

## Correspondence

EDITED BY LOUISE HOWARD

**Contents** ■ Headings in structured abstracts ■ Recovered memories of childhood sexual abuse ■ Antidepressant quandaries ■ Aggression and violence in severe mental illness ■ Prenatal exposure to maternal stress and subsequent schizophrenia ■ Evolution of schizotypy ■ Semantic priming in schizophrenia ■ Are first-rank symptoms encryption errors? ■ Lifetime risk of suicide in affective disorders ■ Suicide, country of birth and coroners' verdicts ■ Opportunities for psychiatry from genetic findings – some concerns ■ Fluoxetine–terfenadine and sexual dysfunction ■ Data on the Mental Health Act ■ Complementary medicine discussion group

### Headings in structured abstracts

**Sir:** Structured abstracts for articles in medical journals typically use subheadings such as 'Background', 'Aim', 'Method', 'Results' and 'Conclusions'. Authors of articles written for the *British Journal of Psychiatry*, however, are not required to specify the 'Aim' of the studies they report, but simply to give the 'Background'. This parsimony in the number of subheadings leads to difficulties for authors. In my opinion the single subheading 'Background' does not distinguish well between the background to the study (e.g. "Previous research has suggested. . . . However. . .") and the question under investigation (e.g. "The aim of this study was to. . .").

To test this out I examined 100 abstracts published consecutively in the *British Journal of Psychiatry* since January 1997. For each abstract I classified the text written under 'Background' into one of three possible subgroups: 'aim alone'; 'background alone' and 'background and aim together' (see Table 1). A colleague also carried out the same task. We agreed on our classification in 92% of the cases. Discrepancies were resolved by discussion and further reading. The agreed percentages classified under the three headings were: 'aims alone' 26%; 'background alone' 37%; and 'background and aims together' 37%. (Aims were also sometimes given in the 'method' sections if they were not provided in the 'Background'.)

The majority of the authors thus provided both the aims and background to their studies in one way or another. It is my contention that these authors would be able to do this more clearly if, when writing abstracts for the *British Journal of Psychiatry*, they were aided by the explicit use of

**Table 1** Examples to illustrate the classification of the texts written under the subheading 'Background'

---

**Category 1: 'Aim' alone**

"This paper examines the social and psychological impact on victims of stalking."

**Category 2: 'Background' alone**

"Little information is available on the costs of residential care for people with mental health problems, and there are very few research data on how or why the costs of provision vary."

**Category 3: 'Background' and 'aim' together**

"Delusions are assumed to reflect disordered reasoning, but with little empirical support. We attempted to study this in 16 relatively intelligent deluded patients and 16 normal volunteers."

---

the additional subheading 'Aims'. Readers would also find it easier to locate the aims of the reported studies.

---

**J. Hartley** Department of Psychology, Keele University, Staffordshire ST5 5BG

**Editor's reply:** We agree. We will change the 'Instructions to authors' accordingly, asking for both 'Background' and 'Aim' subheadings to be used in summaries from January 1999.

**G. Wilkinson** Editor, *British Journal of Psychiatry*, 17 Belgrave Square, London SW1X 8PG

### Recovered memories of childhood sexual abuse

**Sir:** The report of Brandon *et al* (1998) regarding memories recovered through hypnosis, dream interpretation or age regression was like exposing the nudity of the proverbial emperor to the court audience glorifying his clothes. While most psychiatrists, after decades of experience with cognitive sciences, are willing to admit that they know only about the 'arm of mindbody', it is unethical to allow a therapist with a few years of postal tuition to study and treat psychiatric patients.

The belief that memories of childhood sexual abuse can be recovered by hypnotic age regression stems from an original confusion between suppression of libidinal instincts and experiences. Therapists had misconstrued the Freudian concept of suppression of sexual feelings and true sexual experiences. Sexual feelings are suppressed whereas sexual experiences and associated memories are not forgotten. At the most, only a weakening of the memory could take place or the memory might become less vivid with the passage of time. So hypnosis or hypnotic age regression has no role in unearthing the true sexual memories. On the other hand, such an endeavour could lead to a false memory syndrome. Dingwall (1967) recognised that individuals can fabricate narratives of imagined experiences in greater detail than that for which conscious knowledge would seem to account. Past life regression serves a good example. After spending 30 years investigating 3000 cases of children remembering previous lives in six cultures, Stevenson (1997) is now inclined to believe in the idea of reincarnation. But he also points out that if the memories of all the hypnotically regressed subjects claiming to have been present at the crucifixion scene of Christ in their previous lives were true, the Roman soldiers would not have had space to stand at the mount Golgotha! The ego-strengthening power of hypnosis is wrongly applied and hypnosis can increase the confidence with which the memory is held while reducing its reliability. Medical hypnotherapists like to stay away from matters of childhood sexual abuse cautioning hypnotherapeutic misuse by marginally trained therapists.

Information obtained through age regression is like a historical novel that might contain some facts and fiction. A few items of memories from childhood become

dislodged and get attached to fantasies of childhood like iron filings on a magnetic field. Because age regression techniques involve many pitfalls one should not generalise that all hypnotherapy techniques are bogus. Unfortunately, the media and entertainment industry often portrays hypnotherapists regressing all their clients to younger days. Introducing a more efficient code of practice and special registration to practise hypnotherapy would be more constructive than debunking hypnosis.

**Brandon, S., Boakes, J., Glaser, D., et al (1988)**

Recovered memories of childhood sexual abuse. Implications for clinical practice. *British Journal of Psychiatry*, **172**, 296–307.

**Dingwall, J. E. (1967)** *Abnormal Hypnotic Phenomenon* (4 vols). London: Churchill.

**Stevenson, I. (1997)** *Reincarnation and Biology. A Contribution to the Etiology of Birthmarks and Birth Defects* (2 vols). London: Prager.

**J. Paul** Kingswood Mental Health Centre, Union Street, Maidstone, Kent ME14 1EY

**Sir:** Awareness of the dangers of implanting false memories of childhood sexual abuse must be widespread by now and the recommendations with which Brandon *et al* (1998) conclude their paper will be generally accepted. It is, therefore, a pity that they were not more balanced in presenting the evidence concerning the recovery of forgotten memories. In a paper in this journal Brewin (1996) concluded that there was both experimental and clinical evidence that memories can be recovered from total amnesia and that they may be essentially accurate. It is not clear why Brandon *et al* did not discuss this paper nor why they interviewed only 'retractors' and accused parents. There is also, I believe, a basic inconsistency in their position; why, if false memories can be implanted, and if it is accepted that people may "be unable to remember considerable parts of their past experiences", should not the inability to recall what actually occurred ('false forgetting') also be induced?

Memory is not held only in the head; the constructions, reconstructions and fallibility of autobiographical memory are the products of the individual in relation to his or her social and personal context. The injunctions of abusers to keep silent, the interpretations of memories of abuse as fantasy by psychoanalysts and the social taboo on discussing the issue combined for a long time to make memories of abuse unsayable and in some instances unremem-

berable. Psychotherapists working in the late 1970s and 1980s met many more patients than previously who remembered childhood abuse, once the issue had been aired in the media. Since then, I have carried out or supervised the treatment of a great many patients receiving a form of therapy which does not ferret after or suggest hidden memories. I have encountered a very small number of cases in whom memories were recovered from complete amnesia and a very large number who, once a therapeutic alliance had been established, revised and extended their memories in terms of the timing, details, meaning and associated emotions of partially remembered abuse. Many of these patients sought and found corroboration of these memories, most often from siblings.

While it is crucial that professionals avoid implanting false memories of sexual abuse and important to assess such memories judiciously, responsible clinicians must also recognise the ways in which memories recovered from partial or total amnesia may, and in most cases do, refer to actual experience. To paraphrase Brandon *et al*, there is abundant evidence that false forgetting occurs, and it is important that clinicians do not reinforce it in the many individuals whose experiences need, but have never been granted, acknowledgement.

**Brandon, S., Boakes, J., Glaser, D., et al (1998)**

Recovered memories of childhood sexual abuse. Implications for clinical practice. *British Journal of Psychiatry*, **172**, 296–307.

**Brewin, C. R. (1996)** Scientific status of recovered memories. *British Journal of Psychiatry*, **169**, 131–134.

**A. Ryle** ACAT Office, Munro Clinic, Guy's Hospital, London SE1 9RT

**Authors' reply:** We should have made it clear that the literature review which we made was much more exhaustive than the reference list to our paper might suggest. The material was so voluminous and much of it of such poor scientific quality that, space considerations apart, much of it did not justify a reminder of its existence and we confined ourselves to that which was essential to our argument.

It is true that we confined our references to hypnosis to a single book but this was such a rich source of further references that we deemed it sufficient.

We quite accept that patients report and psychiatrists hear what conforms with their beliefs and the social milieu. Many

patients go through life never mentioning abuse which occurred in childhood. The setting up of ChildLine resulted in some women in their 70s and 80s ringing up to talk about their childhood abuse for now 'that it was out in the open' they could talk of the pain they had carried throughout their lives. Men who were Japanese prisoners of war when recently interviewed gave horrific and detailed accounts of their suffering which they had never felt able to mention to anyone who had not shared the experience. Their families knew nothing of what had occurred. Many memories suppressed or avoided for years can come forward following a related emotional trauma or within a trusting relationship.

We did not specifically discuss Professor Brewin's paper but believe that most of the points he made are covered within our review. We disagree with him on some matters but his conclusions are much the same as ours. False beliefs and false memories can occur and extreme caution must be observed when new 'memories' emerge whether during or outside a therapeutic intervention.

We are somewhat perplexed by 'false forgetting' and cannot imagine how it could be proved. People continually forget and remember things. What is at issue and is the key area for clinicians is the creation of new and false memories through unsound beliefs and unsafe practices. The mounting body of evidence of such practices among psychiatrists and established therapists as well as among 'fringe' practitioners is in danger of discrediting psychiatry in general and psychotherapy in particular.

We sincerely hope that the guidelines published in the *Bulletin* (Royal College of Psychiatrists' Working Group on Reported Recovered Memories of Childhood Sexual Abuse, 1997) will enable psychiatrists and others to stem the tide of these potentially harmful practices.

**Royal College of Psychiatrists' Working Group on Reported Recovered Memories of Childhood Sexual Abuse (1997)**

Recommendations for good practice and implications for training, continuing professional development and research. *Psychiatric Bulletin*, **21**, 663–665.

**S. Brandon** University of Leicester, Post Graduate Dean's Office, Royal Infirmary, PO Box 65, Leicester LE2 7LX

**J. Boakes** St George's Hospital, London

**Sir:** Brandon *et al* (1998) have produced a commendably careful, comprehensive and