LETTERS TO THE EDITOR

Irish Journal of Psychological Medicine 1995 December; 12 (3): 152-5

Allegations of child sexual abuse: delayed reporting and false memory

Sir – While I was pleased to see that your journal has addressed the issue of false memories,[1] I was distressed at the authors' inaccurate description of the False Memory Syndrome Foundation. I challenge the authors to find any publication from the FMS Foundation that speaks of "psychotherapists as a unified whole, practising hypnosis, 'recovered memory therapy' or using 'truth serum' to provoke false allegations", or that even hints that FMSF resists allegations of CSA ("allegations of CSA are now met with organised resistance").

Indeed, not only is the Scientific Advisory Board of the FMS Foundation comprised of many of the world's most famous clinicians and not only have we stated that the problem is from the subset of the psychotherapy community that practises risky techniques, we have also written again and again that false accusations undermine the credibility of true victims and in addition drain valuable resources from the problem of child sexual abuse.

I noted that the authors' source of information about the False Memory Syndrome Foundation was gleaned from newspaper articles. Is this the standard of scholarship for your journal?

Pamela Freyd, Ph D,
Executive Director
False Memory Syndrome Foundation,
3401 Market Street – Suite 130,
Philadelphia, PA 19104,
USA.

References
1. Byrne P, Sheppard N. Allegations of child sexual abuse: delayed reporting and false memory. Ir J Psychol Med 1995; 12: 103-6.

Sir – By wrongly suggesting that the British False Memory Society (BFMS) is presenting "organised resistance" to allegations of child sexual abuse (CSA), the article by Drs Byrne and Sheppard[1] demonstrates that they have, in common with many others, failed to appreciate the distinctions between two quite separate problems: child sexual abuse and accusations by adults arising out of 'recovered memories' of childhood sexual abuse.

Surely CSA is not, as the authors write, "a valid diagnosis"? It is a serious, damaging crime which should be punished by the full force of the law. As with other forms of assault, genuine victims of CSA may well suffer both physical and mental symptoms but to use diagnostic terminology for the crime of CSA, endows it with a quasi-medical status. Amongst other misconceptions that this creates is a trend to retrospectively 'diagnose' CSA from adult psychological symptoms – a dangerous procedure indeed.

To attempt to clarify the issues involved: the BFMS was started in 1993 in response to the growing number of parents who were reporting that they had been falsely accused of CSA by their now adult sons (15%) and daughters (85%). With every case reported to the BFMS, as far as the parents knew, there had been no prior memory of the abuse and in the vast majority of the cases these new-found 'memories' had been revealed while the person was undergoing therapy for a seemingly unrelated problem such as postnatal depression, marriage failure or an eating disorder.

In addition, they all rely on the unproven theory of 'massive repression'. A whole history of childhood abuse is supposedly locked away in a psychic deep-freeze totally inaccessible to the conscious until unlocked decades later in the therapist's consulting room.

Despite 60 years of research no such mechanism has been discovered[2] and even if it had been, there is still no one who can 'diagnose' whether the recovered material is true or false *without* some form of external verification or corroboration.

Naturally, because of the secret nature of CSA, this presents a difficult forensic task but that cannot be allowed to over-ride natural principles of justice. King James I's dictum, at the height of the witch hunt craze in Europe, was "Where evidence is hard to come by an accusation may suffice".

This is mirrored today in the irresponsible recommendation that adults with newly 'recovered memories' but with no corroborative evidence, sue their parents or report them to the police as Bass and Davies do in their self-help book[3] cited by the authors.

The BFMS does not group "psychotherapists as a unified whole" as the authors claim. What we do group together are the questionable theories and therapeutic techniques which give cause for concern. These frequently involve hypnosis or quasi-hypnotic methods which, incidently, many therapists would claim are not hypnotic. They involve guided imagery, age-regression, journaling and relaxation. Unshakeable belief in the benefit of these theories and other non-hypnotic techniques to search for some supposed buried trauma, posited to be the deep-seated cause of adult problems has become known as 'recovered memory therapy' (RMT).

At the BFMS we have compelling evidence (which we are prepared to share) from 650 case histories which shows that RMT theories are neither safe nor effective. Whether it is practised by a consultant psychiatrist in a leading teaching hospital or by a correspondence course-trained hypnotherapist in the back room, the results can devastate a family when used on a suggestible patient who has not been abused. It is clear from our evidence that the mental health profession is profoundly divided by this issue; one camp which uses RMT techniques and the other which believes that "the use of recovered memories is fraught with the problems of potential misapplication".[4]

At one point the article shifts to personal attack and quite what the alleged discrediting (in *The Guardian* newspaper) of "two founder members of the American False Memory Foundation" has to do with these issues, the authors don't clarify, especially as the research of one of them is then cited approvingly by them.

It is also not clear whether they are implying that because only 11 cases of 'retraction' were found (from five reporting

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consultant psychiatrists serving Waterford over seven years), the problem is minimal. If that is so, it is important to appreciate the fuller picture:

- very few adults, after making 'recovered memory' accusations, are referred to a psychiatrist by their therapist. Psychiatrists, as a group, are therefore a poor litmus for false memories;
- from our initial analysis, only 13% of 'recovered memory' accusations arise while the patient is actually undergoing psychiatric treatment (as opposed to other forms of 'therapy');
- accusations which are not retracted may nevertheless be false accusations. However sincerely believed at the time, retracting the allegation, when it is realised that it is false, is a difficult, guilt-laden process for the accuser;
- there have been no "massive repression/recovered memory" accusations against parents which have subsequently been verified by independent sources. With the vast number of claimed cases around the world this lack of evidence might well render them liable to the same scepticism with which allegations of multi-generational satanic ritual abuse are now being met.[4]

Unfortunately this article does little to advance our understanding of why adults 'recover' false memories of childhood abuse.

Until the mental health professions realise the dangers involved in validating patients' uncorroborated, long-delayed abuse 'memories' and stop using coercive, directive therapy and interviewing techniques, all based on pseudo-science, to uncover what *they* presume to be buried sexual trauma – as Freud did 100 years ago[6] – wrongful accusations will continue to divert our attention from the genuine cases which do deserve our understanding, respect and sympathy.

Roger Scotford,
Director BFMS,
Bradford on Avon,
Wiltshire BA15 1NA,
England.

References
1. Byrne P, Sheppard N. Allegations of child sexual abuse: delayed reporting and false memory. Ir J Psychol Med 1995; 12: 103-6.
2. Pope, Hudson. Can memories of childhood sexual abuse be repressed? Psychological Medicine (Cambridge University Press) 1995; 25: 121-6.
3. Bass and Davies. The Courage to Heal (and workbook). New York: Harper & Row, 1988.
4. American Medical Association. Report of the Council on Scientific Affairs, CSA Report 5-A-94; 1994.
5. LaFontaine JS, Prof. The extent and nature of organised and ritual abuse, HMSO 1994
6. Webster R. Why Freud was wrong, sin, science and psychoanalysis, Harper Collins, September 1995

Allegations of child sexual abuse: delayed reporting and false memory

Authors' reply:

Sir – In reply to the general criticisms of the US and British False Memory Foundations, we would wish to remind readers of both letters and our paper[1] that we are aware of the limitations of the case series *(see Subjects and methods)* and that psychiatrists may be reviewing a biased sample. Our central point is that in the variety of experiences of delayed reporting of child sexual abuse and/or allegations subsequently withdrawn, the new 'syndrome' of false memory represents only a proportion of those patients, and that many other possibilities, some with psychiatric diagnoses, exist *(see Discussion)*. In her observation that psychiatrists have learned of the false memory syndrome (FMS) societies through the lay press, Freyd makes our point for us: the FMS debate has taken place largely in this arena, and we argue for discussion and standardisation within the mental health professions *(see Conclusion)*.

Our monograph does not advocate or deny the validity of false memory – it seeks to clarify this difficult clinical setting. Nor did we speculate on the theoretical basis of repression; our cases, having accepted the above limitations, presented a wide range of reasons (not causes) other than FMS, and raised the possibility of true FMS in only two cases *(cases C and K)*.

With regard to some of the specific points raised by Scotford, we agree with the four points and appreciate that neither FMS society is condemning the totality of psychotherapeutic practice. His letter does, however, juxtapose the "consultant psychiatrist in a leading teaching hospital" with the "correspondence course-trained hypnotherapist in the back room".

Certainly no psychiatrist can defend the so-called recovered memory therapy, and we share the concerns about one best-selling self-help book.[2]

Peter Byrne,
Registrar in Psychiary,
St John of God Hospital,
Stillorgan,
Co Dublin.
Noel Sheppard,
Consultant Psychiatrist,
St Otteran's Hospital,
Waterford,
Ireland.

References
1. Byrne P, Sheppard N. Allegations of child sexual abuse: delayed reporting and false memory. Ir J Psychol Med 1995; 12: 103-6.
2. Bass and Davies. The courage to heal. New York: Harper & Row, 1988.

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Dissociative psychosis: an atypical presentation and response to cognitive analytic therapy

Sir – Having trained and worked in psychiatry on both sides of the Atlantic, I am puzzled by the apparent North American-European discrepancy in diagnostic and therapeutic practice with respect to dissociative disorder. I am pleased to see that the *Irish Journal of Psychological Medicine* is attempting to bridge the gap by publishing Drs Graham and Thavasothy's article.[1]

However, I am mystified by their statement that "there is very little literature on the treatment of such disorders". There have been many advances in the field since the work of Freud and Janet referred to by the authors. There is now a wealth of literature on the treatment of dissociative disorders.[2-4] The International Society for the Study of Dissociation has held conferences and workshops for over 10 years and publishes a journal, *Dissociation*, devoted entirely to the subject.

The case subject of Dr Graham and Dr Thavasothy's article would not be considered greatly unusual or atypical on this side of the Atlantic. I commend the authors for pursuing

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