT THE PERSON:**

Here the therapeutic alliance is weak, though the therapist may not have realised it, in her/her quest to meet more and unusual alters. The patient recognises the therapist’s interest in them as a phenomena and for a time tries to maintain the therapist’s interest by giving them what they seem to want. The misuse of treatment in this way perpetuates splitting and multiplicity along with distorting apparent memory.

9. **MEMORY AS THE “CURRENCY” OF THERAPY:**

Where a therapist makes a major focus of therapy the “recovery” of all memories, to the exclusion of other issues and where the patient is particularly dependent or prone to adopt the recovery of ‘memories’ as the currency of relatedness, an symbiotic dyad can be created where memories are in exhaustible and where there is no sense of a therapeutic management plan. The therapist endlessly pursues ‘memories’ and the patient endlessly produces them to the exclusion of dealing with anything else.

10. **“TRANSFERENCE MEMORY”:**

Here the patient recasts contemporary paradigms of evil, danger etc. in a way that replays issues in a “therapy” setting that were never addressed originally by those who could have, but didn’t provide protection in the face of severe and continued childhood abuse.

11. **LACK OF IMPARTIALITY BY THERAPISTS:**

At times patients with severe dissociative disorders are uncertain about the authenticity of what may be fragmentary memories. If their therapist enthusiastically endorses what has been uttered and anoints it with the impremata of absolute historical truth and strongly suggests that the patient will find a lot more where that came from, a powerful and disturbing message has been sent, particularly, as is common with the victims of trauma, there is likely to be in existence a significant propensity for dependency. The lack of impartiality frequently extends to notions of the patient being ‘special’ with the therapist seeing their own role as heroic or unique.

12. **SUGGESTION OR ACTIVE SHAPING ON THE PART OF THERAPISTS:**

If a therapist is for whatever reason convinced that what in reality are a fairly non-specific group of posttraumatic symptoms e.g. sleep disturbance, amnesia, aggression, anxiety, sexualised behaviours, etc., constitute confirmatory evidence of an as yet unacknowledged syndrome, e.g. satanic ritual abuse, then we have a traumatised patient and a therapist who not only shows interest and an overt willingness to step into the role of protector, but as well provides the explanation for behaviours and feelings with an implicit message that such interest and protection is conditional on the patient accepting the framework of the role unconsciously offered to them and reinforced by leading questions.

13. **TRANSGENERATIONAL IMPRINTING:**
A patient who as a child witnessed the spontaneous and frightening abreactions of a parent may so identify with what the parent was reacting to, that they will remember the content of the abreaction as if it happened to them.

14. **MULTIPLE REALITIES:**

Patients with dissociative disorder, as much as they may manifest differing ego states, may experience life as multiple different realities.

15. **SOURCE ATTRIBUTION ERRORS:**

In non-dissociative individuals source attribution errors are common e.g. an individual may recognise a face in a crowd but despite the familiarity of the face may have marked difficulty placing the context from which the individual is known. In the dissociative individual where there are repeated gaps in memory associated with episodes of partial or complete amnesia and where frequently the individual is being triggered into flashback states the standard difficulty that exists in being able to correctly source a memory is compounded such that events, stories, films seen, the distant past and flashback experiences may exist as fragmentary memories that are difficult to accurately source.

**Appendix 3:**

**Examples of historical cases involving the recovery of traumatic memories.**

1. The Case of Mme. D described by Morton Prince, 1905.

In his book, “The Dissociation of a Personality (1905), Morton Prince details his assessment and treatment of Christine (Sally) Beauchamp. In doing so he draws on the existing literature on dissociation and includes references to many dissociative patients including Mme. D.

“The second consciousness, as was afterwards shown, was not Sally. Such observations show the character of this kind of amnesia, but in these experiments no attempts were made at synthesising the disintegrated fragments of consciousness.

These phenomena confirm what Janet has so strongly insisted upon as the characteristic of hysterical amnesia; namely, that from one point of view it is not amnesia at all, that the lost memories are conserved, but so dissociated from the personal consciousness that they cannot be recalled. They can, however, be awakened as automatic phenomena.

The classical case of Mme. D. is a good illustration of extensive amnesia of this kind in an otherwise intelligent mind. It was studied by Charcot, and later by Souques, and Janet. On August 28, 1891, the poor woman received a terrible mental shock. She was working in her house when suddenly a strange man entered and roughly called out to her, ‘Your husband is dead. They are bringing him home. Prepare a bed, Madame D.’ The news was false, but the neighbours assembled and there was much emotional excitement. In the midst of it one of the women, seeing the husband approaching in the distance, was unfortunate enough to cry out, ‘There he is!’ On hearing these words, Mme.D., believing that her husband was being brought home dead, fell into a hysterical attack, characterised by delirium and convulsions. This attack lasted three days. At the end of that time Madame D. came to herself, but then it was found that a curious thing had happened. She had forgotten everything that had occurred
since July 14, six weeks previous to the shock, - a retrograde amnesia. But this was not all. She continued to forget everything that happened, everything she experienced, as fast as it occurred, hour by hour and minute by minute. (This is called continuous amnesia.) She lived her life as usual, but under the restrictions of this amnesia, which lasted nine months, until May, 1892. Among other experiences she was bitten by a mad dog, and was taken to Paris to the Pasteur Institute to be immunised. Her husband, taking advantage of her being in Paris, brought her to Charcot, at the Salpêtrière, on November 23. She had no recollection whatever of anything that had taken place subsequent to July 14. For everything previous to that date her memory was good. She remembered nothing of the accident that caused her troubles, nothing of being bitten by the dog, of the journey to Paris, or of being treated at the Pasteur Institute. Later, after having been some time at the hospital, she could not remember, at any particular moment, where she was, or recall the names of those whom she daily met. Charcot was the sole exception. She had seen his portrait before July 14, and remembered his face.

Now it was easy to show that these lost memories were only dissociated, and not absolutely effaced. In the first place that patient was heard to talk in her sleep; that is, she dreamed about events which had occurred during the periods of the retrograde and anterograde amnesia. ‘That dirty dog’ for instance, she said, ‘he has bitten me and torn my dress.’ In the second place, when hypnotised she recalled all the forgotten events and related them with exactness. She recounted the scene of August 28, the bite of the dog, her arrival in Paris, her inoculation against rabies, her visits in Paris, her entrance in the Salpêtrière, etc., with striking care and accuracy.

It thus was shown that in hypnosis the memories of past experiences were associated among themselves, systematised, and preserved, as if in the memory of a second personality. Janet, experimenting still further on the same subject, showed that the lost memories could be recovered in the waking state by the process of abstraction and automatic writing. The memorial images, therefore, were not obliterated but were merely dissociated from the waking personality. It required only a device to awaken the systematised memories, dissociated from the personal consciousness.

But the facts were something more than this. It was not alone that by an artifice Mme. D. was made to recall what she had forgotten. We do this in a different way every day of our lives. It is rather that at a time when the subject is unable to remember anything of a certain period, at this same time while in another state she possesses completely the lost memories, and lose them again when she goes back to the waking state. With the alternating states there is an alternation of memory and amnesia, but during amnesia the memories almost seems to be waiting, as it were, to be recalled by the proper signal or device (pg 250-252).

ii. The Case of a 31 year old airman described by Abram Kardiner and Herbert Speigel, 1947.

In their book, “War Stress And Neurotic Illness” Abram Kardiner and Herbert Spiegel in 1947 describe the case of 31-year-old man who presented with “severe headaches, fainting attacks, insomnia, distressing dreams, constant apprehensiveness, inefficiency, and fear of high places”, some seven years after discharge from the army.

“His attacks came at frequent intervals, occurring everyday during the first four years after the war, though only about three times a week during the last year. The anxiety dreams which in part caused his insomnia, were all the same character –falling from high places. Nothing in his pretraumatic history was relevant to his present condition...
All the patient’s complaints followed in the wake of the trauma that he suffered. He was in an airplane one day, when, at a height of 3,000 feet, something went wrong with the machine. Apparently one of the wings crashed, and the plane began to fall. At the time he first recovered consciousness he had a complete amnesia for all details of the fall and could only remember awakening to find himself unstrapped from the plane and climbing up the tail. He lost consciousness again and woke up to find himself in the hands of a rescue party. There was an interval of several hours between the time of the fall and the time of rescue, since he fell into a marsh which was difficult to reach…

The attacks lasted from twenty minutes to half an hour and were of variable intensity. They could be brought on by external stimuli, such as a great deal of noise or some other form of irritation… The loss of consciousness was not always complete, the patient retaining at times some contact with the environment, though he was unable to make voluntary movements or to speak. He always emerged from this attack very weak, in a sweat of agony and anxiety. The anxiety dreams which he had at night made sleep horrible… They were always about falling off some high place… While awake, the patient naturally avoided all high places…

The patient began by not being very cooperative. Treatment for his condition had become a routine matter of getting more pills and he found my questioning decidedly unpleasant.

This first reaction to me was taken as a starting point. He was urged to try to make clear to himself why the procedure was so unpleasant and as a consequence made him want to stay away. After considerable fumbling the patient recognised that his reaction was due to the fact that he felt uncomfortable while with me and retained a considerable amount of discomfort after he left. The next step was to identify the nature of this discomfort and his answer was, ‘I don’t like to be thinking about those things you make me think about; I’m trying to forget them.’ Furthermore, the ‘feeling worse’ meant also that when he talked to me, particularly about the circumstances of his trauma, he had a ‘queer sensation in the pit of his stomach- the way I often get before I go off.’ After a little more prodding about the nature of this sensation he said it was 'like going down in an elevator very fast.’ This was the first clue and I showed him immediately that he was reproducing the traumatic event. That is, the sinking sensation in the abdomen was actually the experience he had in the falling plane immediately before losing consciousness…

In the subsequent interviews I could easily observe that his tolerance was increasing, judged by the length of time he would stay. In this manner all his hallucinatory symptoms –such as the cutting sensation on his forehead – could be reunited to his original experience in the cockpit. At this point the patient spontaneously discovered why he could not fall asleep. He could not abandon himself to sleep because whenever he closed his eyes, images of being in the airplane would obtrude themselves, from which he would immediately try to get away… The patient thus began to understand that the insomnia really represented an unwillingness to abandon himself to an ever-present awareness of the traumatic situation, and that he was continually reproducing the experiences he had on the original occasion.

Consequent upon his first understanding of the nature of his attacks I became a protecting parent, this being easily discernible from the exclamations he would utter during the first weeks of the treatment. Frequently, as he was about to lose consciousness he would shout, ‘Doc, hold my hand; here I go;’ and a reassurance on my part would often abort the attack… It was not very difficult to convince him of two important things. First, that all these devices he was using were defensive manoeuvres of a more or less reflex and disorganised kind. And secondly, that these defensive devices were quite irrelevant to the actual world in which he was living…
Within a month or six weeks the frequency of his attacks began to subside and the patient learned not only to tolerate but actually to rehearse the traumatic event, this latter to such an extent that he actually recovered most of the details of the fall in the airplane…

The treatment lasted about six months and the results achieved at that time were truly dramatic. In addition to the above mentioned consequences were his increasing interest in his family, his ability to participate in normal social activities, and finally, his efforts to go back to his old occupation of being an automobile mechanic. He could now tolerate the shock of a sudden noise and the backfire of an automobile would not throw him into spasms. I considered him at that time a sufficiently good result to dismiss him. I asked him, however, to return from time to time to report on his progress and to fill in any gaps that we might have omitted. During the next three months he voluntarily reported to me once. On this occasion he told me that during his absence he felt so completely recovered that he had even ventured to try another flight. He made the flight without mishap. Six months after this – that is, about fifteen months after treatment was begun – I sent for him with the idea of checking on the permanence of the improvement. During this interval he had been working all the time as an automobile mechanic, was entirely self-supporting, and had had but three attacks. The first two of these were minor in character but the last, as he put it, ‘was a pip… It was the worst attack I ever had in my whole life.’ Needless to say, my disappointment was very keen. However, I asked him to describe his experience fully and the following was his story.

‘That day on which I had my last attack I got up in the morning after a bad night. I don’t remember what I dreamed, but I did feel very blue. There was something on my mind, but I did not know what it was. I had a small job to do that day which was to take me only a couple of hours. I didn’t feel much like working but did, and I came back to lunch. I didn’t feel very well and decided to take a walk. I did that for while, then I went home. Again I felt restless and went to a movie but did not stay to the end. I finally decided that I would go to bed early. I slept until about 4.30 in the morning, when I woke up suddenly with a terrific pain in my back, running up to the base of my head. And I remember waking up crying, George乔治。(George was the name of the pilot in the plane which collapsed.) I remember seeing my wife; I remember that she left the room and that somebody else came in with her – one of the neighbours. She asked me what was the matter with me but I couldn’t answer. I didn’t lose consciousness, but kept staring into one corner of the room which was dark and I saw something. I saw all this and yet I was in it. It looked as if I and George started out in the plane and we flew around for a while. Then we developed some engine trouble and had to land. We had it fixed and then we started out again. We got just above the clouds when I told my buddy to get down underneath the clouds. He paid no attention to me so I took the plane from him – that is, the controls – and began to get down under the clouds. Just as we were going down I noticed another black object coming from the clouds. It was another plane, but we couldn’t get away from it in time. All of a sudden we heard a crash and the right wing collapsed, clear over our heads, and we started right down. I couldn’t do anything; I lost all power. I thought of my buddy because I knew he was nervous. I remembered that I had to jump. And then there was a sensation of striking the ground and the buckle which held my strap unloosed and I began to climb up the tail of the plane.’

Then there followed a description of the rescue party and of how the patient, after helping to pull his buddy out of the space between the motors, held him in his lap. Then followed something in his hallucinatory panorama which was not in the original experience. The scene shifts from the falling plane to his bedroom, where he sees his buddy alive. The latter hands him a photograph of himself and then places it on the buffet. This ended the dream or hallucination.
The patient came out of his experience weak and in a sweat. He said that it was the worst attack he had ever had and insisted that it was not a dream because he remembered shouting, ‘George’; remembered seeing his wife come into the room; and recalled making the effort to move and speak, neither of which he could execute. He said that it took him an unconscionable time to recover his composure and that when he was completely himself again it flashed through his mind that the day of the attack was the ninth of February, exactly seven years after the original fall from the plane. He remembered, furthermore, that on the preceding day his wife had taken his buddy’s picture from the wall and put it on the buffet, as happened in the hallucination.

This episode was quite remarkable. Such complete recovery of amnesia is the kind that takes place only under the influence of very deep hypnosis. Secondly, it took place on the anniversary of the fall. Thirdly, it reproduced many details of the original accident for which the patient had previously an almost complete amnesia. Although much of this amnesia had been lifted in the course of the treatment there were still a considerable number of details, which he had forgotten. He recalled for the first time that he was in charge of the controls when the accident took place; that the accident was caused by a collision with another plane; that the right wing had broken off; his concern about his buddy; how his buckle had become unloosed; and finally, how he held his buddy in his lap after the rescue party had reached them. As to the meaning of the last episode – his buddy placing his picture on the buffet – it is probably another way of undoing the whole traumatic incident, because it assures him that his buddy did not die. However, no conclusive construction of this episode could be reached with the patient. The time the patient saw me was about a month after the last episode. He had been feeling well since and had no more discomforts of any kind. I had only one further contact with this patient and that, some six months after this last reported episode. He had been well during the entire period. On the strength of my knowledge of his case I ventured to predict to him that he would probably never again have another attack.

To consider that the therapy consists of the lifting of the amnesia would be an error. This cannot be made an objective of the treatment for the reasons indicated. The amnesia is already a symptom of a collapse in ego resources and of the continuous defensive policy of the new adaptation. The amnesia can be lifted only when the individual’s picture of the outer world has been changed, when his courage and resources in handling this new external reality have been increased or restored, at least in part, to their erstwhile state. The circumstances instrumental in the creation of this hallucinatory episode were several. Some were accidental, such as his wife’s taking the picture from the wall and putting it on the buffet; another was a repetitive phenomenon, namely the anniversary of his fall; and finally the patient showed in the ability to reproduce the whole original event that his resources were equal to it without losing consciousness (pg 382-389)."

Appendix 4:

**Documented examples of verified extreme/complex traumas.**

Not infrequently patients with dissociative disorders give accounts of traumas which in terms of their severity, or in terms of the reported context, can strain credulity. Some such accounts can occur with a patient in which there has already been verification for traumas that occur within the more commonly reported spectrum. Whilst some memories of traumas can be deduced as inaccurate based on the impossibility of what has been reported, it is nevertheless wise to remain both objective and open-minded. It is unwise to assume the historical accuracy of reported memories of trauma on the basis of
the degree of conviction displayed by the patient, the intensity and congruity of the affect associated with the telling of the reported trauma, or on the basis of the reported severity or duration of the trauma.

Richard Kluft (1984) observed in regard to patients with Multiple Personality Disorder (since renamed Dissociative Identity Disorder) that “one may find episodes of photographic recall, confabulation, screen phenomena, confusion between dreams or fantasies and reality, irregular recollection, and wilful misrepresentation. One awaits a goodness of fit among several forms of data, and often must be satisfied to remain uncertain (pg 14).”

Whilst reported memories of satanic ritual abuse that include references to widespread conspiracies, ‘incubators’ and serial human sacrifices or memories that focus on abductions, experimentation and impregnation by ‘aliens’ or memories that include an individual’s birth and pre-birth experiences not to mention, past lives, stretch credulity, it is worthy of note that many humans believe things (frequently with tenacity and conviction) for which there is absolutely no scientific evidence. Wishes to see our lives as meaningful and death not as inescapable oblivion are central to religious systems of belief, the devotees of which are generally seen as sane and rational people.

In the defensive need to marginalise victims of severe trauma by dichotomising complex issues or dismissively using generalisations about ‘satanic abuse’ or ‘alien abduction’ it would be easy to characterise all accounts of complex long-term traumas as similarly improbable but for the fact that as society belated and patchily develops a willingness to know, so many such accounts are corroborated and criminal prosecutions undertaken against perpetrators of extreme abuses. Such abuses occurred in seemingly unremarkable societies before being finally exposed to the public gaze.

Briefly referred to below are representative examples of such trauma scenarios.

Demonstrably awful things can happen in families over extended periods of time without any apparent awareness on the part of the community of which they are a part. The magnitude of such proven traumas should induce mental health professionals to take extreme care not to be summarily dismissive.

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Family life at the West residence in 25 Cromwell Street, in Gloucester would make some horror movies seem tame, yet for over 20 years Fred West and his second wife Rose, lived without undue attention. Fred was noted by neighbours to be “a real gentleman” albeit one with penchant for excavating and concreting.

Police, who were investigating the whereabouts of the West’s oldest daughter, last seen in 1987, first focused on the Cromwell Street residence following a tip off from one of the West’s eight surviving children in 1992. Over several weeks police excavated the dismembered and decapitated bodies of nine women and girls from under the cellar, the back patio and the bathroom. Among the bodies was that of Heather West, the 16 year old daughter who had disappeared. The bodies of Fred’s first wife and an 18 year old pregnant nanny were dug up at another site. The body of Charmaine West, the eldest daughter of Fred’s first wife was found in a foetal position under the kitchen of the West’s previous home.

From early in their relationship Fred watched through a hole while his wife entertained men. Rose would regularly go out to clubs or pubs and would either not return that night or she would bring men
back with her. The children knew when Rose was “entertaining” because there was a light in the living room that if switched on meant she was not to be disturbed.

Fred’s step-daughter Anne Marie, at the age of 30, reported how from the age of 8 she was tied up in the cellar and regularly sexually abused by her parents, often with crude homemade instruments. When she protested, Rose ordered her to be quiet, telling her that ‘other families were doing exactly the same thing’. She was once forced to perform oral sex on her mother. On another occasion Fred inserted a semen-filled condom, knotted closed, into her and made her keep it there for several hours. When she was eleven, Rose forced her to have sex with a number of her clients. Her parents told her that she would be better prepared for her husband and that, “I was a lucky person that they cared so.” Fred also had sex with Anne Marie on numerous occasions until she left home at 15, in the same year she had surgery for an ectopic pregnancy.

Exemplifying the extremes of ambivalence that commonly are represented in the stances shown in different ego states towards familial abusers, Anne Marie who said of her parents, “I couldn’t understand how they could treat me so badly”, has also said that she still loves her step-mother and father, “despite what happened to me over the years.”

And what of Fred West’s family of origin? Brought up in a rural village by an illiterate father and a mother who according to his brother, seduced him at the age of 12, Fred left school at 15 barely able to read or write.

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Ongoing, unrecognised trauma can be occurring in the most respectable of households, a prominent example being described by Lenore Terr in her book “Unchanged Memories” (1994), and concerning the Van Derbur’s.

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Marilyn’s older sister, Gwen, has likewise gone public about her own incestuous abuse at the hands of her father, but unlike her younger sister, was never aware of recovering the memories of her abuse - they had never been inaccessible. She escaped the family home at 18, never to return.

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Serial killers may take many forms. In 1995, Waneta Hoyt faced court in New York State charged with the murders of her five children (Ragg, 1995). Originally the deaths had been attributed to S.I.D.S., but in March 1994 after two hours by questioning of police she confessed to the murder of her five children. Three, she said, had been smothered with pillows, one with a bath towel, and, one by pressing its face against her shoulder. She told police, “I could not stand the crying. It was the thing that caused me to kill them all, because I didn’t know what to do for them”.

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One of the more extreme cases of documented extreme familial sadism extending over almost forty years was that of Tommy Thompson who in 1988 was shot by his two daughters using his shotgun. The story of their family life based on the accounts of Tommy’s wife Hilda and her two daughters June and young Hilda was published in 1993 (Artley) and details Tommy’s extreme physical and emotional cruelties to his wife including chronic disfigurement from his beatings, almost daily assaults to the point of unconsciousness in front of the children, threats to use his shotgun on her and the children and forcing her to undergo an abortion carried out by himself on the kitchen table. His assaults were administered with commands such as, “Stand still when I am hitting ye, ye thick bitch”. From the age of 13 the older of his two daughters was subjected to regular incestuous attacks. The daughters were allowed no outside friends and were forced by their father to wear wedding rings. Within the house there was no attempt to be secretive about the incest; Tommy’s wife was forced to buy the condoms that he used on his daughters. Throughout, the three Thompson women had many medical contacts. They were treated for heart disease, cancer, back pain, epilepsy, diabetes, depression etc. etc. The younger Hilda seemed particularly troubled yet when asked by GP’s or psychiatrists if there was something wrong invariably said that there was “nothing I can think of”. By the early 80’s she had become alcoholic. In 1984 she was admitted for a course of ECT. When she told her father she wanted to kill herself, his only reply was that if anything happened to her, he would kill June and their mother....

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In May 1995, Dr. Sarah Hamilton-Byrne’s book on her life in Anne Hamilton Byrne’s cult, “The Family” was published. It is an entirely credible, corroborated account complete with photographic and documentary proof of the bizarre child-rearing practices perpetrated by Anne Hamilton-Byrne and a group of her sadistic followers known as “aunty” and “uncle”. Illegally adopted and with documentation based on false declarations, Sarah and the other children were made to believe that Anne who functioned in the role of guru was their natural mother. The children’s life in a fenced off compound which denied them virtually all access to the outside world, was one of continuous severe beatings, cold showers, being locked in cupboards, starved and humiliated. They were threatened with bull ants, held upside down over open septic tanks, publicly stripped and thrashed, their food was laced with minor and major tranquillisers, their heads were held under water to the point where they’d believe they were drowning and physical violence extended to the point where one child sustained a fractured skull and life-long epilepsy. The children for the most part were systematically starved, leading in the extreme examples to severe malnutrition and failure to thrive, yet the standard punishment for stealing food was to be denied meals... Most of the children were forced to have their
hair dyed a uniform platinum blond colour. As they grew older each adolescent was forced to undertake a bizarre ritual initiation into the cult based around the forced ingestion of LSD. The cult controlled Newhaven Hospital, itself the focus of media investigations in the 90’s due to the way in which LSD was used on the premises. Sarah made her first suicide attempt at the age of 5 and life in general went downhill from there.

Sarah Hamilton-Byrne’s description of her adjustment in the years following the Police raid which released the children, is typical of a highly traumatised and dissociative individual struggling to reconcile her ambivalence towards the person primarily responsible for her enduring trauma. She describes trying to suicide several times “almost subconsciously” during a year that for the most part she does not remember. As she puts it, “I think I was constantly in a trance or a daze, not functioning on a rational level at all” (pg. 208). Despite the horrendous nature of her abuse and that of her “siblings”, Sarah Hamilton-Byrne’s account contains the same sort of unresolved ambivalence towards her mother figure as that present in other accounts already mentioned. She wrote in 1995, “Perhaps she still has a little power over me. Secretly, maybe I still love her. I don’t know. If she walked into my life now and said, I love you, Sarah, and I want you to come back and be part of The Family; I wouldn’t do it, but I would have a hard time withstanding her. I’d try to I suppose, but she looms so large in my life. The mother I never had, the mother I craved. She was all there was...”

Like so many traumatised individuals Sarah Hamilton-Byrne became a health professional (see Middleton & Butler, 1998) qualifying as a doctor and ultimately going into general practice before in July 2005 escaping conviction in the Ringwood Magistrate’s Court after pleading guilty to 160 charges relating to forging prescriptions to obtain pethidine from November 2004 to April 2005. She had had three court appearances between 1998 and 2001. Magistrate, Nunzio La Rosa said Sarah Moore (formerly Sarah Hamilton-Byrne) claimed she sought relief with pethidine for pain caused by an incision in her abdomen made as part of her initiation into the cult. He said she was the only victim of her crimes and had taken near-lethal doses of pethidine (see O’Connor, 2005, a & b).

In April 2005 Time Magazine reported on a trial underway in Angers, just 265 kms from Paris, in which 39 men and 27 women had been committed to answer charges arising out of alleged involvement in a massive prostitution trade of 45 children – many of them their own. Vivienne Walt in Time reported that, “at least 26 men and 13 women are accused of directly prostituting and raping girls and boys, some of whom were still in kindergarten. Prosecutors say that over three years, some 21 couples traded their children for cash, groceries and, in one case, a new car tire. According to prosecutors, Marine V., a pretty blond girl who’s now 9, was just one of the victims. She was allegedly raped by about 30 men, including neighbours, uncles, her father and grandfather. Marine’s mother acted as banker allege prosecutors, collecting envelopes full of cash...

The children’s details of their long ordeal are almost unbearable to hear. But equally disquieting are the apparent failures of the French social system: police failed to protect the children from nearly three years of abuse, and did not act when social workers warned of possible pedophilia. And France’s prisons could not apparently rehabilitate those accused men who had already served time for pedophilia; they resumed their crimes after they were released on probation (pg 37).”

13 of the women in trial were charged with raping boys under 15 and organizing child prostitution. 21 of the 23 families implicated were under the supervision of social workers, who paid frequent visits to
their homes... Three of the accused men had been convicted previously of pedophilia, including Marine V.’s grandfather, who in 1991 was sentenced to 13 years for raping his son.

Walt describes a trial conducted in a purpose built courtroom built at a cost of about $1 million. “The accused sit silently listening as witnesses and prosecutors recount how some of the women helped their husbands organise a steady flow of customers to have sex with their daughters, sons, nieces and nephews. In their defence, many of the women have testified that they, too, were victims of incest, abused as children, by alcohol-soaked men at home (pg 38).”

“Meanwhile, the children remain deeply traumatised. After an intensive period of psychotherapy, 40 have been placed with foster families in western France, while five are living with their relatives. Social workers and psychiatrists keep a close watch on them. Many of the children still have difficulties eating and sleeping, let alone speaking to strangers or studying at school, according to their lawyers. ‘There was a family omertà [rule of silence], like the Mafia’, says Jacques Monier, who represents 11 of the children. ‘Now there are children who regret denouncing their parents. They think it’s their fault that they are on trial’ (pg 39).”

In 1997 Kevin Lynch who had enjoyed high regard as a teacher and counsellor committed suicide via carbon monoxide poisoning prior to formal questioning by police in regard to his involvement in the serial sexual abuse of almost 100 boys in his care. Assoc Prof Don Grant who published a profile of 15 of Lynch’s victims stated, “Externally, Lynch was a sociable, charismatic man who was popular with fellow staff and students, and was married to a teacher with whom he had three children. Originally entering the school system in 1965 as a humanities teacher, he began working at Brisbane Grammar School in 1973. His interest in vocational counselling led to a diploma and his subsequent appointment to the then-new role of school counsellor in 1977. He was highly respected in his teaching and counselling roles, and was promoted to Head of Department in 1984, although during his divorce in 1988 he resigned from Brisbane Grammar and later gained a position at St Paul’s Anglican College in Brisbane.

While rumours about Lynch had apparently been common knowledge in the schoolyards of both establishments, it was not until 1996 that a complaint against Lynch was investigated by police...The shooting of three police officers and subsequent suicide of former Lynch victim Nigel Parodi in April 2000, led to media reports of sexual abuse by Lynch as a factor in this tragedy. Subsequently, 65 former pupils from Brisbane Grammar and 25 from St Paul’s reported being abused by Lynch while they were at school...

In many cases, Lynch apparently used hypnosis to induce amnesia or repression of the abuse, and several victims reported feeling that they often left his office ‘in a fog’. A number of those interviewed referred to traumatic, sudden recall of the abuse – one former school student reported seeing Lynch’s photo in the newspaper following the Parodi case and felt as though he had been ‘hit over the head’, after which memories flooded back over the following weeks (pg 8-9).”

Grant reported on his assessments of 15 of Lynch’s victims. In the 15 he identified 5 with a mixed personality disorder, 8 with personality dysfunction, 4 with depression, 7 with alcohol and substance abuse, 3 with anxiety disorders, 2 with delayed post-traumatic stress disorder, 4 with sexual ambivalence and 1 with a dissociative disorder. He commented. “All of the boys interviewed in the sample showed varying degrees of psychological or psychiatric disturbance. Whatever their diagnoses,
all of these boys had suffered psychologically (and sometimes physically) at the hands of Lynch, and this had persisted – and in many cases intensified – into their adult lives. To quote one victim’s poignant question: ‘I lost my virginity to a guy in a room who was also a school counsellor – how do you think that makes me feel (pg. 9)?’

In November 2005, Paul Weston, writing in The Sunday Mail reported on how Tommy Campion a 58 year old Gold Coast pensioner in Queensland had written a five-page letter to the Anglican Church “in which he graphically details the sadistic treatment he and fellow orphans suffered at the church’s North Coast Children’s Home at Lismore in northern NSW in the 1950’s (pg 24).”

It was reported that instances of “cowardly physical, verbal, emotional and sexual abuse from the staff, clergymen and matron” had been corroborated by many other victims who contacted Mr Campion’s Brisbane lawyer, Simon Harrison. Mr Harrison was quoted as saying, “It will probably become one of the most significant abuse claims in Australia – that’s how it is developing at the moment…. The orphanage housed 50 people at any one time. The abuse appears to be systematic and ongoing for some time.

This was open abuse – most kids were witnessing it, on the ends of their beds watching it. And it was the intensity of it… it gave me the impression of Dante’s version of hell (pg 24).”

On receiving Mr Campion’s letter, the Anglican Church Dioceses of Grafton registrar the Rev Pat Comben went on the public record promising to help Mr Campion “move beyond the pain caused in an Anglican place that should have been safe.” He added, “I am unable to adequately express my feelings of revulsion, sorrow and helplessness which the letter raises inside of me (pg 24).”

Outlined below is an extract from Tommy Campion’s letter to the Anglican Church:

“I lived in the Children’s Home for almost 14 years and most of those years were complete and utter hell.

During that time I suffered horrifying cowardly physical, verbal, emotional and sexual abuse from the staff, clergymen and, especially, from the matron in charge.

Today I still clearly see images of children being flogged and beaten until they could no longer stand up. I still hear the yelling and screaming of the children, their panic-stricken voices pleading for help.

I dream about it, I think about it and cry openly and curse the people from the Home and the Anglican Church for allowing it to happen to me and other children.

I still picture the down-trodden children desperately begging for food and I bitterly relive the abuse and shocking treatment we received time and time again. Matron dished out punishment, seemingly without the blink of an eye and seemed to revel in it.

One night in the dormitory, standing with the boys I was flogged so brutally, by her, the skin on the back of my neck split open. To this day I still have the scars from that terrifying beating.
Children who had the misfortune to soil their beds had their faces rubbed in the urine or faeces by the staff or Matron would wrap a sheet around their heads and beat them while being paraded up and down the dormitory as an example to her children.

For punishment some children were ordered to stand on one leg. If the leg was placed on the ground before they were allowed to, they were flogged with a stick, an electrical cord, a strap or flexible twig from a tree.

One time that’s still clear in my mind was when a child collapsed to the floor from absolute fatigue; he was callously belted and made to do the same thing, this time, on the other leg. And, of course, under immense pressure he collapsed again and received another brutal whipping from Matron.

I should explain that the child was 10 years old. It was me.”

Weston’s original report prompted more than a dozen “former inmates” of the North Coast’s Children’s Home at Lismore to contact lawyers acting for Mr Campion to lodge similar complaints.

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The Cannan Institute Limited is a non-profit mental health organisation, which has a research and educational charter. It endeavours to sponsor or convene conferences and seminars which tackle substantive issues of both theoretical and clinical interest.

Conferences in recent years convened by The Cannan Institute include, “Blind to Betrayal: Forgetting, Unawareness and Interpersonal Trauma”, featuring Professor Jennifer Freyd and held at the Bardon Conference Centre, Brisbane on 23rd February 2002, “Boundaries”, featuring Professor Glen Gabbard, opened by the Queensland Health Minister, Wendy Edmond, and held at the Sheraton Hotel, Brisbane on 13th and 14th April 2002, and, with The Delphi Centre, the international conference on trauma, attachment and dissociation, “Transforming Trauma: Critical, Controversial and Core Issues”, held at The Grand Hyatt, Melbourne on 12th-14th September 2003, the conference series “Complex Trauma: New Developments in the Treatment of Personality and Stress Disorders, Attachment Disturbance and Relational Dysfunction” featuring Assoc Prof John Briere held in Melbourne, Sydney and Brisbane in August-September 2004, and the conference series, “Healing Chronic Traumatization” featuring Dr Ellert Nijenhuis and held in Melbourne, Sydney and Brisbane in April 2005. All these conferences tackled major contemporary issues of particular interest to mental health professionals, but also of great relevance to the wider health, legal and education communities etc. In addition to conferences The Cannan Institute has been involved in organising an ongoing series of dinner meetings at Belmont Hospital featuring innovative speakers addressing topics of particular relevance to the mental health field. These dinner meetings have included presentations by Prof Jack Pettigrew, Dr Ray Kerr, Prof Max Stampler, Mr Hedley Thomas (discussant Dr James Scott), Prof Pankaj Sah, Prof Michael Fenech, Prof Barry Nurcombe and Prof John McGrath. The Delphi Centre in collaboration with The Cannan Institute and the Trauma and Dissociation Unit, Belmont Hospital convened a seminar, “Feeling, Knowing & Being: Perspectives on Dissociative Disorders & Their Treatment”, Victoria University, presented by Assoc Prof Warwick Middleton, 8th-9th April 2006. A three state conference series which The Cannan Institute, in collaboration with The Delphi Centre and the Trauma and Dissociation Unit Belmont Hospital, convened was “Trauma Model Therapy: Treatment Techniques for Borderline Personality, Psychosis and Dissociation” featuring Dr Colin A. Ross and which was presented in September 2006. Other seminars involving The Cannan Institute and scheduled during 2006 include “Trauma, Dissociation & Psychosis: Conflicting Realities” featuring Assoc Prof Warwick Middleton (WA, July), “Integrating DBT into a Clinical Approach for the Management of Complex Trauma” featuring Sandi Plummer (Brisbane, Oct) and “Surviving Childhood: Understanding Childhood Trauma and its Sequelae” (Tas, Nov). Further seminar series featuring Prof Warwick Middleton (May) and Assoc Prof Christine Courtois (Sept) are scheduled for 2007.

The Cannan Institute Limited has been involved in a number of research projects in which a substantial amount of the research has been carried out within Belmont Hospital. Such research projects include a large body of work examining cognitive inhibition in Dissociative Identity Disorder (Dorahy, M.J., Irwin, H.J. & Middleton, W.), auditory hallucinations (Hargreaves, L., Dorahy, M.J. & Middleton), patterns of changes in cerebral hemispheric switching in Dissociative Identity Disorder (Pettigrew, J. & Middleton, W.), the patterns of major road incidents in patients with D.I.D. (Antoce, G., Middleton, W. & Dorahy, M.J.) etc. Papers written citing the affiliation of The Cannan Institute regularly appear in Australian (and other) psychiatric journals.

The Cannan Institute Limited Board consists of Dr Georgiana Antoce (Treasurer), Dr Jeremy Butler, Dr Michael Martin, Professor Warwick Middleton (Chair), Mr John Smith, Dr Mark Spelman (Secretary), Dr John Thearle and Dr Al Unwin. The patron of the Institute is Sir Llew Edwards.

For further information on
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ADVANTAGES OF JOINING THE CANNAN INSTITUTE

Members of the mental health community or those with a professional interest in mental health issues are invited to become members of The Cannan Institute.

Ideas for the formation of The Cannan Institute took shape in the late 1990’s and by 1999, articles of association had been prepared, a board appointed and a mission statement and objectives delineated and agreed upon. The Cannan Institute’s Mission Statement is to “support and promote research into and education about mental health.” From the time of inception, Sir Llew Edwards, Chancellor, University of Queensland, has been the patron of The Cannan Institute.

The Institute has been well served by a motivated board and has involved itself in organising and convening conferences/seminars/dinner meetings concerning topics or issues of particular relevance to the mental health community. The Institute has continued to work collaboratively with a number of organisations or companies in supporting particular projects, it has conducted research and it has provided opportunities for others to have access to clinical settings/facilities in order to further their own appropriately approved research projects, it has facilitated an ongoing series of peer based clinical presentations, and there have been ongoing publications in scientific journals reporting on research/clinical matters including research completed in association with the Institute and/or written by members of the Institute.

All educational events (conferences, seminars, dinner meetings) with which The Cannan Institute has been associated have been characterised by a welcoming, friendly inclusiveness and there are now a considerable number of colleagues who are regular attendees.

Annual membership of The Cannan Institute is a modest $55 (inclusive of GST). Membership is renewable at the end of each financial year, (though new members who join in the 2nd half of the financial year have their renewal held over to the middle of the following year).

Members of the Institute receive a discount on the registration charges for all conferences or seminars that The Cannan Institute has a role in convening. Members receive free registration (assuming they register in time) for any of the ongoing series of dinner presentations convened by the Institute and held at Belmont Hospital. Aside from being on The Cannan Institute’s mailing list and receiving notification regarding forthcoming educational events involving the Institute, members will shortly be receiving a regular email bulletin concerning Institute’s activities, research projects etc. The Institute will do what it can to assist in furthering approved research projects put together by Institute members.

Categories of membership of The Cannan Institute are available for medical and non-medical professionals. Application forms are available from the Institute secretariat.

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3) Declaration and Application

I acknowledge that if my membership application is accepted by the Board, I will be expected to abide by the Constitution of the Cannan Institute Limited and any By-laws or Rules and Regulations published by the Board from time to time.

The charter of the Cannan Institute Limited, a non-profit organisation, includes the conduct of research into and education about the causes and treatment of mental illness.

I apply for general membership of the Institute. I acknowledge that the Board will determine an annual membership fee. My cheque for the yearly membership in the sum of $50.00 + $5.00 GST payable to “The Cannan Institute Limited” is attached. (Membership is renewable on June 30, annually.)

Signature: ............................................................ Date: .................................................
The Trauma and Dissociation Unit, Belmont Hospital is now in its tenth year of operation and it offers both inpatient and day-hospital programs for individuals who are suffering with the complex sequelae of long-term developmental traumas. Such sequelae include dissociative disorders, post traumatic stress disorder and a proneness to chronic dysphoria. As well such individuals have experienced the impact of trauma on personality development, affective stability, sexual functioning, sleeping patterns and on a propensity to utilise a range of self-harming/self-soothing strategies. Not infrequently such individuals are struggling with ambivalent attachments and how to maintain a basic level of safety. The vast majority have lived long-term in environments in which safety and trust were infrequently experienced and where boundaries were not much in evidence. Patients treated in TDU for the most part, in addition to their dissociative disorder would fulfil diagnostic criteria for a range of trauma-spectrum DSM-IV specific conditions.

TDU has had an active research program since inception and an ongoing series of papers by individuals associated with the Unit regarding trauma and dissociation, have been published in Australian and international scientific journals. Whilst employed in TDU, Dr Martin Dorahy completed the first PhD awarded in Australia for research into dissociation/dissociative disorders. As a result of the very high standard of his doctoral thesis he was, in November 2002, awarded The David Caul Memorial Award by the International Society for the Study of Dissociation. By maintaining active research and by being involved in convening and participating in cutting-edge seminars and conferences, TDU has been well positioned to remain very up to date with international developments in the trauma and dissociation field and for TDU staff to apply such knowledge in constantly updating the focus and the content of unit programs. Both Prof. Warwick Middleton and Dr Martin Dorahy (who is currently working overseas) are members of the Editorial Board of the Journal of Trauma and Dissociation.

Whilst at times, within the mental health community perspectives may be offered that characterise dissociative disorders/psychological trauma as some narrowly defined subspecialty area or alternatively as an area particularly associated with exaggerated claims, iatrogenesis, suggestible patients, gullible therapists, false memories etc., the view always taken in the running of TDU, is that the understanding and treatment of complex adaptations to long-term developmental traumas should always be viewed as main-stream psychiatry. Numerous studies over the last quarter century have amply shown that around two thirds of all randomly selected psychiatric inpatients or outpatients will have a history of childhood sexual or physical abuse. In females in particular, over a third of all patients will have a history of both physical and sexual abuse. Of all the relevant factors studied, the one factor above all others that is most likely to predict the future utilisation of mental health services is having a history of childhood trauma. Depending on the study some 15-30% of randomly assessed psychiatric inpatients will fulfil diagnostic for a dissociative disorder. Some 4-5% of randomly assessed inpatients will fulfil diagnostic criteria for the most extreme form of dissociative disorder, dissociative identity disorder.

TDU in its staffing, structures and relationships with admitting psychiatrists is designed to be mainstream, open, accountable and to adhere to the sorts of quality assurance processes that would apply to any well run unit focussing on running inpatient and day programs for a particularly defined patient group. It is unhelpful to view
traumatised/dissociative patients as “special”, just as it is a mistake to characterise trauma units or those individuals that work in such environments as “special”. It is with this perspective very much in mind that over the years a series of papers on dissociative disorders authored by professionals associated with TDU have been published in mainstream Australian psychiatric journals. A detailed account of TDU is contained in the paper, “Establishing and Running a Trauma and Dissociation Unit: A Contemporary Experience”, Middleton W. & Higson D., Australasian Psychiatry 12:4, 338-346, 2004.

Referrals to TDU

Whilst many patients referred to TDU are already patients of psychiatrists who admit to the Unit, other patients (frequently from outside Brisbane or from other Australian states) are accommodated in the Unit by being admitted under the care of one of the TDU affiliated psychiatrists who take part in an admission roster. Some such patients are admitted due to being particularly unwell or in crisis, others more electively in respect to focussed assessment and/or gaining improved functioning in areas that are a focus of current clinical attention. It is anticipated that all patients on discharge will return to/continue in the care of their usual therapist. Personal responsibility, sound boundaries and respect for others are issues that are emphasised and are represented in the need for all patients to sign admission contracts that emphasise the mutual contributions of both parties to treatment and the responsibilities of both. The average length of stay for the Unit is in the order of 15 days. It is recognised that while for some, periods of inpatient care are an adjunct to treatment and/or provide additional safety and support at times of crisis, overall successful treatment of dissociative disorders principally involves fairly long-term, predominantly out-patient based psychotherapy. In supporting predominantly outpatient based treatment of patients who often have limited family or social support, there is a valuable role for a hospital-based day program. The TDU day program is offered on two days per week  (Tuesday and Friday).

Any individual who would like more information about TDU and its clinical programs is most welcome to contact the Unit via phone, post or email. Those who would like to take the opportunity to visit the unit in order to better acquaint themselves with it can make an appointment to look over it and to meet Unit staff. The Unit has worked closely with organisations or individuals on educational or research projects and staff/consultants associated with the Unit value contact with colleagues working in related fields.

The Unit Director (Prof. Warwick Middleton), Senior Consultants to the Unit (Dr Jeremy Butler and Dr Michael Martin), Area Clinical Coordinator and Director of the Day Program (Ms Lenaire Seager) have all been involved with the Unit since inception. The Nurse Area Manager is Mary Williams.

For more information contact:-

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Selected Relevant Publications by Researchers/Staff Associated with the Trauma & Dissociation Unit (TDU), Belmont Hospital.


McAllister, M., Higson, D., McIntosh, W., O'Leary, S., Hargreaves, L., et al. (2001). Dissociative Identity Disorder and the nurse patient relationship in the acute care


Recent Conferences/Seminars involving The Trauma and Dissociation Unit (TDU), Belmont Hospital &/or The Cannan Institute.


“Boundaries”, featuring Prof. Glen Gabbard convened by The Cannan Institute, Sheraton Hotel Brisbane, 13th-14th April 2002.
“Transforming Trauma: Critical, Controversial and Core Issues”, international conference on trauma, dissociation and attachment with 8 international and 3 national keynote speakers and 2 one-day pre-conference, and 2 one day post-conference workshops. Convened by The Delphi Centre in collaboration with The Cannan Institute and TDU, Belmont Hospital, Grand Hyatt, Melbourne, 11th-15th September 2003.


“Healing Chronic Traumatisation: Integrative Treatment and the Theory of Structural Dissociation of Personality”, featuring Dr Ellert Nijenhuis. Convened by The Delphi Centre in collaboration with The Cannan Institute and TDU, Belmont Hospital, Leondra by The Yarra, Melbourne, 8th-9th April 2005, Westmead Hospital, Sydney 11th-12th April 2005 and Novotel Hotel, Brisbane 15th-16th April 2005.

“Feeling, Knowing and Being: Perspectives on Dissociative Disorders and their Treatment”, featuring Assoc. Prof. Warwick Middleton. Convened by the Australian Society of Hypnosis (Qld Branch) with assistance provided by TDU, Belmont Hospital, and The Cannan Institute. University of Qld, 22nd-23rd October 2005.

“Feeling, Knowing & Being: Perspectives on Dissociative Disorders & Treatment”, featuring Assoc. Prof. Warwick Middleton. Convened by The Delphi Centre in collaboration with The Cannan Institute and TDU, Belmont Hospital. Victoria University, Melbourne, 8th-9th April 2006.


SELECTED TEXTS SUPPORTING A CONTEXTUAL FRAMEWORK WITH WHICH TO VIEW DEVELOPMENTAL TRAUMA AND DISSOCIATION, AND THE SOCIETAL AND HUMAN CONDITIONS WITH WHICH IT IS ASSOCIATED.


The above list is not selected to be exhaustive or even begin to fully represent the many writers who have made major contributions to the field of trauma and dissociation. Essentially, what have been selected are monographs and not the very many relevant journal papers or book chapters that likewise address core issues. The monographs are selected for two reasons, 1) they are well written and very readable, and, 2) they represent a particularly important vantage point that helps an individual to personally map the territory that he/she is trying to understand and form a developed perspective of. Not all are books that even explicitly focus on dissociation, ie the works by de Waal, Greene & Elffers, Kardiner, Masson, Masterson, Salter and Wright, yet these works provide important additional reference points to assist in forming a broadened conceptual framework incorporating the historical, societal and clinical issues that are of particular relevance to better understanding psychological trauma and the societal and individual responses to it (including dissociation).

There are many excellent papers/book chapters on abuse, trauma, dissociative disorders etc. by Richard Kluft that address many of the areas encompassed by this selection – however his book publishing endeavours have been directed at edited volumes. There are many first rate writers who have perhaps, concentrated on more specialised areas, and whose works are those that one might move towards depending on particular areas of interest arising out of a sound knowledge of more broad spectrum texts. Included in such works are those by John Briere or Eve Bernstein Carlson on researching trauma, Jennifer Freyd on betrayal trauma, Ellert Nijenhuis and Onno van der Hart on structural dissociation, John Douglas Bremner on neuroimaging, Bessel van der Kolk on the neurobiology of trauma, James Chu on therapy, Ken Pope boundaries/forensic issues, Marsha Lineham on dialectic behaviour therapy or George Fraser on auto-hypnotic techniques etc., etc.

This list is prepared for attendees at the seminar, “Trauma, Dissociation & Psychosis: Metaphor, Strategy and Reality” convened by The Delphi Centre in collaboration The Cannan Institute and the Trauma & Dissociation Unit (TDU), Belmont Hospital, Carina, Brisbane. The Delphi Centre, The Cannan Institute and TDU have had an enduring and close involvement with the trauma and dissociation field, either singly or collaboratively convening many conferences or seminars in Australia that continue to regularly feature many of the authors that are mentioned here. An additional resource, compiled by the writer with this and other seminars in mind, is the paper “Reconstructing the Past: Trauma, Memory and Therapy.” This background paper which runs to 129 - A4 pages represents an extension to the exploration of some themes covered in the paper:- Middleton W, De Marni Cromer L, Freyd JJ (2005). Remembering the past, anticipating the future. Australasian Psychiatry, 13:3, 223-233. It is available by emailing me (warmid@tpg.com.au) or is available as a FREE DOWNLOAD from The Delphi Centre website (www.delphicentre.com.au) –access it on the front page of the Middleton PD site.

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DISSOCIATION AND TRAUMA – SELECTED PAPERS & BOOK CHAPTERS

This listing has been prepared as a resource for those attending the seminars, “Trauma, Dissociation & Psychosis: Metaphor, Strategy and Reality”, Westmead Hospital, Sydney, 4th-5th May 2007 & The Bardon Conference Centre, Brisbane 18th-19th May 2007. Seminar convened by The Delphi Centre in collaboration with The Cannan Institute and the Trauma & Dissociation Unit, Belmont Hospital, Brisbane, (Healthcare Australia).

There is a voluminous literature on dissociative disorders, dissociation, and the role dissociation plays in the short and long term responses to trauma including the ways in which trauma is remembered or re-enacted. This listing is representative of the many very readable and highly relevant papers that add clarity to areas in which a developed awareness has only really been much in evidence in fairly recent years. It is not meant to be exhaustive and many excellent papers are not included – however a reading of these papers would be very orientating to someone wanting to establish a grounding in the literature and they complement the list of 22 texts that has also been provided.


Chu JA. It’s Déjà vu all over again. Journal of Trauma and Dissociation 2003; 4:2: 1-10.

Chu JA, Bowman ES. Trauma and dissociation: 20 years of study and lessons learned along the way. Journal of Trauma and Dissociation 2000; 1: 5-20.


Kluft RP. High-functioning multiple personality patients: three cases. *Journal of Nervous and Mental Disease* 1986; 174: 722-726.


Kluft RP. Treatment trajectories in multiple personality disorder, *Dissociation* 1994; 7: 63-76.


Tarnopolsky A. The concept of dissociation in early psychoanalytic writers. Journal of Trauma and Dissociation 2003; 4:3: 7-25.


ACCESS TO THE JOURNAL, “DISSOCIATION” ON LINE: -

Dr Richard Kluft the editor of the former journal, “Dissociation” which ceased publication in 1998 (to be replaced by The Journal of Trauma and Dissociation) in 2005 kindly offered to have the entire contents of a decade of issues of “Dissociation” made freely available. The journal can be accessed from the following website: http://libweb.uoregon.edu/news/stories/dissociation.htm

“Guidelines for Treating Dissociative Identity Disorder in Adults (2005)” This document is available via website: http://www.issd.org/indexpage/treatguide1.htm

Other useful websites include: -

- Alibris Books (www.alibris.com), a useful site for tracking down out of print texts.
- Open Leaves Book Shop (Rodney Harris, email:open.leaves@bigpond.com)
- (Website: www.openleaves@openleaves.com.au), the most specialised bookshop in Australia in the trauma/abuse/dissociation field.

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