4. Effective treatment of an accuser harbouring false memories involves:
   a willingness of the patient to suspend judgement and to make contact with someone who has a sceptical but tolerant approach
   b willingness of the psychiatrist to listen to allegations which demonstrate a need for adequate corroboration
   c the ability of the physician to conduct a global psychiatric interview and make specific diagnoses and recommendations
   d the ability to treat the patient for a variety of specific diagnoses
   e none of these statements is true.

5. Recovered memory treatment has included:
   a regression to infantile experiences
   b emergence of multiple personality disorder
   c recollections of past lives
   d experience of alien abductions
   e all of the above.

MCQ answers

1	2	3	4	5
a F	a T	a T	a T	a T
b F	b T	b T	b T	b T
c T	c T	c T	c T	c T
d F	d T	d T	d T	d T
e F	e F	e T	e F	e T

Commentary

Peter Whewell

The study of trauma is inherently political. It is hard for psychiatrists to maintain an open mind, to respect and tolerate uncertainty and to maintain standards of scrutiny of scientific data when there are powerful political and emotional pressures to take up a polarised view of recovered memories of child sexual abuse. The two polarisations that have arisen are of recovered memories as invariably historically accurate versus recovered memories as invariably false and created by suggestion by clinicians. Current evidence suggests the psychiatrist should take up a cautious position somewhere between these two poles.

Merskey does not present empirical evidence for the existence of FMS. He only quotes figures calculated by Prendergast, who is a journalist (not a clinician) who has been accused of abuse by his daughter, and thus has a particular position to advocate. The FMSF states that there are several thousand cases in the USA and a thousand cases in Britain, but their claims are based upon their own conclusions from their own data. Pope & Brown (1996) make the following comment:

> "Those claiming that scientific research has validated FMS and identified an epidemic have a responsibility to disclose the methods for determining that each case involved a memory that was objectively false. The peer-reviewed scientific literature still lacks adequate information about this methodology. It continues to be unclear if the protocol of any research purporting to validate FMS diagnosis in large numbers of persons used any criticism other than the decision-rule that all recovered memories of abuse are inherently false".

The British Psychological Society (1995) concluded from an independent examination of the British False Memory Foundation records that the FMSF's claims that accusers fitted a certain profile,

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https://doi.org/10.1192/apt.4.5.260 Published online by Cambridge University Press

and that the accusations proceeded from a prior period of complete amnesia, were unproven by their own evidence.

The base rate for the incidence of child sexual abuse is subject to variance because of problems of definition of abuse and problems of corroboration of events from the past. Self-report surveys in Britain (Hooper, 1990; Kelly *et al*, 1991) have tended to find that between 5% and 10% of women have suffered coercive contact sexual abuse, with figures for men being half those for women. These are robust findings and similar prevalence is found in other European countries and in America. It is clear that child abuse is not rare. In his paper Merskey confuses a frequent trauma (child sexual abuse) with psychotic phenomena such as regression to past lives and belief in abduction by aliens as if to suggest that there is no difference between a known frequent event and an unrealistic idea. Psychiatrists need to exercise their normal common-sense judgment in evaluating possible psychotic phenomena (Fonaghy & Target, 1997) and be aware of the actual high prevalence of child sexual abuse. Psychiatrists should also be aware that people who have been sexually abused are sometimes told by their abusers that if they disclose their abuse they will not be believed or will be treated as being 'mad'.

Merskey hypothesises that FMS is caused by suggestion by "therapists who believed in searching for repressed memories of childhood sexual abuse". It is important that the psychiatrist is not deterred from taking a proper sexual history, which will include questions about sexual abuse, because of a fear that false memories of abuse will be implanted. Lindsay & Read (1994) in an extensive review conclude:

> "There is little reason to fear that a few suggestive questions will lead psychotherapy clients to conjure up vivid and compelling illusionary memories of child sexual abuse".

Care and patience need to be taken in creating a setting in which patients are able to disclose abuse, as disclosure is often defended against because of powerful affective states: fear of being disbelieved, shame, anger, self-blame and confusion.

No evidence is given for Merskey's contention that certain therapists cause false memories, nor evidence of who these therapists are who are searching for repressed memories, nor their location, nor their procedures. Instead, he gives a caricatured account of a false memory therapist in action and goes on to assert that "the propagation of false memories has been undertaken by psychiatrists" without giving any evidence for this assertion. There is no empirical evidence that aggressive retrieval of memories of sexual abuse is anything but sporadic and infrequent in Britain.

Furthermore, there is little experimental evidence that completely false memories of sexual abuse can be implanted, though there is more evidence that explicit narrative memory may be distorted by suggestion. After reviewing the current evidence the British Psychological Society (1995) concluded:

> "while there is a great deal of evidence for incorrect memories, there is currently much less evidence for the creation of false memories".

Merskey states that there is no controlled evidence for repression, showing an inconsistency in the way he is prepared to use evidence given the lack of empirical evidence for his assertions throughout the paper. There is now robust evidence of the forgetting of childhood sexual abuse in adults (*vide infra*) and there is a lively scientific debate on possible mechanisms which include not only repression but also dissociation. Nor does Merskey attempt to present a view of the complicated arena of traumatic memory. Amnesia is a complex state and in-depth case studies of the amnesia following shell shock (Rivers, 1918), in holocaust survivors (Laub & Auerhahn, 1993) and in survivors of child sexual abuse (Davies & Frawley 1993) show that there is a dynamic continuum between 'knowing' and 'not knowing', which represent ends of a spectrum rather than alternatives. Bollas (1987) has described the concept of the "unthought known", whereby an experience has not yet been translated into words, and this is consistent with our current understanding of differences between implicit and explicit memory (Pillemer & White, 1989). There is also a growing body of neurobiological evidence that trauma inhibits explicit autobiographical memory in a verbal form and facilitates the visual/perceptive memory fragments of implicit memory (Van der Kolk & Fisler, 1996). These findings are sufficient to provide a coherent theoretical framework for amnesia for childhood sexual abuse.

Forgetting corroborated child sexual abuse as an adult is now well documented. In a recent review of 15 studies on amnesia in childhood abuse Scheflin & Brown (1996) report that:

> "No study failed to find it. Amnesia for childhood sexual abuse is a robust finding across studies using very different samples and methods of assessment. Studies addressing the accuracy of recovered memories are no more or no less accurate than continuous memories for abuse".

Merskey rightly points out that the various professional societies that have considered the subject of recovered memories have urged caution in this area. However, to conclude from these studies that "the stronger position statements are unequivocally helpful in promoting disbelief in alleged recovered memories" is to skew the reports

https://doi.org/10.1192/apt.4.5.260 Published online by Cambridge University Press

in his preferred direction of disbelief. It is important to be aware that the reports accept that we do not yet know the true incidence of false memories compared with the large volume of true recovered memories (American Medical Association Council on Scientific Affairs, 1995; British Psychological Society, 1995). In this respect it is helpful for psychiatrists to be aware that the narrative truth, legal truth and historical truth do not always coincide. The historical truth in many cases of adults who have been abused as children can never be known and the psychiatrist needs to work with the narrative truth of the patient, with the usual rules for psychiatric evidence of psychosis being applied, without an aggressive search for the historical truth. It is important for the psychiatrist to be able to believe the patient's narrative truth when this seems likely given the evidence available, while holding on to the awareness that the complete historical truth cannot be known. Similarly a search for the legal truth is not the province of the psychiatrist.

Merskey mentions the phenomenon of 'retractors' – accusers who subsequently retract their stories of abuse. It is possible for accused parents to exert enormous suggestion or coercive pressure on the accusers. The American Psychiatric Association (1994) acknowledges that:

> "hesitancy in making a report and recanting following the report can occur in victims of documented abuse. Therefore those seemingly contradictory findings do not exclude the possibility that the report was based on a true event".

The present state of evidence is not sufficient to accord FMS a corroborated existence, nor does current evidence point to false memories of sexual abuse being anything except sporadic and of low frequency. The psychiatrist should approach each case with an open mind, tolerating the historical uncertainty of narrative truth and not jumping to premature conclusions that recovered memories, before or during therapy, are necessarily true or false. If the psychiatrist is able to keep an open mind, he/she will avoid the factor of suggestion that seems to be more important than any specific technique in distorting memory (McConkey, 1992; Brown, 1995). The psychiatrist should avoid the aggressive use of hypnosis, abreaction and related techniques to search for undisclosed memories, and should not get involved in seeking the legal truth of recovered memories (Royal College of Psychiatrists' Working Group on Reported Recovered Memories of Child Sexual Abuse, 1997).

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Harold Merskey's response will appear in the November issue of *Advances in Psychiatric Treatment*.

https://doi.org/10.1192/apt.4.5.260 Published online by Cambridge University Press