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Commentary

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In my view Dr Mollon fails to achieve the balance he is seeking and at times appears to take a partisan position.

He refers to the trauma of being told that one's long-standing memories of childhood abuse may be false memories and I agree.

However, I am concerned not with memories of long standing, but with those which have been 'recovered' after long-standing amnesia.

It may be true to assert that: "the experimental evidence for the creation of completely false memories is considerably less than that for the distortion of memories of actual events". In terms of volume this is certainly true, memory distortion of actual events occurs on a daily basis. The central question is: can false memories of childhood sexual abuse be created? The evidence has indicated that they can.

It is surely inappropriate to quote newspaper reports as clinical evidence, for example, "A patient is reported to have committed suicide after being told by a psychiatrist that her memories of abuse by her father were an instance of false memory syndrome; her mother corroborated her account (*Sunday Independent*, 5 April 1998)". Another source quoted in this section is unpublished.

Other quotations in Mollon's paper are from newspapers which attribute statements to members of the working group which they did not make.

It is asserted that: "advocates of the false memory syndrome sometimes claim that childhood history should not be explored, on the grounds that doing so is to convey an implicit suggestion that childhood trauma is responsible for the adult psychiatric condition". Kihlstrom is quoted as an example of those making such claims, but I suspect that he has been misunderstood. I know of no psychiatrist who recommends that childhood history should not be explored. The Royal College of Psychiatrists' guidelines (Royal College of Psychiatrists' Working Group on Reported Recovered Memories of Child Sexual Abuse, 1997) strongly advocate normal psychiatric practice, including careful history-taking. My understanding is that this includes a comprehensive social, family and childhood history.

Mollon goes on to say:

> "Distortion is inherent in some of the language, which permeates the debate. Terms such as 'false memory syndrome', 'recovered memory therapy' and 'robust repression' are invented by those allied to the false memory societies and have a questionable validity (Hovedestad & Kristiansen, 1996)."

These terms were widely used in the USA and many of those who use them designate themselves as 'recovered memory therapists'.

Another quotation: "Despite being described as a 'useless trendy therapy from the United States' (Sidney Brandon quoted in *The Guardian*, 1 April 1998)" is incorrect. I did not utter these words and I wrote a letter to the Editor of *The Guardian* denying that I had used these words or that I had been interviewed.

I am at a loss to understand the statements: "The use of a noun ('a memory') to describe a process may itself mislead, giving rise to a reified notion of memory, as if it were a computer file, to which access can be blocked" or "For example Brandon *et al* (1998) with typical reification of memory state: Despite widespread clinical support and popular belief that memories can be 'blocked out' by the mind, no empirical evidence exists to support either repression or dissociation".

The recommendations and report emanating from the Royal College of Psychiatrists' Working Group were concerned with 'memories' and emphasised the dynamic nature of memory using Bartlett in support. They were very specific that memory could not be compared with a computer file. The group feels justified in making the statement regarding repression and dissociation.

Mollon confidently states that in this country patients usually seek help after they have recovered

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memories of abuse usually triggered by a chance event. This is certainly not my experience. He does not consider the influence of books such as the *Courage to Heal* (Bass & Davis, 1988), the activities of some women's groups or therapists without mental health training. We really do not know what is happening in this country, but in the USA the majority of cases appeared in therapy of some kind.

It is interesting to note that in May 1998, for the first time in many years, the American Psychiatric Association did not have a session on recovered or false memories of childhood abuse.

Discussion with colleagues in the USA suggested that there had been a sharp decline in new cases, one asserting that 'the epidemic is over'.

Factors associated with this dramatic decline include successful litigation against therapists, the refusal of insurance companies to provide reimbursement for recovered memory therapy, restrictions imposed on memory recovery techniques by hospitals and other health care organisations and professional and public education by both professional organisations and the media.

We may still be able to avoid the full American experience and we hope that the College guidelines will help prevent psychiatrists and others to avoid falling into the traps which facilitate the development of false memories and multiple personalities.

It is imperative to emphasise three things:

(a) Child sexual abuse does exist and the community must protect its children from this obscenity.

(b) Good psychiatric practice reduces the possibility of the development of false memories.

(c) Any adult reporting memories of abuse in childhood must be treated with sympathy and concern. Disclosure should not be automatically followed by confrontation.

There is an urgent need to extend training in order to understand the nature and prevalence of child sexual abuse, the nature of memory and the power of the therapeutic relationship which carries the risk of communicating to the patient beliefs which fulfill the therapists expectations. These subjects must be high on the priority list of all postgraduate and continuing medical education programmes.

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