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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).

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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.

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