

in man using PET. *International Journal of Neuropsychopharmacology*, **1** (suppl. 1), S65.

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Neurosurgery for obsessive-compulsive disorder

Sir: In a valuable review Jenike (1998) details the psychosurgical procedures currently available worldwide for the treatment of obsessive-compulsive disorder. In the description of the technical procedure of stereotactic subcaudate tractotomy (SST) it is stated that the brain lesion is created by means of radioactive yttrium (Y^{90}). However, we feel it is important to mention that the operation was modified in 1995 and a new procedure using the Leksell instrument and frame to create thermo-controlled high-frequency electrocoagulation has been in place since 1996 (Malhi & Bartlett, 1998). The new procedure successfully replicates the original method and has enabled the operation of SST to continue without any fundamental change in the characteristics of the lesions. The operation is not longer dependent on the availability or optimum activity of Y^{90} , and this affords greater flexibility in terms of scheduling surgery. Of particular importance is that the new procedure incurs less expense and may produce clinical response sooner. The indications for SST have not changed and it is still made available to those with treatment-resistant depression, intractable anxiety disorders and obsessive-compulsive disorder.

Jenike, M. A. (1998) Neurosurgical treatment of obsessive-compulsive disorder. *British Journal of Psychiatry*, **173** (suppl. 35), 79–90.

Malhi, G. S. & Bartlett, J. R. (1998) A new lesion for the psychosurgical operation of stereotactic subcaudate tractotomy (SST). *British Journal of Neurosurgery*, **12**, 335–339.

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Loss of consciousness and post-traumatic stress disorder

Sir: In their editorial on post-traumatic stress disorder (PTSD) and loss of consciousness, O'Brien & Nutt (1998) highlight the

lack of information and research into the prevention and treatment of PTSD, despite its increased prevalence in the literature and its medico-legal implications. They note the importance of coma as a protective element. We would like to report our findings in support of this and highlight some of the conflicting reports from the literature. Although there have been few studies, when rates of PTSD were looked at in head-injured patients they were found to be quite low, which led to the theory that loss of consciousness and post-traumatic amnesia may be protective. Mayou *et al* (1993) found that among 188 victims of road traffic accidents, 19 met PTSD criteria but among 51 traffic accident patients who had sustained loss of consciousness for more than five minutes, none developed PTSD. The recurrence of memories of the injury/event was predictive of PTSD. Creamer *et al* (1992) suggest that adjustment in PTSD involves cognitive processing of threat-related information in a way that permits resolution of anxiety. The cognitive impairment associated with head injury may impede the individual's ability to process information in a manner that permits resolution. It also appears that a proportion of head-injured patients experience intrusions about events for which they are amnesic (Bryant & Harvey, 1995). Bryant & Harvey also found rates of PTSD of 42% in non-head-injured *v.* 26% of head-injured motor vehicle accident victims.

In our population-based study of head-injured patients, we looked at 196 adults attending the emergency department in South Glamorgan (catchment population 400 000) over a one-year period (1994–1995) who required in-patient admission with traumatic brain injury (defined by loss of consciousness and/or Glasgow coma scale 14 or less and/or post-traumatic amnesia and/or radiological evidence of skull fracture and/or localising neurological signs). As well as psychiatric screening questionnaires, all patients were administered a questionnaire specifically designed to identify the symptoms of PTSD. Of the entire cohort only five patients had experienced PTSD, and of these one had recovered at time of interview (one year after the head injury), as she had been treated by a psychiatrist specialising in the illness. All five had no or minimal loss of consciousness and had recollection of the traumatic event. These rates are far lower than would be expected when rates of

PTSD are looked at in other physical injuries such as burns (Perry *et al*, 1992). PTSD is now recognised to develop in the context of bodily injuries as well as emotional trauma, and physical injury may be a risk factor. However, head injury can be considered to differ from other injuries because the injury itself may interfere with recollection or memories of the accident. As O'Brien & Nutt (1998) point out, brain injury and its resultant loss of consciousness may have a paradoxical beneficial effect on the psychological recovery from trauma. We feel our findings support this theory and hope that further research can lead to the development of therapeutic approaches to prevent PTSD.

Bryant, R. A. & Harvey, A. G. (1995) Acute stress response: a comparison of head injured and non head injured patients. *Psychological Medicine*, **25**, 869–873.

Creamer, M., Burgess, P. & Pattison, P. (1992) Reaction to trauma: a cognitive processing model. *Journal of Abnormal Psychology*, **101**, 452–459.

Mayou, R., Bryant, B. & Duthie, R. (1993) Psychiatric consequences of road traffic accidents. *British Medical Journal*, **307**, 647–651.

O'Brien, M. & Nutt, D. (1998) Loss of consciousness and post-traumatic stress disorder. A clue to aetiology and treatment. *British Journal of Psychiatry*, **173**, 102–104.

Perry, S., Difede, J., Musngi, G., et al (1992) Predictors of posttraumatic stress disorders after burn injury. *American Journal of Psychiatry*, **149**, 931–935.

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Recovered memories of abuse and dissociative identity disorder

Sir: Brandon *et al* (1998) and Pope *et al* (1998) have claimed that there is no evidence for delayed recall of authentic childhood trauma, implying that this recall involves pseudo-memories.

Although no relevant retrospective, prospective or case study is without its methodological limitations, all such studies have found evidence consistent with the hypothesis that a proportion of cases retrieve delayed memories of trauma (Brown *et al*, 1998). This convergent evidence is strengthened by recent data from studies which circumvent such limitations (e.g. Duggal & Sroufe, 1998). The question is not whether trauma can be partially or completely forgotten and recalled after a substantial delay, but what

the prevalence of delayed recall is, and which factors promote its occurrence. As several studies have found that memories of trauma were equally accurate, whether continuously remembered or recalled after substantial delay, there is no empirical basis to argue that delayed memories should be met with unusual reservations.

The *a priori* rejection of the possible partial or complete validity of delayed memories of trauma is likely to yield false positive diagnoses and to inhibit persons with partial or recently retrieved memories of trauma from seeking therapy. Since delayed recall may involve pseudo-memories, authentic memories, or combinations of false and true elements, professionals should take an open-minded, neutral stance toward the (in)validity of delayed memories. This neutrality is best sustained until independent evidence supporting or refuting the memory is found, or when therapeutic neutrality becomes untenable following thoughtful consideration of all the evidence.

Most of the clinical recommendations Brandon *et al* (1998) presented should be welcomed by those who take this neutral stance. However, this does not apply to their recommendations on the diagnosis and treatment of dissociative identity disorder (DID), about which they express sceptical opinions with great conviction but unsupported by evidence. For instance, although both false negative and false positive cases of DID exist, there are no empirical data for their claim that many cases are iatrogenetically determined. In fact, the existence of DID and its origins in childhood trauma have been objectively documented (Lewis *et al*, 1997).

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.

Brown, D., Schefflin, A. W. & Hammond, D. C. (1998)
Memory, Trauma Treatment, and the Law. New York: Norton.

Duggal, S. & Sroufe, L. A. (1998) Recovered memory of childhood sexual trauma: a documented case from a longitudinal study. *Journal of Traumatic Stress*, **11**, 301–322.

Lewis, D. O., Yeager, C. A., Swica, Y., et al (1997)
Objective documentation of child abuse and dissociation in 12 murderers with dissociative identity disorder. *American Journal of Psychiatry*, **154**, 1703–1709.

Pope, H. G. Jr, Hudson, J. L., Bodkin, J. A., et al (1998)
Questionable validity of 'dissociative amnesia' in trauma

victims. Evidence from prospective studies. *British Journal of Psychiatry*, **172**, 210–215.

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Author's reply: My colleagues and I (Brandon *et al*, 1998) were unable to identify from our own experience or from the literature a case where severe and repeated sexual abuse in childhood was totally forgotten. The possibility of such cannot be denied but we remain to be convinced. Our paper was primarily directed towards offering an explanation of and succour to the families whose lives had been disrupted by belated accusations of sexual abuse of dependant children. The central question addressed was whether or not such false memories could occur and if so what factors were concerned in their production.

We concluded that false memories could and did occur and that certain practices encouraged their development. This led to the production of the guidelines for good practice (Royal College of Psychiatrists' Working Group on Reported Recovered Memories of Child Sexual Abuse, 1997) of which van der Hart & Nijenhuis apparently approve. They are, however, critical of our scepticism regarding dissociative identity disorder.

This condition is now enshrined in the DSM-IV (American Psychiatric Association, 1994) and many more people are now trying to make this diagnosis through the check-list approach. My own experience of watching colleagues in the USA make this diagnosis has been that the diagnostic interview resembled a coaching session rather than psychiatric interview. I have had a number of vulnerable patients who have virtually invited me to help them develop alters but who have settled for therapy on a one-to-one basis. While familiar with the work of Lewis *et al* (1997) I cannot agree with their conclusion that their study has established "once and for

all, the linkage between early severe abuse and DID". In their study of 12 murderers who had an objective history of severe childhood abuse, usually physical and emotional, and who met the DSM-IV criteria for DID, they certainly provided vivid illustrations of psychological efforts to cope with intolerable situations but did not demonstrate that abuse is the necessary and sufficient cause of the disorder.

I believe that multiple personality disorder develops when therapists or others encourage suggestible individuals to embark upon exaggerated use of familiar psychological mechanisms. The centres where this diagnosis is frequently made commonly have troupes of performing patients who delight in demonstrating their diverse alters to visitors. There is at least one such centre in England.

Having expressed my prejudice I have to admit that I have not conducted research in this area or engaged upon an extensive review of the literature. It was for these reasons that the Royal College of Psychiatrists' Working Group on Reported Recovered Memories of Child Sexual Abuse recommended that a consensus paper on multiple personality disorder be written, based upon a substantial review of the literature. Having expressed my views I would not wish to take part in such a review but would rely upon the College to find open-minded individuals who could take an objective view.

American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders* (4th edn) (DSM-IV). Washington, DC: APA.

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.

Lewis, D. O., Yeager, C. A., Swica, Y., et al (1997)
Objective documentation of child abuse and dissociation in 12 murderers with dissociative identity disorder. *American Journal of Psychiatry*, **154**, 1703–1709.

Royal College of Psychiatrists' Working Group on Reported Recovered Memories of Child Sexual Abuse (1997) Recommendations for good practice and implications for training, continuing professional development and research. *Psychiatric Bulletin*, **21**, 663–665.

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