balanced report on the evidence with regard to recovered memories of childhood sexual abuse. The report's conclusions and guidance clearly suggest that some clinical practices carry an especially high risk of inducing illusory memories, with potentially harmful consequences to patients and their families. As these practices involve the imposition of the clinician's beliefs upon the patient, with no proven benefits and a distinct risk of harm, they can only be regarded as potentially or actually abusive and unethical.

The Royal College of Psychiatrists has a long history of principled opposition to unethical practice, particularly with respect to political abuse of psychiatry in South Africa and the Soviet Union. We are therefore puzzled by the College's failure to endorse fully its working group's report. This apparent equivocation has been widely reported in the national press, and has created an impression that evidence (rather than opinion) may exist which contradicts the report's main conclusions. This undermines the credibility of these important findings and recommendations. In order to resolve this ambiguity, we call upon the President of the College to explain why the full report was not published under the College's imprimatur.

**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.

**R. Poole, R. Higgo** North Mersey Community (NHS) Trust, Acute Directorate, Broadoak Unit, Thomas Drive, Liverpool L14 3PJ

**President's reply:** Drs Poole and Higgo ask why the original report of Professor Brandon's working party on recovered memories of childhood sexual abuse was not published under the College's imprimatur. Although the sequence of events was rather complex the explanation is quite straightforward.

The Executive and Finance Committee of the College (a sub-committee of Council) originally decided to establish a working group to draft a College report on the false or recovered memory syndrome in July 1994. Professor Brandon was invited to chair the working group and nominations for its other members were invited from the then General Psychiatry, Child and Adolescent Psychiatry, Forensic Psychiatry and Psychotherapy Sections of the College. It was subsequently decided, in view of its predominant interest in the topic, that the Psychotherapy Section should have two representatives. As a result the working group eventually had six members.

The working group's draft report was first seen by the Executive and Finance Committee on 13 September 1996 and it was clear that it was contentious. One of the two representatives of the Psychotherapy Section was dissociating himself from the report, the Executive Committee of the Psychotherapy Section was disturbed by some of its conclusions, and those conclusions were significantly different from those previously published by the British Psychological Society and the American Psychiatric Association. For this reason comments on the report were solicited from the Psychotherapy and Forensic Psychiatry Sections and Professor Brandon and his colleagues were asked to consider revising their report in the light of those comments.

After a further meeting of the working group Professor Brandon returned to the meeting of the Executive and Finance Committee on 10 January 1997 and proposed that, as his working group was still unable to produce a report on which consensus could be achieved, either within its own membership or within the College's wider membership, the College should restrict itself to issuing guidelines on good practice in this area (including recommendations for training and future research) as this was the most urgent need. This very sensible proposal was accepted by the Committee and it was agreed at the same time that Professor Brandon and his colleagues would be free to publish the other, more contentious parts of their draft report under their own names wherever they wished. One possibility that was discussed was a book published under the Gaskell imprint.

The working group then reconvened and was able to reach unanimous agreement on a set of guidelines on good practice which were subsequently accepted by Council, subject to a few minor changes in wording, at its meeting on 28 April 1997. Those guidelines were published under the College's imprimatur in the October 1997 issue of the *Psychiatric Bulletin* (Royal College of Psychiatrists' Working Group on Reported Recovered Memories of Child Sexual Abuse, 1997) and have been widely welcomed. The following month (i.e. in November 1997) Professor Brandon and three of his original five colleagues submitted the article referred to by Drs Poole and Higgo to the editor of the *British Journal of Psychiatry*, where it was published in April this year.

**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.

**R. E. Kendell** President, Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG

## Antidepressant quandaries

**Sir:** Moncrieff *et al* (1998) and Healy (1998) provide thought-provoking articles comparing treatment outcomes for antidepressants and active placebos. The findings documenting fragility of antidepressant effects parallel concerns my colleagues and I have raised in several publications analysing the antidepressant literature (e.g. Greenberg & Fisher, 1989, 1997). Of paramount importance is the research-supported conclusion that ratings of drug effectiveness relative to placebo decrease as blindness increases. It is, therefore, critical to check that the double-blind design is truly double-blind. Surprisingly, this is rarely verified. Almost all investigators simply assume that using a double-blind design guarantees blindness. In gathering evidence about validity for this assumption, we located about 30 studies attempting to discover whether the double-blind was breached. It was disconcerting to discover that the double-blind was penetrated in about 90% of the reports. The data provided in the typical double-blind psychotropic drug trial appear to be tainted and estimates of effectiveness likely inflated.

How is unblinding accomplished? Although it is possible that unblinding might be facilitated by active drugs producing more beneficial effects than placebos, at least equally plausible is the idea that differential levels of side-effects between drugs and placebos serve as the tip off. This is the reason why active placebos (those that produce bodily sensations) may be helpful in preserving blindness. In further support of this idea is a meta-analysis we published which was not cited by Moncrieff *et al* (1998) or Healy (1998). This work analysed the results of all available placebo-controlled double-blind studies of fluoxetine (Greenberg *et al*,

https://doi.org/10.1192/S0007125000151074 Published online by Cambridge University Press