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REVIEW ARTICLE

Recovered memories of childhood sexual abuse

Implications for clinical practice

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Background The growth in the USA of 'recovered memory therapy' for past sexual abuse has caused great public and professional concern. It became apparent that the polarisation of views and fierce controversy within the American psychiatric community was in danger of bringing psychotherapy into disrepute and it seemed important to examine objectively the scientific evidence before such polarisation developed in the UK.

Method A small working group reviewed their own experience, visited meetings and centres with expertise in this field, interviewed 'retractors' and accused parents, and then began a comprehensive review of the literature.

Results There is a vast literature but little acceptable research. Opinions are expressed with great conviction but often unsupported by evidence.

Conclusions The issue of false or recovered memories should not be allowed to confuse the recognition and treatment of sexually abused children. We concluded that when memories are 'recovered' after long periods of amnesia, particularly when extraordinary means were used to secure the recovery of memory, there is a high probability that the memories are false, i.e. of incidents that had not occurred. Some guidelines which should enable practitioners to avoid the pitfalls of memory recovery are offered.

In May 1995 the Royal College of Psychiatrists set up a working party to (a) enquire into reports made by adults, usually but not exclusively arising within a therapeutic relationship, of recovered memories of long-forgotten childhood sexual abuse, and (b) to provide guidance for British psychiatrists in this difficult area. The working party submitted its report in the summer of 1996. For a number of reasons the College eventually decided not to publish the report under its imprimatur and instead agreed to the publication of consensus re-commendations for good practice (Royal College of Psychiatrists' Working Group on Reported Recovered Memories of Child Sexual Abuse, 1997). The present paper is a revised version of the report originally submitted to the Royal College of Psychiatrists.

CONTEXT OF CHILD SEXUAL ABUSE

Sexual abuse of children is a relatively common experience that has probably always existed in all times, social groups and cultures. However, the full extent of sexual abuse and incest has become widely known only in recent years, in part through the influence of the women's movement. Freud's theory of the Oedipus complex led to a belief among some professionals and others that girls harboured sexual desires for their fathers and that adult women 'unconsciously' wished to be raped and were incapable of telling fact from fantasy. Often, children and adult women who were abused remained silent and those who did tell were often not believed or, worse, were blamed for what had happened.

Creation of the Working Party

There is no doubt that childhood sexual abuse is widespread, distressing and harmful; the true extent of the problem is uncertain. Official statistics almost certainly under-estimate the phenomenon, as many cases may never come to light, while some independent surveys may over-estimate it. Problems with the definition of sexual abuse and lack of firm corroborative evidence make it difficult to compare studies (Browne & Finkelhor, 1986; Beitchman *et al,* 1991, 1992; Kelly *et al,* 1991; Mullen *et al,* 1994; Cicchetti & Toth, 1995; Halperin *et al,* 1996).

Legally and morally there is no such thing as consensual sex between a child and an adult. Such abuse often has a distorting effect on personal development and later relationships.

When numbers of women and children began, in the early 1970s, to speak out, they had no trouble in remembering what had been done to them. Their trouble lay in not being able to forget. In the 1980s, at first in the USA and spreading in the early 1990s to the UK, came reports of a new phenomenon. Adult women, and some men, during counselling or psychotherapy, reported recovering apparent 'memories' of previously unknown childhood sexual abuse. Many of them made accusations against elderly parents, and harrowing accounts of family disruption resulting from such accusations have been published. In the USA a number of prosecutions for sexual offences and at least one for murder were based upon evidence 'recovered' in this way. Now, however, some patients have retracted their 'memories' and they or those whom they accused have successfully sued the therapists involved for implanting 'false memories'.

The furore has caught the public imagination and the debate has been mainly carried out in the public arena, with newspaper and magazine articles, radio and television shows in addition to a flood of popular books. For several years, meetings of the American Psychiatric Association provided an arena for bitter disputes between professional protagonists of different beliefs. The controversy has been admirably reviewed by Crews (1997).

Accused families have formed themselves into societies to proclaim their in-nocence, raise awareness of a new problem and promote research and education. More than 18,000 families have sought information from the False Memory Syndrome Foundation (FMSF) established in Philadelphia in 1992. False

memory societies have since been formed in Australia, Canada, The Netherlands, New Zealand, Sweden, Israel and the UK. The British False Memory Society (BFMS), founded in 1993, has received requests for information from nearly 900 families.

Gudjonsson (1997*a,b*) undertook a questionnaire study of accused families who were members of the BFMS and reported that 87% of accusers were female. Only 3% of accusations were made against stepfathers and 50% were made against biological fathers. This contrasts sharply with abuse reported in childhood, in which stepfathers were more likely to be accused (Russell, 1983; Kelly *et al,* 1991). Gudjonsson (1997*b*) also noted that recovered-memory abuse was reported to start at a much younger age (childhood and infancy) than never-forgotten abuse, which typically occurs in preadolescent children or in early adolescence. Accusations were usually non-specific and had arisen primarily within the context of a therapeutic relationship. Depression, followed by eating disorder, were the most common reasons for seeking therapy. Significant relationship problems was the common stress factor prior to the accusations being made and it is interesting to note that most of the accusations had been made in the previous six years.

In a further study (Gudjonsson, 1997*c*) of 37 cases in which criminal proceedings were reported, 23 of the alleged perpetrators were charged by the police. Three prosecutions were subsequently discontinued by the Crown Prosecution Service, 20 went to court and in eight there was a conviction and lengthy prison sentence. Five of the successful prosecutions did not involve recovered memories.

Many professional associations have offered guidance to their members (American Psychiatric Association, 1993; American Psychological Association, 1994; American Medical Association, 1994; Australian Psychological Society, 1994; Canadian Psychiatric Association, 1996). In their efforts to remain impartial they have failed to resolve the impasse between research and clinical observation. Only the Australian Psychological Association has given clear and unequivocal guidance, which criticises some practices and beliefs of clinicians. The British Psychological Society produced its report on this phenomenon in January 1995 but there was a poor response rate to their questionnaire and strong criticism of their analysis of the problem (Weiskrantz, 1995). In May 1995 the Royal College of Psychiatrists Working Group on Reported Recovered Memories of Child Sexual Abuse was set up to examine:

(a) current views on the psychology of memory;

(b) current beliefs and practices on the recovery in adult life of previously forgotten memories of childhood sexual abuse;

(c) the effectiveness of memory enhancement techniques;

(d) the validity of memories of long-forgotten childhood sexual abuse;

(e) the consequences of memory recovery; and

(f) the distinction between true and illusory memory.

On the basis of findings in these areas, the Working Group would then recommend guidelines for good and acceptable practice in this area.

A survey of College members was carried out in an attempt to discover how widespread particular beliefs and practices are among members. This failed to achieve a response rate sufficient to justify a full analysis.

DEFINITIONS

Recovered memory

A recovered memory, in the context of this paper, is the emergence of an apparent recollection of childhood sexual abuse of which the individual had no previous knowledge.

An individual who had always had a memory of sexual abuse, but who chose not to think or talk about it, is excluded by this definition, as are memories of non-sexual events. Reports of childhood abuse which had never been forgotten, and reports by children of current abuse are also excluded. We were concerned exclusively with adults, often in their 30s and 40s, who reported memories of child sexual abuse after decades in which no such suspicion had been raised and of which they had no prior memory. 'Recovery' of memory should be distinguished from 'retrieval' of memory by active recall or simple 'remembering', which are normal, everyday occurrences.

False memory

A false memory is the recollection of an event which did not occur but which the individual subsequently strongly believes (also called pseudo-memory or illusory memory).

False memory syndrome

False memory syndrome (FMS) after Kihlstrom (1998) is:

". . . a condition in which a person's identity and interpersonal relationships are centered around a memory of a traumatic experience which is objectively false but in which the person strongly believes. The memory often rules the individual's entire personality and lifestyle, and disrupts all sorts of other adaptive behaviors. The memory tends to take on a life of its own, encapsulated and resistant to correction. The individual avoids confrontation with any evidence that might challenge the memory and may be effectively distracted from coping with the real problems of living"

Thus, FMS is more than a simple recollection of a forgotten event, or even of a disputed event. It entails major disruption of the personality and family relationships.

Repression

A Freudian concept, repression, is said to occur when a memory is actively kept out of consciousness because it is unacceptable to the conscious mind, to which its admission would generate anxiety. 'Robust repression' allegedly permits individuals to lose all recollection of major life events, extremely long series' of traumatic events, and immensely complicated patterns of social behaviour (Herman, 1992; Ofshe & Watters, 1994).

NATURE OF THE PROBLEM: FALSE MEMORY SYNDROME

The term 'false memory syndrome' arose as popular shorthand to describe the 're-covery' in adult life of apparent memories of having been sexually abused in child-hood. 'Memories' usually, but not always, occur during the course of therapy under-taken for a range of psychological issues.

1. The survey of College members generated a 29% response rate (n=933) and any results must be treated with caution. Of those who responded, as many as one in five had attempted to recover memories of forgotten sexual abuse, one in six accepted the use of check lists as diagnostic of repressed sexual abuse and one in 10 recommended the book *The Courage to Heal* (Bass & Davis, 1988) to their patients.

In a stereotypical example, a patient who presents with a variety of psychological symptoms but with no history of having been abused may be explicitly informed that the symptoms are due to forgotten sexual abuse and be actively encouraged to remember the abuse. The patient, usually female, is encouraged to search for possible memories, and to read popular literature describing re-covered memory and sexual abuse. In extreme cases even to assume that she has been sexually abused. One woman reported:

"I would walk around saying 'my family abused me.' I had to say it a lot to really believe it. My first year and a half. was spent just accepting the fact that I had been abused." (Fredrickson, 1992)

Eventually the patient accuses a parent, or other person, and frequently severs all contact with the accused, and other family members who disbelieve the allegations. In many cases personal injury litigation or criminal prosecution of the accused have followed.

Not all cases of false memory arise from therapeutic practice. Increasingly the request for 'memory recovery therapy' is initiated by a client who has read one of a number of self-help books. *The Courage to Heal* (Bass & Davis, 1988) promulgates the view that forgotten sexual abuse lies at the root of almost all adult psychiatric problems and that unless it is brought fully into consciousness treatment will prove ineffective. The very inability to recall abuse is taken as a sign that abuse has occurred but is being 'denied' through the process of repression. The therapist and patient embark together upon the process of recovering hidden memories. This approach is supported by the existence of check-lists of symptoms that these therapists believe to be indicative of repressed sexual abuse.

The therapist will generally refuse to meet other family members and it is rare for a collateral history to be obtained. Rather, the therapist may assert that to seek objective evidence to substantiate the accusations would be a betrayal of the patient's trust. Some, however, join the patient in confrontation of the alleged abuser before links with the family are severed.

THE PSYCHOLOGY OF MEMORY

It is popularly believed that memory operates as a video recorder with events being recorded and stored, awaiting recovery essentially as they were laid down.

Memory is, however, a much more complex and less efficient process. Bartlett (1932) showed that biographical memory is essentially a reconstructive process in which only some elements of past experiences are stored and are retrievable. Far from being recovered unchanged, he demonstrated that memories may be reconstructed and elaborated by all kinds of subsequent influences.

Episodic memory

Episodic memory is the system associated most closely with traditional approaches to learning and memory and is that most readily disrupted by brain damage. It is normally associated with awareness of the learning process and strongly influenced by the degree of concentration and organisation.

Autobiographical memory

Memory is known to be fallible, altered by the passage of time and subject to error and distortion. Two interacting components, personal memories and autobiographical facts, are described. Individual autobiographical memory is unreliable; people will sometimes have startlingly accurate memories of some events yet be unable to remember considerable parts of their past experiences. Newly acquired facts may alter personal memories through reorganisation, reappraisal and revision. Autobiographical memory develops over the pre-school years and becomes more detailed with age (Hudson & Nelson, 1986; Pillemer & White, 1989). It becomes enriched through social construction (Nelson, 1993) and through active reinterpretation of experiences while remembering (Neisser & Harsch, 1992). However, confidence in one's memory does not correlate with the accuracy of the memory, nor does the detail involved in the memory or its emotional strength give any indication of it's accuracy.

Few people seem able to remember events which took place before about the age of three years. This 'infantile amnesia' (Campbell & Spear, 1972; Campbell *et al,* 1974; Coulter *et al,* 1976) depends upon delayed integration of the brain, which has been demonstrated in other species of mammal. Episodic memory does not develop until after age four years and most people have limited memories before about five or six years of age (Hudson & Nelson, 1986).

Implicit memory

This term includes behavioural, emotional and perceptual learning due to a past experience but not involving a sense of conscious recollection when retrieved.

Baddeley (1993) argues that implicit memory is a cluster of learning systems independent of episodic memory. Episodic memory is characterised by the capacity to associate previously unrelated events in a single trial, to associate an event with a context and hence locate it in time and place. This, stated simply, is memory for events including autobiographical experiences. In contrast, implicit memory systems are specialised for accumulating information from the world but are incapable of keeping separate the individual episodes.

Pillemer & White (1989) similarly postulate a dual memory system with a conditioned-emotional memory expressed through feelings, behaviour and images; and a narrative-autobiographical memory, which emerges around four to five years of age and is accessible by intentional retrieval.

Memories of trauma

Numerous studies in children (Terr, 1983; Malmquist, 1986; Pynoos & Nader, 1989) and adults (Leopold & Dillon, 1963) have shown that psychologically traumatic events are vividly though not always accurately recalled and are frequently followed by intrusive recollections in one form or another. The problem following most forms of trauma is an inability to forget, rather than a complete expulsion from awareness, and amnesia for violent events is rare.

Psychogenic amnesia following psychological trauma in adults is associated with sudden onset, temporary loss of personal information and usually total amnesia of the particular trauma. In contrast to so-called repressed or dissociated memory, patients with this form of amnesia are well aware of the gap in their memory. (Loftus & Ketcham, 1994; Kopelman, 1996). Some workers have suggested (Terr, 1991; Herman, 1992; van der Kolk & Fisler, 1995) that memories of repeated sexual abuse are laid down in the brain through a unique process which does not apply to other forms of trauma and which results in total loss of awareness both of the trauma and also of the amnesia. They argue further that the emotional component of a traumatic event can be stored as an implicit memory, even while the terror of the event prevents its

being recorded as an explicit memory trace. These memories, they claim, may then return via the sensori-motor system as context-free, meaningless, kinesthetic sensations, smells, tastes or visual images, often marked by intense emotional reactions. This remains an unproven hypothesis.

This hypothesis has nevertheless given rise to the popular belief in so-called 'body memories'. Proponents of this view believe that memories are recorded in cellular DNA and that if the mind forgets, the body will remember (van der Kolk, 1994). There is no empirical evidence to support this notion (Smith. 1995).

There is no evidence that an implicit memory can be translated into auto-biographical memory. Links which emerge in therapy or personal introspection between an implicit memory and explicit auto-biographical memory need to be recognised as constructions or creations of the mind.

It has not been possible to demonstrate any clear link between clinical accounts of trauma, and the neurobiology of memory. Nor is it clear why sexual trauma alone should behave in a special manner.

Hartmann (1984) also notes that solid evidence exists that implicit memories are found in people who have not suffered trauma.

Suggestion and memory

A growing body of research indicates that partially or completely inaccurate mem-ories are not uncommon. Memory is vulnerable to suggestion. Implanted false stories can be 'adopted' and subsequently 'remembered' as actually experienced events Those recollections are vivid and subjectively indistinguishable from recollections of actual events (Johnson & Suengas, 1989; Ceci & Bruck, 1993; Loftus, 1993). 'Flashbulb' memories of critical moments such as the loss of the *Challenger* or the assassination of Kennedy have been shown to be completely unreliable but held with absolute certainty. (Neisser & Harsch, 1992). Suggestibility and confabulation increase with the length of time between the event and later attempts to recall it. Repeated questioning over time and the authority of the questioner also heighten suggestibility.

Children

Recollections of childhood events are particularly vulnerable to misleading suggestions and distortions. Evidence suggests that children who *spontaneously* report current or recent abuse are usually telling the truth. Nevertheless, young, non-traumatised children may confabulate as Ceci & Bruck (1993) have demonstrated. They highlighted the dangers of repeated interviewing of children who produce stories of abuse to please the interviewer and come to believe their own imaginings. Where a report is made in circumstances of undue influence, caution in the interpretation of children's accounts is required. This applies, for example, when contentious divorce or marital separation proceedings are in progress or where other accusations have been brought within the family on the basis of newly recovered memories.

Conclusion

Memory is constructive and reconstructive rather than reproductive. It is fallible, altered by the passage of time and subject to error and distortion. Individual autobiographical memory is unreliable and people are often unable to remember considerable parts of their past experiences. Experiments have shown that expectations and beliefs can colour people's recollections, and that gaps in memory will be filled to create a satisfying narrative. Confidence in one's memory does not correlate with the accuracy of the memory (for a comprehensive review of the literature see Lindsay & Read, 1994). No autobiographical memory can be relied upon without some external corroboration but the frequent denial, even by proven abusers, and the secrecy surrounding child abuse often make such corroboration difficult to obtain.

BELIEFS AND PRACTICES IN THE RECOVERY OF MEMORIES OF CHILD SEXUAL ABUSE

A number of reviews have reached the conclusion that childhood sexual abuse can have long-term sequelae but that not all abused children are harmed. A significant proportion of adults who were unequivocally abused in childhood have made good adjustments and are symptom-free (Constantine, 1981; Browne & Finkelhor, 1986; Beichtman *et al*, 1992; Kendall-Tackett *et al*, 1992). The long-term effects of abuse appear to be largely non-specific. There is no pathognomic post-abuse syndrome.

Despite popular belief, empirical evidence linking childhood sexual abuse with bulimia nervosa is sparse (Pope & Hudson, 1992). A recent paper by Wonderlich *et al* (1996) provides some evidence of an association between the two but does not support a causal link (Pope, 1997). At present all that can be said is that childhood sexual abuse is a vulnerability factor for psychiatric disorder in general but for no condition in particular (Romans *et al,* 1995; Vize & Cooper, 1995).

Recovered memory therapy

Although there has been discussion of the significance of purportedly repressed or otherwise lost memories for nearly 100 years, there is still little agreement on the mechanisms of any loss or the effect that such lost memories may have upon psychological well-being. There is equal uncertainty on the effects of the recovery of previously lost memories.

Recovered memory therapy is not a single or unified therapy, nor is it an officially designated treatment. It is a label to describe the practices of a heterogeneous group of clinicians who share a particular set of beliefs (Yapko, 1994). They accept as a basic proposition that present symptoms are caused by past traumatic sexual abuse and that the memory of these events has been lost to consciousness. The second proposition they accept is that this lost material can be recovered and that the recovery of these memories is essential to the remediation of a patient's symptoms. Neither of these propositions have been proven.

Psychiatrists are as likely in-advertently to be practising 'recovered memory therapy' as non-psychiatrists if they accept these propositions. Surveys of the membership of the FMSF and the BFMS have shown that a significant proportion of disputed and probably false allegations arise from treatment by mainstream health care professionals.

It is important to be aware that memory recovery is not confined to any particular therapeutic approaches. It may equally occur in any form of talking therapy, from long-term psychotherapy to brief bio-logically-based interventions. It may arise from any intervention coloured by similar beliefs about the cause of psychological distress. Television programmes, popular self-help books, talking to individuals or groups who are convinced that repressed memories of childhood sexual abuse are responsible for many, if not most, adult ills may act as triggers or 'flashbacks' to generate false memories.

TECHNIQUES EMPLOYED TO ENHANCE MEMORY RECOVERY

In the service of uncovering 'forgotten' traumatic events some therapists use a number of techniques to enhance the recovery of lost memories. Some of these are regularly in use in orthodox therapy but are questionable when used as 'memory recovery' procedures (Yapko, 1994).

Check-lists

These derive both from professional literature and from popular self-help books. Foremost in the field, *The Courage to Heal* (Bass & Davis, 1988) encourages the irresponsible views that: "Many women who were abused don't have memories, and some never get any. This doesn't mean they weren't abused", and "if you think you were abused, and your life shows the symptoms, then you were".

Secret Survivors (Blume, 1990) includes in a list of symptoms of sexual abuse: "depression, phobias, eating disorders, low self-esteem, fear of the dark, nightmares, headaches, gastro-intestinal disorders, gynecological problems, wearing baggy clothes, drug or alcohol abuse or total abstinence, sexual aversion or sexual promiscuity". Many of the symptom check-lists are so all embracing that few people would be excluded. One article (Bradshaw, 1992) advises:

> "if you identify with five or more (symptoms), yet have no memory of incest, you might try an exercise. Accept the theory that you were abused, live cautiously with the idea for six months, in context with an awareness of the traits you acknowledge. and see whether any memories come to you."

Several authors emphasise the use of prolonged or repeated interviews in efforts to secure the patient's acceptance that they were abused despite their continuing rejection of the idea. This may be associated with statements such as "You were abused even if you have no memory of it". Thus, direct leading questions are standard techniques for some 'recovered memory therapists' (Maltz & Holman, 1986; Bass & Davis, 1988; Fredrickson, 1992) and some patients report coercive interrogation rather than interview.

There is no evidence that any check-lists, syndrome, symptoms or signs indicate with any degree of reliability that an individual has in the remote past been sexually abused.

Drug-induced abreaction or drug-mediated interview

During the First World War some physicians observed that abreaction under hypnosis was effective in relieving symptoms following traumatic combat experiences in soldiers (Culpin. 1920; Freud *et al,* 1921).

Blackwenna (1923) may have been the first to use barbiturates as a means of therapeutic narcosis. Lindeman (1923) demonstrated that small doses of sodium amytal injected intravenously produced a sense of serenity and well-being with some disinhibition, which enabled some to speak easily of intimate thoughts and experiences.

After Dunkerque, Mallinson (1940) and Sargant & Slater (1940) reported the effectiveness of abreactive treatment using intravenous barbiturates in achieving rapid resolution of hysterical symptoms associated with what they referred to as 'a repressed trauma'.

These and similar observations led to the myth of intravenous sodium pentothal (a barbiturate) as the 'truth drug' but these ideas were quickly discredited. Sargant & Slater (1944) acquired by far the widest experience of abreactive techniques and they wrote:

> "Often the doctor would be told fantastic stories under the drug straight from the world of night-mare. The falsity of these would be apparent on the surface. But it may also be that he will be told quite plausible and circumstantial stories which are no less the product of dream fabrication. Truth and fantasy will have to be sifted when the patient is in a state of clear consciousness, events seen in reasonable perspective and. shorn of exaggerated affect, integrated with the rest of the patient's experiences. A cautious and sceptical attitude on the part of the doctor will save him from swallowing all of his patient's hocum, hunting Snarks and exploring nightmares nests".

Although single drug-induced abreaction may be of value where it is known that a traumatic event has occurred, it is inappropriate to use repeated abreaction to 'trawl' for traumatic events. There is a good deal of anecdotal clinical evidence that in repeated sessions, patients will eventually produce material that is often a product of fantasy, and even in a single session great caution is required.

Case report

One of us (S.B.) was asked to see an otherwise healthy middle-aged man who presented to a neurology unit with severe pain and 'locking' of his back. Extensive investigation failed to produce an explanation and a psychiatric view was sought. The man denied any current problems and asserted that his job and marriage were unusually trouble free. He was somewhat evasive about his earlier history and claimed to have a memory gap of several years.

Pentothal abreaction was attempted and was 'dramtically successful' in that he recounted a period of sustained terror as he and his small Royal Air Force wireless section retreated in Burma and found themselves behind the Japanese lines. He was on solitary guard duty as they continued to move towards the British lines when he dropped off into an exhausted sleep. He suddenly awoke behind a bush to see all of his companions being bayoneted by the Japanese. He tried to cry out but had no voice and when he tried to stand up his back locked. Subsequently he wandered in the jungle until found by a patrol and was evacuated to India.

This provided an adequate psychopathology, including survivor guilt. Unfortunately when this explanation was offered to his wife she pointed out that he had never served in the Royal Air Force. He had en-listed in the army but was discharged as unsuitable during his basic training. He had never been out of England.

Hypnosis

McConkey & Sheehan (1995), in personal research and in their comprehensive review of the literature, clearly demonstrated the unreliability of hypnosis as a means of eliciting memories of past events. Memories recalled under hypnosis are recognised to be so unreliable that they are no longer admitted as legal testimony. Hypnotic recall increases the confidence with which the memory is held while reducing its reliability.

The dominant role of the hypnotist and the passivity of the subject create a situation in which the hypnotist may, intentionally or otherwise, influence the subject in creating or modifying memories. Where the relationship with the hypnotist is established over a number of sessions or where the situation itself is one creating clear expectations, for example in a forensic setting, the possibility of distortion is increased. A major difficulty also exists in determining whether the individual is in a true hypnotic trance or is manipulating the situation for reasons of which the subject or therapist may not be completely aware.

The creation under hypnosis of memories of previous lives, often as distinguished historical subjects, or of abduction by aliens (Mack, 1994) and sexual abuse in space ships reveal the extent to which this technique is suspect. Of concern is the extent to which people who elicit and report such memories appear to believe them despite their quasi-delusional nature.

Age regression

Age regression (usually but not always with the use of hypnosis) is undertaken both in a search for forgotten abuse and as part of the cure. The patient is encouraged to regress to an age at which abuse is thought to have occurred in order that, through both remembering and reliving the experience, some resolution and healing will take place. 'Body memories' and flashbacks, among other things, provide the cue to seek for abuse via age regression.

Accounts are at times so fantastic that they are beyond belief and there is no evidence of the efficacy of this technique. Nor is there evidence that the subject's memories or cognitions do indeed 'regress' to the target age.

Dream interpretation

Dream interpretation is used to infer previous sexual abuse through the interpretation of symbols and nightmares. There is no evidence that dreams are a 'royal road' to historical accuracy and interpretations usually reflect the training and personal convictions of the therapist.

It is frequently observed that patients dream to fit the theoretical model of their therapist. Since dreams are generally agreed to contain a residue of the day's events, it is at least plausible that, if the day is spent in an attempt to prove or disprove previous sexual abuse, one's dreams may come to reflect that preoccupation.

Imagistic work, 'feelings work' and art therapy

Imagistic work, guided imagery and guided fantasy involve the creation of images, often minutely detailed, by a variety of introspective techniques sometimes amounting to self-hypnosis. Similar criticisms apply to the practice of journaling and creative writing in which, in a state of reverie amounting to trance, subjects are encouraged to write down their thoughts in a flow of consciousness. One girl describes herself as writing questions with her right hand to which her 'inner child' replied to in a child-like scrawl with her left hand (Brewer, 1991; Fredrickson, 1992).

'Feelings work' is similar in that the patient is encouraged to recognise feelings of distress and consider how these might reflect past abuse. This is pure suggestion.

Art therapy may be used in a manner similar to dream and imagistic work with the emphasis on searching for complete and detailed memories of past abuse. Again, there is no valid basis for this belief.

Many of these techniques are applications of accepted clinical practice. The beliefs of the therapist are the determining factors in how a patient's productions are shaped. These approaches provide a rich backdrop for projection and fantasy elaboration. The encouragement of reverie and imagery of various kinds readily produces trance-like states. Practitioners who aver that they do not use hypnosis may nevertheless be doing so unwittingly since some of these techniques are powerfully suggestive and induce trance-like states.

Survivors' groups

Survivors' groups are often supportive, helpful in restoring self-esteem and in reducing shame and isolation (Herman, 1987). However, the practice of mixing those who clearly remember abuse with those who are suspected by the therapist of having repressed their memories of abuse (Herman & Schatzow, 1987) has been strongly criticised (Ofshe & Watters, 1994; Pope & Hudson, 1995; Pendergrast, 1995) because of the risk of suggestion and contagion among group members.

Conclusion

Evidence does not support the view that memory enhancement techniques actually enhance memory. There is evidence to support the view that these are powerful and dangerous methods of persuasion. Many of the memories 'recovered' using these measures refer to events in the early months or years of life which fall within the period of infantile amnesia and must be regarded as implausible for that reason. There is sufficient evidence of distortion and/or elaboration of memories to assert that entirely new and false memories can be created, not only experimentally but also in clinical practice. The evidence suggests that this is true of all of the techniques we have described above.

CAN REPEATED, SEVERE CHILDHOOD SEXUAL ABUSE BE FORGOTTEN?

Repression and dissociation

Trauma (recovered memory) theory postulates that forgotten trauma lies at the root of adult psychopathology and must be remembered for healing to occur. This approach harks back to early theories of Janet (1907) and Freud (Breuer & Freud, 1893; Freud, 1893, 1896). Janet (van der Kolk & van der Hart, 1989) postulated a vertical 'split' in the psyche whereby traumatic memories were kept apart, 'dissociated' or disconnected, from normal consciousness. This *condition seconde* became the basis for present-day theories of dissociation and multiple personality disorder or dissociative identity disorder. It is of interest that at the end of his life Janet turned his back on the *condition seconde* (Hacking, 1995), believing it to be an extreme and unusual form of manic-depressive disorder.

Freud outlined an active process of defence against painful wishes, thoughts and memories via repression which prohibited access to conscious awareness. It was the repression from awareness of psychic trauma and, specifically, childhood sexual abuse which was believed by Freud to be the cause of adult neurosis.

As is well known, Freud later repudiated his early theory of incest in the aetiology of hysteria.

In recent years repression has been taken over and developed beyond Freud's original theory. The concept of 'robust repression' holds that repeated episodes of severe sexual abuse can be dismissed from memory almost as soon as they occur. Proponents claim that each event is forgotten as it happens and that repeated assaults are experienced as if for the first time. This capacity to 'block out' memory permits the child to present a placid and unremarkable facade during the childhood years, so that no one, including the child, is conscious of anything untoward until decades later when the memories come back during therapy. This is very far removed from the traditional psychoanalytic under-standing of repression, although there are a few American psychoanalysts who appear to subscribe to these beliefs (Herman, 1992; Davies & Frawley, 1994). Some cite in support Summit (1983) who described the 'child abuse accommodation syndrome' in which under social pressure children tend to withdraw and deny their accusations; however, he did not contend that the memory was obliterated.

Dissociation is the mechanism put forward to account for this unlikely scenario. In extreme cases the dissociation is said

to lead to fragmentation and the creation of alternative personalities. This is the basis of multiple personality disorder in which it is believed that multiple 'alter' personalities exist within an individual, usually without knowledge of each other. The frequency with which this condition is diagnosed has increased 10-fold in the USA and it is beginning to be diagnosed more frequently in the UK. Slater & Roth (1969) stated unequivocally: "It seems that these multiple personalities are always artificial productions, the product of the medical attention that they arouse". Many specialists still doubt the existence of multiple personality disorder as a distinctive psychiatric condition and consider it to be iatrogenic in origin (Piper, 1994; Merskey, 1995). It does appear that diagnoses cluster in a few specialist clinics and this suggests that bias may be operating in referral or practice. Video-tapes and clinical demonstrations of the condition suggest that it arises in suggestible individuals as a consequence of the expectations of the therapist. As in hypnotic states, it is not easy to differentiate between involuntary and simulated states. There is evidence that attention (particularly from therapists perpetuates the dissociation and leads to the creation of ever more 'alter personalities' (Merskey, 1995).

'Robust repression' is said to account for recovered memories of ritual satanic abuse, cannibalism, ritual murder and other disturbing events generally thought unlikely to be forgotten. In the USA 18% of recovered memories known to the FMSF are of this sort. The figure from a survey of BFMS families conducted by Gudjonsson (1977b) is that 8% of these British families report accounts of satanic abuse. Some therapists believe that abduction and sexual abuse by aliens occurs in reality (Mack, 1994), while others are sincerely convinced that Satanic abuse occurs (Sinason, 1994). Extensive investigations by the Federal Bureau of Investigation in the USA and by the police in Britain have failed to find evidence of such practices. We accept the conclusions of a study commissioned by the Department of Health (La Fontaine, 1994) which found no evidence to support a satanic conspiracy of cult activity, although three isolated cases of abuse including ritual elements were verified. It is clear that sex abuse rings do exist and some abusers may use ritual to terrorise and coerce their victims (La Fontaine, 1998).

Evidence for repression

Despite widespread clinical support and popular belief that memories can be 'blocked out' by the mind, no empirical evidence exists to support either repression or dissociation. Three often-quoted studies (Herman & Schatzow, 1987; Briere & Conte, 1993; Williams, 1994) which, at first sight, appear to lend some support to the theory of repression of memories of early sexual abuse, have been severely criticised (Ofshe & Watters, 1994; Pendergrast, 1996; Pope, 1997) and are all capable of alternative and equally plausible explanations. In a review of Janet's theories, van der Kolk & van der Hart (1989), who espouses trauma and repression, admits that we know no more now than we did 100 years ago about the biology of the mind.

Pope & Hudson (1995) required that to demonstrate the existence of repression a research study must confirm first, that the sexual abuse had initially occurred and that confirmation should be verified by the experimenter who should not rely on self-report; and second, that the individual actually developed amnesia of a non-biological nature, after the age of five years old, which exceeds ordinary forgetting. Cases of amnesia due to biological causes such as brain injury or intoxication and those due to infantile amnesia must be excluded.

Herman & Schatzow (1987), in a short-term group programme for incest survivors, treated 53 women, whom they believed had been abused, with the goal of recovering memories of abuse. Before joining the group all patients reported either sexual abuse by a relative or a strong suspicion of abuse but no actual memory of the events. Alleged abuse ranged from indecent exposure and propositions to sexual intercourse. The women were divided into three groups on the basis of the type of amnesia they described. 'Severe amnesia' was defined as having no memory of abuse before entering therapy, 'partial amnesia' as having some memories with further ones emerging during therapy, and 'no amnesia' as those where memory was always present and no new memories emerged during treatment. 'Severe amnesia', reported by 26% of the women, was correlated with memories of earlier and more violent abuse. The authors argue that this represents true (massive) repression, in which the more severe the trauma, the more complete the memory loss. However, the mean age of abuse is 4.9 years and in many of the women, abuse, if it took place, had occurred within the period of normal infantile amnesia, from which 'recovery' is improbable. Fewer than half of the 53 women obtained confirmation, and of those who did, the age of onset, degree of amnesia for the event of severity of abuse are not specified. Those women who were able to find corroboration may have been those who did not forget, or had only partial amnesia. From the evidence presented in the paper it is likely that the more extreme memories reported were confabulations.

Briere & Conte (1993) gave a questionnaire to a clinical sample of patients in therapy who reported they had been sexually abused in childhood; 59% of 450 subjects reported periods of amnesia for the abuse before the age of 18 years. It is not clear how many of the alleged abuse events were confirmed. More importantly the amnesia is assessed solely on the basis of a single question: "During the period of time between when the first forced sexual experience happened and your 18th birthday was there ever a time when you could not remember the forced sexual experience?" The subjects were not asked further questions to distinguish between those who gave no thought to the abuse, those who attempted to minimise the event, and those who had truly forgotten it. Nor is it certain how many patients were reporting abuse sufficiently severe that they would reason-ably be expected to remember it. Moreover, these subjects were in treatment with therapists who formed part of a sexual abuse network of referral. It is not known whether the therapists were committed to recovered memory therapy or whether the patients themselves had expectations based on such beliefs. Thus, the influence of the therapy itself is uncertain.

Femina *et al* (1990) and Williams (1994) studied individuals with documented evidence of childhood abuse followed-up in adult life and found that they were not invariably able to report those experiences more than a decade later. Williams interviewed 129 women, who as children had been known to the authorities for sexual abuse, ranging from touching to intercourse, 17 years after the event. Three women had to be excluded from the study because they admitted that the original abuse had been faked. The age of the women at the time of the abuse ranged from 10 months to 12 years and at

interview they were aged 18-31. Over an extended interview in which they were asked detailed questions about their sexual histories, 38% failed to report the documented episode of sexual abuse. Williams concludes that this represents repression of the event. However, while the documented episode was not always reported, the general experience of abuse was, and the majority had no amnesia (62% reported the index event and 88% a history of some form of sexual abuse). It is not clear how many of those who did not report abuse would have been older than five years at the time, nor how many were trivial events that might reasonably have been forgotten. However, there were undoubtedly some cases of severe abuse which was not reported 17 years later. Perhaps the abuse had been forgotten, but the following study suggests another possible explanation.

Femina *et al* (1990) interviewed adults (mean age 24) with a documented history of physical abuse in adolescence; 38% (18 individuals) failed to report the index event (the same proportion as in the Williams (1994) study). Femina then performed a second interview with eight from that subgroup, in which they were told of their abuse. All eight admitted that they did remember the event and had withheld the information. Reasons presented included embarrassment, a wish to forget the past, to protect their parents or lack of rapport with the interviewer.

Williams (1994) did not conduct a second interview and it is premature to conclude that her subjects actually had amnesia for the event when a similar study found no amnesia. (For a detailed critique of these papers see Lindsay & Read, 1994; Ofshe & Watters, 1994; Pope & Hudson, 1995; Pendergrast, 1996.) What the Williams study does show is that childhood sexual abuse is significantly under-reported. Research evidence also shows that under-reporting of other significant events in childhood, such as hospital admissions or accidents, is common (Pope & Hudson, 1995) and this accords with clinical experience.

A number of further studies have attempted to look at the forgetting and recovery of memory of sexual abuse (Feldman-Summers & Pope 1994; Andrews *et al,* 1995). None of them meets Pope & Hudson's (1995) stringent criteria for an acceptable study. Most are accounts arising during therapy, most researchers fail to confirm the factual basis of abuse. They rely upon self-reports or unverified reports from third parties, for instance where a patient tells the therapist that her sister has proof that the abuse occurred but the therapist does not check it. They fail to indicate the severity of the forgotten abuse or whether extraordinary means, such as hypnosis or regression therapy, are needed to recover the memory, and whether mechanisms such as 'massive repression' must be invoked to explain it having been forgotten.

Conclusions

Individuals regularly remember long-forgotten events but it does not follow that repression of these memories had occurred. Some of these are accurate memories of actual events, but often they are elaborated, distributed or even invented by processes involving recall and reminder by others.

It is possible that the memory of events that are associated with anxiety or discomfort are suppressed or pushed to the back of the mind but remain accessible. Some painful memories of trauma are never forgotten but by an act of will the individual avoids thinking and talking about them.

Some 'recovered memories' may be elaborated recollections of real events which may or may not have been abusive. Abuse which was relatively minor may be forgotten and sometimes later remembered. Other episodes are forgotten if they were not perceived as abusive at the time, and may be recalled when their significance is recognised. There is no evidence to support the wholesale forgetting of repeated experiences of abuse, nor of single episodes of brutality or sadistic assault, apart from the normal experience of infantile amnesia. False memories can and do occur (Loftus & Ketcham, 1994) and some memories are so incredible that most clinicians would regard them as evidently false.

No evidence exists for the repression and recovery of verified, severely traumatic events, and their role in symptom formation has yet to be proved. There is also a striking absence in the literature of well-corroborated cases of such repressed memories recovered through psycho-therapy. Given the prevalence of childhood sexual abuse, even if only a small proportion are repressed and only some of them are subsequently recovered, there should be a significant number of corroborated cases. In fact there is none (Pope & Hudson, 1995; Pendergrast, 1996).

THERAPEUTIC OUTCOMES OF MEMORY RECOVERY TREATMENT

Despite the lack of evidence for repression there are many accounts which support the belief that abreaction and verbalisation of painful traumatic memories are clinically effective. Recovery of memories of childhood sexual abuse is said to empower the patient, provide a sense of security and confidence, replace confusion and obscurity with clarity, reverse the sense of isolation and helplessness and relieve guilt (Bass & Davis, 1988; Herman, 1992). There is evidence of the beneficial effect of recall and abreaction following war and natural disasters (Sargant & Slater, 1944; Grinker & Speigel, 1945; Archibald & Tuddenham, 1965; Kolb, 1984). These studies are often inaccurately cited as providing evidence of repression. What they describe is suppression of affect for the event, rather than that the event itself was forgotten. Loftus (1997) reviewed 30 cases selected at random from 670 claims submitted to the Washington Victims Compensation Program. Twenty-six had 'recovered' a memory of abuse through therapy. All 30 were still in therapy after three years, 18 for more than five years. After treatment 20 were suicidal compared with three before treatment began, 11 were hospitalised (c.f. two before treatment), eight engaged in self-mutilation (c.f. one before) and marriage break-up occurred in almost all. It appears that in these cases, recovery and abreaction had serious adverse effects.

Clinical accounts highlight the distress experienced as some patients 'recover memories' or 'relive trauma'. Patients do not always want their 'memories' and some cannot believe them to be true. Some therapists regard this as proof of their inherent reliability, suggesting that the patient who cannot face the truth is battling against the processes of denial and repression. It is an equally plausible explanation, however, that the patient is struggling to maintain a hold on reality in the face of powerful suggestive influences. Undoubtedly, there are clinical accounts of 'memories' being recovered with apparent long-term benefit. Unfortunately, they are almost universally uncorroborated by evidence to show that the remembered event actually took place.

Spence (1982) distinguished between narrative truth and historical truth, shifting interest towards establishing the patient's

perception of events irrespective of whether the events had really happened. Some clinicians believe, as did Freud, that historical truth is not important to therapy. It may be the case that abreaction of an imagined but believed-in event is effective in relieving symptoms, and clinical examples of 'reincarnation therapy' have been described. However the effects of such distorted truth should not be overlooked. The damage done to families if the accusations are untrue is immense. Moreover, it is not only families that are damaged by mistakes in this area. Patients who are mistakenly diagnosed as having been abused, frequently end as mental health casualties (Loftus, 1997). Where apparent improvement is based upon a false belief, there seems a serious possibility of further mental distress.

HOW CAN WE DISTINGUISH BETWEEN TRUTH AND ILLUSORY MEMORY?

The common experience of remembering is for a memory to return suddenly and completely. 'Recovered memories' differ from other forms of forgotten and remembered events in being built-up over time. Close examination reveals that they resemble narrative rather than memory, with more being added at each attempt at recall, often becoming increasingly elaborate and bizarre. Accounts of recovered memories may sometimes be vague and imprecise and accusations are often based upon innuendo. It often seems that the key element is a firmly held belief rather than a clear memory. Clues to the probable reliability of a recovered memory lie in the circumstances of the recall, the beliefs of the individual, and any external influences, including memory-enhancing techniques, the suggestive effects of books, media influence and direct suggestion.

Some therapists (Putnam, 1989; Davies & Frawley, 1994) hold that supposed re-enactments in the clinical setting, including feelings arising within the therapist (the countertransference), provide evidence of previously forgotten abuse. While they may be pointers towards characteristic ways in which the patient forms relationships, it is dangerous to extrapolate from these to any statement about past history.

There is no reliable means of distinguishing a true memory from an illusory one other than by external confirmation. There are, of course, some memories so bizarre or impossible that they are not credible. If something could not happen, it did not happen.

SUMMARY OF THE EVIDENCE

(a) There is no empirical evidence to support either repression or dissociation though there is much clinical support for these concepts. Evidence does not support the existence of 'robust repression'.

(b) Events are constantly forgotten and remembered on a daily basis.

(c) There is abundant evidence, both clinically and experimentally, that memory can be distorted and that false memories do occur.

(d) Illusory memories can arise during the course of any psychological treatment, whether or not it is designated as 'recovered memory therapy'. Their creation seems to depend upon the conviction of the therapist or the patient that child sexual abuse underlies adult psychopathology.

(e) Memory-enhancing techniques do not improve the quality of remembering. They do increase the conviction with which memories, true or false, are held. They appear to be dangerous methods of persuasion.

(f) More research is needed into the reported associations between childhood sexual abuse and later adult psychopathology. At present we can only conclude that there is no pathognomic post-sexual abuse syndrome.

(g) There is no means of determining the factual truth or falsity of a recovered memory other than through external evidence, difficult though this is to obtain. Some reported events are so incredible that they could not have occurred and should not be believed.

GENERAL COMMENTS

Psychiatrists have a responsibility not to cause harm to patients or their families and to ensure that members of related health care professions within their teams are properly informed of the vagaries of memory and are adequately supervised.

Any report by an adult of childhood sexual abuse should be listened to seriously and sympathetically. Those who have never forgotten abuse are likely to be reporting a real experience. However, great caution is needed if a memory is reported after years of apparent amnesia. There is considerable evidence that such memories cannot be relied upon. Therapist and/or patient expectations, reinforced by guided reading, particular techniques and survivors' group participation may distort any existing memory or implant a wholly new one.

There can be no justification for the use of memory recovery techniques which involve significant departure from normal interview or psychotherapy techniques. In particular, consciousness-altering techniques involving drugs, hypnosis, prolonged interrogation or strong suggestion should not be employed as a means of 'recovering' memories whose existence is hypothesised. Memories of satanic abuse or other bizarre events, memories from before the age of four years and memories of repeated abuse over many years forgotten until recovered therapy are not credible. There is a reason-able chance that they will wither away if not reinforced through attention.

Whether a patient who seeks help from a psychiatrist has true or false memories of past sexual abuse, they are entitled to sympathetic and competent care. Good, standard psychiatric practice offers the best prospect of helping a patient to identify and come to terms with past traumatic events.

RECOMMENDATIONS

The following recommendations are particularly concerned with the use of specific memory recovery techniques; however, it is important to emphasise that distortion of memory may occur in any therapeutic situation. Psychiatrists need to be aware of the techniques employed by other members of their teams, including community psychiatric nurses, psychologists and social workers. Any professional, including senior psychiatrists, working with cases of sexual abuse or recovered memories should have access to expert advice and the possibility of regular peer supervision.

These recommendations assume a familiarity with General Medical Council ethical guidelines, particularly with reference to the need for confidentiality.

(a) The welfare of the patient is the primary responsibility of the psychiatrist.

Concern for the needs of family members and others may also be

necessary, within the constraints imposed by the need for confidentiality.

(b) In children and adolescents symptoms and behaviour patterns may alert the clinician to the possibility of current sexual abuse but these are no more than pointers for suspicion. Psychiatrists should be aware that there are reported associations but no clear causal connection between childhood sexual abuse and adult psy-chopathology. The use of check-lists and 'syndromes' as indicators of past sexual abuse are unreliable. Sexual abuse cannot be diagnosed through use of a symptom check-list.

(c) Psychiatrists are advised to avoid engaging in techniques which are intended to reveal evidence of past sexual abuse of which the patient has no memory, and should regard with extreme caution memories of this kind whenever they appear. There is no evidence that the use of consciousness-altering techniques, such as drug-mediated interviews or hypnosis, can reveal or elaborate evidence of childhood sexual abuse. Techniques of 'regression therapy' (age regression, guided imagery, 'body memories', journaling, or literal dream interpretation, where this is used as evidence of fact) are of dubious provenance.

(d) Forceful or persuasive interviewing techniques are not acceptable in psychiatric practice. Doctors should be aware that patients are susceptible to subtle suggestions and reinforcements, whether or not these communications are intended.

(e) The psychiatrist should alert the patient to any doubts about the historical accuracy of recovered memories of previously unknown sexual abuse. This is particularly important if the patient intends to take action outside the therapeutic situation. Memories, however emotionally intense and significant to the individual, may not necessarily represent historical truth. Memories may be historically true, metaphorical representations, caused by the psychological state of the patient or be the result of unintentional suggestion by the practitioner.

(f) It may be legitimate not to question the validity of a recovered memory while it remains within the privacy of the consulting room**,** although this introduces the risk of colluding in the creation of a life history based upon a false belief.

(g) Action taken outside the consulting room, including the revelation of the accusations to any third party, must depend on circumstances and the wishes of the patient, but the full implications of such action must always be considered. Adults who report previously forgotten childhood abuse may wish to confront the alleged abuser. Such action should not be mandated by the psychiatrist and it is rarely, if ever, justifiable to discourage or forbid the patient from having contact with the alleged abuser or other family members. The psychiatrist should help the patient think through the consequences of any confrontation. In these circumstances it is important to en-courage a search for corroborative evidence before any action is taken. The truth or falsity of the underlying memories cannot be known in the absence of such evidence.

(h) Once an accusation is taken outside the consulting room, especially where any question of confrontation or public accusation arises, there is rarely any justification for refusal to allow a member of the therapeutic team to meet family members.

(i) Where an alleged abuser is still in touch with children, serious consideration must be given to informing the appropriate social services. This *must* be done where there are reasonable grounds for believing that the alleged assault took place and that children may still be at risk. The psychiatrist must also be prepared to state clearly whether he or she believes that the grounds for any accusation are unlikely or impossible.

(j) The patient may wish to take legal advice with a view to the prosecution of, or litigation against, the alleged abuser. It is inappropriate to make any decision about this a condition of continuing treatment.

(k) Alongside reports of recovered memories of sexual abuse there have been growing numbers of cases of multiple personality disorder (also known as dissociative identity disorder). There seems little doubt that many of these cases are iatrogenically determined. Any spontaneous presentation of multiple personality disorder should be sympathetically considered but should not be made subject of undue attention nor should the patient be encouraged to develop 'alter personalities' in whom to invest aspects of their personality, their fantasies or their current life problems. Psychiatrists should be particularly aware of the unreliability of the memories reported in these cases and of the close association both with prolonged therapy and with recovered memories of sexual abuse, particularly alleged satanic abuse. Since there is no settled view of the validity of multiple personality disorder, and because of the very strong correlation with recovered memories of sexual abuse which is itself a disputed concept, there is a strong case for a consensus paper on multiple personality disorder based upon a substantial review of the literature.

This review seeks to provide clinical practitioners with some clear guidelines for practice, recognising the needs of those sexually abused in childhood but reducing the risk of creating false memories of abuse which will cause the patient and family further suffering.

No one can fail to be aware of the highly intense and emotional debate which has polarised into two 'camps' which appear deaf to each others' arguments. The time has come to put aside the disputes and concentrate on maintaining and improving standards of practice and initiating more high-quality research. There is some evidence that past protagonists are now attempting to achieve reconciliation (Lindsay & Briere, 1997).

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