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.

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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.

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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;