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revisited with the publication of ICD–11 and DSM–V.

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Memory recovery among adults in therapy

Sir: Andrews *et al* (1999) base their study upon the British Psychological Society survey (Andrews *et al*, 1995) in which 4005 questionnaires were sent to chartered psychologists and 810 replies were received – a response rate of 20%. Of those who responded, 36% (291) had recovered memories in at least one client and 71% (208/291) identified themselves for future research, of whom 180 were interviewed by telephone. In this telephone interview 16/180 denied having a case of recovered memory, 9% could not remember the client, 10/118 did not have the case records, 17% declined to be interviewed and 2% could not be traced.

Thus, the study is based upon 118 from a population of 4005 eligible (2.9%) and they were found to be more likely to believe in the accuracy of recovered memories and to have seen satanic/ritual abuse cases.

The authors found that 36% of recovered memories were from the first five years of life and 9% fell within the period of infantile amnesia. Memory recovery techniques "seemed to be used more to help the clients to elaborate the memories than to facilitate their initial recovery", but the authors do not comment on the doubtful validity of such techniques or, indeed, of early memories. They also observe that "it is difficult to know how representative respondents were of professional psychologists who encounter recovered memories in their practice"; 2.9% of the original sample are hardly representative of anything other than the views of those psychologists questioned. They were discussing patients "40% of [whom] were no longer in treatment and notes were not consulted", and it is not clear how systematic the notes were on the remaining patients.

In our experience many who have recovered memories have been involved with multiple therapists and often do not inform their current therapist of this. Some people have also read literature such as Bass & Davis (1988) and have been members of survivors' groups.

We are still appallingly ignorant of the way in which real memories of abuse are dealt with. Do some people push the events to the back of their mind and avoid distress by not thinking or talking about them, only to feel compelled to share their experience after some trigger? Do some people who create 'false memories' do so through autistic thinking in the isolation of distress? There are many unresolved issues in this area, which needs less debate and more research. The only certain thing is that memory cannot be relied upon without external verification. We trust that there is at least agreement that recommendations for good practice such as those published by the Royal College of Psychiatrists' Working Group (1997) should be observed by all clinicians.

Andrews, B., Morton, J., Bekerian, D., *et al* (1995) The recovery of memories in clinical practice: experience and beliefs of British Psychological Society Practitioners. *Psychologist: Bulletin of the British Psychological Society*, **5**, 209–214.

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Author's reply: Drs Brandon & Boakes' letter contains some misconceptions concerning our past and present research. The criticisms they raise involve the representativeness of our sample of therapists, and the validity of their reports. They suggest that the sample of interviewed therapists referred to in the paper constitutes 2.9% of our original sample and hence is unlikely to be representative of all 4005 'eligible' British Psychological Society practitioner members from the original survey (we should add that the response rate in the original survey was 27% (Andrews *et al*, 1995), not 20% as stated). However, the 4005 practitioners were only 'eligible' in the sense that they were all sent the original questionnaire. Many will not have been working therapeutically with non-psychotic, non-organically impaired adult psychiatric patients, and hence the survey would not have been relevant to them. It is almost certain, therefore, that the response rate among respondents seeing the appropriate group of patients was considerably higher than 27%. The response rate among practitioners who had actually had recovered memory patients is likely to have been higher still, considering that the subject of the survey would have been of special interest to them. Without a 100% response rate to our original questionnaire survey, the number of such eligible practitioners can, unfortunately, not be specified with any greater precision.

Therefore, we did our utmost in the paper to examine the representativeness of the therapists we went on to interview, when compared with the rest of the eligible respondents who in the original questionnaire survey reported having had a patient reporting recovered memories in the previous year. We compared the original survey item responses of eligible respondents in terms of whether they identified themselves for research or not, as well as in terms of whether they were actually interviewed by us or not. Very few differences arose and these were fully discussed where relevant with regard to their possible impact on our results. Thus, it seems fair to conclude that our sample is in almost all respects representative of the 291 eligible respondents from the original postal survey. There is some uncertainty about whether the 291 respondents constitute a large or small proportion of the total number of British Psychological Society practitioners with patients reporting recovered memories. There is inevitably, at this stage in the research, a tension

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between sampling as widely as possible, with a consequent reduction in response rates, or sampling more narrowly and missing important pockets of data. With regard to the validity of the therapists' reports, as explained in our article, we did, in fact, tackle this issue by comparing respondents who had referred to notes with those who had not. No differences were found on any of the variables in the analyses.

In responding to our research, Drs Brandon & Boakes refer to their own experience of therapists and individuals who claim to have recovered memories. However, they do not provide any numbers or information about the source of their data. As they will be the first to acknowledge, the people who form the basis of their experiences are unlikely to be a representative sample. In contrast, our survey involved what is, to date, the largest number of observations of clients reporting recovered memories collected systematically in a sample of therapists of all theoretical persuasions.

Andrews, B., Morton, J., Bekerian, D. A., *et al* (1995) The recovery of memories in clinical practice: experiences and beliefs of British Psychological Society Practitioners. *Psychologist: Bulletin of the British Psychological Society*, **5**, 209–214.

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Ecstasy use and neuropathology

Sir: Obrocki *et al* (1999) claim to reveal long-term effects of methylenedioxymethamphetamine (MDMA) on the central nervous system in a study of seven subjects, but in fact repeat the errors of previous published studies of neurotoxicity in humans (McCann *et al*, 1998). McCann *et al* provided convincing evidence of an association between decreased serotonin (5-HT) transporter binding sites and MDMA use, and Obrocki *et al* demonstrate an association between MDMA use and altered glucose metabolic uptake in Brodmann's area 11 in particular. However, association does not imply causation, and the findings could be explained in terms of neuropathology caused by MDMA use, MDMA use caused by neuropathology, or both arising from a common denominator. Both Obrocki *et al* and McCann *et al* focus exclusively on the first hypothesis to the detriment of their otherwise convincing results. As has already been noted (Morgan, 1999), it is equally plausible that MDMA use results from pre-existing 5-HT function abnormalities; in other words, affective disturbance may lead individuals to 'self-medicate' with MDMA. Since absence of psychiatric disease constituted an exclusion criterion for Obrocki's control subjects, *P* values would be expected to be lowered further if Morgan's (1999) hypothesis were true. Future studies should consider Axis I disorder prior to MDMA use, subclinical mood disorder, and previous or current Axis II diagnoses with particular reference to impulsive behaviour in which hippocampal pathology may be involved. Since MDMA use in the community is so prevalent, prospective studies would be valuable and possible, although ethically difficult.

McCann, U. D., Szabo, Z., Scheffel, U., *et al* (1998) Positron emission tomographic evidence of toxic effect of MDMA ("Ecstasy") on brain serotonin neurons in human beings. *Lancet*, **352**, 1433–1437.

Morgan, J. F. (1999) Positron emission tomographic evidence of toxic effects of MDMA ('ecstasy') on brain serotonergic neurones in human beings: users may self-medicate for axis I and II disorders. *Lancet*, **353**, 1268–1269.

Obrocki, J., Buchert, R., Väterlein, O., *et al* (1999) Ecstasy – long-term effects on the human central nervous system revealed by positron emission tomography. *British Journal of Psychiatry*, **175**, 186–188.

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Authors' reply: We agree that there is a theoretical possibility that the alterations in glucose metabolic rates detected by positron emission tomography within the ecstasy user group might be caused by pre-existing aberrant neuronal activity. Yet, to our knowledge, conclusive neuropathological findings that are characteristic for secondary drug misuse do not exist. Putative psychopathological phenomena mediating the secondary use of ecstasy are most likely heterogeneous and too diffuse with regard to the 2-(^{18}F)-fluoro-2-deoxy-D-glucose PET method. It therefore seems more reasonable that the detection of altered glucose metabolic rates in ecstasy users is a consequence of experimentally well-documented neurotoxic serotonergic lesions caused by MDMA. In this sense, we disagree that it is equally plausible that MDMA abuse results from measurable pre-existing 5-HT function abnormalities. We have examined the relations between psychiatric disorders and PET findings mentioned by Dr Morgan in a completed study with 107 ecstasy users (Thomasius, 1998). The publication of the results is in preparation.

Thomasius, R. (1998) Ecstasy: user groups and risk levels. An empirical study based on psychiatric-, psychodynamic-, EEG-, EP-, PET and other medical diagnostics of 100 Ecstasy users. *Wiener Zeitschrift für Suchtforschung*, **21**, 9–14.

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Selective serotonin reuptake inhibitors and personality change

Sir: In Ekselius & von Knorring's (1999) study, I find it difficult to accept the assumed independence between depression and the majority of the self-rated Karolinska Scales of Personality (KSP) (e.g. somatic and psychic anxiety, muscular tension, monotony avoidance, indirect aggression, inhibition of aggression, irritability, guilt, detachment, social desirability). The authors considered the Montgomery–Åsberg Depression Rating Scale (MADRS) change (baseline – after 24 weeks) as an indicator of improvement in depression, and used this variable as a single predictor in a series of stepwise regression analyses with changes in single different KSP scores as outcome variables. The consistently low coefficient of determination R^2 values lead the authors to conclude that factors other than improvement in depression must explain their findings, and speculate that there is a direct effect of selective serotonin reuptake inhibitors (SSRIs) on the personality scales. These conclusions can be challenged. I believe that MADRS change is unsuitable for solving this problem, as it expresses magnitude of change (interval level). Suppose that in a sample of 40 improved subjects who experience change in KSP, 20 show large MADRS change values and small differences for many KSP items, and the other 20 show small MADRS change values but large differences for many KSP items. Then, the correlations between MADRS change and differences in KSP will be relatively small, despite the strong correlations between KSP changes and improvement considered at a categorical level. The Clinical Global Impression scale, also measured in this study, could address this question more