Advances in Psychiatric Treatment (1999), vol. 5, pp. 395–398

Correspondence

False memories

Sir: I am concerned that by allowing the discussion around the consequences of abuse to be increasingly beset by the question as to whether memories can be false (Mollon, 1999), we may do our patients a disservice. Whatever the fact about the possibility of memory being false, most commonly to the one who remembers, the question is not whether the memory is false, but how much it is acceptable to the listener. Whatever this leads to, some facts remain.

Sexual and other abuse occurs, more frequently than any of us finds comfortable.

Acknowledging the fact that one has been abused, particularly by someone close or valued, is usually a shockingly traumatic experience. An individual not infrequently finds it impossible to maintain secrecy to which he or she has felt bound for years, and the feelings accompanying the avowal have a frightening intensity.

In that it may reinforce the idea that speaking up is dangerous or unacceptable, it is potentially further damaging to encounter a professional who cannot listen supportively and without judgement to one's recollection of abuse.

If psychiatrists become too concerned to avoid enabling the construction of false memories to offer an open and attentive audience to peoples' experiences, we will be in danger of repeating the cycle of repression described by Judith Harman (1992).

As a profession we must encourage respectful and attentive listening: it must not become the patient's problem that the psychiatrist is worried about false memory syndrome.

I say this with feeling because of my work with such patients. I say it with more feeling still because of patients bringing memories of abuse by therapists, presenting an even greater challenge to us to be able to listen to what we are being told.

Harman, J. (1992) *Trauma and Recovery*, pp.7–32. New York: Basic Books.

Mollon, P. (1998) False memories: finding a balance. *Advances in Psychiatric Treatment*, **4**, 335–342.

Dr Chris Holman Consultant Psychiatrist, The Retreat, York YO10 5BN

Author's reply: I am grateful to Dr Holman for emphasising the detrimental effect which the prevalent concern about false memories may have upon the capacity of patients to speak about their childhood abuse and the capacity of psychiatrists to hear these communications. The dangers arising from a facile acceptance of false memory rhetoric must be balanced against the legitimate worry about the potentially devastating effect which false memories and false beliefs may have upon patients and their families. There probably is no comfortable position for a psychotherapist to adopt with regard to these matters. I think we have to try to live with the tension and the epistemological anguish. This is just one of the many ways in which work with those who may have been abused in childhood is fraught with hazard for both patient and therapist.

Dr Phil Mollon Adult Psychotherapist, Mental Health Unit, Lister Hospital, Stevenage, Herts SG1 4AB

The clinical relationship

Sir: "A collaborative exercise in which the clinician uses their skills and experience to select potentially therapeutic options while the patient's task is to stay in treatment...". Thus, Philip Cowen describes partnership in the treatment plan for people with chronic depression, who are "understandably demoralised, pessimistic and despairing" (Cowen, 1998).

Since this was approved and printed without comment, I want to ask whether this prescription for the clinical relationship, in this or any case, is endorsed by your Editorial Board? Is there an evidence base for such a position? If not, should we tolerate the transmission of such a patronising attitude? Does anyone care?

Perhaps the prescription sounded anachronistic because shortage of space prevented proper exposition. Certainly it has the potential to be understood in terms of John Locke's theory of causality: doctors being agents and patients being patients. We have to pay attention to the possibility that people can take more part in their own treatment (Radford, 1983;

Bolton & Hill, 1996), and to the need for a new medical ethics (McIntyre & Popper, 1983).

Bolton, D. & Hill, J. (1996) *Mind, Meaning and Mental Disorder: The Nature of Causal Explanation in Psychology and Psychiatry*. Oxford: Oxford University Press.

Cowen, P. J. (1998) Pharmacological management of treatment-resistant depression. *Advances in Psychiatric Treatment*, **4**, 320–327.

McIntyre, N. & Popper, K. R. (1983) The critical attitude in medicine: the need for a new medical ethics. *British Medical Journal*, **287**, 1919–1923.

Radford, M. D. (1983) Psychoanalysis and the science of problem-solving man: an appreciation of Popper's philosophy and a response to Will (1980). *British Journal of Medical Psychology*, **56**, 9–26.

Dr Michael Radford Consultant psychiatrist, South Birmingham Mental Health (NHS) Trust, Vincent House, Vincent Drive, Edgbaston, Birmingham B15 2TZ, and Honorary Senior Clinical Lecturer, Birmingham University

Author's reply: To "stay in treatment", and indeed to get through the day when one feels unremitting despair, takes courage and endurance. I did not state this explicitly to an experienced psychiatric readership; perhaps I should have done. The practitioner in turn has several tasks, one of which may be the expert use of psychotropic medication. The successful use of medication in chronic depression is inevitably a collaborative exercise because unless patients understand and agree with what is being suggested, why should they be concordant with treatment?

I sense from Michael Radford's comments that his ability to detect patronising attitudes in his colleagues is unusually well-developed (although not necessarily evidence-based). As John Locke pointed out, passion often tempts men into error. Presumably your readers, some of whom will know only too well what it feels like to be depressed, will judge whether the thunderbolt was merited on this occasion.

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Editor's reply: Michael Radford asks whether a statement in an article is endorsed by the Editorial Board. All articles in *APT* are peer-assessed, and articles that are accepted for publication are revised in the light of the assessors' comments. This does not make articles into an expression of either the assessors' or the Editorial Board's opinion, neither is *APT* meant to express any agreed 'party line' of the Royal College of Psychiatrists. Discussion and debate form the essential ethos of *APT* and that is why we are so glad to publish Michael Radford's letter.

Professor Andrew Sims Editor, *Advances in Psychiatric Treatment*, Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG

Sleep disorders in the elderly

Sir: I read with great interest the excellent review by Jagus & Benbow (1999). In a local sleep disorder clinic in north Cheshire, 463 patients were seen during a period of three years. North Cheshire has an estimated elderly population of 40 000. Of all the sleep disorder clinic attendees, 16% were over the age of 65 years, of whom 88% were males and 12% were females. Eighty-eight percent presented with primary snoring, 41% had sleep apnoea, and in 4%, restless legs syndrome and other reported periodic movements were diagnosed. Daytime complaints included irritability (3%), headache (5%), impotence (2%), and daytime sleepiness (45%). Associated physical features included: hypertension (30%), angina (20%), nocturia (11%), chronic obstructive airway disease (14%), and 23% had a large uvula. Of all elderly attendees, 40% reported using alcohol, 60% took regular night sedation and 22% smoked. Only three (4%) of the total 73 elderly attending the clinic were found to be known to the elderly psychiatric service.

In their review, Jagus & Benbow reported that up to 50% of the elderly suffer from sleep disorder which gives an estimated 20 000 potential sufferers in north Cheshire. Surprisingly, only 25 of those potential sufferers found their way to the sleep disorder clinic each year, a probability of 0.001 of being referred to the sleep clinic. The low rate of referral to specialist clinics may be due to the fact that sleep disorders in elderly patients are either underdiagnosed by their general practitioners or are not regarded as serious enough to warrant therapeutic intervention.

There is a need for proper education of health care professionals in the assessment of the neglected area of sleep disorders in the elderly population. Jagus & Benbow's article provides and excellent start.

Jagus, C. E. & Benbow, S. M. (1999) Sleep disorders in the elderly. *Advances in Psychiatric Treatment*, **5**, 30–38.

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Treatment of sleep disorders in adults

Sir: I was disappointed when reading the article by Wilson & Nutt (1999) that very little was said about non-pharmacological interventions for insomnia, although what was said did involve a behavioural approach using sleep hygiene and stimulus control. I was looking for a more detailed discussion in these areas, although it is possible they were not allowed the space to discuss such interventions in detail.

I work in the field of substance misuse – I have been through the temazepam traumas (e.g. Ruben &

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